RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW JOHN

2021

Reviewer: Patrick Hopkinson

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SAFEGUARDING ADULT REVIEW – JOHN

Richmond and Wandsworth Safeguarding Adults Board

1. INTRODUCTION

1.1. John was a 50 years old black British man who lived in a flat in the London Borough of Wandsworth. The flat had a living room upstairs and a bathroom and kitchen downstairs. John's wife had died about 16 years ago, but her mother, John's mother-in-law, remained in contact with John. John had three adult children, one of whom, John's son, lived with him at times.

1.2. John was described by his son and daughter as a softly spoken and quiet man, who had worked in construction and as a reggae DJ. John had not worked since 2015 and spent a lot of his time looking after his own mother to whom he was very close. John's mother died in 2016 and, according to members of his family, this had a very significant negative impact on John. John was grieving for this mother during the timescale of this safeguarding adults review.

1.3. John had eczema from a very early age but during a trip to Jamaica in 2016 he was sunburnt, and his eczema became inflamed. As a result, John developed a severe and very painful type of eczema which covered his body, it was so severe that he experienced multiple hospital admissions for related infections and complications. John had previously received light therapy treatment for eczema, to which he had such a bad reaction that he was placed in an induced coma afterwards. John's eczema negatively impacted on his wellbeing, quality of life and subsequently his mental health. On 4/04/18, John's daughter telephoned London Borough of Wandsworth adult social services to ask for support for John who had just been discharged from hospital and was struggling to cope at home. John was seen at home by a Wandsworth social services OT assistant on 18/05/18 and equipment to assist with daily living activities was provided to him. John was placed on the waiting list for a Care Act assessment in June 2018 but died in Guys Hospital from sepsis and related complications on 29/07/19 having never had a Care Act assessment.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Richmond and Wandsworth Safeguarding Adults Board to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Richmond and Wandsworth Safeguarding Adults Board the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-final-.pdf

2.4. All RWSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.5. This case was referred to the SAR Sub-group of the RWSAB in August 2019 and considered for a Safeguarding Adult Review at the meeting on 02/09/19.

2.6. The SAR Sub-group considered this case as meeting the criteria for a SAR, and the SAB Executive ratified this on 25/09/19.

2.7. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Richmond and Wandsworth Safeguarding Adults Board, or its partner agencies.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. On 04/04/18, John's daughter contacted Wandsworth Adult Social Services to request support for John. John had recently been discharged from hospital and required support with personal care, practical household tasks and meal preparation due to his severe eczema. John was struggling to keep his flat clean and was in pain when bending down. John was contacted by the Wandsworth Access Team on 12/04/18, which noted that John was, "… *happy to wait for an*

assessment to be carried out before starting his care package providing it does not take too long". John was asked to contact the Access Team if his situation became urgent and was referred to a locality team on 16/04/18.

3.2. On 20/04/18, John was admitted to the Chelsea and Westminster Hospital. This was one of a number of hospital admissions in which investigations were made to identify and treat John's skin condition, which at this stage was identified as painful eczema, and to treat infections. John was in pain, had difficulty sleeping, moving and in maintaining personal hygiene and was socially isolated. John was asked to follow up assessment by Wandsworth adult social services when he was back at home and to contact his GP. John was discharged home on 09/05/18 and Chelsea and Westminster Hospital made a referral for an Occupational Therapy assessment.

3.3. On 18/05/18 an Occupational Therapy Assistant (OTA) assessed John and provided equipment to assist him with daily living activities: a commode, perching stool and bath board. The OTA made a follow up 'phone call to John on 07/06/18 to check how effectively the equipment was supporting him. The OTA was aware that there was a waiting list for Care Act assessments but did not discuss this with John at the time of the visit. The OTA then closed the case since no further action was required.

3.4. John was admitted to hospital again on 30/08/18 since his skin condition had worsened and he had not attended out-patient appointments, which he said was due to lack of transportation and difficulties in walking. He was discharged on 04/09/18. There were concerns that John may be having suicidal thoughts and so he was assessed by liaison psychiatry (a specialist service provided by the North West London Hospitals Mental Health Trust, which assess the mental health state and needs of patients at the Chelsea and Westminster Hospital). No further concerns, however, were identified.

3.5. On 21/09/18 and 25/09/18, John asked Wandsworth Council for home care support.

3.6. John was admitted to hospital on 28/09/18 and was discharged on 12/10/18. John was seen again by the liaison psychiatry service and it was reported that his mood had improved.

3.7. Following a number of outpatient appointments, including ten attendances for treatment between 15/10/18 and 09/12/18, John was admitted to hospital on 09/12/18 due to an infection. Whilst in hospital, on 21/12/18, John was asked by the Wandsworth locality team to tell the hospital staff that he required a social work assessment, and he was transferred to the hospital social work team. Despite this, John was discharged on 14/01/19 without an assessment by the hospital social work team having taken place.

3.8. John was admitted to hospital on 06/02/19 with an infection. John was again assessed by liaison psychiatry and was prescribed sertraline (an anti-depressant). During this stay, a hospital team duty social worker asked Chelsea and Westminster Hospital to issue a notification of the need for an assessment when John was to be discharged.

3.9. On 14/02/19 and 22/02/19 the Chelsea and Westminster Hospital discharge coordinator told a hospital team duty social worker that John was independent in personal care tasks and that he had declined Occupational Therapy input. The action recorded by the hospital social work team was that John was suitable for a district nurse referral but there is no record that one was made.

3.10. On 14/02/19, John's son contacted Wandsworth Housing asking for an inspection of John's property due to its state of disrepair. Arrangements were made to remove mould and redecorate John's home but due to difficulties contacting John since he was in hospital, work was not begun before he went into hospital again for the last time on 12/04/19.

3.11. John was discharged from hospital on 26/02/19. Following this a hospital team social worker telephoned John for a "safe and well contact" on 27/02/19. John said that he wanted a social work assessment under the Care Act. The social worker emailed the locality team requesting that John go on their waiting list for an assessment and then closed the case to the hospital team. In fact, the hospital social work team closed John's case in error and he was not transferred to the locality team.

3.12. On 07/03/19 the housing estate manager telephoned the Access Team to ask for an OT assessment for John, as had been advised by John's GP due to John's skin condition.

3.13. On 13/03/19, John was admitted to the Chelsea and Westminster Hospital following attendance as an outpatient with an infective exacerbation of eczema. He was discharged on 25/03/19.

3.14. On 15/03/19 the Access Team telephoned John whilst he was in hospital. John explained his needs and was told that an OT referral was being progressed, as requested by the housing manager, and that a care and support package would be arranged by the hospital social work team when John was ready for discharge. The Access Team worker asked John to tell the hospital staff of his need for care and support at home. This was a repeat of the advice given to John on 21/12/18, which had not led to an assessment of need or a package of care.

3.15. John did not attend an outpatient appointment on 08/04/19. Efforts were made to contact him but without success.

3.16. On 11/04/19 John's GP, following contact from John's mother-in-law, referred John to the Central London Community Health Care Trust (which provides district nursing services) Quick Start Team.

3.17. On 12/04/19, the Quick Start Team attempted to contact John and spoke to both his daughter and his mother-in-law, who explained that John's condition was rapidly deteriorating. The Quick Start Team then escalated this concern and John was admitted hospital later that day and was moved to the burns unit on 15/04/19.

3.18. On 13/04/19, Chelsea and Westminster Hospital raised an adult safeguarding concern to Wandsworth social services about the lack of care and support that John was receiving. On 15/04/19 a further safeguarding concern was received

from the London Ambulance Service, stating that John was unable to care for himself, had not eaten for last two days and had been found in his own faeces and urine with worsening eczema and pain for the last two weeks. John reportedly told the ambulance crew that he had been in contact with Wandsworth adult social services and had not heard anything yet and that he would like to speak to someone to find out what kind of help he could get as he was finding it difficult to cope looking after himself.

3.19. On 15/04/19 the Access Team noted that John had requested an assessment for support with meals and housekeeping. The hospital social work team had intended to transfer John's case to the Locality team for a Care Act assessment on 01/03/19, but instead John's case was closed in error and was not transferred.

3.20. On 16/04/19 the safeguarding concern from the London Ambulance Team was closed by an Assistant Service Manager in the Wandsworth hospital team on the basis the John had not experienced abuse and was not at risk of abuse or neglect and was to be allocated to a social worker for care management input.

3.21. On 08/05/19 a member of the hospital social work team visited John's home with John's mother-in-law and noted that before John could return home the property needed to be cleaned and prepared for him. The assumption was that John would be able to return home but there does not appear to have been any further action or planning to do this. The allocated locum social worker left the Council and John was reallocated to another social worker on 23/05/19. From 14/06/19 onwards, following a complaint from John's mother-in-law about the lack of multi-agency support provided to John in the community, there was frequent contact between the hospital social work team, John's mother-in-law, and occasionally with John, to prepare his flat for his discharge from hospital.

3.22. John remained unwell, however, and was transferred to Guys Hospital on 08/07/19 with sepsis. He received treatment for pain, his skin condition and investigations were made into whether or not he had skin cancer. John died at Guys Hospital on 29/07/19

4. THE EVIDENCE BASE FOR THE REVIEW

4.1. Preston-Shoot (2019) argues that, "*Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice".*

4.2. The advantage of this approach is that, *"The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills*" (Preston-Shoot, 2017).

4.3. Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with someone in John's situation: experiencing a long-term, debilitating but potentially underestimated health condition; experiencing multiple hospital admissions that did not lead to changes in the way services were provided and being placed on a local authority waiting list but never receiving an assessment of need.

4.4. Evidence from research

4.4.1. John's health condition and eczema

a) John had what was described as very severe eczema, which at the time of his death was diagnosed as: *mycosis fungoides, cutaneous herpes simplex and advanced cutaneous lymphoma.* Whilst this safeguarding adults review is not a piece of academic work, and nor is it a medical report, some useful practice advice can be gained from a brief analysis of John's health condition.

b) Mycosis fungoides is a severe skin condition. It is also a serious health condition with a high risk of infection and of becoming cancerous. It impacts negatively on quality of life and has an associated negative impact on mental health, frequently leading to depression. The research surveyed for this safeguarding adults review suggests that it is life-threatening (or fatal), especially in advanced forms but that its presentation can vary considerably from person to person.

c) Cutaneous herpes simplex is a common and potentially progressive viral skin infection, which might complicate and exacerbate the symptoms of mycosis fungoides. Advanced cutaneous lymphoma is an associated form of skin cancer.

d) Consequently, and in terms of John, a diagnosis of mycosis fungoides presents a considerable health risk. John had received phototherapy to treat his skin condition but this was reported to have exacerbated rather than improved his condition. The risk of infection can be further exacerbated by living in unhygienic conditions. Unfortunately, the diagnosis was made only in the last stages of John's life.

e) It appears that the severity of John's skin condition was not necessarily recognised by all the services that were in contact with him and was instead understood to have a bad case of eczema. This appears to have minimised both its seriousness and the extent of its impact on John in the minds of social services practitioners. At the latter stage of John's life, it was diagnosed as cancerous.

4.4.2. Repeated hospital admissions

a) John was admitted to hospital eight times between 09/12/17 and 12/04/19 and stayed on average for 22 days each time (discounting his final admission to hospital). In 2019 John was in hospital each month. None of these admissions were planned in advance. Previous Safeguarding Adults Reviews, for example, that of Ms H and Ms I (London Borough of Tower

Hamlets, 2020) have identified that repeated emergency department hospital admissions are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018) and that, for some adults at risk of abuse, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014).

b) Hospital admissions also provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions (Boutin-Foster et al, 2005; Gersons, 1990).

4.4.3. Individual characteristics

a) John was a relatively young black man who has mourning the death of his mother and whose partner had died some years previously. Whilst John was not self-neglecting in the usually recognised way (for example, he was not refusing services, was not difficult to engage and his health condition meant that he was not able to care himself) the literature on self-neglect provides some useful insights. For example, one of the two most common experiences cited by individuals who self-neglect is the loss of a loved-one (the other is being a victim of violence) (Lien et al, 2016). Self-neglect also occurs more frequently in people who are black, male and have low incomes (Day et al, 2016). John met these criteria.

b) There is an extensive literature on the difficulties faced by people from black and minority ethnic communities in accessing, and being recognised by, health and social care services (see for example Szczepura 2005). There is also a growing literature on the difficulties faced by men (Baker et al 2015), which include seeking help less often than women (Wang et al, 2013) and facing preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson. 2011). Practitioners and managers recognised in hindsight that the perception and understanding of John's needs may have been affected by these barriers and biases.

4.5. Evidence from practice

4.5.1. Care Act assessments

a) Section 1 of the Care Act (2014) states that, "*The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being*". A definition of well-being is provided (see appendix 1) but for the purposes of this review, it is sufficient to note that well-being includes personal dignity (including treatment of the individual with respect); physical and mental health and emotional well-being; and suitability of living accommodation.

b) Section 9 of the Care Act (2014) states that where is appears to a local authority that an adult may have needs for care and support, the authority must assess (a) whether the adult does have needs for care and support, and (b) if the adult does, what those needs are.

c) This Care Act duty applies regardless of the authority's view of (a) the level of the adult's needs for care and support, or (b) the level of the adult's financial resources.

d) The Care Act also empowers local authorities to meet urgent needs without an assessment (section 19, Care Act 2014).

e) According to Healthwatch in 2017 (https://www.healthwatch.co.uk/news/2017-01-26/are-people-experiencing-problems-accessing-social-care-support), *"Although there is no specific timescale in which the assessment has to be completed, the Local Government Ombudsman (LGO) deems anything between four to six weeks to be reasonable when investigating complaints about delays*".

4.6. Evidence from John's family.

4.6.1. John's son, daughter and mother-in-law provided information about John, his background and contact with services for the review by telephone. Meetings in person were not possible due to the Covid19 pandemic restrictions in place during the time in which this safeguarding adults review was undertaken.

5. THEMATIC ANALYSIS AND FINDINGS

5.1. Using this research and practice evidence-base it is possible to identify a number of analytical themes. These include the recognition and response of services to John's needs and the way that agencies worked together and communicated with each other.

5.2. There were repeated hospital admissions, but these were not used as opportunities to create change.

5.2.1. Between 09/12/17 and 12/04/19, John was admitted to hospital on eight occasions. None of these admissions were planned. All were made in response to John's condition at outpatient appointments or in emergencies and, in line with the evidence from previous safeguarding adults reviews and research, each might have provided an opportunity to reconsider how best to meet John's needs, or to escalate concerns about him in order to prompt action to be taken. No referrals were made for District Nurse input, despite references to the need for them (for example, on 14/02/19) until 11/04/19 when John's mother-in-law intervened with John's GP.

5.2.2. Repeated hospital admissions and repeated requests for assessment or services (John is recorded to have made four requests and his sister and mother-in-law to have made one each) were not recognised as patterns that required attention. Instead, a pattern developed in the way services responded to John in which he was discharged home without ongoing support and was left responsible for making contact with services. For example, on 21/12/18 and 15/03/19, John was asked by the Wandsworth Social Services locality team to tell the staff at the Chelsea and Westminster Hospital that he required a social work assessment. Similarly, no notice of John's discharge from hospital, or a request for an assessment of John's needs prior to his return home, was made by Chelsea and Westminster Hospital until 15/04/19. This was after John had

been admitted to hospital for the final time. Notices to assess under the Care Act 2014 may have prompted Wandsworth Social Services to reprioritise John's position on its waiting list.

5.3. John remained on the local authority waiting list for an assessment of needs

5.3.1. Despite ten references to John asking for an assessment or stating that he needed support, each of which were recorded on Wandsworth Social Service's client records system, no assessment was made of John's care and support needs under the Care Act (2014). John's support needs appear, therefore, to have gone unmet. The immediate impact of this was that the practical impact of John's health condition upon his ability to care for himself was left unmoderated. For example, John reported that he had difficulties looking after himself and in maintaining his personal hygiene and the cleanliness of his property. John also reported that this was impacting on his mental health.

5.3.2. The provision of equipment following the occupational therapy assistant's assessments on 18/05/18 partially helped John but John still asked for and required by law (the Care Act 2014) an assessment of his social care and support needs. Wandsworth Social Services did not operate a "trusted assessor" model in which occupational therapists and social workers (and assistants), with suitable training, can put in place a limited range of support or equipment options, pending a more comprehensive assessment by a suitable professional. As a result, an opportunity for the occupational therapy assistant to put at least a small and temporary package of care was missed.

5.3.3. In addition, and speculatively, practitioners and managers agreed in hindsight that the provision of a care package following an assessment of need may have created a situation in which a care worker was present with Johnl The care worker who might have been able to identify that John's condition was deteriorating and may have been able to prompt more rapid access to health care services in the community as well as in hospital. This is however hypothetical, since as no assessment was made, its outcome cannot be judged. The assessment may or may not have resulted in the provision of a support package to John.

5.4. As a result, there was lack of clarity about, and understanding of, John's needs and ability to care for himself.

5.4.1. Physical health

a) Despite John's known physical health condition, John's, and his daughter's, frequent reports of the impact that it had on him and his consequent need for support (for example, on 04/04/18; 20/04/18, 05/09/18, 21/09/18, 21/12/18, 22/01/19 and 21/02/19) there was still uncertainty about John's need for care and support. The seriousness of John's physical health problems were also not well understood or communicated. The impact of these factors was most apparent on 22/02/19 when the discharge coordinator at Chelsea and Westminster Hospital told a Wandsworth hospital team social worker that John did not require a care package and only needed help to put cream on his back. A Wandsworth hospital team social worker discussed John's care needs with him on 27/02/19 and emailed the Wandsworth locality team

asking that John be put on their waiting list for an assessment. Unfortunately, John's case with the hospital social work team was closed by accident before it was transferred to the locality team.

5.4.2. Mental health

a) The records show that between 30/08/18 and 19/06/19, John was seen 17 times by the liaison psychiatry service provided by the Central and Northwest London NHS Mental Health Trust at the Chelsea and Westminster hospital. During these consultations, John reported that he felt depressed, was overwhelmed by his physical health problems and his living conditions, and that he was struggling to come to terms with the death of his mother and with his financial difficulties. John also mentioned the impact that the death of his partner 20 years previously had upon him. John questioned why all this had happened to him.

b) John spoke about his loss of independence, his concerns about his health, being sick, dying, being able to spend time with his family in the future and wanting peace from his disease. John was also scared, angry and upset about having a Do Not Attempt Cardiopulmonary Resuscitation placed on him, which had then been rescinded.

c) Overall, John's mental health state was assessed to be a normal adjustment reaction to his situation. There were concerns about whether or not John was suicidal, which he constantly denied.

d) The outcome of these 17 liaison psychiatry consultations was that John was provided information about the CRUSE bereavement service and the IAPT (Improving Access to Psychological Therapies) service and was prescribed the anti-depressant sertraline. Discharge summary letters were sent to John's GP (for example on 04/09/18) but there does not appear to have been any attempts to follow up John's use of these recommended services or to contact Wandsworth adult social services, or community mental health services to alert them to, or engage them in meeting, John's physical and emotional support needs.

6. PRACTICE AND CONTEXTUAL FACTORS

6.1. Demand management and austerity

6.1.1. It is generally well known that both social care and health care in the UK have faced years of financial constraints and cuts to funding since 2010 (if readers are still in any doubt about this, then an internet search using terms such as "austerity and social care" of "austerity and health care" will reveal a wealth of resources that do not need to be reproduced in this report).

6.1.2. Austerity has impacted on practice, particularly in social care, to the extent that decisions about who should receive services, and what the extent of those services should be, are influenced by financial constraints as well as need (for example, Olaison et al, 2018). Data for England in 2018/19 (Kings Fund, 2019) showed that whilst requests for social care services had increased by 6%, the

actual number of people who received formal care packages had decreased by 2%.

6.1.3. Perhaps the need to manage demand and to ration services in response to financial constraints impacted on perceptions of John's social care needs? On reflection, practitioners and managers involved with John were concerned that the information obtained about him was interpreted through the constraints of demand management, which meant that there was insufficient professional curiosity about his needs and an over willingness to accept that John was able to care for himself.

6.1.4. In response to staff vacancies and the need to manage demand, Wandsworth Social Services was operating a waiting list for assessment during the time of its contact with John. Contact was made with him by telephone, but in hindsight, practitioners and managers were concerned that this would not gather the whole picture about clients. There did not appear to be, and certainly no use was made of, a system for escalating or reprioritising the needs of clients for assessments. No use was made of the Care Act s19 power to provide services without assessment in an urgent situation.

6.1.5. John was frequently passed between the Access team, the locality team and the hospital social work team but no assessment of need was made.

6.1.6. Wandsworth Social Services also held its own internal review following the death of John, from which an action plan was created. Please see section 8, Recommendations.

6.2. Operational practices

6.2.1. As already highlighted in 5.3 above, Wandsworth Social Services did not operate a "trusted assessor" model during the time period covered by this review and so the one occasion on which John was visited at home became a missed opportunity to assess his needs, beyond the provision of equipment. During the course of this safeguarding adult review, practitioners and managers expressed confusion about whether or not the "trusted assessor" model was actually in operation or not at the time. Practitioners reported that at the time the merger of Richmond and Wandsworth Councils' operations has not fully settled, and operational changes were still being implemented and challenges were being resolved.

6.2.2. A process was also in place whereby only Chelsea and Westminster hospital could refer directly to the Wandsworth hospital team. This resulted in John being asked by the Access Team (on for example 15/03/19) to tell the hospital staff that he needed an assessment so that the hospital could request this from the hospital social work team. This process inadvertently placed another barrier in the way of John's access to an assessment.

7. SUMMARY OF THEMES

7.1. A number of factors were present which the published research and practice evidence links with poor outcomes. For example, John had repeat hospital admissions, yet it appears that no patterns were identified and that none of the

admissions led to a change in the approach taken by services. Similarly, the impact of John's health condition upon him and upon his ability to care for himself was not fully realised. No consideration was given to John's individual characteristics and how these might have influenced his perception of services and service's perception of his needs.

7.2. No individual workers or agencies took responsibility for coordinating approaches to assessing and meeting John's needs. He was frequently passed between teams, often without follow up or checking that referrals had been received or interventions had worked

7.3. No agencies used escalation processes, including raising an adult safeguarding concern, to prioritise John and to advocate for him to access services. There was little inter-agency communication about him.

7.4. No questions were raised about John's mental capacity to manage his situation despite concerns that he was depressed and was not coping.

8. CONCLUSIONS

The following conclusions are drawn from the thematic analysis and more widely from other safeguarding adults reviews.

8.1. The lack of assessment of need under the Care Act 2014 impacted on John's well-being.

8.1.1. Despite the evidence available that John had physical health needs, mental health needs and care and support needs, no assessment, required by the Care Act 2014, was made. The Care Act threshold for access to assessments and services is low and there was enough information available about John for an intervention to have been made and at least a minimum service to have been provided pending a full assessment of his needs.

8.1.2. Consequently, John did not receive support with managing his own care and did not receive help with managing the hygiene and cleanliness of his home.

8.1.3. As a result, John's well-being in terms of, inter alia, personal dignity and respect; physical and mental health and emotional well-being; social and economic well-being; suitability of living accommodation was not promoted.

8.1.4. No escalation process was in place, or used, to raise the priority of the assessment of John's needs.

8.1.5. Despite references to the need for input from District Nurses (on, for example, 14/02/19) community nurses were not involved with John until 11/04/19, the day before he was admitted to hospital for the last time.

8.1.6. Unlike in many other safeguarding adults reviews (Preston-Shoot, 2020) there was no evidence that John was self-neglecting, was difficult to engage or refused support. Instead, John was clear that he wanted an assessment of need and about what his support needs were.

8.2. There was little inter-agency communication that could lead to joint working to meet John's needs.

8.2.1. Wandsworth social work teams, housing and Chelsea and Westminster Hospital exchanged information about John, but this did not lead to any recognition that a change in approach might be necessary or that other agencies might be asked to be involved, such as district nurses and John's GP.

8.2.2. The Central and North West London NHS Mental Health Trust liaison psychiatry service similarly did not share information or prompt joint working with other agencies such as Wandsworth Social Services or community mental health services but did send a discharge summary to John's GP.

8.2.3. As a result, the services that John came into contact with carried out much of their work in silos and did not formulate a shared understanding of John's needs. Neither did they prompt or encourage each other to change their approaches since John's needs were not being met by their current ways of working.

8.2.4. Evidence that such an approach might have worked is that when John's mother-in-law contacted John's GP on10/04/19, following (according to the GP's notes) a suggestion from Wandsworth Social Services, and explained the extent of John's support needs, the GP made a referral to the Quick Start district nursing team, members of which were involved in the decision to call an ambulance on 12/04/19 to take John to hospital. Earlier contact with the GP about John's circumstances, rather than about details of medical results, by the other agencies might have led to involvement of district nurses when there was still time for this to make a difference.

8.3. Safeguarding referrals were made but no action was taken

8.3.1. Perhaps surprisingly, no adult safeguarding concerns were raised until 13/04/19. This was despite John's repeated contact with services over the previous year and his requests for help and support.

8.3.2. Safeguarding concerns were raised by the London Ambulance Service and by Chelsea and Westminster Hospital following John's final admission to Chelsea and Westminster Hospital on 12/04/19. These concerned whether John was receiving adequate support from his son and was subject to neglect and acts of omission. On 16/04/19 these concerns were closed and John was allocated to a social worker for case work. This was despite the lack of success in undertaking an assessment since 04/04/18. By this time, however, John had been admitted to hospital for the last time.

8.3.3. The local authority is the lead agency for adult safeguarding under the Care Act and must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

8.3.4. Furthermore, the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (s42.2, commonly known as “other” enquiries) and interventions where the three-part test is not met but where there is sufficient concern that someone may come to harm. It is likely that John met at least the criteria for a non-statutory adult safeguarding enquiry from April 2018 onwards and either this or a s42 enquiry might have led to an intervention to meet John’s needs or reprioritised an assessment of his needs.

8.4. There was insufficient engagement with John’s family and there was insufficient professional curiosity or responsibility in exploring John’s circumstances.

8.4.1. There was limited contact with John’s family. John’s daughter telephoned Wandsworth social services on 04/04/18 and asked that John required support with personal care and practical household tasks/meal preparation due to his severe eczema. John’s mother-in-law was contacted by Central London Community Health Care Trust, with provides district nursing services, following a referral for a quick start service from John’s GP on 12/04/19. There is no evidence of any other attempts to work with them to either gain a clear picture of John’s needs or to engage then in finding a way of meeting these.

8.4.2. John’s family relationships were also not fully understood. There was confusion over whether or not John was being supported by, or living with, his son. The first contact assessment completed by Access Team when John was first referred to adult social services by his daughter on 04/04/18 was that John’s son worked full time and could not assist with housework tasks. Yet on 13/04/18 the Chelsea and Westminster Hospital notes stated that John lived with his 22-year old son who was his main carer and next of kin and that John was regularly visited by his sister(s).

8.4.3. This confusion persisted. On 15/04/19, over a year later, the Chelsea and Westminster Hospital had John’s son as his next of kin but there was a note attached stating that the next of kin was John’s mother-in-law but the contact details had not been updated. Only during John’s final stay in hospital were discussions had with his mother-in-law about preparing the flat for John’s return there.

8.4.4. On 12/02/19 the liaison psychiatry notes recorded that John felt pressured by his son’s requests for financial support but also that his children were protective factors. It remained unclear in what capacity John’s children were “protective factors” who might meet his father’s needs or be in position to alert services to any problems. Despite this uncertainty, no exploration was made to clarify the situation.

8.4.5. John was a relatively young (50 years old) back man who was not assertive in the way he contacted services. Whilst there was no evidence of overt discrimination on the basis of age, gender or ethnicity, there does not appear to have been any operational recognition of how John’s characteristics might have influenced the way he approached services and the way that services responded to him. Biases, both unconscious and in judgement, may have been at play. Some of these assumptions and biases are normative whilst others come from rigidly applying service frameworks and processes.

8.4.6. These biases may have influenced professional decision making and risk assessments and included not recognising the need to question why John was so patient and unassertive and the extent to which this may have been influenced by his prior experience or inexperience of contact with services rather than because his needs were small; not recognising the poor state of John's home because he was a single man who would not be expected to keep it tidy and clean in the first place (Thebaud et al, 2019, Hamberg, 2008); not exploring John's needs further since he was relatively young and was expected to be self-caring and independent, especially when compared with the usually older, female and white population that the Wandsworth teams in contact with John were more familiar with. There was no clarification of what being described as self-caring in a hospital setting meant and whether or not it meant the same as being self-caring at home.

8.5. No referral was made for a carers' assessment

8.5.1. Despite some awareness of the presence of family members who might provide support to John there is no evidence that a Carer's Assessment was offered or advised provided to ask for one under the Care Act (2014). This is despite family members having come into contact with several agencies in the time period covered by this review.

8.6. No assessment of John's ability to manage his own care needs or to advocate for himself was made and another opportunity to intervene was missed.

8.6.1. Concerns had been expressed during John's admissions to the Chelsea and Westminster Hospital that he was depressed and might be suicidal. Despite concerns about his mental health state, John was frequently left to make contact with services, and particularly, community mental health services such as bereavement counselling and psychological therapies, himself despite mounting evidence that he did not do this.

8.6.2. The difficulties John experienced, due to his physical and mental health condition or to any other individual or social factors, in making contact with these services does not appear to have been considered. If John had been offered support to make these contacts, then his emotional and psychological needs might have been better met and there might have been other agencies involved that could have advocated for him to receive an assessment or support services. Consideration should have been given to how able John was to organise his life from a hospital bed.

8.6.3. There was growing evidence that John was in need of help, but no concerns were raised about, nor assessments made of, John's ability to articulate his own needs or to assert that these must be met. Despite several contacts with services, he was easily persuaded to wait. The lack of professional curiosity into why this was the case was not alleviated by professionals advocating on John's behalf. There was no communication, for example, by Chelsea and Westminster Hospital with Wandsworth Social Services of the significance of John's health condition and its impact on his well-being. The OTA assessment on 18/05/18 similarly did not lead to any further action other than a telephone review on 07/06/18.

8.6.4. Despite there having been no concerns about John's mental capacity, a DNACR (Do Not Attempt Cardiopulmonary Resuscitation) notice was placed on him in May 2019 much to John's distress. This was removed but, according to the liaison psychiatry notes, affected John's feelings of safety and trust in the Chelsea and Westminster Hospital.

9. RECOMMENDATIONS

9.1. The recommendations from this Safeguarding Adult Review are considered in the following domains:

Domain 1: direct practice with individuals

9.2. London Borough of Wandsworth, Chelsea and Westminster Hospital and Central and Northwest London NHS Mental Health Trust should increase staff awareness of the impact and risks of severe and infected eczema so that it is recognised as a need for multi-agency exploration especially when it leads to frequent hospital admissions.

9.3. London Borough of Wandsworth, Chelsea and Westminster Hospital should ensure that practitioners clarify what self-caring means in a hospital setting and whether or not it means the same as being self-caring at home

9.4. London Borough of Wandsworth, Chelsea and Westminster Hospital and Central and Northwest London NHS Mental Health Trust should develop and implement action plans to address how resource pressures and biases impact on the way that services are provided to Black, Asian and Minority Ethnic groups and to men.

9.5. London Borough of Wandsworth to review cases where safeguarding was not progressed and to take corrective action if needed.

Domains 2 & 3: Agency and interagency practice

9.6. London Borough of Wandsworth should identify and implement a way of removing the waiting list for assessments or implement a robust and widely understood escalation process and review process so that cases like John are not left behind

9.7. London Borough of Wandsworth, Chelsea and Westminster Hospital and Central and Northwest London NHS Mental Health Trust should use this safeguarding adult review to agree how information on clients will be shared and actioned to reduce silo working and improve inter-agency cooperation and information sharing

9.8. London Borough of Wandsworth should introduce a single point of access for housing so to enable faster information sharing between housing and social services and other partners.

Domain 4: Board level

9.9. The SAB should monitor the implementation of the London Borough of Wandsworth's internal review action plan of December 2019, which was produced following John's death.

9.10. The SAB should promote safeguarding and mental capacity literacy amongst hospitals, GP surgeries, housing and mental health professionals

APPENDIX 1: Wellbeing

Section 1(2) of the Care Act (2014) states that:

“Well-being”, in relation to an individual, means that individual’s well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual’s contribution to society.

APPENDIX 2: Literature review

The literature review was conducted in November-December 2020 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine’s on-line journals and related sources
3. The British Psychological Society’s on-line journals and related sources
4. The Athens on-line journals and related sources

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