7-minute Learning Summary
Safeguarding Adult Review – John

Richmond and Wandsworth Safeguarding Adults Board

Case Summary

John was a 50-year-old black British man who died from sepsis. John was softly spoken and quiet. Both his wife and mother had died but he was still in contact with his mother-in-law and had three adult children. John had a severe and very painful type of eczema which covered his body. This negatively impacted on his wellbeing, quality of life and subsequently his mental health and he had frequent hospital admissions for related infections and complications. Despite repeated requests for an assessment under the Care Act and multiple contacts with health and mental health services, John only received equipment to help him with personal care. He was on the waiting list for an assessment for over a year but died in hospital in July 2019 having never had Care Act assessment.

Summary findings

1. **The lack of assessment of need under the Care Act 2014 impacted on John's well-being.**
   - 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.
2. **There was little inter-agency communication that could lead to joint working to meet John's needs.**
   - 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.
3. **Safeguarding referrals were made but no action was taken**
   - 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 either this or a s42 enquiry might have led to an intervention to meet John's needs or reprioritised an assessment of his needs.
4. **There was insufficient engagement with John's family and there was insufficient professional curiosity or responsibility in exploring John's circumstances.**
   - There was limited contact with John's family and 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.
   - John was a relatively young (50 years old) Black 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, unconscious biases may have influenced professional decision making and risk assessments. There was no consideration of what might influence the way that John approached services and the way that services responded to him. 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.
5. **No referral was made for a carers' assessment**
   - 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 was despite family members having come into contact with several agencies in the time period covered by this review.
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.**
   - Concerns had been expressed during John's admissions to a 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 himself (particularly community mental health services such as bereavement counselling and psychological therapies), despite mounting evidence that he did not do this. Consideration should have been given to how able John was to organise his life from a hospital bed and from his home when he returned there.

Lessons

1. Just because someone is undemanding when contacting services, it does not mean that their needs are low. Always consider what might influence someone's contact with your service, such as their previous experience of contact with you and similar agencies, their knowledge of what is on offer, their awareness of their own needs and their ability to understand and explain these.
2. Remember that unconscious biases may influence the way that you make sense of someone's needs, medical conditions and circumstances. Showing curiosity to find out more about someone can help you recognise and overcome these biases.
3. Your contact with someone in need may be the only one that they have, so make the most of it by doing all you can and bringing them to the attention of other workers or organisations who might be able to help them
4. Remember that multiple hospital admissions can be a warning sign that someone's situation is deteriorating. Always look for patterns and events that keep being repeated. These suggest that a different approach is required and that escalation through your line management or through processes such as adult safeguarding may be needed.
5. Work with family members to better understand someone's needs and to find ways to meet these. They may have information that you need and may be able to assist you.