

Salford Safeguarding Adults Board

Safeguarding Adults Review Francis

Final Report

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INTRODUCTION

“Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult [...] Safeguarding Adults Boards are free to arrange for a Safeguarding Adults Review in any other situations involving an adult in its area with needs for care and support” (DHSC, 2023). Safeguarding Adults Reviews, both mandatory and discretionary are statutory reviews, carried out under section 44 Care Act 2014 and Care and Support Guidance.

The purpose of a Safeguarding Adult Review (SAR) is to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented Francis’ death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again. Salford Safeguarding Adults Board considered the case of Francis who died in 2022. Francis had been known to a number of agencies and following their death it was felt that agencies could have worked together more effectively to support them. The Salford Safeguarding Adults (SAR) Panel agreed that Francis’ case met the criteria for a Discretionary Safeguarding Adults Review. An Independent Reviewer was commissioned, and a Discretionary Safeguarding Adults Review.

Background to the case

Francis was a white British male who was in his 50’s at the time of his death. Francis lived alone and had limited contact with his family. Francis did not have a partner, or children and his social network consisted of close friends and neighbours. Francis received support from within his social network, including help with his home and pets. Concerns about Francis’ vulnerability and risk of exploitation were raised by others in his network with concerns about the circumstances of his death.

Francis was known to be alcohol-dependent and use illicit substances including cocaine and cannabis. Francis’ health conditions included traumatic brain injury and alcohol-related epilepsy. Francis had physical health problems and took pain medication for chronic neuropathic pain. Francis often presented to services with complaints of headaches, memory, and concentration problems, falls, and recurrent seizures. He was on regular anti-epileptic medication and was treated for hyponatraemia, a potentially life-threatening condition relating to low sodium, which is common in people who use alcohol to excess. At the time of his death Francis had been admitted to Hospital following a potential drug overdose which resulted in Francis collapsing and suffering cardiac arrest and brain hypoxia. Francis died in hospital 10 days later.

About the Reviewer

This Safeguarding Adults Review (discretionary) has been led by an Eliot Smith, an Independent Health and Social Care Consultant who has no previous involvement with this case, or prior connection to the Safeguarding Adults Board, or partner agencies.

Organisational involvement

Agencies across the Safeguarding Adults Board area contributed fully to the review, providing documentary evidence and attendance at learning events. Agencies were open in their approach and demonstrated a commitment to learning from Francis' case.

Family involvement

Francis had an informal support network and occasional contact with his family. Individuals from within Francis' informal support network and known family have been invited to contribute to the review.

Principles

The review will be completed with a level of understanding and sensitivity because if individuals and organisations are to be able to learn lessons from the past, then the reviews should be trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. Its purpose is not to hold any individual or organisation to account but to:

- Establish what lessons are to be learned about the way in which local professionals and organisations work together to safeguard people with care and support needs.
- How effective the safeguarding procedures are within Salford.
- Identify what went well and examples of good practice.
- Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Determine what agencies could have done differently that could have prevented harm or death and that might prevent similar harm in future.
- Understand more about service improvement or development needs for one or more service or agency.

Methodology and limitations

The review methodology draws on systems learning theory and uses established qualitative research methods to collect, organise, and analyse information and evidence from a range of sources. Review evidence includes detailed chronologies based upon organisations' contemporaneous records, assessments, and case summaries, and involved agencies own analysis of lessons learned. Detailed agency chronologies covered a period of five months leading to Francis' death, with inclusion of significant events only for the preceding year.

Evidence will also include the views and opinions of practitioners and agencies involved in Francis' case, and information provided from his informal network. The experience of the case of Francis will be used to gain insights into the multi-agency safeguarding system and identify areas for system development or improvement "to prevent future deaths or serious harm occurring again" (DHSC, 2023)

Specific terms of reference

The Terms of Reference for this review were agreed by the Salford Safeguarding Adults Board and include potential themes to be explored. Thematic terms of reference, or research questions, help to provide structure and frame the review process. This does not prevent additional learning being identified during the review. The themes identified by Salford Safeguarding Adults Board for the review to consider include, but may not be limited to:

- **Self-neglect** – professional response to self-neglect.
- **Care and support needs in the context of drug & alcohol misuse** – recognition of care and support needs relating to ‘social support’.
- **Timely allocation** – Delay in case allocation from initial safeguarding. No planning meeting coordinated, sec 42 enquiries not initiated (maybe because of above point) Leading to case drift & crisis management. Outcome of Safeguarding not shared with referrers leading to professional assumption “things are in hand”.
- **Information sharing around risk management** – multiple areas of risk include risks to self through self-neglect, risks from others in context of exploitation, risk to others in context of background of offending behaviours, risks to professionals, and markers. Including within professional and informal support networks.
- **Community Pharmacy role in safeguarding process** – what are the legalities around this & due process around safeguarding responsibilities.
- **People with additional needs** – adult with limited or no literacy skills (not able to read or write) and how do we support them with care & support needs/access to services.
- **Professional curiosity in risk management** – How did professionals use their knowledge about risk within the case, and did this inform their perspective and evaluation of presenting information or did professionals simply accept information at face value?

SIGNIFICANT EXPERIENCES TIMELINE

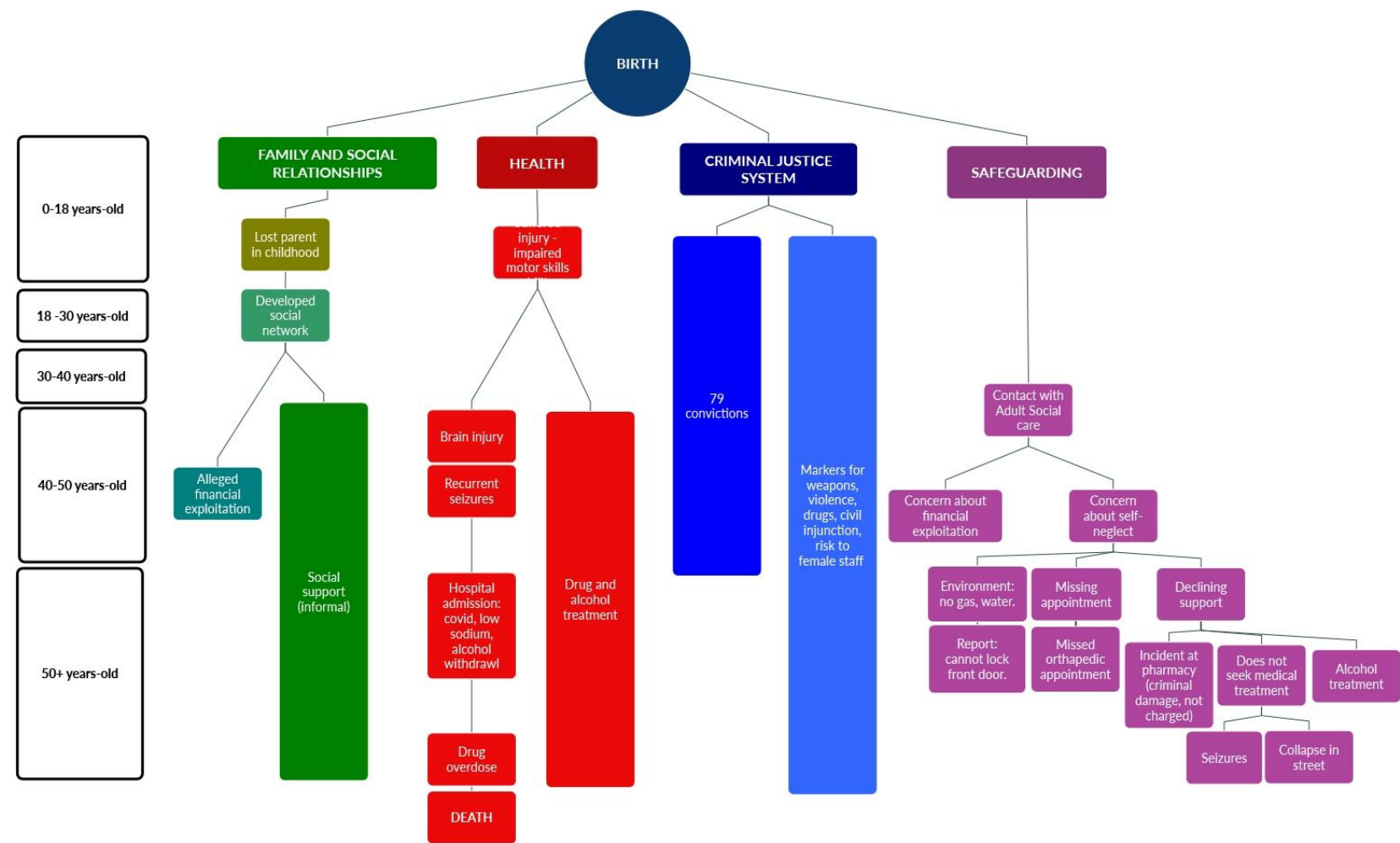


Figure 1: Visual representation of significant events in the life of Francis

Case context

Past experiences can shape an individual throughout their lives, influencing the way a person views themselves, the world around them and others. In the context of adult safeguarding these experiences also have an impact on an individual's vulnerabilities and their resilience to crises and stresses. During his childhood Francis experienced the loss of a parent, and an injury amounting to a physical impairment. Francis came into contact with the criminal justice system and had risk markers for weapons, violence, drugs offences, and other offences. He was assessed as a significant risk to women. By the start of the chronological period Francis was dependent on alcohol and suffered from alcohol-related epilepsy and had experienced a traumatic brain injury. Patterns of self-neglect, refusal or disengagement with services, poor medication compliance and recurrent seizures, were recognisable.

Concerns about the state of Francis' accommodation, open front door, lack of gas supply and hot water had been identified and referred into safeguarding services. Francis was a regular attender at a local food bank and here made allegations to a Food Bank Support Worker of financial exploitation by an adult female demanding money from him for jobs she had not done, such as cleaning. This was noted by Adult Social Care to be an 'ongoing issue' but one that Francis did not want to address. Concerns about medication compliance and missed doses of anti-epileptics also became more apparent with an associated impact on Francis' physical health and seizure activity. These concerns and patterns of risk continued until his death. Francis' GP practice were concerned about his physical presentation, disengagement from services, and risks of further seizures and injury, the GP practice raised a safeguarding concern. The referral was processed on the same day, however Francis was not contacted or seen until later the next month.

Two months later a safeguarding referral was made after Francis made allegations to his GP that his medication, mobile phone, and television had been stolen. Adult Social Care carried out a home visit but found Francis breathing abnormally and non-responsive. Paramedics attended and were able to rouse Francis, who did not require admission to hospital. The outcome of the visit was a plan to i) provide a package of care and support to assist with medication ii) support with nutrition, and iii) stay safe, and iv) to change the locks to the property. No further actions on the risk of financial abuse and exploitation were taken. Later Francis suffered a seizure at the side of the road and was admitted to hospital. Professionals meetings and multi-agency risk management meetings were arranged but did not happen due to non-attendance of some agencies.

Francis was discharged home later that month. Three days later Francis was re-admitted to Hospital following a potential drug overdose which resulted in his collapsing and suffering cardiac arrest and brain hypoxia. Francis died in hospital 10 days later.

ANALYSIS AND FINDINGS

This section takes events and examples of practice in the case of Francis and considers them in the context of the wider system. The aim of findings in Safeguarding Adults Reviews (discretionary in this instance) is to enable “lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again” (DHSC, 2020). This section applies theoretical and practice frameworks in order to generate findings that can be applied to the safeguarding adults system. Findings are structured against the research questions in the terms of reference, and additional learning that is relevant to the local system.

TOR 1: Self-neglect

What was the professional response to concerns of self-neglect?

Context

Care and Support Guidance defines self-neglect as encompassing “a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding” (DHSC, 2023). Research into self-neglect on the causes and risk factors for self-neglect often focuses on health-related or underlying medical causes connected to an individual’s own capabilities, illnesses, and mental health. Commonly cited causes include, but are not limited to:

- Dementia
 - Brain injury
 - Obsessive Compulsive Disorder
 - Physical illness, reduced energy levels, attention, or organisational skills and motivation
 - Reduced motivation as a side effect of medication
 - Addictions
 - Social isolation
 - Traumatic life-change, such as a loss of a carer or loved one.
- (SCIE, 2018) (Abumaria, 2020)

Individuals may also self-neglect as a result of extreme poverty and lack of financial resources, food insecurity, or as a result of influence or abuse by others.

Guidance on the Salford Safeguarding Adults’ Board website states that *Serious self-neglect is a complex issue which usually encompass a complex interplay between mental, physical, social and environmental factors. It frequently covers inter-related issues such as drug and alcohol misuse, homelessness, street working, mental health issues, criminality, anti-social behaviour, inability to access benefits and / or other health related issues*¹ (SSAB, 2023).

Preston-Shoot (2018) identifies practice with the individual adult as the first domain of themes from cross-case analysis of learning from Safeguarding Adults Reviews (Preston-Shoot M. , 2018). Within this domain recommendations from reviews included: consideration of repeated

¹ Taken from: SSAB. (2023). Self-neglect. Retrieved from Salford Safeguarding Adults Board: <https://safeguardingadults.salford.gov.uk/professionals/self-neglect/>

patterns, the tension between autonomy and duty of care, and criticism of mental capacity assessments (Preston-Shoot M. , 2018). Safeguarding Adults Reviews also emphasise a person-centred, relationship-based approach based upon developing trust, exploring the reasons for self-neglect and individual perspectives and preferences, offering support, and negotiating interventions (ibid.).

Findings

Concerns about Francis fell into two broad categories: concern about his home environment, and concerns about his health. Concerns about his home environment related to the security of his property, utilities, and cleanliness and clutter. In relation to Francis' health, concerns focused primarily on the impact of alcohol use and poor medication compliance – the risk of seizures and physical collapse. Figure 2 demonstrates how different services responded to the concerns of self-neglect: with social care responding to environmental concerns, and health focused on medical self-neglect.

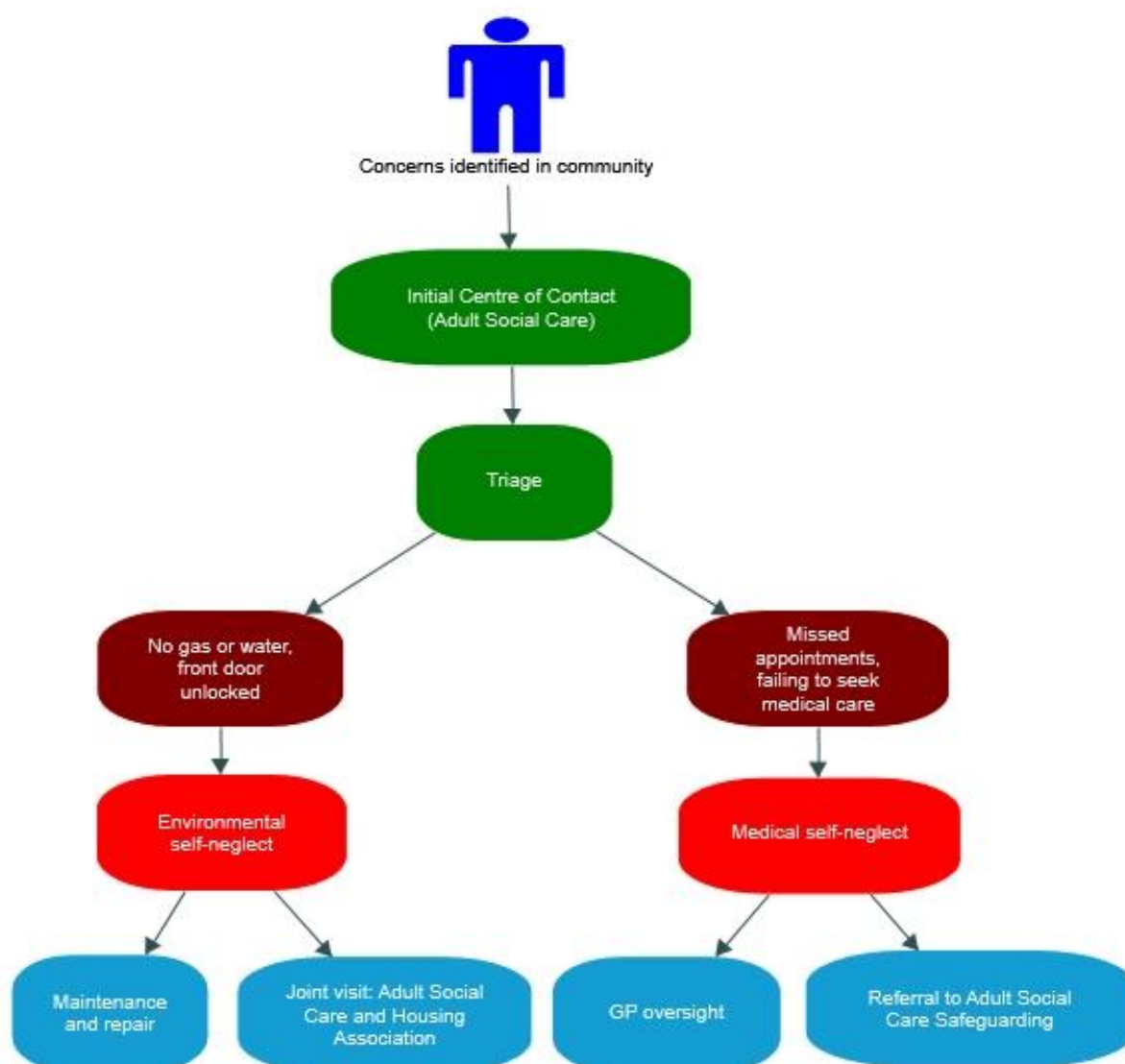


Figure 2: How services responded to concerns amounting to self-neglect

Conceptualisation of self-neglect

Multi-agency service responses to self-neglect in Salford are governed by the Safeguarding Adults Board policy and guidance which is published on the Safeguarding Adults Board website² (SSAB, 2023). This guidance is comprehensive, and evidence based. The main part of the guidance provides including sections on:

- Definitions
- Guiding principles
- Empowerment and engagement
- Responses to service refusal
- Legal framework
- Mental capacity
- Children
- Self-neglect and domestic abuse
- Assessments
- Interventions
- Managing and monitoring self-neglect

The appendices to the guidance include further guidance, an assessment tool, case examples, template agendas for multi-agency meetings and a hoarding scale. The guidance supports a multi-agency, person-centred approach, making space for engagement, the importance of relationship, and the analysis of underlying causes, the guidance states:

“Self-neglect or hoarding needs to be understood in the context of each individual's life experience; there is no one overarching explanatory model for why people self-neglect or hoard. It is a complex interplay of association with physical, mental, social, personal and environmental factors. A starting point is trying to understand why the person is disengaging and the context for why they may mistrust services” (SSAB, 2023)

In the case of Francis agencies did not sufficiently explore the reasons for Francis' disengagement with services and poor self-management of his health conditions. Assessment and interventions were mostly single-agency or single-issue and were reactive, focusing on presenting problems, such as the supply of his utilities and door locks, poor nutrition, or medication compliance.

Environmental self-neglect

Francis' neglect of his home environment was responded to through care management and housing interventions. Professional responses were practical and pragmatic. Joint visits by Adult Social Care and the Housing Association resulted in offers of care, works on the property, repair, and maintenance. Further practical support was offered but declined. Professional responses to concerns about Francis' home environment were addressed through Adult Social Care and Housing care management processes rather than safeguarding and the terminology of 'self-neglect' was rarely used in this context.

² <https://safeguardingadults.salford.gov.uk/professionals/self-neglect/>

Medical self-neglect

Concerns about Francis' medication compliance, harmful use of alcohol, recurrent seizures and the impact on his physical health dominated health services interventions. Francis received input from a range of health services including the GP practice, drug and alcohol recovery services, the hospital trust, and ambulance services. Physical health services generally demonstrated a flexible and engaging approach to care with frequent offers of support however, this help was often declined by Francis. Evidence from practitioners after Francis' death and in the reflective session, is that the Adult Social Care safeguarding response was complicated by risk to female workers, and a general lack of provision for people with chronic substance misuse problems who are not engaging in treatment. Safeguarding concerns were raised with Adult Social Care concerning medical self-neglect and health risks, however Francis' case was not taken into safeguarding, rather was held within a duty system in Adult Social Care.

Finding 1: Self-neglect: exploring underlying causes

Underlying issue in the case

Assessment and interventions were single-agency or single-issue and were predominantly focused on presenting problems. Services considered immediate risks but did not explore underlying reasons for Francis' self-neglect. By working in isolation and focusing only on the presenting issues, practical interventions offered Francis some short-term benefit but failed to address the underlying reasons behind his self-neglect.

Rationale for change

SSAB Guidance encourages services to explore the underlying reasons behind an individual's self-neglect behaviours. This engages a more person-centred longer-term approach that seeks to address the causes of self-neglect not just the symptoms.

Questions for the Safeguarding Adults board

Finding 1, Q1: How can the Safeguarding Adults Board raise awareness and use of the self-neglect guidance?

Finding 1, Q2: How can the system support practitioners, especially during safeguarding processes, to explore the underlying reasons behind an individual's disengagement from services and self-neglect behaviours?

Impact and measurement

This finding is intended to encourage the use of the guidance, in particular the practice of exploring underlying causes of self-neglect. After actions have been completed, a cost-effective way of measuring impact would be to ask a random sample of practitioners to complete an online survey about their awareness of the guidance and practice. An alternative or triangulation to a practitioner survey would be to conduct an audit of safeguarding case records for evidence that the guidance has been followed and underlying causes explored.

TOR 2: Care and support needs on the context of drug and alcohol use

How / were Francis' care and support needs recognised in relation to 'social support'

Context

Safeguarding enquiry duties under section 42 (Care Act 2014) cover adults with needs for care and support – whether or not those needs are being met. One of the aims of the Care Act 2014 was to consolidate existing community care law, and to standardise eligibility for adult social care. Eligibility criteria is set out in regulations and includes any needs arising from physical or mental impairment, or illness (s.1 Care and Support (Eligibility Criteria) Regulations 2014). Mental health, and substance misuse and dependence disorders, fall within the eligibility criteria by virtue of mental impairment. The inclusion of dependence on alcohol or drugs is also referred to in section 92 (5) (Care Act 2014). An adult will usually be considered eligible if as a result of their physical or mental impairment they are unable to achieve two or more of the following:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Maintaining a habitable home environment
- Being able to make use of the home safely
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education, or volunteering
- Making use of necessary facilities or services in the local community including public transport and recreational facilities or services

Section 18 (Care Act 2014) places duties, under certain circumstances, on Adult Social Care to meet eligible needs through a care and support plan (s.24 Care Act 2014) involving a funded package of care or through self-directed support utilising personal budgets or direct payments. In many cases packages of care and support will be provided by specialist care agencies who offer care in a person's home in order to maintain as near independent in the community as possible.

Care and support needs are also important in the context of safeguarding adults. Duties to cause or make enquiries under section 42 (Care Act 2014) exist when a person with care and support needs (whether they are being met or not), experiences or is at risk of abuse or neglect, and where they are unable to protect themselves because of those needs. Nationally there is limited data in the public domain on the numbers of people eligible for a safeguarding enquiry due to mental impairments relating to drug or alcohol dependence. This means that at a national level this vulnerable group are effectively hidden from view and reports on safeguarding. In safeguarding data reporting, individuals with drug and alcohol dependence fall within the broader category of social support; in 2022-23 in Salford, 4.8% of people involved in s.42 safeguarding enquiries had a primary support reason of 'social support' (NHS Digital, 2023). While the numbers are relatively low compared to other support reasons such as physical support (33.8%) or mental health support (29%), this cohort of individuals can present with a range of vulnerability factors and may be at particular risk of self-neglect, exploitation, and abuse within their informal networks and relationships.

Findings

Recognition of Francis' care and support needs

Nationally, individuals with alcohol dependence are not always recognised as eligible for social care services (Alcohol Change UK, 2019). In the case of Francis, it was his co-existing physical health difficulties that meant he was considered to have care and support needs, under the primary support reason of physical support. Francis' harmful use of alcohol, and drugs were recognised only as compounding factors that increased his vulnerabilities and created additional challenges in providing care and support. Francis' substance misuse, combined with risks to female staff, and a reluctance to engage, effectively excluded him from many local service providers who lacked the necessary staff and skills to work with his needs. Practitioners, reflecting on the case after his death, noted that few services existed that were able to offer care services to individuals who use drugs and alcohol and who were reluctant to engage in treatment. Addressing multiple needs and ambivalence in engagement is time-consuming and required flexibility and an investment of time on the part of the practitioner.

One service that was able to maintain a working relationship with Francis was the Drug and Alcohol Recovery Service, however this relied on an individual practitioner following an assertive approach model, beyond the usual scope of their role within that particular team. While Achieve operate an Assertive Outreach service Salford, in this case, they were not involved with Francis. Compared to Assertive Outreach Teams in the mental health sector (see Kent & Burns, 2005) there is good evidence for multi-agency alcohol assertive outreach approaches. Research at Salford Royal Hospital found significant reductions in alcohol-related unscheduled hospital admissions among patients receiving an alcohol assertive outreach approach (Hughes, et al., 2013).

Alcohol Change UK (2023) identify the common elements of an assertive outreach approach:

- **Outreach:** taking the service to the individual
- **Assertive engagement:** persistent attempts at contact
- **Multi-disciplinary working:** linked to mainstream services
- **Holistic understanding of needs:** health, social care, housing, activity and employment, and social contact
- **Flexibility**
- **Reliability**
- **Non-threatening approach**
- **Honest and open**
- **Responsive:** person-centred in goals and outcomes
- **Human:** success is dependent on human relationships

(Alcohol Change UK: Ward, M & Holmes, M., 2023)

It may be useful to consider these characteristics in the context of safeguarding cases of high risk, either through a bespoke offer by the multi-agency team, or through referral of high-risk cases to the Achieve Assertive Outreach team.

Finding 2: Alcohol Assertive Outreach Approaches

Underlying issue

“Alcohol issues are rarely simple... and may be linked to other physical and mental health issues, and to social and relationship difficulties” (Alcohol Change UK: Ward, M & Holmes, M., 2023). In the case of Francis, he was unable to engage effectively with the traditional alcohol treatment model without a high level of input and the personal commitment of his allocated worker.

Rationale for change

For individuals who are vulnerable and who struggle to engage with a traditional approach to alcohol treatment, there is good evidence that an alcohol assertive outreach approach is effective. (Alcohol Change UK: Ward, M & Holmes, M., 2023) (Hughes, et al., 2013). Targeted assertive outreach teams are effective at addressing health and social care issues, reducing the financial burden of emergency care and hospital treatment, and could support improved safeguarding outcomes for adults at risk of abuse, neglect, or exploitation.

Questions for the Safeguarding Adults Board

Finding 2, Q1: Does the referral process for the Achieve Assertive Outreach Team reach all agencies and service users who need to be referred?

Finding 2, Q2: How can the Safeguarding Adults Board and Achieve Assertive Outreach Team make safeguarding services and potential referral agencies more knowledgeable about the team, its offer, and thresholds for referral?

Impact and measurement

This finding is intended to ensure that referring agencies and safeguarding services understand the service offer and criteria for the Achieve Assertive Outreach Team so that appropriate cases are referred. It may also be useful to review the service offer in relation to the advice that the Assertive Outreach Team could provide to safeguarding where a referral would not meet their criteria for input. An audit of referrals (referring agency, quality, appropriateness, and percentage-acceptance rate) before and after actions will show the impact on referrals.

TOR 3: Timely allocation

Did safeguarding systems respond in a timely manner to risks identified?

Context

The aims of Safeguarding adults with care and support needs are to prevent harm and reduce the risk of abuse, and to protect adults from abuse and neglect. Section 42 (Care Act 2014) applies where there is "...reasonable cause to suspect that an adult in its area:

- a) has needs for care and support (whether or not the authority is meeting any of those needs),
- b) is experiencing, or at risk of abuse or neglect, and
- c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it." Section 42 (Care Act 2014)

In Salford the lead agency for statutory safeguarding is the Local Authority in partnership with Northern Care Alliance Adult Social Care Division. Adult Social Care are responsible for receiving safeguarding concerns and making decisions about whether to cause, or make, an enquiry into the adult's experience or abuse or neglect.

The Care Act does not set out statutory timescales for decisions or actions, but states that decisions and actions should be made in a *timely and proportionate way*, based upon the presenting circumstances. Timeliness is important when working with individuals who have a mistrust of services where there may be a limited window of opportunity to engage and instil confidence.

Findings

Responding to medical self-neglect

Francis' vulnerabilities and experiences of harm as a result alcohol-related epilepsy were the subject of a specific referral to safeguarding in July 2022. The referral was processed on the day and information was gathered by a duty worker. A plan was made to allocate a Social Worker to conduct a visit to Francis to make a decision about whether a section 42 enquiry was necessary. Unfortunately this did not occur until over 6 weeks later, with a planned further follow up 10 days later about which there is no record. The delay and lack of follow up on these concerns were attributed to staffing pressures in the team at the time, compounded by a decision that Francis required a male worker due to the known risks to female staff.

Responding to allegations of financial abuse and exploitation

In October 2022 Francis reported to his GP practice that his medication, mobile phone, and television set had been stolen. Again, the referral was processed on the same day and a duty worker allocated to conduct a home visit. On arriving at his address the ASC duty worker noted that Francis' front door was open and Francis himself was found breathing abnormally and unresponsive. Paramedics were called and treatment offered. Once he had recovered sufficiently, practitioners talked to Francis about his general health and his collapse – including

issues of medication compliance, and diet and nutrition. An offer of a package of care was made, to support him with “medication, nutrition, and staying safe”. Support needs to maintain a clean home environment were also identified. To address his vulnerability to exploitation and prevent further theft of his medication, a plan was made to change the locks to his property.

Safeguarding protection planning

In October, while the initial response was swift, the plan to provide a package of care was never enacted as Francis’ final admission to hospital occurred three weeks later. The decision about whether to initiate an enquiry under section 42 (Care Act 2014) was deferred while “waiting for further information” and for the outcome of a professionals meeting arranged for 21 October 2022. By this point the focus of risk management was on self-neglect in the context of alcohol and seizure-related concerns and on the poor self-management of his physical health condition. No further record or enquiry plan was made to address the report of medication theft or material abuse. In lieu of a safeguarding process to manage these risks, practitioners met regularly through ‘professionals meetings’, including actions to make further referrals to safeguarding.

Delays in decision-making can have a significant impact on how a case is managed, but importantly can also compromise the principles of making safeguarding personal and accountability. A lack of clarity on how agencies are going to manage risk means that an adult at risk does not know what role organisations are playing in their life, resulting in a significant level of uncertainty: is the adult subject to a statutory enquiry? Are other organisations investigating concerns about abuse or neglect? What rights does an adult have, for example, for Advocacy or support through an enquiry process?

Finding 3: Timeliness in decision-making

Underlying issue

Francis' case was referred to safeguarding due to reports from Francis that his medication, mobile phone, and television set had been stolen, and professional concerns about self-neglect. There were delays in response, some due to resource and internal agency constraints, but others related to practice norms. Choices were made to delay decisions about launching section 42 enquiries, in order to wait for more information, or for the outcome of another process. Such delays can lead to uncertainty, to reactive decisions, and associated delays in action and outcomes.

Rationale for change

Delays in decision-making can have a significant impact on how a case is managed, compromise service user engagement and Making Safeguarding Personal approaches, and the principle of accountability. The lack of clarity can mean that an adult at risk does not know what role organisations are playing in their life. Timeliness could be improved if safeguarding decision-making were viewed as a continuum rather than a binary event. Rather than delay action, early decisions can be reviewed or even reversed, upon new or changes to case information.

Questions for the Safeguarding Adults Board

Finding 3, Q1: How can good quality safeguarding decisions be made without unnecessary delays in action on the part of referring agencies and multi-agency partnerships?

Finding 3, Q2: When more information is needed to determine if the statutory criteria for s.42 (Care Act 2014) is needed, should an interim risk management process be used?

Finding 3, Q3: How is referral-feedback communicated, so that referring agencies are able to be transparent with the adult at risk about the process and what to expect?

Impact and measurement

Timeliness is about the balance between gathering information to improve the quality and appropriateness of section 42 enquiry decisions, communication, and participation by the adult at risk, and about preventing delays to swift actions to protect adults from abuse and neglect by adult social care *and* partner agencies and those making referrals. Measurements and evaluation of safeguarding decisions should therefore consider the following factors:

- Timeliness
- Quality
- Making Safeguarding Personal
- Partner engagement and actions.

Following SAR actions, a systematic audit of safeguarding decisions and outcomes in these areas could provide greater insight into the overall effectiveness of decision-making processes and the impact of timescales.

TOR 4: Information sharing around risk management

Context

Information sharing is a recurring theme in Safeguarding Adult Review recommendations about inter-agency working (Preston-Shoot, Braye, Preston, Allen, & Spreadbury, 2020). The National Analysis of Safeguarding Adult Reviews from 2017-2019 identified some good practice in information-sharing. The reports found that effective information-sharing was more likely when practitioners made use of multi-layered communication channels, using *“both formal and informal processes, such as meetings, and informal approaches to collaboration in which practised relationships play an important part”* (Preston-Shoot et al., 2020). Other facilitators of good practice in information-sharing included effective communication with family members, local information-sharing protocols, electronic information systems that produce alerts under certain conditions, joint working, the use of interagency meetings, and access to historical information from other agencies (Ibid). Examples of failings in information-sharing often related to individual poor practice – a failure to follow an established process, gaps in information or incomplete sharing of key data, or situations where information was known but not understood by the practitioner. Factors in poor information-sharing included poor understanding of data protection and the use of different data management systems. Failures in information-sharing can result in the over- or under-sharing of an individual’s confidential, sensitive, and personal data. The right to confidentiality engages the human right of respect to privacy and family life (Article 8, Human Rights Act 1998). Sharing personal data must be done carefully and with the appropriate lawful basis. The Information Commissioners Office (ICO) identifies six lawful bases for sharing personal information: consent, contract, legal, obligation, vital interest, public task, and legitimate interest. ICO guidance also notes that legal frameworks to protect the right to respect for privacy, such as the General Data Protection Regulation (GDPR), Data Protection Act (2018), and Human Rights Act (1998) are not barriers to *appropriate information sharing, justified on the basis of risk and protection*. Where personal data and information are shared practitioners should follow the 7 golden rules for information sharing, ensuring that it is “necessary, proportionate, relevant, adequate, accurate timely, and secure³” (HM Government, 2018). Further guidance on information sharing is available on the Salford Safeguarding Adults Board website⁴.

Findings

Precision in information sharing about self-neglect

In the case of Francis organisations regularly shared information, but often within sector boundaries on the basis of legitimate interest; that is health organisations shared health information between themselves, public protection organisations processed offender and crime related information, and within Local Authority services information about housing and social care functions were shared within the social care and housing sector as needed. Information sharing across sectors was less effective, did not follow established processes, or were one way and lacked precision – for example generic referrals of “self-neglect” to Adult Social Care without the quantification of risk. For the referring agency a lack of precision and quantification of risk may also make it harder for them to provide a rationale for information sharing under vital interest, compromising the adequacy and accuracy of the sharing of personal data.

³ Nb. The HM Government Advice document is not statutory guidance.

⁴ <https://safeguardingadults.salford.gov.uk/professionals/information-sharing-and-confidentiality/>

Finding 4a: Precision in self-neglect referrals

Underlying issue

A lack of precision and detail in referrals for self-neglect can make it difficult for decision-makers to quantify and determine the true level of risk. This can result in the need for further clarification, feedback, or follow-up on referrals, delays and referrals being closed where the full extent and level of urgency had not been understood. Safeguarding decision-makers have provided evidence that self-neglect referrals often lacking precision and detail, sometimes simply refer to a risk of self-neglect without quantifying that risk.

Rationale for change

A lack of precision and detail in referrals – for example relying on broad descriptions and generic terms such as “self-neglect” makes it difficult for safeguarding decision-makers to determine accurately the level of risk. A lack of detail can lead to poor quality decision-making and an inadequate or disproportionate (insufficient or excessive) response. Information sharing should follow guidance and local policy, and should be “necessary, proportionate, relevant, adequate, accurate, timely, and secure” (HM Government, 2018). Risks should be quantified and the rationale for information-sharing (with consent, or under vital interest) should be included.

Questions for the Safeguarding Adults Board

Finding 4a, Q1: What makes a good referral for a case involving self-neglect?

Finding 4a, Q2: How can the Board support practitioners to make high quality referrals in relation to self-neglect?

Impact and measurement

This finding is about the quality of professional referrals to Adult Social Care safeguarding for a decision on whether a section 42 (Care Act 2014) enquiry should take place. In particular this finding is about the level of detail included in referrals and about improving the quality of the risk assessment undertaken by the referring agency. Actions may focus on building expertise in the system through guidance, training, supervision, and other workforce development strategies. Measuring the impact of these actions may include feedback from practitioners on their confidence in making referrals, and on evaluation of referrals, pre- and post-SAR actions.

Information about risks to others

In the case of Francis there was a failure to share information about his potential risk to others including members of staff, his neighbours, and their children, who provided support to him in his home and helped care for his dog. Between the age of 18 and 51, Francis had received 79 convictions and 2 cautions. In place at the time of his death, Francis had warning markers for weapons, violence, drugs offences and other offences and his offending profile resulted in him being assessed as a risk to women. His risk profile led to the decision not to allocate his case to

a female Social Worker. In this regard, the risk management approach varied across the partnership. Only the police and Adult Social Care were aware of an identified risk to female staff. Francis' GP practice, Acute Hospital Trust (including Accident & Emergency Department) were all unaware that he may pose a higher risk to female staff. In the case of Francis, opportunities for multi-agency risk assessment and management existed through safeguarding and professionals meetings processes which could have facilitated a minimum amount of information sharing, necessary to enable safe working practices.

Finding 4b: Multi-agency risk management

Underlying issue

Information about serious risks to female members of staff and informal support was known by only two agencies supporting Francis. Other agencies were unaware of information that would have been necessary to ensure safe working practices and the protection of vulnerable others in his network, including children – potentially putting them at unnecessary risk.

Rationale for change

Had agencies combined intelligence during safeguarding or other multi-agency processes about risk they would have been better informed and able to respond and make informed decisions about their personal safety and that of others in Francis' network. The balancing of confidentiality and respect for privacy and family life should not be a barrier to multi-agency risks assessment and management in the context of safeguarding risks and danger to staff.

Questions for the Safeguarding Adults Board

Finding 4b, Q1: How can the Board be assured that risk information is reviewed and updated in the context of multi-agency safeguarding or risk processes?

Finding 4b, Q2: How can the Board use the launch of new Information Sharing guidance to promote training and re-affirmation of commitments to high-quality information sharing in safeguarding processes?

Finding 4b, Q3: How can the safeguarding system support information-sharing and protect staff from harm where there is a known risk of harm?

Impact and measurement

This finding is about good practice in information-sharing, multi-agency risk assessment and management, and the protection of practitioners working with individuals who may present a risk of harm to members of staff. Actions may focus on multi-agency risk assessment and management processes, such as safeguarding or professionals meetings, on the forms and recording systems at key points in safeguarding, and on how the multi-agency system can support and protect staff from harm where there is known or knowable risk. Measuring the impact of actions in this finding may include a mapping of agency and multi-agency recording, forms, and pathways, and of staff safety procedures across the area, including system alerts, warnings, and flags.

TOR 5: Community Pharmacy role in safeguarding process

What was the role of community pharmacy in this case, especially in relation to safeguarding?

Context

Community Pharmacies are a useful resource for individuals in the community who need help with a range of medical and health issues, offering prescription dispensing and advice on many health ailments and over-the-counter medicines. Pharmacists are also able to support with immunisations, and regular medication administration. Pharmacists are experts in the properties and uses of medicines as well as their interactions with other drugs, contra-indications, and side effects. As such a Community Pharmacist is able to offer advice on all aspects of an individuals' use of medicines and drugs – prescribed and non-prescribed. The frequency of medicine prescriptions and dispensing can vary by medicine and by patient. When there are risks associated with dispensing of large quantities of medication of prescribed medication, such as abuse or misuse, then medications may need to be dispensed more often, even daily. In some situations, medications may be provided dose by dose, or under supervision. In the context of safeguarding a Community Pharmacist may see an individual regularly and develop a good working knowledge and relationship. This could be of use within a safeguarding process in assessment of risk, information-sharing, and protective interventions, yet often pharmacies and may remain an underused resource in safeguarding processes.

Findings

In the case of Francis there was evidence of communication between the Pharmacy and other health services in relation to missed medication doses and clinical matters but not about safeguarding or self-neglect. Following an incident after Francis attended the pharmacy intoxicated and causing property damage, his nominated pharmacy stated that they could no longer offer him a service. Difficulties with medication dispensing dominated the interaction and role of the pharmacist in Francis' case – medication not being dispensed due to Francis' behaviour or lateness to collect. Francis' concordance and self-medication-management was already poor and was compounded by this. Key medicines that Francis went without included anti-epileptic medication which when missed increased the risk of seizures, creating a vicious cycle and contributing to the risk of harm.

Joining up the safeguarding system

In the case of Francis and the community pharmacy, issues relating to clinical treatment, risk management and safeguarding were managed within the health sector through liaison and escalation. Engagement with the wider safeguarding system occurred through the GP practice, or safeguarding leads within health rather than at a community practitioner level. Analysis of the role of the community pharmacy in the case of Francis suggests that safeguarding processes relating to health often rely on a smaller number of agencies or professionals, including organisational leads, or specialist safeguarding professionals. Actions for other health practitioners or services outside this network are communicated and addressed separately, outside of the safeguarding process. There are some advantages to this approach in efficiency and multi-agency teamwork, however this approach may also miss first-hand information and a lack of a shared awareness of what is happening in a case, across the multi-agency system may result in single-agency decisions with unintended consequences.

Finding 5: The use of Safeguarding Specialists in Safeguarding processes

Underlying issue

Multi-agency Safeguarding processes relating to health often involve lead professionals to represent the wider health system of agencies or professionals. Actions for specialist health professionals or services outside this network are often taken away and addressed separately.

Rationale for change

There are some advantages to this approach in efficiency and multi-agency teamwork, however this approach may also miss first-hand information and a stronger team around a person and may prevent decisions having unintended consequences. It may not be necessary, or proportionate, for every agency to be involved in the safeguarding processes and meetings, however it is important that safeguarding processes are aware of which agencies are involved, what their role is, and how their contact with the individual may be utilised.

Questions for the Safeguarding Adults Board

Finding 5, Q1: What is the role of organisational leads, specialist safeguarding practitioners, and representatives in the safeguarding process? How does the system account for team approaches to care delivery⁵?

Finding 5, Q2: How can specialist health services, clinicians, and local practitioners contribute to safeguarding processes, including meetings, in a way that is proportionate and effective?

Impact and measurement

This finding is about finding a proportionate balance when individuals are supported by numerous health professionals, or within a large, complex system. Inviting all professionals involved in a case may render meetings and processes ineffective, but missing out key practitioners may also compromise effectiveness. Using organisational leads can provide an efficient and cost-effective way of addressing this risk. In order to determine how this balance can be achieved on a case-by-case basis, measurement and review of the current system could support consistency in the roles that organisational safeguarding specialists play in individual cases.

⁵ For example, some district nursing teams, domiciliary care providers, mental health crisis teams, or hospital wards, and residential settings.

TOR 6: People with additional needs

In particular, adults with limited or no literacy skills (not able to read or write): how do we support them with care & support needs/access to services.

Context

“Literacy is the ability to read, write, speak and listen in a way that lets us communicate and make sense of the world” (Literacy Trust, 2023). The most recent data for England showed that in 2012 1 in 6 adults (16.4% or 7.1 million) had “very poor literacy skills”, this means that they would struggle to understand written communication beyond simple straightforward texts on familiar topics.

Literacy is essential for everyday communication and navigation of life, from completing forms, to understanding road signs, official letters, and instructions on medicines. Low levels of literacy are known to have an adverse effect on employment opportunities, confidence, and self-esteem (Literacy Trust, 2023). A basic level of literacy is often assumed within health and social care where communication about appointments, medication regimes, outcomes of assessments, and care plans are often provided in a written format.

Findings

Francis was described as having limited or no literacy skills. This meant that he struggled to understand communication in written formats and had difficulties in understanding, among other things, appointment letters, medication instructions and how to manage his dossett box. Francis was offered some support in this area – for example workarounds where healthcare professionals agreed to read his letters to him, and the regular provision of a mobile phone so communication could be conducted verbally through a telephone call. These methods proved unreliable however as they relied on Francis seeking support for staff to read his letters and correspondence to him, and he often lost his mobile phones – or they were taken from him.

The impact of Francis’ low level of literacy on medication compliance, keeping appointments, travelling, and engaging with professionals, was compounded by his use of drugs, alcohol, and poorly managed epilepsy on his memory, organisational skills, and on his decision-making ability. The cumulative effect of Francis’ poor literacy and additional communication needs, significantly increased and compounded the risk of or failed engagement. This contributed to Francis’ challenges in being able to manage his health conditions and treatment for alcohol misuse and associated epilepsy. Services often work hard to build and maintain working relationships with people who are described as ‘difficult to engage’, especially in the context of self-neglect. Individuals may be described as ‘difficult to engage’ due to a number of reasons related to *choice*, including but not limited to:

- A mistrust in services
- Pride in independence and self-sufficiency
- Denial of concerns
- Other conditions such as mental ill-health.

Other factors, including low levels of literacy and memory difficulties, or even the ‘undue influence of others’ relate to an individual’s *ability* to engage, to maintain contact, appointments, or organise their treatment. Often the reasons for an individual being seen as ‘difficult to engage’ will be a combination of the two.

Finding 6: Choice or ability to engage?

Underlying issue

When working with individuals who are ‘difficult to engage’ in the context of self-neglect, services often work on the basis that an individual is ambivalent about their support, mistrustful of services, or otherwise reluctant to accept the support and services that they need, i.e., that they are making a *choice* not to engage. It is important that agencies consider an individual’s *ability* factors before non-engagement is attributed to a choice.

Rationale for change

When engagement difficulties relate primarily to ability rather than choice, including literacy or memory, or self-organisation skills, efforts to encourage an individual to *choose* to engage are likely to be only partially effective at best. At worst, an individual who would otherwise accept support may be discharged or closed due to non-engagement.

Questions for the Safeguarding Adults Board

Finding 6, Q1: How can the Board raise the awareness of adult literacy issues and the consequences for engagement with services?

Finding 6, Q2: What support is available for adults with care and support needs to improve their literacy skills and support engagement skills, such as diary and time management? Does the Safeguarding Adults Board produce any easy-read materials about safeguarding?

Impact and measurement

This finding is about raising the awareness of adult literacy issues, and challenge assumptions about *choice* and *ability* in non-engagement and individuals described as “difficult to engage”. In a system dominated by letters and written communication, this finding calls for a more sophisticated approach when an individual is unable to maintain engagement due to communication or literacy issues. Actions may include working with organisations who support adult learners and literacy programmes and providing training or professional development activities focused on the issues of adult literacy. Measures may include surveying staff opinions, attendance and feedback at any events, and mapping and publicising the support available.

TOR 7: Professional curiosity in risk management

How did professionals use their knowledge about risk within the case, and did this inform their perspective and evaluation of presenting information or did professionals simply accept information at face value?

Context

Curiosity, n. **1** a strong desire to know or learn something. **2** An unusual or interesting object (OED, 2006)

Professional curiosity, n. “the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value” (Safeguarding Adult Boards, 2000)

Professional curiosity is a term which has been used often in Child Safeguarding Practice Reviews and Child Practice Reviews, and increasingly in Safeguarding Adults Reviews alongside related terms such as ‘respectful uncertainty’, and ‘think the unthinkable’. It is often used to describe the situation where evidence or signs of abuse have been missed, or where explanations have been accepted that later turn out to be false, or where a professional fails to follow up on what later turns out to be a crucial line of enquiry. Identifying failures in professional curiosity often requires a degree of hindsight, and combined with the focus on individual professional practice, it is important that the concept of professional curiosity is used to encourage rather than to judge. Professional curiosity is an important concept to be aware of where it can encourage practitioners to nurture and develop critical thinking and intuitive assessment skills. It is a matter of both nurturing a strong desire to find out about what is happening in an individual’s life and learn about their experiences, and taking action when evidence of abuse or neglect is found.

Findings

Leading up to Francis’ final admission to hospital and death professionals were presented a situation of multiple risk and safeguarding concerns in the domains of health, medical self-neglect, environmental self-neglect, and of allegations of exploitation. Allegations of exploitation included the theft of Francis’ medication, about which he was reluctant to share further information. Professionals perceived that the greatest risk at that time was to his health and wellbeing as a result of his non-compliance with medication and poor self-care of his health conditions. The allegations of exploitation were not addressed any further, apart from noting the theft of medication as a risk factor for non-compliance. In prioritising the most pressing issue – poor medication and treatment concordance, seizures, and frequent collapses in the street, professionals appeared to have adopted a crisis mentality; planning to intervene through a package of care to support with medication compliance and nutrition, and works on his property to make it more secure.

This could be addressed by finding 1, ‘**Self-neglect: exploring the underlying causes**’ which includes the discussion on prioritising presenting needs over exploration of underlying causes.

SUMMARY OF FINDINGS AND QUESTIONS FOR THE BOARD

No.	Finding	Questions for the Safeguarding Adults Board	Impact and suggested measurement
1.	Self-neglect: exploring underlying causes	Q1: How can the Safeguarding Adults Board raise awareness and use of the self-neglect guidance?	<ul style="list-style-type: none">• Practitioner survey• Guidance Case audit
		Q2: How can the system support practitioners to explore the underlying reasons behind an individual's disengagement from services and self-neglect behaviours?	
2.	Alcohol Assertive Outreach Approaches	Q3: Does the referral process for the Achieve Assertive Outreach Team reach all agencies and service users who need to be referred?	<ul style="list-style-type: none">• AAOT Referral audit
		Q4: How can safeguarding services and potential referral agencies become more knowledgeable about the team, its offer, and thresholds for referral?	
	Timeliness in decision-making	Q5: How can good quality safeguarding decisions be made without unnecessary delays in action on the part of referring agencies and multi-agency partnerships?	<ul style="list-style-type: none">• Safeguarding audit
		Q6: When more information is needed to determine if the statutory criteria for s.42 (Care Act 2014) is needed, should an interim risk management process be used?	
		Q7: How is referral-feedback communicated, so that referring agencies are able to be transparent with the adult at risk about the process and what to expect?	

No.	Finding	Questions for the Safeguarding Adults Board	Impact and suggested measurement
	Precision in self-neglect referrals	Finding 4 Q8: What makes a good referral for a case involving self-neglect?	<ul style="list-style-type: none"> • Guidance and training materials presented to SAB • Practitioner survey • Safeguarding audit
		Finding 4a, Q9: How can the Board support practitioners to make high quality referrals in relation to self-neglect?	
2a.	Multi-agency risk management	Finding 4b, Q10: How can the Board be assured that risk information is reviewed and updated in the context of multi-agency safeguarding or risk processes?	<ul style="list-style-type: none"> • Assurance on members' recording processes • Assurance of members' staff safety procedures
		Finding 4b, Q11: How can the Board use the launch of new Information Sharing guidance to promote training and re-affirmation of commitments to high-quality information sharing in safeguarding processes?	
		Finding 4b, Q12: How can the safeguarding system support information-sharing and protect staff from harm where there is a known risk of harm?	
3.	The use of Safeguarding Specialists in Safeguarding processes	Finding 5, Q13: What is the role of organisational leads, specialist safeguarding practitioners, and representatives in the safeguarding process? How does the system account for team approaches to care delivery?	<ul style="list-style-type: none"> • Specialist staff and organisational representative survey • Measure the frequency in which representatives are used.
		Finding 5, Q14: How can specialist health services, clinicians, and local practitioners contribute to safeguarding processes, including meetings, in a way that is proportionate and effective?	
4.	Choice or ability to engage?	Finding 6, Q15: How can the Board raise the awareness of adult literacy issues and the consequences for engagement with services?	<ul style="list-style-type: none"> • Practitioner survey / feedback on events
		Finding 6, Q16: What support is available for adults with care and support needs to improve their literacy skills and support engagement skills, such as diary and time management tools? Does the Safeguarding Adults Board produce any easy-read materials about safeguarding?	

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