Thematic Safeguarding Adults Review of Self-Neglect

Overview Report

August 2022

Authors: Sarah Williams and Fiona Bateman

Independent Safeguarding Consultants, Safeguarding Circle

Contents

1. Introduction

1.1 In April 2022 Keeping Bristol Safe Partnership [‘KBSP’] commissioned a safeguarding adult review following the deaths of two adults, “Charles” and “Bridget”, who had unmet care and support needs. KBSP agreed the case met the s44 criteria for a review as both adults were in need of care and support, died as they were unable to manage their health and basic care and there is reasonable cause for concern about how persons with relevant functions worked together to safeguard them. Please note that although this review has been described as a thematic review of ‘self-neglect’, it is unclear the extent to which Charles and Bridget were physically able to meet their own needs.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals’ actions and what, if anything, prevented them from being able to help and protect Charles and Bridget from harm.

Themes

2.3. The KBSP prioritised the following themes for illumination through the SAR:

- How well do health and social care practitioners understand risks associated with self-neglect of health conditions and nutrition. Does current practice comply with local policy and best practice?
- How do services work with informal carers where there are concerns regarding self-neglect, abuse or exploitation and the adult at risk is unresponsive to statutory assessment or interventions?
- How do practitioners inform carers of the nature of their duties to meet needs to a safe standard and what mechanisms do they use to assess whether informal carers have sufficient skills or capability to meet necessary care?
- Is the safeguarding process (s42 Care Act) used effectively to escalate concerns and secure multi-agency risk management to reduce risks where there is a risk of self-neglect or unsafe informal care? Is local policy well understood, particularly in relation to wider powers of entry and police involvement when investigating possible criminal liability (e.g. wilful neglect or allowing/causing the death of a child or vulnerable adult)?
- How did the Covid-19 pandemic impact on practitioners’ ability to respond and what should be done to improve system-wide resilience when adverse events create service/

business continuity issues?

Methodology

2.4. The KBSP commissioned independent reviewers to conduct a SAR using a hybrid of the Social Care Institute for Excellence Learning Together and SAR In Rapid Time methodologies. This was to enable learning to be turned around more quickly than usual through a SAR (an initial set-up meeting took place on 29 March 2022 and the report was approved by the KBSP on 11 July 2022), but with a more detailed report than would typically be produced for a SAR in Rapid Time.

2.5. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

2.6. The following agencies provided documentation to support the SAR:

- Avon and Somerset Police
- Avon and Wiltshire Mental Health NHS Partnership
- Bristol City Council's Adult Social Care
- Bristol City Council's Housing and Landlords Services
- Bristol North Somerset and South Gloucestershire Clinical Commissioning Group (now the Bristol North Somerset and South Gloucestershire Integrated Care Board)
- Missing Link
- North Bristol Trust NHS (Southmead Hospital)
- Southwestern Ambulance Service NHS Foundation Trust
- University Hospital Bristol and Weston NHS Foundation Trust
- A third-party provider of food supplements

2.7. Multi-agency learning events took place, with separate events involving the front-line practitioners who worked with Charles and Bridget, then a joint meeting with operational managers who oversaw the services involved in supporting them.

Involvement of Charles and Bridget's families

2.8. The authors wish to thank Bridget's younger daughter "Cara" for meeting with them to share her insight into both her mother's voice and her own experiences as Bridget's carer, which have been incredibly valuable to this review and will be discussed throughout the report. Cara lovingly spoke of her mother's strength and struggles and felt that her mother would have wanted her to speak out to ensure that someone in a similar position in the future will receive the help they need, touchingly commenting "*I hope no one else has to feel so alone.*"

2.9. Members of Charles's family were invited to participate in the review, but may have felt unable to contribute at this time. However, it was very clear during the course of the review that they were very caring and committed to supporting him, visiting him daily, bringing him groceries and advocating on his behalf.

2.10. The reviewers and KBSP partners remain committed to supporting the family's involvement and will invite their comments on this report before publication. Bridget's older daughter will also be invited to comment. The authors wish to express their sincere condolences to all members of Charles and Bridget's families for their losses.

3. Pen picture of Bridget

"*Even when she was feeling weak, she was so strong"*

3.1. Bridget was a White woman born in Ireland, was warm with a quick sense of humour and a talented artist in her youth. She had complex health issues and had been known to health and social care services over many years. The family's involvement with Children's Social Care may have made it difficult for Bridget to view Adult Social Care as a support as opposed to a threat. Bridget's GP noted that even prior to 2014, it was hard to get in to do home visits and that her house was in a cluttered condition, indicating that her need for support in this regard may have been longstanding. She had not been in contact with her older daughter for several years, but continued to speak of her with love.

3.2. In 2014 Bridget was hospitalised with a broken hip following an assault, after she confronted an associate when she found out he had sexually assaulted her daughter Cara a week earlier. Bridget reported she was too frightened to provide details of the assault to enable a prosecution, but she was given victim support through the police, including installation of locks and alarms. Bridget felt unable to complete the recommended physiotherapy to help her rehabilitate from this injury, in part because she was worried about leaving Cara alone at home and the resulting pain made mobilising extremely difficult. Consequently she became increasingly reliant on Cara, who had only just turned 18, for her physical care and their shared trauma resulted in a very close bond, to the exclusion of other people who Bridget often perceived to pose a threat. Bridget later disclosed, during a psychiatric assessment in 2016, that Cara's sexual assault had triggered memories and trauma from sexual abuse Bridget had suffered as a child.

3.3. Bridget had a history of poor mental health and clinicians had raised concerns regarding opiate seeking behaviours and alcohol dependency, which she found very distressing, because she believed that professionals lacked empathy for her physical pain. She did not always engage with community mental health support. Bridget also had several physical health concerns including pancreatic insufficiency, arthritis, chronic pain and Gastroparesis (believed to be linked to a psychological functional disorder). She required feeding via a jejunostomy (feeding tube in her abdominal wall). Whilst arrangements were in place to ensure sufficient feeds were delivered monthly by a third-party provider, management of this was problematic and she experienced frequent infections, vomiting and pain. Cara reported that her mother felt very judged by the label of 'self-neglect' as she felt that her physical health problems and chronic pain prevented her from carrying out many of the tasks of daily living. She felt that many clinicians lacked empathy towards her, but always remembered those who treated her with compassion, often talking about their kindness years later, recalling them by name.

3.4. Bridget was rehoused, along with her daughter, by the Council in 2018 into a two-bedroom bungalow and offered tenancy sustainment support. Bridget's property was at the top of an estate, relatively hidden and not frequently passed. Although an application was completed for direct payments to meet Bridget's care and support needs, this was never progressed. Because she had not completed interview processes for personal assistants, social care had withdrawn the offer of direct payments and had not been able to agree with Bridget how to deliver the social care support they had assessed she required. Although Bridget remained of ill-health, the sustainment support she received from the Council's Supportive Tenancy Management was closed in 2019 as her tenancy was being sustained without issue.

3.5. In September 2019 the dietician saw Bridget and recorded she had lost weight. This was the last time Bridget was seen face to face by a professional before her death in April 2021. From December 2019 and January 2020 monthly arranged visits were cancelled and, though the dietician made several attempts to contact Bridget between May 2020 and March 2021, she

was only able to speak with her daughter who gave different reasons why Bridget was not engaging. However, Cara reports that throughout this period, she was relaying information from professionals to her mother, who was making her own decisions in respect of engagement. Bridget relied heavily on Cara to meet her needs, and Cara was respectful of her mother's wishes. Cara explained, during this review, that she felt it was important to explain to her mother what had been offered, listen and respond in line with her mother's wishes as she did not want to undermine her mother's confidence further by going against her. She explained that Bridget's opposition to external support arose because she had experienced on many occasions a lack of empathy and, on occasions, felt unduly judged by those caring for her needs whilst in hospital and the community. Cara commented her mother had felt 'invaded' when people carried out personal care, so Cara understandably wanted to take things at her mother's pace, as any other action would be detrimental to her mother's mental health. Instead Cara explained she tried to manage the risks her mother's physical and mental health to the best of her ability, as this made it more likely that her mother would accept medical help when she became acutely unwell.

3.6. When England went into lockdown due to the Covid-19 pandemic in March 2020, Bridget and Cara's world shrank even further. Due to the strict restrictions on mixing outside one household, Cara moved into her mother's home full-time. Given Bridget's health conditions, both were understandably fearful of the risk of infection and allowed no one into the home.

3.7. Bridget died in April 2021 at home, a relatively young woman in her mid-40's. Paramedics were called by Bridget's daughter to the home and subsequently alerted the police as they were concerned by level of neglect and the home conditions. They were also concerned that the account given by Cara was inconsistent with state of decomposition. Cara explained she had not realised her mother had died and that she last spoke to her the previous evening. Police noted that the house was in '*a significant state of neglect with copious amounts of rubbish and litter strewn over the floor in every room there was clear evidence of hoarding and there was lots of medication surrounding Bridget prescribed for her*.'[1] Boxes of a prescription nutritional supplement from the third-party provider were stacked outside the house and in the hallway, but because the house was at the end of a cul-de-sac, this would not have been visible from the road.

3.8. Police arrested Cara, but during the interview, raised concern that she may herself be a vulnerable adult. On receiving the report from the post-mortem, which clarified her death was likely consistent with the account Cara had provided, police took a decision that she should not be charged. Cara has subsequently been rehoused, and is attending counselling in respect of anxiety, depression and the trauma surrounding her mother's death. She praised the support she now receives from Missing Link, commenting that the coordination between professionals and understanding of those supporting her in her recovery is so very different to her mother's experience.

4. Pen picture of Charles

4.1. Charles was White British man in his 80's, described by his niece as fiercely independent. Since his parents' death he had lived alone in his own home and there was a sense from his records that he had never really coped with living alone, which became increasingly problematic as he grew older and more frail. He had a history of obsessive compulsive disorder (OCD) and schizophrenia having been diagnosed in 1984 and 1988 respectively, but it does not appear he received any treatment for either condition. He was described as a recluse and told professionals that he did not like people coming to the house because of his OCD. Professionals attempting visits would sometimes shout through windows in an effort to

[1] Avon and Somerset Constabulary Referral Form for Consideration of a Domestic Homicide Review, dated 8 April 2021

gain Charles's attention, which he found very traumatising. He had a history of infected pressure ulcers, requiring weekly treatment in 2016, but because those had been successfully treated at that time, had not been seen 'face to face' by health or social care professionals since September 2016. In May 2020 (during the initial Coronavirus lockdown) he reported to his GP that pressure ulcers on his leg were infected and, following a telephone consultation, was prescribed antibiotics. A subsequent phone consultation (in May 2020) reported he was '*unable to do a video consultation due to poor resolution on mobile phone*' and that he required codeine for the pain.

4.2. In the six months before Charles's death his niece and his GP raised concerns with Bristol City Council's Adults Social Care department that he was at risk as was neglecting his health, personal care and all basic needs. Whilst there is some evidence that social care made contact with Charles and offered assessments, there was no home visit despite concerns (raised by his GP) that Charles did not have capacity to refuse social care. In January 2021 police were contacted to request assistance by his niece as she had been unable to make contact with Charles through his letterbox and she was concerned for his safety. Having been advised to try alternatives, she gained entry and found Charles collapsed. She called for an ambulance.

4.3. When paramedics attended, they found Charles on the floor where he was thought to have been for between 24-48 hours. He was '*emaciated, hypothermic, hypotensive, bradycardic and his feet were infected… his socks and jeans have become an integral part of his skin tissue and [Ambulance staff] could not cut then off, his feet has flies/maggots in the wounds*'.[2] Paramedics conveyed Charles to hospital, but (in line with expectations) also made a safeguarding referral due to severity of his presentation and the very neglected state of the house, including rubbish piled from floor to the ceiling and human excrement visible on most of the floors. The hospital reported Charles was suffering severe sepsis, dehydration, extreme frailty, and an acute kidney injury. A medical review on the 10 January 2021 reported Charles expressed a capacious wish not to be treated in the Intensive Treatment Unit and that he understood the consequences. He sadly died the following day. Hospital staff also raised a safeguarding concern following his death and referred the case for consideration by the KBSP for this safeguarding adults review.

5. Analysis of Agencies' Actions

Professional understanding of the risks associated with self-neglect of health conditions and nutrition

5.1. Charles was receiving weekly care for his pressure ulcers in 2016, by September 2016 this had largely healed so the service stopped, but even before that need arose, he had been diagnosed with significant mental health conditions and this was recorded on his GP records. It is documented that he received no mental health support. He lived alone, in his own home. At the last contact with the GP practice (in 2016) he had been 'blue lighted' to hospital having had to be resuscitated by the practice nurse. There is evidence that he was invited for influenza vaccines and for annual health checks in 2018 and 2020, but no action was taken when he did not respond. In May 2020 he contacted the GP who addressed the immediate risk of infected pressure ulcers with antibiotics. Charles would tell professionals that he would attend appointments, giving the impression of someone who was managing, which may have delayed recognition that he was medically self-neglecting.

5.2. By September 2020 the leg ulcers were weeping and more painful. The GP made a referral to community nursing that was closed as Charles was not believed to be housebound. The GP

[2] Taken from the South Western Ambulance Service NHS Trust records, he was so underweight the paramedics report they were too concerned that even 1g of paracetamol could result in an overdose, so he was given 10mg.

also made wider enquiries with his niece, prompting a referral by her to Bristol City Council Adult Social Care which was triaged as meeting threshold for a safeguarding enquiry[3]. It appears this was closed after social care spoke with Charles and encouraged him to engage with the nurse. The GP persevered, raising a further s42 concern in October 2020, this was transferred for action to the First South team on 18 December 2020 but remained unallocated at the time of his death. The reason for this delay is unclear.

5.3. Bridget was admitted to hospital on numerous occasions throughout 2016 and 2017 with gastrointestinal symptoms (including pain) and struggling to feed successfully. She disclosed significant childhood trauma and that, in 2014, she had experienced a serious physical assault that continued to impact on her emotional wellbeing. In June 2016 she was assessed by a community mental health nurse, where she reported low mood and confirmed her daughter provided her care so felt she didn't need reablement support. Community nurse support was withdrawn as she had not responded to attempts to make contact.[4] In 2017 the district nurses accepted a referral to take Bridget's bloods, but after three failed visits in March 2017 and again in July 2017 referred this back to the GP for further action. In May 2017 the hospital's designated safeguarding lead, concerned about lack of engagement, raised a referral for social care assessment and the dietician requested an urgent mental health assessment in May and again in July 2017. This was explored in September 2017 and impact of psychological trauma on her ability to engage was recognised and reported, including on her ability to form healthy relationships. The nurse assessor also highlighted Bridget '*expressed concern her physical symptoms were not taken seriously. She felt that staff were blaming her for the issues*.'

5.4. During the course of the review, Bridget's GP expressed his concern that the opioids Bridget was prescribed during her hospital admissions were not only creating a dependency but actually exacerbating her gastric condition, as one of the near-universal side effects of opioids is constipation. There is also a strong connection between opioid use and self-neglect as they can be a trigger for depressive illness, and it is extremely difficult to address a patient's mental health conditions until any dependency on pain medication is resolved. Additionally, current NHS guidelines caution against prescribing opioids for chronic pain because tolerance to opioids rapidly increases, requiring progressively higher doses of medication to alleviate pain. NICE guidelines[5] recommend that anyone with a mental health condition should have a full assessment prior to being prescribed with opioids. The guidelines also advocate that primary and secondary care teams should communicate in respect of prescription management plans.

5.5. Although not a feature for Bridget, the gastro-dietician noted that it was not uncommon for people who were reliant on opioids to refuse to take food or fluids whilst in hospital, unless they felt that they were being prescribed sufficient medication to manage their pain. Staff on the ward would accede to this pressure, because their priority was to ensure the person's immediate medical needs were met. Primary care staff would then try to reduce the dose when the person was discharged, often resulting in conflict between the patient and their treating physician in the community.

5.6. Cara recalled that her mother believed that only the hospital pain management team understood her medication needs. She perceived the GP to lack empathy for her pain, and she felt judged by attempts to engage her in conversation about opioid dependency as she felt she was being accused of being a drug addict. Additionally, someone close to Bridget had died as a consequence of drug addiction and she had observed that professionals were judgmental towards people with addictions.

[3] In line with section 42 of the Care Act 2014

[4] In total University Hospital Bristol report that the district nurse made contact on two occasions, CMHT and rehab support worker also attempted visits but were unable to gain access three further times in June 2016. Her GP was informed of the case closure decisions by the community nursing service.

[5] Recommendations | Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults | Guidance | NICE

5.7. This inconsistent approach between the hospital clinicians and primary care services meant that Bridget received mixed messages about the benefits and risks of opioid medication and effectively set the GP up as the 'bad guy'. It is vital in cases of opioid dependence for there to be a collaborative, strategic approach between primary and secondary care teams, to deliver a consistent message to the patient about the need to reduce dependency on opioid pain medication. In addition to sabotaging efforts to reduce the opioid use that was likely exacerbating Bridget's gastric and mental health conditions, this is likely to have negatively impacted Bridget's relationship with her GP, making her less likely to engage with him or attend appointments for her other health conditions. Practitioners agreed that a multi-disciplinary team meeting while Bridget was admitted to hospital, including the GP, gastro-dietician, social care and mental health services would not only have supported more effective intervention in respect of opioid use, but could also have facilitated a more trauma-informed and personalised approach to address the interface between her other complex physical and psychological needs, in particular her psychological functional disorder resulting from the overwhelming traumas she had experienced.

Systems findings

5.8. A consistent strategy and common goal across primary and secondary health and social care are required to tackle complex health issues with a psychological component, such as a psychological functional disorder, addiction to pain medication or medical self-neglect. A lack of coordination between the hospitals and primary health care providers can undermine efforts to treat opioid dependency, and may negatively impact the relationship between those patients and their treating clinicians in the community. As Integrated Care Systems are rolled out, partners should prioritise developing integrated primary care, improving collegiate working and shared training protocols to support a multidisciplinary approach to complex cases. A common language and strategy needs to be agreed between professionals on individual cases, to ensure that a consistent message is provided to patients on the rationale for and health benefits of reducing pain medication.

Recommendation 1: *KBSP to seek assurance that primary and secondary health care partners have reviewed or adapted protocols to ensure a coordinated approach in cases where efforts are being made to reduce a patient's opioid dependency when a patient is discharged home after hospital admission.*

Involving informal carers/family members

5.9. Carers are not a homogenous group. What they usually have in common is a willingness to work alongside statutory, community and voluntary services to promote the cared for person's wellbeing. However, it is not always easy to understand the routes for carers to raise concerns, or who is responsible for explaining possible ramifications for them or their duty of care. There are now specific duties to assess and provide support[6] to carers, irrespective of whether the cared for person is in receipt of social care. However, there is a lack of clarity on duties owed to carers in respect of their own wellbeing where the adult with care and support needs may also pose a risk to those in their household or social network. A recent safeguarding briefing[7] stressed the importance for carers of being '*recognised and valued for what they do, to have the information to be able to care well and safely and make the right decisions for them and their family*.'

5.10. In both cases family played an active role in the adult's life. Charles's niece made a request for his needs to be assessed and raised safeguarding concerns. It is not clear what, if any information was provided or action taken as a result of this. She was asked on a number of

[6] Section 10 Care Act 2014
[7] https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers

occasions to take him to the GP, but it doesn't appear she was asked if he was able to leave his home or probed about any physical or psychological issues that might be preventing him from leaving. Nor does it appear that professionals asked her (or Charles's nephews) what care they were willing or able to provide to reduce risk. Practitioners appear to have relied on Charles's niece as a 'trusted assessor' in terms of discussions about his mental capacity and pressure ulcers, but because no professionals attempted to visit the home, the fact that he was hoarding was not identified and, in the absence of prompts from the social workers, it may well not have occurred to the niece to raise this as a safeguarding issue.

5.11. Cara was the point of contact for professionals providing her mother with support. She showed willingness to engage with agencies and provided information regarding her mother's needs when asked, but was perceived not to follow up with actions assigned to her. It appears that from 2016 most of Bridget's medical care outside of the hospital settings was provided via telephone consultations with Cara, rather than directly with Bridget. However, Cara was not identified as her mother's next of kin or her carer on Adult Social Care's files or Connecting Care, which is a system that allows key health and social care ICT records, including safeguarding records to be shared between partners, nor were her contact details available on the system. Although this is potentially an extremely useful safeguarding tool, practitioners commented that many agencies received limited training on how to access Connecting Care, which meant it was inconsistently used.

5.12. It does not appear that an assessment of Cara's ability to provide the necessary care was assessed. Cara and Bridget were instructed on how to administer feed through the jejunostomy tube and site in May 2016, they were also offered further training by the Nurticia Nurse, accepting this on one occasion in 2018. Cara was offered a carer's assessment, though the purpose of this was not explained to her, so she believed it to relate to a carer's allowance. Consequently she refused this, as she did not want the carer's allowance to be deducted from her mother's disability premium on her benefits.

5.13. By 2017 Cara's involvement was starting to cause concern for some professionals, the GP reported she attended appointments without Bridget, noted she was seeking to renew medication and the police raised concerns about possible coercion and her ability to care for her mother. It does not appear, however, that these concerns were collated and shared with agencies with responsibilities to Bridget in a proactive way (e.g. Housing, District Nursing or Mental Health). The care agency commissioned by Adult Social Care agreed to Cara's request to delay the start of reablement support in 2017, prompting a call to the police for a welfare check. Reablement provides an opportunity for skilled staff to explore the person's ability to regain skills, and it is unclear whether that purpose was considered and weighed against Cara and Bridget's assertions before a decision about the appropriateness of withdrawing this offer.

5.14. Social care advised the GP that Cara was getting support from the Carers' Centre, but it is unclear what this comprised of and Cara reported that the only offer she received was for respite care, which her mother strongly opposed. Certainly, no assessment was completed to determine whether her own needs were understood, she reported her and Bridget were shown how to manage the care of her mother's Jejunal tube, but (despite repeated admissions to hospital because of infections) their ability to manage this was not reviewed between 2018 and her death in 2021. Cara was also not provided support or training to manage her mother's medication and psychological wellbeing.

5.15. Cara explained that her mother found it very difficult to meet with professionals and was very strong-willed in this regard. She could become upset with Cara if she felt that she was siding with professionals against her, and Cara gave a very eloquent lay-person's description of the fact her mother had the capacity to make decisions about her own care and treatment. When professionals made requests or gave advice through Cara, she would give these to her

mother, then relay her response back to professionals. Cara explained that she would try gently, over time, to encourage her mother to follow advice or attend appointments rather than risk breaching her trust. However, by the time she had talked her mother around, often the service would have been closed down due to perceived non-engagement.

5.16. When Cara discussed the experience of caring for her mother with the reviewers, we were struck by how lonely and isolating this must have been for this young woman, particularly during lockdown. Cara described an incident where she had tried to follow the advice of a nurse by pressuring her mother to take a shower and that for months afterward her mother would bring up how distressing and painful she had found this. Consequently, Cara avoided directly challenging her mother on these issues. Bridget's strength of will and reluctance to have anyone other than Cara provide her with care must have been a considerable pressure and impacted on Cara's ability to live an independent life, although Cara's love and respect for her mother were very clear throughout the discussion and she did not want her mother to feel like a burden. Cara found it upsetting to hear that some professionals had viewed her as obstructive and a risk and felt that, given how protective her mother was of her, knowing this would have resulted in her mother communicating with professionals directly. However, Cara also praised practitioners for having her mother's welfare at heart in making these referrals.

5.17. Frontline practitioners receive considerable training on how to identify risk and situations where a vulnerable person may be experiencing abuse or neglect, and the fact that virtually all communication was directed through Cara led to a perception that she was a barrier to access to Bridget. Practitioners were concerned that Cara was subjecting her mother to coercive control, but consideration was not given to whether the power dynamic could be inversed or one of mutual dependence. Gentle probing may have helped to better understand this dynamic and Cara's experience of trying to meet her mother's increasingly complex needs. Carers' assessments tend to be service focussed, for example offering respite, as opposed to a personalised assessment looking at the needs of both the carer and the person they are caring for as an interdependent system.

5.18. Health and social care practitioners involved with Bridget's care were genuinely surprised and reflective when Cara's experiences and perceptions were shared with them. They felt with hindsight, that had they viewed Cara as part of their safeguarding partnership instead of a risk factor and applied a Whole Family approach, this could have created opportunities to engage directly with Bridget or to enable them to support her more effectively by supporting Cara in a trauma-informed manner, ensuring that she understood the rationale behind their treatment plans.

Systems finding

5.19. Health and social care practitioners perceived family members as facilitators or barriers to access to the individual in need of care and support, rather than working with them collaboratively to develop an effective safety plan or carrying out a holistic assessment to understand the family members' experience of trying to support or care for the individual. Understandably, practitioners are trained to identify situations where a vulnerable person may be experiencing abuse and expected to make safeguarding referrals. However a more freethinking approach should be employed, particularly where practitioners have themselves experienced a reluctance from the cared for person to engage with treatment or social care plans. Where concerns arise that someone's care and support needs are not being met by an informal carer, a careful assessment should be carried out that focusses on understanding the experience of caring for that person, as well as the carer's capacity to meet their needs and what information and practical support they might require.

Recommendation 2: *Health and social care partners should develop tools to support practitioners to provide the information and support to informal carers that a professional carer*

would require to meet the needs of the person in need of care, using accessible language and practical guidance. This should include information on medication, specialist nutritional needs etc. Safeguarding referral forms should specifically include a question about whether the subject has a carer and whether they are currently able to meet the subject's care needs.

***Recommendation 3:** Bristol Adult Social Care should review its carers' assessment templates and associated training to ensure that assessors investigate the experience of caring for the individual and challenges faced by the carer, in particular when they are in a close family relationship, to identify a holistic and personalised plan for carer support, particularly in circumstances where safeguarding risks have been identified.*

***Recommendation 4:** KBSP should seek assurance that partners understand and have applied a rights-based, think-family approach to assessment and care planning functions that incorporates learning from this review. Multi-agency training and practice guidance assurance tools should include an evaluation of the adult and their carer's views, similar to the 'making safeguarding personal' outcomes framework employed throughout the safeguarding process.*

***Recommendation 5:** Practitioners with access to Connecting Care should receive appropriate training on use of the system, to make better use of its function to share information in respect of safeguarding and risk. When available, carers' contact details should be consistently recorded on partners' ICT systems, so that this can be parsed through to Connecting Care.*

Use of the safeguarding process to reduce risk

5.20. Section 42 of the Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult with care and support needs is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. An early response to emerging harm is essential to stop risks from escalating. In circumstances where multiple agencies or individuals are making safeguarding referrals, a s42 enquiry should be undertaken, even if individually each concern would not meet the threshold for further investigation. Importantly, section 11 of the Care Act creates an enduring duty for the local authority to carry out an assessment of someone's care and support needs if there is concern that the person is experiencing abuse or neglect, including self-neglect. During discussions with practitioners during the review, awareness of this enduring duty to assess was limited.

5.21. Previously local Safeguarding Adults Reviews (Mr C and Caroline DHR/SAR) identified a lack of understanding about when to override consent in respect of safeguarding, the importance of nutrition and application of the Mental Capacity Act 2005. These made recommendations to enable patients with physical and mental health problems to be managed holistically. The previous reviews also found '*agencies operated individually in their organisational silos*.' These themes, of a lack of multi-agency coordination, information sharing and legal literacy (predominantly in respect of application of the Mental Capacity Act 2005), are identified frequently within Safeguarding Adults Reviews as areas requiring practice improvement, especially where the risk arises from perceived self-neglect.

5.22. This is made more acute in the context of refusal or non-adherence to medical treatment where the adult is suffering from physical and mental health conditions. National analysis identifies that often a focus on specific need or behaviour obscures recognition of foreseeable risk, reporting that:

"even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional

curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-reporting, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary."[8]

5.23. The national SAR analysis raises the possibility that a 'rule of optimism', namely an unconscious bias towards a favourable view of the situation, makes it less likely that practitioners will imagine (and prepare for) the poor outcomes, even if these are, as they were in this case, foreseeable.

5.24. In the months preceding Charles's death both his GP and niece raised safeguarding alerts. The initial contact from Charles's niece in May 2020 appears to have been taken as a request for a service rather than a safeguarding referral and was therefore allocated to the Access and Response team, who closed the case when Charles declined a service.

5.25. Charles's GP stated in the referral that '*his lack of capacity is stopping him from seeking the correct help and treatment for his health, this could be fatal*.' The GP requested a '*review of his living conditions, capacity assessment and if appropriate (it seems it will be) support at home for this patient*.'[9] The GP was persistent in approaching Adult Social Care, following up a referral in November when he had not received a response after a month. However, because the primary risk identified was health-related, social care reverted to the GP, asking him to carry out a mental capacity assessment. This developed into a confrontational rather than collegiate approach, doubtless largely exacerbated by the enormous pressures on both the health and social care systems during this period.

5.26. Charles's GP also made referrals for district nursing support, but this was turned down because on the initial referral he was identified as not being housebound, because Charles's niece had said that she would try to bring him to the GP surgery. This was taken to mean that it was possible to transport him, however, no professional curiosity was exercised when he did not attend the surgery to unpick whether the niece's willingness to assist Charles to attend equated to him being physically capable of travel and the case was not re-referred to District Nursing. It is likely that the pressures on the GP Surgery during the pandemic impacted on this response. Consequently, no professionals assessed the severity of Charles's pressure ulcers, which may in reality have been so severe that he could not have been transported, even if he were not psychologically housebound. Additionally, no mental capacity assessment was undertaken to determine whether Charles had the capacity to take a decision to attend the appointment.

5.27. Following an admission to hospital in October 2017 Bridget was again referred for reablement. Her daughter requested a delay to the start of the care initially for three weeks so that she could provide this. Further requests for a delayed start were agreed by the care provider despite no contact with Bridget. Practitioners reflected that it had been reasonably foreseeable that Bridget would disengage with services at this point, and that a more proactive strategic approach was required to make the most of this opportunity for intervention. Bridget's GP also voiced concerns in November 2017 to social care that her daughter had sought to collect Bridget's medication, but the GP felt it was important for a professional to see her face-to-face.

5.28. The care company raised a further safeguarding concern (by calling 101) on 28 November 2017 as they had not seen her despite daily visits since 20 November 2017 and reported neighbours said they had not seen her for months. Police officers responding, used their powers of entry and reported their safeguarding concerns that Bridget's property was in a state of disrepair, sparsely furnished and very cold. Officers raised concern about potential controlling behaviour

[8] National Sar Analysis. ADASS/LGA, Michael Preston Shoot, 2020 {p101] available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf
[9] Taken from the safeguarding referral submitted on the 27.10.20

and Cara was not coping with the responsibility of supporting Bridget. They requested a strategy meeting, but were informed that this would not meet the threshold (under s42 Care Act) but that her allocated social worker would be asked to follow up. It is also understood that subsequently an appointment was arranged between social services, the care company and Cara. However, Cara did not turn up, and said during the review she did not recall being invited to this meeting. There does not appear to be any further action taken. Subsequent attempts to raise safeguarding concerns by Bridget's GP and the dietician proved unsuccessful.

5.29. In March 2017 the KBSP published multi-agency guidance on responding effectively to self-neglect.[10] This calls for practitioners to work with any 'adult at risk' of self-neglect in a person-centred way, understanding their wishes and the insight they have into their situation. It highlights the characteristics of self-neglect, including neglecting household maintenance and hoarding, neglecting personal hygiene so that it impacts on the person's health (giving the example of pressure ulcers) and lists personal characteristics of importance (e.g. pride in self-sufficiency, mistrust of professionals) and contributing factors, many of which were present in both cases.

5.30. The policy encourages ongoing involvement and contact with the adult to develop trusting relationships that might motivate change and adopting a 'care-frontational approach' rather than confrontation so that challenge is sensitive and trauma informed. The importance of finding consensual ways forward without downplaying or ignoring the risks of the situation is also emphasised. The policy provides links to research to support effective assessment of a person's mental capacity. Local guidance, in common with national best practice, calls for 'proactive rather than reactive engagement' and for the dynamics between family members to be explored, ensuring that carers are not left out of assessment and care planning. It provides templates for multi-agency needs and risk assessments and details of the procedure, including escalation and legal interventions so that any professional disagreement is resolved in a timely way. The policy sets out expectations to support adults with effective engagement, again requiring a personalised approach to help the person recognise the condition, the impact of it on themselves and other people and support them to identify how they can move to self-manage their condition. This is linked to Bristol City Council's 3 tier model.[11]

5.31. The 2017 local policy highlights police powers of entry (s17 Police and Criminal Evidence Act 1984) are '*Only to be used by the police and in an emergency situation. This is a power to enter premises without a warrant in order to save life and limb*.' In both Bridget and Charles's cases requests were made for the police to carry out welfare checks. In November 2017 Bridget spoke of the fear she experienced when the police entered her home to complete a welfare check. A subsequent request for a welfare check (by Adult Social Care staff in February 2021) was turned down as there was insufficient information to suggest a risk to life or a crime was in progress. Likewise, when Charles's family called 101 on 9 January 2021 they were advised police would not attend. In response to this review police have reviewed their decision making and explained '*the decision not to deploy [when Charles's family called on the 9 January 2021] was in line with the 'concern for welfare' policy - given that there was no indication at the time of the call of immediate risk to life or of immediate risk to harm identified, no crime had been committed and there was no breach of the peace. There was no indication for police involvement after Charles was found collapsed*.'

5.32. By January 2021 Bridget's dietician wrote to Cara by text to ask several questions and, having not received a response, discussed her concerns during supervision that Cara was not flagging Bridget's health issues to her. Following confirmation from the GP they had not seen

[10] The current version is available at: **https://bristolsafeguarding.org/media/j2nd32f2/kbsp-self-neglect-guidance-june-21-v2-1.pdf**. As this was updated in June 2021 shortly after the period under review, the report will reference expectations for practice set out in the earlier version (available: https://bristolsafeguarding.org/media/1124/guidance-for-self-neglect.pdf).

[11] Available at: https://www.bristol.gov.uk/documents/20182/305531/Adult+Social+Care+Strategic+Plan+December+2016/2f87741f-a4eb-4a49-a70c-c24b77704380

Bridget, the dietician raised a safeguarding referral, having gauged from reading Bridget's notes that there was a pattern of non-engagement. On the 24 February 2021, having followed up the referral, the dietician was informed that the social worker had seen Bridget through her window and offered assessment, though they noticed a malodourous smell from the doorstep, took no further action as Bridget was '*not keen to engage*'. There is no record of the social worker's perceptions regarding Bridget's physical condition or whether a mental capacity assessment was considered. During the practitioner's event the worker reported speaking to Cara and receiving assurance they would ask for assessment once the risks from the pandemic had passed. They explained they had conducted the visit whilst on duty, and expressed surprise that a decision had been made subsequently by a senior practitioner to close the safeguarding referral. They felt, at the time because of the pressures on the service during the pandemic, unable to challenge that decision.

5.33. Experiencing trauma in the past can affect the ways a person perceives and responds to their environment in the present. Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor, leading the individual to behave in ways that might be labelled as, for example, 'non-compliant', 'aggressive' or 'disengaged'. If an organisation reacts to these behaviours with seclusion or exclusion, further trauma may result. In both Charles and Bridget's cases, key health and care services would discharge them from the service because they did not attend appointments, without regard to the reasons for these non-attendances. The home enteral tube feeding service noted that their service does not close cases due to non-attendance at appointments or failed home visits, commenting that this often meant that they would be the 'last service standing', trying to hold the risk in complex cases with difficult to engage clients, which felt isolating and (all too often) unsafe. Cara said that her mother had really liked the dieticians and it appears that their persistent approach enabled her to trust them. Consequently, they were the only service that Bridget would allow to visit the home without Cara being present, albeit prior to the pandemic when they were shielding. Had other services taken a similarly persistent approach, they too could have built a trusting relationship to enable Bridget and Charles to receive the support they needed.

5.34. This reinforces the paramount importance of a trauma-informed multidisciplinary service for adults at risk of self-neglect. Where one agency is taking the lead in respect of engagement with the individual, it is vital that senior managers and partner agencies offer generous support to sustain this engagement over time, effectively establishing a 'team around the practitioner'. Bristol has already established an innovative risk management process, Creative Solutions, which promotes a personalised, trauma-informed approach for rough sleepers.[12] Indeed one of the practitioners attending the learning event now works within a team that uses an assertive outreach approach and reported this approach should have been available to the team responsible for responding to the safeguarding concerns for both Bridget and Charles, commenting that instead the pressures on the team, meant that all too often decisions to conclude safeguarding concerns that had only been responded to as duty matters felt very unsafe. The Partnership may wish to consider whether its existing Creative Solutions risk management process could be expanded to incorporate self-neglect, given that trauma-informed practice will be vital to tackle these issues.

5.35. Alternatively, bespoke psychologically led services do exist for those at risk of self-neglect, incorporating befriending, peer support and development of a community network with the aim of reducing the shame associated with hoarding behaviours.[13] Responses to self-neglect need to be both timely and persistent, recognising the need to work at the individual's pace whether

[12] As detailed by Kate Spreadbury and Paul England in chapter 7 of 'Adult Safeguarding and Homelessness', (2022) Jessica Kingsley Publications
[13] For example, Hoarding UK's offer.

that be gradually influencing change over time, or responding promptly to windows when the person may be open to offers of decluttering or deep-cleaning.

5.36. However, practitioners in Charles and Bridget's cases noted that a local organisation who offered a psychological service for hoarders had been decommissioned, as the waiting lists for the service had been over 3 years long. Similar waiting lists were reported for decluttering services through a local voluntary organisation, meaning that often the window of opportunity for engagement with someone willing to accept a service would almost always pass. Proactive universal services were generally only offered in cases where the individual was at risk of losing their tenancy, so for homeowners, there was little chance of a service being provided.

5.37. None of the universal services available incorporated psychological support to address the individual's underlying psychological needs or trauma, which are required to effect long-term change in self-neglect cases. Practitioners described that mental health services had very strict criteria for referrals, only accepting cases that could be treated medically, rather than chronic and enduring psychological conditions such as self-neglect and a negligible offer in terms of consultation on cases that were not open to them.

Systems finding

5.38. The perception that Bridget and Charles were self-neglecting, as opposed to having care and support needs that were not being met, or support not being provided in the way they needed it to be may have contributed to their difficulty in accepting professional support, as they felt judged and misunderstood. Likewise, this is likely to have resulted in their family members feeling 'unheard' when they raised concerns or tried to support professionals to meet the needs of their loved-ones. A better understanding of trauma-informed care across the wider professional network may have supported a more insightful approach to meeting their needs.

5.39. Although Bristol has a good quality Self-Neglect policy that meets national standards of best practice and facilitates appropriate assessments, practitioners are then hamstrung by a lack of resource to meet the identified need. In particular, the absence of a long-term psychologically led specialist service means that practitioners become trapped in a 'doom cycle' of unsuccessful short-term interventions that fail to mitigate risk, are resource inefficient and result in the practitioners and the adults at risk of self-neglect becoming frustrated and disengaged.

5.40. The resulting episodic approach to safeguarding and the practice of closing cases after non-attendance at appointments resulted in inter-agency disputes in respect of safeguarding responsibility or a single agency left to manage risk in isolation. Additionally, a safeguarding referral from a family member was not given appropriate weight, being perceived as a request for a service. A multi-agency approach to risk management from an early stage is essential to mitigate harm in cases of self-neglect.

Recommendation 6: *KBSP must consider, as a partnership or as a priority for the Integrated Care Board, how to develop a bespoke multi-agency resource that addresses both the psychological and practical complexities of self-neglect, having regard to the need for both early and long-term intervention and a trauma-informed response.*

Recommendation 7: *KBSP should explore the mechanisms for escalation and satisfy itself that practitioners from any provider agency can utilise that process if they believe that insufficient action has been taken across the partnership to mitigate identified risk.*

Recommendation 8: *KBSP should improve communication to carers and the wider population in respect of the parameters of services in the local area, what information to*

include in referrals and empower people to feel confident to challenge decisions in circumstances where a referral is declined.

Recommendation 9: *Adult Social Care should review its allocation policy for safeguarding referrals to ensure that where a case that meets the threshold for a s42 enquiry includes concerns in respect of self-neglect, cases are allocated to a social worker to facilitate the relationship of trust necessary to implement and monitor the effectiveness of a safeguarding plan in such cases. Staff should be trained, and have sufficient time and case load capacity, to employ assertive outreach approaches. Internal protocols should support staff to identify safeguarding risks within referrals from family members or the wider public, even where these are perceived to be a request for care and support.*

Recommendation 10: *The ICB to provide updated communications to all health care professionals to raise awareness that any changes to patients' mobility, mental capacity and whether they are physiologically housebound regarding appointment attendance need to be considered when making referrals to other agencies.*

Recommendation 11: *To better support a trauma-informed response, KBSP should redesign inter-agency referral forms to include a 'pen picture' of the individual, which should include an analysis of the extent to which interventions that have been trialled with the person have been successful, how the person prefer to work with professionals to improve the likelihood of successful engagement and any triggers that could adversely impact engagement. This should 'travel' with the individual, to build professional understanding and truncate the timescale for developing a positive relationship as each new worker/service is introduced.*

The impact of the Covid-19 pandemic and increasing resilience

5.41. In 2020, the Covid 19 pandemic placed extraordinary strain on health and care professionals, who had to balance the need for individuals with serious health conditions to receive care in the community, with the need to keep them safe from coronavirus infection. During this period, particularly when personal protective equipment was not widely available outside the NHS, professionals and care agencies reported that many clients and service users refused care and home visits due to fear of infection. At a national level there was a significant reduction of new referrals to people accessing preventative mental health support[14] but by May 2020 there was a significant rise in patients accessing secondary mental health services needing urgent and emergency mental health care.[15] In addition, outpatient clinics had to be reduced or abolished to comply with legislation designed to prevent the spread of the virus.[16] In Bristol, GPs were directed that they were not allowed to refer cases to mental health services unless the patient was psychotic or suicidal – practitioners reported that effectively, mental health was '*closed for business*'.

5.42. Inequalities, felt acutely by those providing unpaid care, increased during Covid, while the common stresses experienced during lockdown were acutely felt by those with mental health or anxiety disorders. Cara moved into her mother's home full-time to avoid any risk of infecting her with Covid.[17] Due to Bridget's health conditions, they were both understandably very worried about contact with anyone outside the home. Cara tried calling their GP surgery to find out whether Bridget was clinically vulnerable and the receptionist's advice that 'everyone was worried', almost certainly intended to be reassuring, felt very dismissive to these frightened, isolated women.

[14] Referrals into Improving Access to Psychological Therapies services reduced by 61%
[15] Nuffield Trust Quality Watch blog, published 30.11.20 available at: https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services
[16] The impact of COVID-19 on acute psychiatric inpatient unit, Daniel Hernández-Huerta et al, 2020, NCBI, doi: 10.1016/j.psychres.2020.113107
[17] Prior to March 2020 Cara reported staying overnight one or two nights a week with her boyfriend, once she had settled her mother for the night.

5.43. During the pandemic, the number of safeguarding referrals both in Bristol and nationally sharply increased after the first national lockdown ended in June 2020. New referrals were triaged by the Bristol City Council Safeguarding Team's duty worker, who would assess whether the case met the threshold for a s42 safeguarding enquiry or if further enquiries were required to determine whether the threshold was meet, whether an urgent response was necessary that day, or the matter could be dealt with on the team's waiting list. Cases which clearly met the threshold were transferred to the First North or First South teams, according to where the subject of the enquiry resided.

5.44. Practitioners noted that the First South Team, which covered the area where both Charles and Bridget lived, had a lot of staff turnover and high levels of staff sickness, with team managers left struggling to progress cases. The inherent risks with this situation were highlighted to senior leaders, who made conscientious efforts to address these risks through their business continuity plan, striving unsuccessfully to recruit new staff. Consequently they attempted to support frontline staff by informing them that they "held the risk" at director level, receiving weekly updates on case numbers and numbers on the waiting list. Safeguarding cases were held on duty so that team managers could continue to have oversight of these while allocating specific tasks to duty workers, but the sheer volume of cases meant there was considerable pressure to close cases, at times with fairly superficial analysis of risk. Further, the lack of continuity of this task-finish approach meant that there was no opportunity to build a relationship with either Charles or Bridget, which would have been essential to manage risk from self-neglect. Because cases were not allocated to specific workers, there would have been no opportunity to make use of the reflective practice offered during supervision sessions and working from home limited informal case discussions with managers and peers, which may have helped social workers to consider different approaches.

5.45. During discussions, practitioners recognised that when services become overstretched, the most complex and hard-to-shift cases will often receive the 'smallest' response. Given the extraordinary pressures on the First South service, it would have been nigh-on impossible for practitioners to deliver the persistent, proactive service that both Charles and Bridget would have needed for any meaningful intervention to take place. There has been significant systemic change in the past year, strengthening the First South Team, improving the consistency of the duty system and introducing a Safeguarding Discussion Forum to discuss complex cases with senior management. However, to ensure future resilience during periods of system-wide service disruption, senior leaders should consider how to effectively and consistently balance resource across all services.

5.46. There were examples of support being provided by other services, both within Adult Social Care and across the Council more widely to help manage these service pressures. Safeguarding enquiries and care and support assessments were also reallocated to other services, for example the Mental Health Assessment and Review Service, which usually deals with hospital and prison discharge planning. Practitioners commented that as they had not previously dealt with safeguarding on duty, more detailed prompts on the ICT system would have been helpful in supporting them to analyse risks, for example to prompt practitioners to consider whether a person refusing a service has a history of mental health concerns or self-neglect.

5.47. Estate Management Services also provided additional support as safeguarding partners during this period, carrying out planned, structured and random visits in response to concerns raised. However, housing staff held a case load of 500 properties each, so were limited in the support they could offer, largely focussing on people in sheltered accommodation as these were generally the highest risk cases. It was noted that post-covid, increasing numbers of people were being placed in general needs accommodation who would previously have been placed in sheltered accommodation and who were struggling to manage in their tenancies.

5.48. Estate Management Services are also responsible for deciding when Supportive Tenancy Management should be initiated. The Supportive Tenancy Management process is for those tenants where there are concerns regarding tenancy sustainment. It may also be used for new tenants where housing officers are working with the tenant to prevent tenancy failure. Such concerns can be in relation to the tenant seriously neglecting themselves, their property or where they are at risk of being exploited. Pre-tenancy assessments allow housing officers to proactively assess any support needs of the tenant. If a support need is identified, a referral to a support agency will be offered and a risk-based approach will be undertaken to build a tailored approach to ensure the sustainment of the tenancy. When Bridget and Cara were moved to their new home in 2016, they were initially supported through this process, but as they were successful managing the tenancy and not at risk of eviction, this was concluded. While it was reasonable that the case was kept open for over a year, it may be that in cases where tenants have a history of self-neglect, this support could be extended for a longer period to ensure that improvements can be sustained over time, giving the enduring and cyclical nature of self-neglect.

5.49. The last contact with professionals in Bridget's case was in March 2021, when Bristol City Council's Housing and Landlord Services sent out a gas engineer because the gas safety inspection was significantly overdue and previous appointments had been missed. The officer was met by a young woman, presumably Cara, and checked the boiler in the hallway. Although he reported that there had been some parcels in the doorway, he did not record any concerns in respect of the state of the property. The gas team were reported to be proactive in reporting concerns to the safeguarding team, with a referral form that supported consideration of wider hoarding issues, in particular when they observed safety issues such as fire hazards. Their manager thought that having access to tools such as the clutter rating index could better support staff to objectively determine whether a referral was required. However, he also observed that in cases where staff had made referrals in the past, they would return 12 months later to find the property in the same or worse condition, either because no intervention had been offered, or a short-term intervention such as decluttering had not resulted in long-term risk reduction.

5.50. Following Bridget's death, the duty social worker carried out a home visit and noted that boxes of her food supplement, were piled high in the hallway and outside the flat, spoiled by the rain. The third-party provider of the food supplement is commissioned by the Bristol and Weston Consortium Feeding Group ('the Consortium')[18]. Section 8.10 of the contact between the consortium and the third-party provider[19] ('the contract') sets out that the third-party provider will contact Home Management Services[20] of failed deliveries at the earliest opportunity, although a safe location, such as a shed or garage could be agreed with the patient and carer. Section 8.6 of the contract requires the third-party provider to undertake a monthly stock check of items delivered to the patient's home. This is expected to be done by way of a telephone conversation with the patient and is predicated on the basis of ensuring that there are sufficient stock levels, rather than monitoring an oversupply.

5.51. There is no indication that Home Management Services were notified of the failed deliveries or oversupply in this case. It is also acknowledged that, during the Covid Pandemic, delivery staff would have been prohibited from entering a person's home so would not have been able to verify if there was oversupply. Although beyond the remit of this review, because the membership of the Consortium extends beyond members of the KBSP, the Consortium should explore with the third-party provider what happened and consider whether more robust monitoring of this contract is required. Further, consideration should be given to whether the

[18] Including North Bristol NHS Trust, University Hospital Bristol NHS Foundation Trust, Weston Area Health Trust, South Gloucestershire CCG, Bristol CCG, North Somerset CCG, Bath & North East Somerset CCG and Avon and Wiltshire Mental Health Partnership NHS Trust

[19] Contract Reference F1658, undated

[20] Defined as South Gloucestershire Clinical Commissioning Group, Bristol Clinical Commissioning Group, North Somerset Clinical Commissioning Group and Bath &North East Somerset Commissioning Group collectively

contracts should be amended to explicitly provide for notification to be given to Home Management Services in circumstances where product is piling up.

5.52. Despite the overwhelming challenges caused by the pandemic, it is important to capture and expand on the positive developments, such as the community response to supporting vulnerable neighbours during lockdowns. The First North team has started an initiative to get a better foothold in the community, allocating each team member an area within their locality to build local connections with police, housing and volunteer groups to improve education, communication and proactively identify those at risk. Embedding safeguarding in the community and nurturing a sense of communal responsibility will support the team to identify people for whom risks are emerging before these risks become entrenched.

Systems finding

5.53. Pressure on resources during the Covid-19 pandemic resulted in inconsistencies in safeguarding services across Bristol Adult Social Care, which impacted on the capacity of affected services to effectively manage and mitigate safeguarding risks. Leaders should take the opportunity to build on some of the partnership working and community engagement developed during the pandemic to strengthen system resilience.

Recommendation 12: *KBSP should seek assurance from all partners that their business continuity plans explicitly incorporate measures to address safeguarding during periods of crisis, applying the lessons learned during the pandemic, and that these are regularly kept under review. This should include maintaining a central list of emergency contacts across all safeguarding partners.*

Recommendation 13: *Existing risk assessment tools, such as clutter rating tools, Malnutrition Universal Screening Tool, Pressure Care/ Tissue viability should be shared more widely across the partnership, to ensure that the frontline officers who regularly carry out home visits understand when a safeguarding referral should be made, or re-referred.*

Recommendation 14: *Housing Services should consider whether to include a requirement for tenants to comply with regular Home Fire Safety Visits as a condition of tenancy agreements.*

6. Glossary

ADASS	Association of Directors of Adult Social Services
CCG	Clinical Commissioning Group
KBSP	Keeping Bristol Safe Partnership
CMHT	Community Mental Health Team
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICS	Integrated Care System
SAR	Safeguarding Adult Review