OPEN

Adults and Health Committee

20th November 2023

ANTON – Safeguarding Adults Review

Report of: Helen CHARLESWORTH-MAY Executive Director, Adults

Report Reference No: AH/25/2023-24

Ward(s) Affected: All

Purpose of Report

1 The purpose of this Report is to inform the Adults and Health Committee about the Safeguarding Adults Review regarding "ANTON". The Safeguarding Adults Board appointed an independent author, Mike Ward, to facilitate the review and write the final report, which accompanies this briefing. It has been approved by the Safeguarding Adults Board and is ready to be published on the SAB website.

2 The Safeguarding Adults Board have a legal duty to undertake a Safeguarding Adults Review, when it suspects that an adult at risk has died due to abuse or neglect and agencies could have worked better to support the individual. Cheshire East Council is committed to creating safe communities with accessible services, where people can live free from abuse or harm, and to creating a culture of learning where lessons can be learned to prevent future harm. This Safeguarding Adults Review meets the Strategic objectives of the Council.

Executive Summary

3 A referral was made to Cheshire East Safeguarding Adults Board following the death of ANTON who died at home from pneumonia in November 2021. The Safeguarding Adults Review Panel met in January 2022 and the Safeguarding Board agreed that the criteria for a statutory Safeguarding Adults Review were met. The scope of the SAR covered the period 2019 – 2021, which coincided with COVID restrictions.

4 ANTON was Slovakian. He was 64 when he died. It is understood that he had come to England about 12 years previously. In Slovakia he had been

in military or police service and latterly he had worked as a lorry driver. He had no family and appeared to be socially isolated. His understanding of the English language was poor.

5 ANTON had poor physical and mental health and was known to many services.

6 ANTON died of pneumonia in November 2021. He was found on the floor in the foetal position and was wearing a pair of yellow crocs that were filthy and covered in mould. He had engrained dirt under his fingernails, which appeared to show that he neglected his cleanliness and hygiene.

7 As part of the Safeguarding Adults Review all Agencies submitted Individual Management Reports to indicate how and why they had been in contact with ANTON. The Author collated this information and provided an analysis in line with the key lines of enquiry. A Practitioner Event provided valuable insight into the case. Within the final report the Author was able to identify key message regarding working with individuals who are seldom heard and/or who have language barriers and how loss of settled status can have a devastating impact on access to accommodation, welfare benefits, social and healthcare outcomes.

8 The details of the SAR are not contained within this Report, as they are contained within the SAR Report itself.

RECOMMENDATIONS

The SAR Report has made the following specific recommendations.
The Safeguarding Adults Board will oversee the actions and progress:

1. The Board Partners to ensure that vulnerable foreign nationals have access to expert support through the benefit system.
2. All Agencies should make information available in native languages and use interpreters.
3. The SAB is to provide guidance on how to engage with seldom heard people.
4. All Partners to utilise escalation procedures, Multi Agency Meetings, and the Complex Safeguarding Forum
5. The ICB to improve how it responds to chaotic and seldom heard Individuals.
6. All Partners to ensure compliance with Mental Capacity Legislation, including Executive Functioning
7. All agencies to be aware of how to raise a safeguarding concern.
8. Public Health to ensure Agencies use robust alcohol/drug screening tools.

The Corporate Leadership Team and Adults and Health Committee is requested to accept the SAR Report and Recommendations.

Background

9 The purpose of a Safeguarding Adults Review is to:

- Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard ANTON
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of ANTON are heard regarding his experience of accessing care and support in Cheshire East.

10 ANTON died in tragic circumstances. This case review has highlighted emerging themes around Self Neglect, particularly for someone who could not speak English, had physical and mental health conditions, and was not provided with information or translation services in a timely or consistent fashion by all services, which led to missed appointments and access to treatment.

11 Although many agencies worked effectively to overcome ANTON's language barriers, not all agencies recognised the problems posed by his lack of English and messages and letters were still being sent in English at points near to the end of his life. This is not a general statement that all migrants who lack English language skills should receive all messages and calls in their native language, but when dealing with complex and vulnerable individuals this is clearly going to be a necessity.

12 ANTON's care highlights the need for relevant professionals to have either more training or easier access to expert guidance on supporting foreign nationals through the benefits system. At a more nuanced level it shows the impact that loss of benefits can have on an individual. In ANTON's case, it is arguable that this experience impacted on many of his subsequent interactions with services.

13 Aspects of the Primary Care response to ANTON, particularly in the last two months of his life have been acknowledged to require review e.g. the recording of telephone contacts. However, this response may suggest a wider need to review the way in which Primary Care responds to chaotic

and vulnerable individuals who are seldom heard/hard to engage in standard Primary Care appointment systems.

14 This review agrees that the response to seldom heard/hard to engage clients will be strengthened by the development of a local policy or procedure which guides professionals on how to work with such clients. It should include comment on the level of risk that requires a more assertive approach and identify the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management.

15 ANTON'S care would certainly have benefited from more multi-agency management and escalation to senior staff or groups. The only identifiable multi-agency meeting was held in the month before he died. It was acknowledged in at least one of the IMRs that professionals should be using such approaches with this client group and using Multi Agency High Risk Forums such as the Complex Safeguarding Forum.

16 This SAR raises questions about training on the use of the Mental Capacity Act with vulnerable individuals, including training around executive function / capacity. However, it also highlights the importance of not seeing "having capacity" as an end to the need to make efforts to help people with their decision-making. This has been clearly stated in both the original and draft Codes of Practice to the Act.

17 Two safeguarding referrals were made during the review period. The first of these was closed very swiftly. The second did not progress to a S42(2) enquiry in line with the local safeguarding policy. However, social care involvement did continue up until ANTON's death. It is possible that further safeguarding concerns should have been raised at other points in the two-year period.

18 ANTON may have had a history or pattern of alcohol use disorders. The challenge is that there was a lack of a detailed understanding of the nature of his use. This highlights the importance of standardised screening tools. Following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of communicating information about alcohol-related harm.

19 The Author of the SAR has identified areas of Good Practice: Some agencies and individual professionals made significant efforts to engage with ANTON and to improve the quality of his life. Professionals from his Housing Association and Floating Support service made assertive efforts in the last year of his life to engage with him and secure the help that he needed. Before that, and largely before the review period, his Housing Association's Money Advice Officer had made highly praiseworthy efforts

to resolve the problems he experienced with the loss of his settled status and the right to benefits.

20 ANTON had problems communicating in English and although there were problems around this, many agencies e.g. his Housing Association, Floating Support Service and Ambulance Service, actively used translation services and other agencies including Primary Care and the Hospital were coming to the recognition of this need. He was matched at one point with a Slovakian volunteer from a local service. Again, outside the review period Mental Health Reablement identified a Polish Reablement Worker to support him because of similarities between the two languages.

Consultation and Engagement

21 This section is not applicable. All relevant agencies contributed to the Review which has been approved by the Safeguarding Adults Board.

Reasons for Recommendations

22 The recommendations have been based on the learning from the Safeguarding Adults Review. The Safeguarding Adults Board will oversee actions arising from the Recommendations.

Other Options Considered

23 This Section is not applicable.

Implications and Comments

Monitoring Officer/Legal

24 There are no legal implications for this Report. The Safeguarding Adults Board has fulfilled its Legal Duty to commission a Safeguarding Adults Review.

Section 151 Officer/Finance

25 There are no financial implications for this SAR.

Policy

26 There are no Corporate Policy implications for this SAR.

27 The Adult Safeguarding Board will be monitoring the Recommendations indicated in this Safeguarding Adults Review.

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To protect and support our communities and safeguard children, adults at risk and families from abuse, neglect and exploitation.

Equality, Diversity and Inclusion

28 ANTON was from Slovakia. One of the key lines of Enquiry focussed on how well Agencies communicated with him prior to and during the COVID pandemic. The Safeguarding Adults Board will seek assurance from Partner Agencies about how they are improving access to services, as part of the recommendations from this Review.

Human Resources

29 There are no Human Resource Implications from this Review. However, Staff should be able to access appropriate training to help inform and improve knowledge and skill in managing self neglect.

Risk Management

30 There are no Risk Management Implications from this Review.

Rural Communities

31 There are no implications to rural communities in this Review.

Children and Young People including Cared for Children, care leavers and Children with special educational needs and disabilities (SEND)

32 There are no implications for Children and Young people in this Report.

Public Health

33 The SAR makes a specific recommendation in relation to Public Health and the use of Alcohol Screening Tools. Once applied this will have a positive impact on the health and wellbeing of Cheshire East Residents, but particularly Adults at Risk who may present to Adult Social Care.

Climate Change

34 There are no recommendations connected to Climate Change in this Report.

Access to Information	
Contact Officer:	Sandra Murphy Head of Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk
Appendices:	Appendix 1 - Safeguarding Adults Review Report: April 2023
Background Papers:	Safeguarding 7 Minute Briefing: ANTON