West Sussex Safeguarding Adults Board
Making Safeguarding Personal

Learning briefing in respect of John

About John

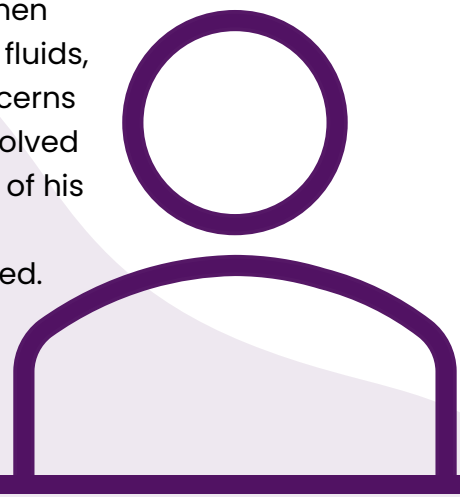
John was a man, devoted to his wife, who loved to collect Rupert annuals and audiobooks. He served in the military for a number of years, subsequently working in a variety of farm and factory jobs, before settling into a role that he cherished, as a postman.

When John's wife became ill, he nursed her until her death, by which time they had been married for 15 years. John moved into a care home in December 2020, after fracturing his hip.

John had a range of physical health issues and was reported to have instances of paranoid ideation, although he did not have any formal mental health diagnoses.

On 12 June 2022 John made the decision to end his life by way of refusal of food and fluids. It was his 88th birthday. Eleven days later, on 23 June 2022, John passed away at the care home where he lived. The official cause of death was listed as renal failure, dehydration, and frailty of old age.

During those eleven days when John was refusing food and fluids, five adult safeguarding concerns were raised by agencies involved in John's care. Assessments of his mental health and mental capacity were also conducted.



Findings of the review

The report into the circumstances surrounding John's death identified the following:

- There was limited evidence of professional curiosity resulting in significant information not being known by professionals, and potentially a lack of defensible decision-making.
- The voice of John's family was not sought or heard.
- There was a lack of multi-agency working.
- The Sussex Safeguarding Adults Policy and Procedures regarding self-neglect were not initiated or followed.
- Limited staff resources led to unnecessary delays for assessments and information-sharing.
- Agencies did not reach an agreement of John's capacity status.

"Where there is a lack of professional curiosity questions may arise concerning how robust decision-making was by professionals. As professionals when we make a decision, we don't have the benefit of hindsight. We do not know what will happen. We may, in the light of later events or evidence, have made a decision that had an untoward outcome. However, it will be a defensible decision if we can justify our decision-making by demonstrating an evaluation of all available information has taken place." (Safeguarding Adults Review in respect of John, 2023, p.17)

Recommendations

The report made five recommendations to the Safeguarding Adults Board in light of these findings.

Professional curiosity and defensible decision-making: Ensure that staff are aware of the importance of, and how to implement, professional curiosity.

Self-neglect procedures: Ensure that agencies are promoting the self-neglect procedures and incorporating them into staff training.

Agency resources: West Sussex County Council should provide assurance that it is aware of the risks arising from Approved Mental Health Professional service pressures, has processes in place to manage these risks, and is working to achieve a service that can meet demand in line with statutory requirements.

The voice of carers and families: The voice of carers and families should be heard when undertaking assessments of capacity and mental health.

Mental capacity: Agencies to be aware of mental capacity practice in cases of self-neglect, including executive function and fluctuating capacity.

Key considerations for your practice

Consider, within your teams, how you can implement the recommendations into your own practice. Consider:

- How can you strengthen your decision-making, to ensure that you are making defensible decisions? How can increased professional curiosity support this?
- Can you promote the Sussex Safeguarding Adults Policy and Procedures self-neglect chapter within your agency? Have you shared the new Self-Neglect Practice Guidance for Staff (PDF, 274KB)?
- How can you prioritise hearing the voice of carers and family, where appropriate, when undertaking assessments of capacity and mental health? What impact might their view have on your assessments?
- Are there opportunities to review your agency's training in relation to mental capacity? Does it refer to mental capacity in cases of self-neglect? Does it cover executive function and the challenges of fluctuating capacity?

Further reading

To extend your learning, refer to the following learning resources:

- Sussex Multi-Agency Procedures for supporting adults who self-neglect
- Professional curiosity learning briefing and podcast
- Self-neglect learning briefing and podcast
- Mental capacity learning briefing and podcast
- Self-Neglect Practice Guidance for Staff (PDF, 274KB)