Response to Report to Prevent Future Deaths

I am writing in response to your Regulation 28 report following the investigation and inquest into the circumstances of the death of Gerald Goodwin on 11th November 2022.

I hope to answer the concerns you have raised as follows:

1. **The Liaison and Diversion team of Lancashire and South Cumbria NHS Foundation Trust had contact with Mr. Goodwin in September and October 2022. Liaison and Diversion Team members visited Mr. Goodwin at home and concluded he was at risk of self-neglect. They noted his appearance, his living conditions and the fact that he was not taking prescribed medication. On any view Mr. Goodwin was vulnerable: he suffered from Alzheimer's dementia and was thought o misuse alcohol. The Liaison and Diversion Team considered that there were safeguarding concerns in respect of Mr. Goodwin and referred hm to the Adult Social Care Team of Cumbria Council. I understand that the team in question now forms part of Westmorland and Furness Council. Despite this referral from practitioners who had personally visited Mr. Goodwin, it was rejected at triage on 5th October 2022. I am concerned that this indicates that an approach to triage is being taken which pays insufficient regard to the concerns of practitioners who had personally witnessed apparent safeguarding concerns.**

The referral in question was received by Adult Social Care on 5th October 2022. The referral identified potential safeguarding concerns and was therefore considered initially by the Safeguarding Team which sits within Adult Social Care. It was decided at that stage that the threshold for a statutory safeguarding enquiry was not met and the provision of social work support was considered to be more appropriate. The fact that the initial triage concluded that the threshold for a statutory safeguarding enquiry was not met does not mean that any safeguarding issues would not be addressed. The approach would generally be that the individual should be given the opportunity to engage with a Care Act assessment and potentially reablement but that any safeguarding issues would also be addressed if they emerged during the process. One of the options available to the social work team is to make a referral to the reablement service. This service helps individuals to learn or re-learn skills to engage in activities or tasks that are important to them.

Whilst the referral relating to Mr. Goodwin was never rejected by Adult Social Care, the need to improve the management of referrals from three key perspectives is accepted and the following areas of improvement have been identified:

a. Where self-neglect is a possible factor in the individuals' circumstances.
b. The approach taken to triaging a referral.
c. The timescale between reablement intervention being requested and contact being made**.**

These three issues have been addressed below.

<u>Where self-neglect is a possible factor in the individuals' circumstances</u>

A Self-Neglect Strategy was put in place under the direction of the Westmorland and Furness Council Principal Social Worker and this was implemented on 1st July 2023. This strategy aims to strengthen Adult Social Care's practice and response to people who are or may be self-neglecting.

The strategy ensures that if a referral such as the one relating to Mr. Goodwin should come into Adult Social Care now, a face-to-face visit would take place which would take into account factors relating to capacity and risk.

The key messages of the strategy are as follows:

- ALL circumstances where self-neglect is or may be a factor MUST have a face to face in-person visit from a practitioner to determine risk, need and appropriate support.
- Assessments of the person's capacity for decision-making must be completed regularly. Practice should reflect our common law duty of care and professional accountability. The appearance of capacity and/or non-engagement do not equate to risk reduction.
- Risk assessment must be thorough, dynamic and involve other relevant parties/professionals as appropriate.
- Practitioners must employ concerned curiosity and respectful challenge. This means not taking information on face value, but being alert to differing perspectives, our own professional accountability and the issues around executive functioning.
- Managers and supervisors must provide support around the nature and timeframes for working with self-neglect, reflection in supervision and consider escalation either internally or externally if required.

<u>The approach taken to triaging a referral</u>

In respect of making improvements to the triaging process new guidance on 'Decision Making for Single Point of Access and Practitioner Teams' has also been introduced under the direction of the Principal Social Worker. This guidance was introduced in September 2023.

The guidance aims to strengthen practice in response to people referring themselves or being referred into Adult Social Care through our Single Point of Access (SPA).

It reflects the learning from our SPA and Multi-Disciplinary Team (MDT) pilot in the summer of 2023. This pilot sought to ensure that decisions about individuals referred for our services are made in a timely way and supported by a thorough multi-disciplinary process so that the right professionals are involved from the earliest opportunity. Through actively seeking to improve the timeliness and streamlining of decision making, and reducing the number of professional 'hand-offs', the learning and recommendations from that pilot seek to strengthen and embed the following principles:

- Decision-making to be collaborative, respectful and supportive.
- Decisions to be made on the basis of the best outcome for the person.
- All decisions to be made by the end of each working day.
- Decisions made will result in a referral's one way journey from SPA to the agreed team or practitioner. Any further change in allocation of the work will be the responsibility of the team manager.
- All duty officers for the day must prioritise participation in the twice daily SPA Multidisciplinary calls unless they are out on a duty visit.
- The practice guidance should be followed but does not replace professional judgement in circumstances of significant concern, need or risk.

I am confident that following the implementation of the guidance summarised above, should a similar referral to that of Mr. Goodwin's be received in the future, a more robust triage discussion would be in place and that would include consideration of mental capacity.

<u>The timescale between reablement intervention being requested and contact being made</u>

Adult Social Care and Cumbria Care Services (who operate the reablement service) have set up a task and finish group to undertake a quality assurance review and to identify required process changes.

The remit of the task and finish group is to bring together the relevant individuals to undertake a process mapping review to determine which parts of the current process work well, and which parts require improvement or change. One of the lessons learned from this investigation is the need to review how cases are triaged in the first instance to determine priority and to avoid unnecessary delays for those most in need.

The triage guidance referred to above and the self-neglect policy, also now ensures where there are concerns of self-neglect, we would carry out a visit by a social worker which includes a robust risk assessment, prior to making any onward referrals for reablement.

2. **The witness statement on behalf of the Adult Social Care Team explains that after the refusal to conduct a safeguarding enquiry, Mr. Goodwin was nevertheless referred for the Social Work Team to 'engage' with him. A Social Worker took steps to engage with Mr. Goodwin and his family and concluded that a care assessment was appropriate. Despite this the 'Reablement Team' referred the case for closure indicating that they did not consider that such an assessment was not required. I am concerned that this indicates further circumstances in which the needs of a vulnerable person might be overlooked. After a Social Worker considered that a care assessment was needed the Reablement team appear to be able to come to an alternative view and close the case without further discussion or rationale. In another case this might lead to a vulnerable person being disregarded.**

In some situations the threshold for a statutory safeguarding enquiry is not met and this can also apply in circumstances where self-neglect is a factor. In this case the practitioner recognised that although a formal safeguarding enquiry was not necessary, there needed to be further involvement via Adult Social Care in order to engage with Mr. Goodwin regarding the concerns that had been raised. As stated earlier reablement was identified as appropriate but it was an error not to refer the case back to the social work team when Mr Goodwin declined reablement input. It is recognised that the reablement team and the social work team should have worked together more closely in relation to Mr. Goodwin in order to promote engagement. We now have weekly meetings between reablement and adult social care which provides an opportunity for similar situations to be discussed. In addition to this risk assessments are carried out by social workers for those customers who are awaiting a reablement service.

Both the Self-Neglect Strategy and the guidance on Decision Making for Single Point of Access and Practitioner Teams referred to in section 1 address some of the issues that have been raised in respect of the above. Examples of how this is achieved include office-based duty workers who have face to face timely discussions regarding the appropriate action in respect of inkling referrals. It also includes twice daily multi-disciplinary meetings (including safeguarding staff where appropriate) to resolve any concerns relating to incoming referrals and weekly meetings between Social Work and reablement

teams so that any concerns regarding particular individuals can be highlighted and actions agreed quickly.

3. **Fortunately, the Closure Team noticed that the Reablement Team were seeking to close a case in which another social worker had recommended a Care Assessment. They sent the case to the 'Short Term Allocation Tray'. This should have resulted in a referral but that did not happen. I am concerned that in a future case a referral might not be generated and a person's needs overlooked. The witness statement prepared by the Service Manager indicated 'we are looking at a way of ensuring that notifications requiring an action are only acknowledged once the task is complete'. This indicates that such work has not yet borne fruit and the risk still exists.**

Following completion of the witness statement a process was put in place in place and a directive was shared with Adult Social Care staff on 10th October 2023. This instructs staff that when they receive a case note asking for an action to be completed, the case note is only acknowledged once the task has been carried out. This will ensure that when there are competing demands for practitioners the case note notification will serve as a prompt and a task is not overlooked.

4. **Thereafter Mr. Goodwin's case was allocated and de-allocated to a social worker within the space of one day, without anything being done. It is said that there is no note or explanation for this. I am concerned that, once again, the ability of a case to be allocated and deallocated within a short period and without anything having been done may enable a case to 'fall through the cracks'. Indeed, the referral for the care assessment was not ultimately actioned until 25th November 2022, 2 weeks after Mr. Goodwin died.**

Following completion of the witness statement a process was put in place in place and a directive was shared with Adult Social Care staff on 10th October 2023. This instructs staff that if a case is picked up to be allocated and is subsequently de-allocated this must be recorded as a case note on the electronic case recording system with a clear explanation of why the case is being closed, thus ensuring a clear audit trail is in place. We have also implemented a system where there is management oversight of all case closures to provide increased governance in this area.

Regular case file audits are already in place which do look at the case chronology to ensure that appropriate actions have been taken.

5. **More generally, it is striking how many different teams and systems appear to co-exist and require mutual communication and cross referencing. I am concerned that the above narrative demonstrates that those systems do not function effectively. I am concerned that this exposes other vulnerable adults to risk.**

This has been recognised and new guidance on decision making for Single Point of Access (based on the pilot work undertaken to improve the Multi-Disciplinary Discussions relating to new referrals) together with the new strategy relating to Self-Neglect have been introduced under the direction of the Principal Social Worker. As stated previously, this guidance introduces a structured approach to improve communication both between professionals and between different teams. Examples of how this is achieved include office-based duty workers, twice daily multi-disciplinary meetings to resolve any concerns relating to incoming referrals and weekly meetings between social work and reablement teams so that any concerns regarding particular individuals can be highlighted and actions agreed quickly.

I hope this helps to answer the points that you have raised. However, if we can assist with anything further, please let me know.