Chief Executive's Office
BCP Council Civic Centre
Bourne Avenue
Bournemouth
BH2 6DY

FAO Mr Allen

Date 19 June 2024
Your ref 2309778
Our ref GF/ER
Contact [redacted]

Sent via email: Dorset Coroners
[redacted]

Dear Mr Allen,

Re Regulation 28 Report following the inquest touching on the death of Neville Abbott

We acknowledge receipt of the Regulation 28 Report issued to BCP Council following the inquest touching on the death of Mr Neville Abbott. The report, dated 3 May 2024, was received by BCP Council on the same day. Our thoughts are with Mr Abbott's family following their loss.

After Mr Abbott died, we undertook a review of the care and support offered and we have made changes to the way in which we support people who find it difficult to engage with support services. These changes were shared with the Inquest parties in our Action Plan.

Following the Inquest, we undertook a series of debrief discussions with the witnesses and the further learning and actions are included in our response to your concerns below.

In respect of the specific Regulation 28 matters of concern notified to the Council, I will respond to each of these in turn:

1. **The lack of use of the Professionals Checklist by the Adult Social Care (ASC) Practitioners who had contact with Mr Abbott.**

We linked with the practitioner and manager, who still works for ASC, as part of a debrief after the Inquest. During these discussions, they shared that several actions to prevent future deaths had already been undertaken and they made several reflections on how the Inquest has impacted on their practice:

The reflections of the practitioner, in relation to their own practice and actions, are listed below:

a) Gained a deeper understanding of her responsibilities as a registered practitioner to provide direction to non-registered practitioners.

b) Reflection that undertaking a Care Act assessment of Mr. Abbot's needs could have prompted consideration of other interventions or prompted convening a Multi-Agency Risk Management meeting (MARM).

c) Reflection that had she or her colleague sought management oversight, the above may have been prompted.

d) Reflection that had she completed a Self-Neglect Checklist, she would have considered convening a MARM and will do so in the future.

e) The above reflections have prompted her to now require practitioners who she oversees to undertake regular contact with people living in similar circumstances to Mr. Abbott, i.e. a weekly welfare check.

f) Reflection that a MARM can be effective in sharing information and a method to escalate unmitigated risks; she was supportive of Option 2.1.f below re: Complex Case Panel as a method of escalating issues within ASC and with partner agencies, such as contact with Community Mental health Team.

The reflections of the manager, in relation to their own practice and actions, are listed below:

g) Prompted discussion with the practitioner above, to facilitate reflection during and after the Inquest.

h) Prompted discussion with peer managers, which has led to an approach of undertaking regular face to face welfare checks with people who find it difficult to engage and where risks are not fully mitigated. This included managers considering enabling joint working of such cases.

i) Prompted review of all people where ASC manages their finances, to ensure any concerns for welfare are addressed and monitored as detailed above.

j) Reiterated need for management oversight of all cases and closures, i.e. managers must ensure a case note is added to the person's record and include any actions/options that have been discussed as required. Regular monitoring should be undertaken and recorded by the manager to ensure actions are completed.

k) Prompted discussion within Locality and Acute Hospital Services to raise awareness of the Self-Neglect checklist, MARM framework and to encourage their use were discussed at the service managers planning meeting. This has led to service managers discussing in their team managers meeting and further cascading to front line staff. This included raising awareness of available self-neglect/hoarding training and MARM Training.

l) Checked that safeguarding training is up to date for all practitioners and instructed uptake if not.

m) Reminded managers that all cases should be risk screened using the Risk and Demand Guidance (so high-risk cases allocated quickly).

n) Reminded managers to check that assessment of risk in assessments is robust and that a full risk assessment is completed where unmitigated risk is identified. Ensure risk assessment is shared where necessary and communicate with partner agencies over mitigation of risk, possibly through use of a MARM. Ensure practitioners give evidence-based rationale for both actions and inactions.

o) Reminded managers of need to raise awareness with practitioners of the need to consider executive functioning alongside capacity; specifically, to explore why a person is making what appear to be unwise decisions and whether they have the skills to carry out tasks to improve the quality of their lives and are perhaps choosing not to because they can't achieve it without support. This relates to professional curiosity and not assuming capacity if there may be reasons to doubt it.

p) Reminded managers to encourage practitioners to use professional curiously and not accept the status quo without thorough assessment of needs and risk.

q) Reminded managers to discuss cases where consent to contact family/those with an interest in the person to be revisited if refused and ensure contact details for Next of Kin are recorded when consent given.

r) In relation to the General Practitioner Multi-Disciplinary Team meetings, which are held weekly in most surgeries, when actions are identified the person will remain on Virtual Ward to ensure any actions have been completed satisfactorily.

s) Reminded managers to ensure they and practitioners have good legal literacy and seek advice, to ensure all statutory interventions and frameworks are considered.

In respect of your concern that little has changed regarding the awareness and use of the Professionals Checklist more widely in ASC, we will respond to this below - however, we also hope that the actions detailed above provide reassurance too.

2. **The lack of knowledge of and use of the Professionals Checklist by ASC practitioners. Consequently, missing the requirement to consider calling a MARM.**

The changes we have made are detailed below:

a. On 6 June, we instructed all operational staff in ASC via email to complete the Self-Neglect Checklist when they are allocated a person who appears to find engaging with services challenging. We will update our own 'Managing Risk and Engagement Guidance', to include this information.

b. The Self-Neglect Checklist is now much more prominent on our updated Adult Social Care intranet site, to help raise awareness in the future.

c. Based on the above instruction, we will also be holding a mandatory webinar for all staff on 26 June 2024. The purpose of this webinar is to further highlight what constitutes self-neglect, to highlight the guidance that is available in the Safeguarding Adults Board (SAB) Procedures and our own guidance, including the requirement to use the Self-Neglect Checklist. We will remind practitioners that they are required to undertake a Risk Assessment if a person 'declines an assessment, services or support' and to discuss this issue with their line manager. We will promote the use of the MARM framework in supporting the formulation of a multi-agency risk assessment and management plan.

d. We will continue to direct all case holding ASC staff to watch the SAB MARM training videos at the above webinar.

e. We will be undertaking a deep dive audit during June and July into cases where self-neglect is mentioned in case records. We will be looking for assurance that practitioners have been curious, assertive and have sought to manage risks appropriately, including consideration of holding a MARM. We will seek to redress any circumstances where risks are not managed appropriately through robust practice and management oversight, escalating matters to Section 42 Enquiries if necessary.

f. We are undertaking a review of our existing Self-Neglect & Hoarding Panel function to explore whether a Complex Case Panel is more likely to prompt practitioners to escalate cases where risks are not fully mitigated. We anticipate that this will allow a formal route for practitioners to escalate issues to both their own senior managers, but also other partner agencies. We aim to have completed this review by August.

g. As part of our ongoing improvement journey, we will be publishing Mental Capacity Act practice guidance in August. This guidance includes reference to self-neglect and links it with the need to consider assessment of executive functioning when people are self-neglecting. We are developing a plan on how to promote the practice guidance; we intend on its publication being high profile within services.

h. We will continue to operate monthly peer group drop-ins for practitioners to discuss complex cases with advanced practitioners.

I hope this detailed information is useful to you and reassures you about the depth of our response to the issues raised in this case, but please let me know if you need any more information.

Yours sincerely,

[redacted]

[redacted]
Chief Executive
BCP Council