Croydon
Safeguarding Adults Board

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Safeguarding Adults Review
Mrs Valerie Beeden

Report Author

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1 THE REASON FOR THE SAFEGUARDING ADULTS REVIEW

1.1. On the 8th February 2017 police responded to a call from a safeguarding social care worker who had attended the address of Valerie, an 89 year old widow. This was following concerns for her safety. The worker was unable to get any response from Valerie. Police were called and gained entry to the premises. Once inside they discovered Valerie's body. A small fire and a radio were still on. Whilst it has not been established, it is possible that she may have passed away a couple of months previously.

1.2. Valerie was born in India and worked as a teacher until 1992. She owned a 4-bedroom premises in Croydon. She had a history of severe mental health problems but had not been actively known to the mental health service for ten years. The service ceased trying to assertively engage with Valerie in 2007. She had been deregistered by her GP in 2010.

1.3. Valerie was a vulnerable adult who had been in receipt of services during her life. She had been the subject of two safeguarding referrals and two adult at risk referrals during 2016. The Croydon Safeguarding Adults Board (CSAB) independent chair agreed that these circumstances reached the requirements for a Safeguarding Adults Review (SAR) as set out in the Care Act 2014.

1.4. There has been a significant delay in commencing this SAR. The case was initially referred to the Croydon Safeguarding Adults Board (CSAB) SAR group in April 2017. At that time the group did not consider that the case met the threshold for a SAR. In June 2017, the previous independent CSAB chair decided that it would be a SAR. This was one of a number of cases being considered for a SAR. In July 2018, the current independent chair reviewed the cases and it was agreed to continue to progress this case as a SAR.

2 THE REVIEW PROCESS

2.1. The author of this report was commissioned in January 2019 to undertake the review in line with guidance set out in the Care Act 2014. The independent reviewer is Brian Boxall, a retired Detective Superintendent who served in Surrey Police for 30 years. Since his retirement, he has been an independent safeguarding consultant who has undertaken a number of serious case reviews, in relation to both adults and children. He is currently the independent chair of a Safeguarding Adults Board.

Methodology

2.2. Terms of reference were agreed (Appendix A) and the following agencies were identified as having some involvement with Valerie:

- South London and Maudsley NHS Foundation Trust
- GP
- Croydon Adult Social Care

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- Metropolitan Police
- EDF Energy
- Environmental Health
- Clinical Commissioning Group

2.3. Each organisation provided initial information and then follow-up information as requested by the author.

2.4. A Safeguarding Adults Review (SAR) Panel was appointed to work with the author. This panel was chaired by Annie Callanan, the independent CSAB chair, with representation from the following agencies:

2.5.
- Croydon Adult Social Care
- Croydon Police
- Croydon Health Services
- Clinical Commissioning Group
- South London and Maudsley NHS Foundation Trust
- Panel Administrator

Review Period

2.6. It was set out in the terms of reference that the period of time under review would be 2005 to 2016. The author requested that this time should cover the period up until the discovery of Valerie's body in February 2017.

Parallel Process

2.7. The Coroner's inquest has still to be completed at the time of this review.

Family Involvement

2.8. Valerie had no children. A nephew living in Australia who was close to Valerie and had been in contact with her up to 2016, was contacted and spoken to by the author and was able to supply some important information.

Report Structure

2.9. This report has been written taking into account that it may become a published document. The report sets out a brief overview of the case history and then focuses on an analysis of the agency responses.

3 CASE SUMMARY

3.1. Valerie was 89 years old when she died. She was born in India and moved to England at the age of ten. She became a teacher and moved to London where she continued teaching until 1992. She was married for 45 years until the death of her husband in 2003. They owned a 4-bedroom premises in Croydon which she continued to live in after her husband's death. She informed the mental health service that it was rather a large house which was difficult to cope with but it had many memories and she could not cope with the stress of moving.

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Events pre-2016

3.2. In 1971 Valerie was diagnosed with Schizophrenia. She had a number of admissions under the Mental Health Act (MHA) between 1971 and 2001.

3.3. In 2001 Valerie believed that she had fully recovered and stopped taking her medication. She relapsed and was again admitted under the MHA in 2001. This cycle of events recurred and she was admitted again in 2002, 2003 and 2005.

3.4. The service ceased actively trying to engage with Valerie in 2007. Her last face to face contact was in 2006 when her family raised concerns to the community mental health team [1](CMHT). She was assessed as not being detainable under the MHA. The team continued to try and engage with Valerie but she stated that she wanted to be referred back to her GP. In September 2006, Valerie sent a letter formally stating that she did not wish to be seen by the CMHT but wanted to be referred back to her GP. A decision was made to discharge her from the service. A letter was sent to her and her GP in October 2006 to inform them that she had been discharged from CMHT.

3.5. An attempt to engage with Valerie was again made in January 2007, following concerns raised by neighbours and family members. CMHT sent her a letter offering a home visit. Valerie sent a letter in return declining CMHT's intervention. A further attempt to contact Valerie was made in February 2007, following concern from a family member that she was isolated and possibly not eating properly.

3.6. In respect of her contact with primary health services, it has been established that she was deregistered from her GP in 2010.

3.7. Valerie's contact with other local services was very limited until 2016. Police records show that in March 2002 police attended a domestic abuse argument when Valerie argued with her husband because she thought the house was bugged. A social worker was in attendance.

3.8. At this time and up until the time of her death Valerie was extremely paranoid. She believed she was being spied on and that people were trying to break into her house.

3.9. In February 2008 her GP visited her home address to see if she still resided there. There was no reply with a large notice on the door stating "no entry".

3.10. In 2009 she reported to police that things had gone missing from her home. Officers considered that she was suffering from mental health problems. In July 2009 Valerie was arrested for common assault as she was thought to have thrown dirty water at a man who had parked his car near her house. No further action was taken by police with regard to any offences she may have committed. This decision was taken due to

[1] Community Mental Health Teams (CMHTs) support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

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Valerie's mental health issues. There is no evidence that police referred Valerie to any other agency.

3.11. In March 2010 her GP made a visit to undertake a Mental Health Review. It is not clear from records whether the doctor managed to speak with Valerie. There appears to have been no further contact with her GP.

3.12. In October 2012, an EDF Energy pre-disconnection visit (PDV) officer noted on Valerie's account that she had mental health issues.

3.13. In June 2016 her EDF account was passed to the EDF warrant officer; they were aware of her vulnerability. In July 2013, EDF received a letter from Valerie informing them that rather than the hassle of court etc, they should just make an appointment to remove the meter. They wrote back to her, seeking to confirm whether she meant the complete removal of the meter or exchanging it for a prepayment meter. The letter confirmed that they would not remove a meter and leave her without electricity. They received no reply.

3.14. In August 2013 EDF officers attended the address. They received no reply and sought confirmation from EDF Energy on whether to continue with the execution of the warrant and installation of a prepayment meter.

Events 2016

3.15. On the 12th February 2016 police attended a third party report that a male was seen breaking Valerie's guttering. No damage was found but police raised a Pre-Assessment Check (PAC) on the 1st March 2016, highlighting a number of concerns raised by neighbours about Valerie's poor health and lack of family support. There is no indication that the police made contact Valerie.

3.16. The Multi-Agency Safeguarding Hub[2] (MASH) sergeant closed the case having requested but not received, further information from the attending officer as to what they expected adult services to do. A referral to Adult Social Care (ASC) was not made at that time.

3.17. The PAC was picked up by the MASH team on the 13th April 2016 (two months after police attendance) and it was indicated that the report would be passed to adult services.

3.18. Whilst Croydon only has a Children's MASH, local police do pass their adult MERLIN reports via their MASH team staff. (These reports identify vulnerable adults who have come to notice of the police). If necessary, they then make referrals to ASC. This is what they did in this case.

3.19. A police MERLIN report linked to the incident was received by ASC and stated that

[2] Multi-agency safeguarding hubs are structures designed to facilitate information-sharing and decision-making on a multi-agency basis often, though not always, through co-locating staff from the local authority, health agencies and the police. Croydon council and partner agencies have established a children's Multi-Agency Safeguarding Hub (MASH) which is borough wide.

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Valerie would not engage with her nephew and that officers had attended but she refused to engage with them. The police concluded that it was her choice not to engage. In response, ASC sent a letter to Valerie offering an assessment and outlining support if she wanted to take up a service.

3.20. In June 2016 a neighbour sent an email to the Anti-Social Behaviour team at Croydon Council. She expressed concerns about the behaviour of individual tenants of number 33; a house being used to support young people. The neighbour expressed concern that it may be having an impact on Valerie who was vulnerable and had mental health problems.

3.21. On the 22nd June 2016 the Anti-Social Behaviour (ASB) officer sent an email to the police Safer Neighbourhood Team, setting out concerns relating to complaints of behaviour of the tenants at number 33. It included the following:

There appears to be an older person living at 35 and the complainant stated that she is vulnerable adult with mental health issues who lives alone. I have nothing to support this.

The email requested the following:

The complainant has contacted our licensing team that was advised is no landlords licence or a HMO licence and suspects that the activities are likely to be linked to narcotics.

Can you please advise if you are aware of this address?

Also can we please increase patrols and I will ask for more information regarding times and will pass on any information I have to you.

3.22. There is no evidence that anyone contacted Mr Beeden.

3.23. In September 2016, EDF Energy engineers tried to execute a warrant to fit a prepayment meter at Valerie's address. They could not fit the meter due to a large wasps nest preventing them from getting near the meter. Engineers reported that they had spoken to a neighbour, who stated that they had not seen Valerie for a year and did not know whether she was still residing at the address.

3.24. Ten days later they returned to fit the meter. They forced entry but as they made their attempt, an old lady was seen disappearing to the back door. Due to this they walked away because they did not know the extent of the customer illness.

3.25. EDF alerted the council that they had attended Valerie's address under a warrant. She had not paid them since 2012 and owed £5000. They stated that she had not replied and they had spoken with a neighbour who thought Valerie had been moved to a nursing home. The garden was unkempt. They had gained entry and realised that Valerie was in occupation. She was frightened so they closed the door and left. They

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reported that they had concern about her mental health as she had previously told them that she had mental health problems. Neighbours were surprised that Valerie was still in residence.

3.26. The ASC duty team undertook checks. They spoke with the GP who stated that she had been deregistered for two years. They also spoke to her nephew.

3.27. On the 30th September 2016 the duty team made a no contact visit. Valerie did answer the door. A neighbour told them that she had seen her going out and seen her the day before. As a result, the case was transferred to the Croydon ASC Safeguarding Team as a self-neglect case. It was passed to the local Older People North Team. It was placed on the P2 low priority waiting list rather than the P1 list.

3.28. On the same day, Valerie's nephew received an email from ASC in respect of the referral. He responded with the following information:

- His aunt did not have a phone
- She had been sectioned a number of times for schizophrenia and would not open the door.
- She would not open any letters sent to her.
- She was known to use foul language and had been violent in the past, so if they were attending to enter the house they should take precautions.

3.29. He received an email from an ASC worker stating that they had visited but could not gain entry so had left a note.

3.30. In November 2016 Valerie's nephew received a phone call from social services stating that Valerie's electricity bill had not been paid. He sent an email to ASC expressing concern that Valerie might be left without electricity. He received an email stating that her case had been referred to Older People North Team for allocation to a social worker for assessment. He received a further email confirming that her electricity would not be cut off.

3.31. On 24th January 2017 Environmental Health received a complaint from a neighbour about the condition of Valerie's premises. The Environmental Health Officer (EHO) undertook a visit. They received no answer. They spoke to neighbours who confirmed that Valerie still lived at the premises but they had not seen her for a while, she never answered the door but they thought she may have a social carer. The (EHO) placed a calling card through the letterbox.

3.32. On the 26th January 2017 the EHO submitted an Adult at Risk referral. They had received complaints about the poor state of the property. They had attended the address but the occupant did not open the door. The EHO spoke with neighbours who informed him that they had not seen the occupant for a while and they thought she might have a social carer. The EHO wanted to know whether social care were involved with the owner so that a joint visit could be arranged.

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3.33. The EHO chased up the case on the 30th January 2017. They were informed by ASC that a triage had taken place in October and Valerie was not considered a risk. The social worker stated that he would investigate further, as he believed Valerie had been seen. The EHO again followed up by email asking for confirmation that the Safeguarding Team had contacted Valerie. On the 30th, Valerie's nephew received an email from an individual introducing herself as Valerie's case worker.

3.34. As a result, the case was taken off the North Team waiting list where it had remained since September 2016. On the 8th February 2017, a joint visit with a social worker was undertaken and Valerie was found dead in the premises. It has not been established when she died.

4 FAMILY VIEWS

4.1. Valerie lived alone and had no children of her own. She did have a level of contact with her extended family but this contact appears to have been difficult for family members. Her nephew, living in Australia, did try and contact Valerie when he visited the UK. This was not always successful as she would not always answer the door to him. He had more success if he was able to meet her when she was away from the house shopping.

4.2. The nephew did have concerns and he raised these with police in March 2016 and then later with social care in September 2016. What he was able to provide was history of his aunt's long-term mental health condition, reasons why she would not open the door and why sending letters or leaving notes would not elicit a response.

4.3. The nephew was able to provide some more detail about Valerie's last few weeks. She made entries in her calendar every day. In November 2016 entries stopped and for days before they stopped she wrote that she was vomiting. It is possibly around this time that she passed away.

4.4. The nephew has two main concerns; why was there a delay in acting between September 2016 (when he was first contacted by ASC) and January 2017? He had by that time informed social care and police about his concerns. He also had concerns about the premises next door that was being used to support young people.

4.5. The reviewer has attempted to establish the condition of Valerie's house. Police reports indicate that it was untidy but the nephew was able to confirm that it contained hundreds of old newspapers. This is important when considering self-neglect and hoarding.

5 ANALYSIS OF EVENTS

5.1. This section will consider the response to Valerie from agencies.

5.2. Valerie was an elderly lady who suffered from significant mental health issues. As

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previously set out, she was paranoid and this condition was evident even after she disengaged from mental health services and her GP. Her nephew confirmed that she would not answer the door to him at times and he used to try and meet her when she went out as she would then let him in. When she did go out she would take all her valuables with her including her husband's ashes, because she believed someone would break in and steal items from her.

Disengagement from Services

5.3. Given the serious nature of her mental health, it is significant that Valerie appears to have had no contact with any health services for at least nine years. She had disengaged from all health services for a number of years.

Mental Health Services

5.4. Valerie disengaged from the mental health service in 2007. This was before the commencement of the Care Act 2014 so post-Act changes need to be considered.

5.5. In 2006 Valerie had a relapse but unlike previous occasions she was not assessed to be sufficiently unwell to consider the use of the MHA. The community team tried to maintain contact but found it increasingly difficult. Valerie made numerous requests to be discharged back to her GP. In 2006 she stated this request in a letter, at which time it was agreed to refer her back to her GP.

5.6. Relatives and neighbours continued to raise concerns. In 2007 an attempt was made to contact Valerie but this failed. A letter was sent suggesting a home visit but she responded by letter, declining a visit or any involvement with mental health services.

5.7. Valerie's case was reviewed by the multidisciplinary team and the Consultant Psychiatrist It was agreed that they should not actively engage her in treatment. A letter was sent to her GP setting out the action to try and engage, and the conclusion was that "*it does not seem appropriate to continue to assertively engage with Valerie*" The letter did acknowledge that "*at some point in the future, a further assessment by mental health services is likely to be needed*".

5.8. This course of action raises a number of concerns. There was no formulated risk assessment, care plan or capacity assessment. But these relate to a service operating 12 years ago. There have been a number of changes since that time which should mean that circumstances similar to those presented by Valerie would be dealt with differently today.

5.9. The introduction of the Care Plan Approach Policy in 2017 and the Trust Policy on discharge and transfer policy 2015 have made significant changes as to how individuals such Valerie are now discharged including:

Setting out arrangements for managing the risks associated with the discharge/transfer of service users within the care planning process.

5.10. The SLaM IMR made a number of recommendations for this case. They are as follows:

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- *Service Leads and Team Managers must ensure that staff work within the framework of these policies through team meetings, zoning meetings, complex case forums, supervision.*
- *Some teams discuss potential discharge cases as a team and it is recommended that this be the case for all teams and expectation will be to follow the policy on discharges for ensuring it is done safely and inclusive of relevant safeguarding stakeholders*
- *Supervision is to be made effective where the care provision and delivery for all patients under the team is discussed.*
- *Interventions and challenges should be documented with a risk assessment and care plan completed to reflect input and review.*
- *Capacity assessments should be used to support difficult to engage patients.*
- *Physical Health must be part of the care plan of a patient under CPA. The Trust have a new physical health strategy and staff are to be supported in its implementation*

5.11. **RECOMMENDATIONS**
SLaM:
To progress the recommendations made in the SLaM IMR.

Croydon SAB:
To monitor the progress of the SLaM IMR recommendations.

General Practice

5.12. Having referred Valerie back to her GP (primary care), the deregistration of Valerie from the GP practice in 2010 is of concern as that was her only link to health services. Despite attempts in 2008 and 2010 by her GP practice to visit her, there is no evidence to indicate that she was spoken to. She was sent a number of letters prior to 2010. There is no evidence recorded to indicate that any further attempt to contact her, either in person or by letter, was made. It is not clear when an application was made for deregistration.

5.13. The process adopted at the time by that practice was that if no contact was made over a period of time an individual was deregistered. This approach did not consider the vulnerability of a patient including mental health and age in Valerie's case.

5.14. The NHS England Standard General Medical Services Contract 2015/16 document [3] sets out in chapter 13 the conditions for registration and deregistration. The list of reasons is set out as follows:

[3] July 2015: *NHS England Standard General Medical Services Contract 2015/16* : Gateway Publications Reference: 03679

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- *Removals from the list at the request of the patient*
- *Removals from the list of patients who are violent*
- *Removals from the list of patients registered elsewhere*
- *Removals from the list of patients who have moved*
- *Removals from the list of patients absent from the United Kingdom etc*
- *Removals from the list of patients accepted elsewhere as temporary*

5.15. Whilst GPs can request the removal of a patient from their list, a lack of contact is not, in its own right, a reason. In 2016 there were articles in the media suggesting that no contact for five years was going to be included as a reason to remove. However, there is no indication that this ever happened. Removal on the basis that a patient has moved is allowed but no response to letters (unless they are returned with indications that the individual no longer lives at the address) should not automatically lead to removal.

5.16. It has not been possible to establish what the NHS England Standard General Medical Services standard was in 2010 so this practice should not be criticised for their approach at that time.

5.17. The impact of deregistration was that in 2016 when agencies tried to establish a link with Valerie's GP, they were informed that she was deregistered. Had she still been registered then agencies could have worked with her GP to try and establish contact and the GP could have worked as part of a multi-agency response. Not being registered removed a vital element of local agency support.

5.18. The practice subject to this review have made a number of changes in response to the review. These changes are:

- *If there is no response to a letter it will be followed up by phone or a home visit with an option of contacting next of kin.*
- *Will not deregister any patient who might have documented medical conditions until they have sought managerial and clinical guidance around the possible impact.*

5.19. This approach may have reduced the possibility of an individual such as Valerie being deregistered.

5.20. **RECOMMENDATION**
Croydon SAB:
To be assured that GP practices do not deregister vulnerable individuals on the basis of non-contact only.

Police

5.21. Whilst it appears that Valerie had minimal contact with the health services for many years, she did interact with police. In 2009 she reported that things had gone missing from her home. Attending officers correctly identified that she was suffering from mental health problems. It appears that no further action was taken and their concerns were not forwarded to social care. She was arrested later the same year

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after attacking a car parked outside her house. Her nephew confirmed that she was very suspicious of any vehicle parked outside her house and would, as she did on this occasion, throw things over it.

5.22. Once again police identified that she was suffering from mental illness, but again failed to bring this to the attention of social care. This was a missed opportunity to have informed social care as early as 2009. At this stage she was still registered with a GP.

5.23. The next police involvement was in February 2016, when they attended a report that someone was damaging Valerie's guttering. It appears that this was caused by the person climbing up Valerie's downpipe to walk across her roof to gain access to the upstair's window of the neighbouring property. Police were unable to contact Valerie. They did however raise an incident report following concerns raised by neighbours, specifically in respect of poor health and lack of family support.

5.24. The report was not forwarded to social care. In April 2016 Valerie's nephew contacted the police as he was aware that Valerie had attacked a car parked outside her house, and he wanted to pre-empt any police action by making them aware of his concerns about her. He was informed to contact her GP or social services. He did contact social care but was not sure exactly when he did this.

5.25. The February PAC incident report was picked up in April 2016 by the MASH team. Officers who attended in 2016 identified that Valerie was vulnerable and submitted an incident report. It was unfortunate that there was a delay, the scrutiny was good practice and led to a MERLIN report being passed to social care.

5.26. The author has attempted to establish the condition of Valerie's home when police entered in February 2017. This has been a difficult task and was reliant on her nephew's recollection. The attending local police officers have very little recollection and recorded minimal information. As the circumstances were not considered to be suspicious they do not appear to have recorded the scene on their body-worn cameras. Regardless of circumstances, recorded scenes would help subsequent enquires, including inquests.

5.27. **RECOMMENDATION**
Police:
To consider officers using their body-worn cameras to record scenes regardless of the circumstances of a death.

Adult Social Care (ASC)

5.28. Valerie had no known direct contact with any social care worker. The service had no recorded involvement with Valerie until 2016.

5.29. In 2016 they received a number of referrals. In April they received a MERLIN from police. This was as a response by police to the nephew's concerns, and reports of a male thought to be breaking into her house. The ASC response was to send a letter

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offering an assessment as it was felt, at that point, that Valerie was a client choosing not to engage rather than any concern regarding self-neglect.

5.30. This was an inadequate assessment based on the view that an individual not opening the door evidences choice. Had they spoken to the nephew, he would have been able to highlight his concerns and Valerie's mental health history.

5.31. The second contact was in September 2016 when they received a referral from EDF Energy. This was good practice by EDF Energy. ASC made some initial checks with Valerie's GP becoming aware of her deregistration. They also spoke with her nephew. They then made a home visit with no response.

5.32. As a result of this initial assessment the case was transferred to the Safeguarding Team. This indicates that there was a level of concern. It was also identified that in order to establish contact with Valerie, the best team to achieve this was the Older People Team. The logic for this was sound. However, the case was placed on the waiting list as P2; ie. a lower priority than P1. P1 cases are worked on the day they are received; P2 cases can wait up to six months.

5.33. This was a significant mistake as it meant that the case remained on the waiting list until January 2017 when the EHO raised concerns. This mistake was not picked up because there was no management of the waiting list in place at the time.
Had the referral been marked as P1 there should not have been a significant delay. It is now known that by January 2017 Valerie had probably already died.

Updated Processes

5.34. At the time of Valerie's death the Local Authority had a high waiting list across most areas of social care. As a direct result of the Valerie case, ASC undertook the following actions:

- A full review of the waiting list
- Review of the prioritisation process
- Development of the In-Touch Team.

5.35. The In-Touch team was introduced to monitor and review the waiting list. This initiative was able to resolve some cases more quickly, before they became more complex and demanding and identified some cases where the need had increased. This was a short-term initiative to try and alleviate some of the immediate concerns identified at the time of Valerie's death.

5.36. It was recognised that cases were still building up. There was increased activity at the "front door" and there was a need to develop an integrated approach. In order to address these issues a more focused long-term solution was required.

5.37. **One Croydon Alliance**.

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The One Croydon Alliance is a formal agreement to integrate services' pathways between the National Health Service in Croydon and the Council. It has seen the development of such initiatives as the Huddles – whereby a multi-disciplinary team surrounding the GP surgery meet to discuss patients/clients in common who may need a multi-agency response. This has helped to ensure that responses are holistic and timely with a focus on prevention.

5.38. A further key step taken by ASC has been the move to a locality-based model, with social workers allocated to one of six locality teams which are aligned to the six Integrated Care Networks. This change was achieved by reorganising the Older People (North, South and reviewing) social work teams into six locality teams in order to work closely with GPs and other related professionals. This has had the advantage of:

- Developing a more integrated, multi-disciplinary approach focused on localities.
- More oversight and management – moving from two managers to six managers.
- A locality focus on the waiting lists. Rather than two unwieldy waiting lists (North and South), each Locality team is responsible for their own waiting lists.

5.39. Early data supplied by ASC indicates that changes are making a significant difference to the number of residents on the waiting list. Between April 2019 and July 2019 it has reduced from 1600 to 700.

5.40. **RECOMMENDATION**
Croydon SAB:
To monitor the waiting list, numbers and the ongoing time delay and indicators of how many referrals have been identified as being on the wrong list.

5.41. **Croydon Adult Support (Front Door)**
A key issue identified was the complexity of processes faced by those seeking to access ASC.

In order to simplify this process for residents, the Council has brought together different teams (which are involved in the first point of contact for adults requesting support from social care) into a multi-disciplinary 'front door', known as Croydon Adult Support. This will encourage sharing of information and knowledge by multi-agency working to reduce, prevent and delay people's need for social work; working more with the resident up-front, wrapping primarily non-social work, multi-disciplinary resources more holistically around the person. ASC will be able to focus more on those with specialist and complex social care needs.

5.42. The involvement of the police and health in the front door team would increase its effectiveness. (see recommendation at 5.89)

EDF Energy

5.43. The company EDF Energy played a significant part in this case. As set out in the

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chronology, Valerie had a debt of £5000, having not made a payment since 2012. In that year they attempted to visit Valerie but failed to make contact. They appear to have been aware that she had mental health problems. They contacted Valerie in 2013 via letter. She responded.

5.44. EDF officers appear to have considered Valerie's vulnerability due to her mental health. EDF staff contacted social care following the attempt to execute a warrant in 2016. They did not contact social care in 2013 when they first became aware of Valerie's debt.

5.45. The author explored with EDF Energy how they respond to vulnerable individuals. They work to Ofgem's consumer vulnerability strategy. They have in place a Priority Service Team (PST). This is the point of contact for front line staff. If staff have concerns about a customer they can contact the PST. It is the PST that would consider contacting ASC.

5.46. EDF Energy confirmed the following:

- A debt of £5000 is not unusual.
- The team hold a list of vulnerable people with whom they try to engage to ensure that they have electricity.
- If on the vulnerability list, alternative ways of paying are suggested and they are referred to the debt team.
- Engineers are trained to respond to recognise vulnerability.

5.47. EDF Energy manage their own priority service register (PSR). This is a register of vulnerable customers. PSR information is shared with the electricity and gas transporters but only with a customer's expressed consent. From April 2020, water companies come into the same industry process meaning that information about attributes such as kidney dialysis, restricted movement and lung ventilator will be shared providing consent has been secured.

5.48. The author explored the training provided to EDF Energy staff. They stated the following:

To support front line staff EDF have completed 'consumer vulnerability training', high consumption training and more recently dementia awareness where many of the skills are transferrable to other mental health illnesses. To date over 2,500 staff members have registered as a dementia friend. Our Priority Services team have had bespoke MIND training and MacMillan were invited to complete emotional resilience training for a cross section of our business including members of our Priority services, Complaints and Revenue Collection teams.

5.49. They also actively engage with other companies and charities to set up partnerships. The partnerships include Citizen Advice Plymouth, IncomeMax, Shine, NEA and MacMillan. They have others being progressed such as Age UK and Christians Against Poverty but these are not yet active. The partners, IncomeMax and Citizens Advice

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Plymouth, who both offer specialist support on debt advice and income maximisation (benefits checks), have been active for over 18 years combined.

5.50. The EDF Energy Priority Service Team has additional training around such issues as dementia and mental health. They are looking to improve working across other utility services and have made links with other agencies that they can contact to help support vulnerable customers. In this case EDF Energy did eventually identify the risk and contacted the ASC.

5.51. The author, during the course of this review, has been made aware of the role of these initiatives. This knowledge should be shared across agencies so that there can be collaborative working and better outcomes for vulnerable individuals.

5.52. **RECOMMENDATION**
Croydon SAB:
To work with EDF to raise awareness of EDF support initiatives

Croydon SAB:
To highlight the work of EDF Energy through national forums

Housing and Anti-Social Behaviour Teams

5.53. A big area of concern raised by Valerie's nephew, was the impact on Valerie from the house next door which was being used as supported living accommodation for young persons. He believed that she was frightened; it was very noisy and she started to sleep in her living room. There were complaints by the neighbours in respect of the tenants of the property. The author has seen photographs of individuals climbing across Valerie's premises to reach the house next door in order to climb into a first-floor window.

5.54. It is important to consider how the environment may be impacting upon a vulnerable person, so the reviewer has attempted to establish what processes are in place when multiple occupancy of rented property is being considered.

5.55. The regulations are set out in the provisions of the Housing Act 2004[4].
The Act sets out the registration for a house of multiple occupation (HMO). If the house fits the requirement of an HMO, then it is inspected prior to a licence being issued. This particular premises did not fit the definition of an HMO but Croydon did require the premises to be licenced under a selective licence.[5] In the case of Croydon this area is suffering from anti-social behaviour.

[4] The **Housing Act 2004** introduces a new definition of a **HMO**. ... Generally a house in multiple occupation will be a property occupied by more than one household, more than two people, and may include bed sits, shared **houses** and some self-contained flats.

[5] The **Housing Act 2004** allows local authorities to apply for **Selective Licensing** of privately rented properties in areas which are experiencing low **housing** demand and/or suffering from anti-social behaviour. The same **Act** also introduced a new **licensing** regime for **Houses** in Multiple Occupation (**HMO**).

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5.56. In Croydon there are 35000 selectively licenced properties. Selective licence premises (unlike an HMO) are not visited prior to issuing of a licence. Issues are considered upon receipt of complaints.

5.57. In this case a complaint was received in June 2016 from a neighbour. The author has seen the complaint email and it sets out numerous areas of concern, including the police being called because tenants were climbing over the roof. There was a constant stream of visitors, groups of youths hanging around outside and noise in the early hours of the morning. The email expressed particular concern about Valerie, highlighting that she was a vulnerable adult with mental health issues who lived alone.

5.58. The Anti-Social Behaviour (ASB) officer made enquiries but did not feel they could substantiate most of the allegations. They confirmed with the house owner that they had dealt with the complaints and one tenant had been evicted.

5.59. It is of note that there was significant contact with police in respect of this premises. Over a three year period there were roughly 300 calls to police about incidents in that road, 240 were related to the hostel. They related to ASB and missing persons. It is apparent that these premises were problematic. Given the number of concerns the management of the premises is questionable.

5.60. They did try and contact Valerie but received no reply. The nephew was contacted and a card left at the address. It would appear that there is limited action that can be taken by Housing if the management of the premises appears to be responding to concerns.

5.61. Having spoken to the nephew and the neighbours it appears that the vulnerability of Valerie was not pursued further and no referral was made as they had not contacted Valerie. Again, as with the police contact in 2013, no reply was considered as a choice.

Environmental Health Officer (EHO)

5.62. As previously highlighted the EHO comes under the Public Protection department. It is interesting to see how the EHO responded compared to the ASB team. It is important to highlight the role of the EHO, as their actions (as set out below) should be considered as good practice.

5.63. Having received a complaint about the condition of Valerie's property they tried to make contact and spoke with neighbours. As a result of their concerns they contacted ASC. They were informed that ASC had triaged Valerie's case and she was not considered to be at risk.

5.64. The officer was persistent, and this persistence led to ASC identifying that the case had been placed on the wrong waiting list. As a result, they visited the premises and entered.

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5.65. Whilst in the case of Valerie it was too late, the action of the EHO not taking the lack of contact as a response, is what was missing from previous agency responses.

5.66. As the ASB team and the EHO both come under the management of the Public Protection department, the ASB team should adopt the same level of response to safeguarding and vulnerability as that of the EHO. The head of the team highlighted that they did not have access to the IT system used by the safeguarding team, so would not have been aware of any issue of concern that had already been raised in respect of Valerie.

5.67. **RECOMMENDATION**
Local Authority Public Protection department:
The ASB team to assess, as a matter of routine, whether there should be a safeguarding response to vulnerable residents.

Difficult to engage, self-neglect and hoarding

5.68. The Care Act 2014 sets out six principles:

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

5.69. In the context of the legislation, specific adult safeguarding duties apply to *any* adult who:

- has care and support needs
- is experiencing, or is at risk of, abuse or neglect
- is unable to protect themselves because of their care and support needs.

Self-neglect is one of the categories of abuse.

5.70. This case posed difficulties for all agencies and it is relevant that none of the professionals ever had face to face contact with Valerie. Her nephew emphasised that she was a difficult person with whom to make face to face contact, as she would not answer the door to him.

5.71. An article by Deborah Barnett: Safeguarding Adults: Self-Neglect and Hoarding Toolkit sets out the spiral of self -neglect[6]

People who self-neglect and refuse care, services, and treatment are essentially self-harming. Refusing essential services will eventually result in discomfort and pain. Self-harm is described as a coping mechanism for those hoping to deal with the anxiety

[6] Deborah Barnett March 2019: *Safeguarding Adults: Self-Neglect and Hoarding Toolkit; Careknowledge.com*

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and overwhelming distress of loss, abuse, or neglect.

Social isolation and self-neglect are a toxic mix and will only result in increasing deterioration in physical and mental wellbeing. Added to the risk to personal wellbeing are:

- *Fire risk*
- *Falls risk*
- *The risk from poor housing structures and lack of repairs*
- *The risk from falling objects*
- *Nutritional risks*
- *Risk from insanitary conditions*
- *Risk to others.*

Without sensitive and lawful intervention, over a prolonged period of time, there is a definite possibility that these behaviours will result in the death of the person concerned. The behaviours can represent a continuum of deterioration towards a fatal final outcome and all public sector services have a duty to do everything that is within their lawful capability to support the person in a manner that is appropriate and proportionate to their needs, to prevent this potential outcome.

5.72. The lack of contact in Valerie's case resulted in minimal risk assessments being undertaken, with assumptions being made that lack of engagement was Valerie's choice. There was information available which should have been considered. Sources included her nephew, neighbours, historic information and information about the environment she was living in. the following was known or available:

- Mental health, her paranoia.
- Poor condition of the house and outside space.
- Her debts both EDF Energy and Community Council Tax.
- The fears of her nephew and neighbours.
- Her failure to engage.
- Her age

5.73. It is of note that when her nephew entered the house after her death he saw that there were hundreds of newspapers hoarded.

5.74. Lacking, until the January 2017 visit, was any recorded consideration as to how to engage to try and speak with Valerie. Her nephew stated that he would intercept her when she was out shopping. This approach seemed to work for him. There is no evidence that this type of approach was considered or the possibility of neighbours notifying social care when she went out. Local shops could have been approached to establish what she purchased and her behaviour whilst out in public. These actions may have been time consuming, but they do not appear to have been considered. There is little evidence, until the EHO became involved, of any agency demonstrating persistence or creativity in order to try to speak with Valerie.

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5.75. Croydon SAB Self Neglect Dignity and choice guidance[7] states the following:

A multi-agency approach may be needed to explore options for encouraging engagement. Various professionals may have information about the adult and some may have been better able to establish a relationship with them. A multi-agency network meeting enables information to be shared and decisions to be made about how best to intervene. The meeting should consider level and aspects of risk and ways in which agencies can contribute to managing the risk alongside the service user.

5.76. The potential area of concern in Valerie's case was self-neglect and her ability, due to her mental health condition and age, to look after herself.

SCIE guidance Safeguarding Adults in Practice[8]states the following:

Self-neglect can be a complex and challenging issue for practitioners to address, because of the need to find the right balance between respecting a person's autonomy and fulfilling their duty to protect the adult's health and wellbeing. Both perspectives can be supported by human rights arguments.

The Care Act 2014 statutory guidance includes self-neglect in the categories of abuse or neglect relevant to safeguarding adults with care and support needs. In some circumstances, where there is a serious risk to the health and wellbeing of an individual, it may be appropriate to raise self-neglect as a safeguarding concern. However, interventions on self-neglect are usually more appropriate under the parts of the Care Act dealing with assessment, planning, information and advice, and prevention.

………If it is impossible to complete the assessment, or if the person refuses to accept care and support services, you should be able to show that you have tried, and that information and advice have been made available to the person on how to access care and support and how to raise any safeguarding concerns. All your decisions, and the considerations that have led to them, should be recorded in light of the person's wishes and their particular circumstances. You should be able to show that whatever action you have taken is reasonable and proportionate.

5.77. In this case options considered for making contact with Valerie, other than knocking on the door, were not recorded.

5.78. Croydon SAB have recently produced a report; Multi Agency Safeguarding Adults Self Neglect Audit Report. This comprised the findings of an audit of 12 cases where self-neglect was identified. It was supported by a workshop. The report highlights several challenges, a number of which are relevant to the findings of this review.

- Communication/information sharing
- Recording

[7] 2015 CSAB Self Neglect Dignity and choice guidance
[8] Safeguarding Adults in Practice 2018 www.scie.org.uk/safeguarding/adults/practice/questions

- Risk assessments
- Mental capacity
- Making Safeguarding Personal
- Missed opportunities

5.79. The report identified a number of actions:

- *Review Learning and Development around self-neglect in light of the audit findings.*
- *Learning Event based on the audit findings with practitioners across CSAB.*
- *To review multi –agency forums such as RVMP [Risk and Vulnerability Management Panel] to ensure they are effective, have strong governance and are being taken up by practitioners.*
- *To consider taking forward the communication theme from the audit and holding a multi-agency workshop on this topic – "Communication for front line staff".*
- *Repeat multi – agency audit on self-neglect in two years.*

5.80. **RECOMMENDATION**
Croydon SAB:
To progress the proposed actions set out in the self-neglect report.

Multi-Agency Working and Information Sharing.

5.81. A theme identified in this case is that of multi-agency working and specifically a process that enables this to happen. If a situation does not reach the section 42 threshold then agencies struggle. Having identified the difficulties and the possibility of self-neglect, the review has considered what is now in place locally that might support multi agency working in difficult/complex cases.

Risk and Vulnerability Management Panel (RVMP)

5.82. CSAB Self Neglect Dignity and choice guidance states the following:

Managing the balance between choice, control and duty of care is a complex process. If the multiagency network finds that all agreed actions have failed to reduce the risk of harm to a manageable level, the case should be referred to the [RVMP]. Again this should be with the consent of the adult if this can be obtained or without their consent if there is a public interest and duty of care due to very substantial risks of harm.

5.83. Croydon introduced the RVMP. This is a forum where police and other agencies can refer an individual who is at risk or vulnerable. The current meeting panel have representatives from SLaM, Housing, London Ambulance Service, London Fire Brigade, drug and alcohol abuse team, safeguarding, FJC and police.

5.84. The Panel was set up in 2015. Changes were made in May 2019 with new chairing

arrangements put in place. This is a positive approach to difficult cases and if Valerie had been considered, then a multi-agency discussion about how best to try and engage her may have worked. RVMP is managed within the Anti-Social Behaviour team.

5.85. **RECOMMENDATION**
Croydon SAB:
To raise awareness of and monitor the use of the RVMP, including audits to measure outcomes

Multi Agency Safeguarding Hub (MASH)

5.86. The MASH [9] is a multi-agency approach to safeguarding, in most authorities designed to support children and young people. This is the case in Croydon.

5.87. This approach to children referrals has proved to be positive and has helped support the multi-agency approach. At this stage only a few authorities have introduced an integrated adult MASH. In London there are two.

5.88. One of the authorities is the London Borough of Havering. Whilst the system is not perfect it does support both adults and children.

5.89. In respect of adults its role is to:

- *Undertake the threshold decision for all adult safeguarding referrals.*
- *Gather and review information that is already known within separate organisations in order to inform safeguarding decisions and formulate an initial risk assessment.*
- *Facilitate information sharing across organisations involved in safeguarding adults and utilise this to inform an updated risk assessment if necessary.*
- *Facilitate a more integrated and holistic approach to the protection and safeguarding of adults at risk.*
- *Establish the strategy for any further investigation required and, where necessary, ensure that the case is passed in a timely manner to the appropriate team responsible for the investigation*.

5.90. The author is aware that, in March 2019, Croydon commenced a project called “Improving the Adult Front Door”; information on which was shared with the Croydon SAB in January 2019. (discussed at 5.39). The aim is to bring together the different teams involved at the “front door”, ie. to provide a multi-agency first point of contact for adults wanting support.

5.91. This is a positive approach and will help assess referrals. It appears to have many similarities to the MASH. It currently does not have individuals from police and mental

[9] The Multi Agency **Safeguarding** Hub (**MASH**) brings key professionals together to facilitate early, better quality information sharing, analysis and decision-making, to **safeguard** vulnerable children, young people more effectively.

health in the team. This would enhance the Adult Front Door.

5.92. **RECOMMENDATION**
Croydon SAB:
To review the implementation and impact of the new Croydon Adult Support (Front Door) project.

Police and Mental Health:
To consider supporting the Croydon Adult Support (Front Door) Team with staff.

Croydon Local Authority:
To consider introducing an integrated adult MASH.

6 CONCLUSION

6.1. This is a difficult case, as at no stage from 2012 onwards was any agency able to have face to face contact with Valerie. It is evidenced that a number of agencies during 2016 had concerns or were responding to concerns about her situation, and attempted to make contact by knocking at the door but all failed to get Valerie to respond.

6.2. Why she failed to respond was explained by her nephew. Valerie was paranoid and believed that people were trying to gain entry to steal things. Her attacks on cars parked outside her house and the fact that she took her valuables with her when she did go outside, evidences her difficulties.

6.3. It is also evidenced that she appeared to look after herself in terms of food until she appears to have become ill in November 2016. But how she was living otherwise was never assessed. Some agencies considered her failure to engage her choice, but without face to face contact this cannot be evidenced. Her mental capacity and her ability to look after herself could not be assessed.

6.4. ASB were made aware of Valerie via the police MERLIN in April 2016. The referral was not progressed. The risk to Valerie was potentially high due to her mental health problems and her age. Decisions regarding eligibility were not based on assessment of need.

6.5. The Bray, Orr, Preston Shoot 2015 serious case review[10] findings on the challenges of self-neglect highlight this concern as being relevant to many reviews, states:

Difficulties of securing or maintaining engagement were a common theme. These could arise because the individual remained resistant to contact; for example one SCR warned against assuming that being "hard to engage", in the sense of declining

[10] Braye, Suzy, Orr, David and Preston-Shoot, Michael (2015) *Serious case review findings on the challenges of self-neglect: indicators for good practice.* Journal of Adult Protection, 17 (2). pp. 75-87. ISSN 1466-8203

services, was indicative of informed choice being exercised; it "may be an alert that something is wrong which requires assessment and intervention". But commonly the SCRs commented that opportunities were lost through services' lack of responsiveness, for example where cases were closed while risk remained high, or long periods passed without visits being made, or missed medical appointments were not followed up. Consistency of approach was compromised by changes of worker with each re-referral, and by decisions on eligibility that were not based on re-assessment of needs. A reputation for being "hard to engage" could prompt case closure and refusal to reassess. SCRs were critical here, noting that such cases should not be closed without assessment of risk and capacity, and exploration of reasons for non-engagement, through which possible alternatives could emerge. A number mentioned the importance of considering the role of advocacy services where engagement is hard to establish.

6.6. The difficulty faced by agencies was how they could engage with Valerie. It has to be acknowledged that there is no easy solution. What was required was a multi-agency approach, as is evidenced there were a number of agencies trying to make contact.

- Police
- EDF
- ASB/Housing
- EHO
- ASC

6.7. All needed to speak with Valerie, had concerns and were aware that she had a mental health history. If they had worked together they may have been able to pull together a multi-agency plan. The nephew explained to the author that she would not answer the door to him but if he met her whilst she was out shopping, she would talk to him. Could this have been an option? Could the neighbours not have been recruited to help inform when Valerie went out? Most of the agencies' assessment of risk was based on neighbour information.

6.8. By September 2016 ASC had received a second referral which was placed on a priority list. Unfortunately, it was placed on the P2 not the P1 list. In November 2016 they had contacted the nephew who expressed concerns. It was not until the involvement and the persistence of the EHO in January 2017 that any positive action commenced, leading to the visit in February 2017. Unfortunately, by that time Valerie had died. When exactly she died is unknown but her calendar entries indicated that she was sick at the end of November, two months before she was found but three months after a referral was made to ASC.

6.9. The review has identified recent changes in agency responses. These plus the introduction of processes which, if fully supported, may help to provide coordinated multi-agency responses to difficult/complex cases in the future.

6.10. It is not possible to state whether Valerie's death could have been prevented but had positive, persistent action to engage with her in September 2016 been undertaken by

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agencies, then she may have responded.

7 RECOMMENDATIONS

1 **SLaM:**
To progress the recommendations made in their IMR.

2 **Croydon SAB:**
To monitor the progress of the SLaM IMR recommendations.

3 **Croydon SAB:**
To be assured that GP practices do not deregister vulnerable individuals on the basis of non -contact only.

4 **Police:**
To consider officers using their body-worn cameras to record scenes regardless of the circumstances of a death.

5 **Croydon SAB:**
To monitor the waiting list, numbers and the ongoing time delay and indicators of how many referrals have been identified as being on the wrong list.

6 **Croydon SAB:**
To work with EDF to raise awareness of EDF support initiatives.

Croydon SAB:
To highlight the work of EDF Energy through national forums.

7 **Local Authority Public Protection department:**
The ASB team to assess, as a matter of routine, whether there should be a safeguarding response to vulnerable residents.

8 **Croydon SAB:**
To progress the proposed action set out in the self-neglect report.

9 **Croydon SAB:**
To raise awareness of and to monitor the use of the RVMP including audits to measure outcomes.

10 **Croydon SAB:**
To review the implementation and impact of the new Croydon Adult Support (Front Door) project.

11 **Police and Mental Health:**
To consider supporting the Croydon Adult Support (Front Door) Team with staff.

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12 **Croydon Local Authority**

To consider introducing an integrated adult MASH.

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8 Glossary of Acronyms

- Adult Social Care (ASC)
- Anti-Social Behaviour (ASB)
- Clinical Commissioning Group (CCG)
- Community Mental Health Team (CMHT)
- Croydon Safeguarding Adults Board (CSAB)
- EDF Energy pre-disconnection visit (PDV)
- Environmental Health Officer (EHO)
- Houses in Multiple Occupation (HMO)
- Mental Health Act 2001 (MHA)
- Multi Agency Safeguarding Hub (MASH)
- Police Pre-Assessment Check (PAC)
- Priority service register (PSR)
- Priority Services Team (PST)
- Risk and Vulnerability Management Panel (RVMP)
- Social Care Institute for Excellence (SCIE)
- South London and Maudsley Hospital (SLaM)

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