Croydon Safeguarding Adults Board

Safeguarding Adults Review
Catherine

Report Author

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1 THE REASON FOR THE SAFEGUARDING ADULTS REVIEW

1.1 On the 10th January 2019 police entered the flat of Catherine an 85 year old women and widow. This was in response to a request from a social worker for a welfare check. Upon entry to her flat they found her dead in bed. Her body was in a state of decomposition.

1.2 Catherine owned her own property (a flat) which was situated above a business premises which she also owned and rented out.

1.3 Catherine was born in Ireland, her husband died in 2002 and she owned her own property, a flat which was situated above a business premises which she also owned and rented out to a tenant. Her first contact with Mental Health services was in 1974 when she had a diagnosis of Paranoid Schizophrenia. She had further contact with mental health services between 2002 and 2011 receiving both inpatient and community services. She was last seen face to face by her GP in 2014.

1.4 Catherine was a vulnerable adult who had been in receipt of services throughout her life. She was subject to a couple of safeguarding referrals and was subject to a hospital admission in November 2017. The Croydon Safeguarding Adults Board Independent Chair agreed that these circumstances reached the requirements for a Safeguarding Adults Review (SAR) as set out in the Care Act 2014.

2 THE REVIEW PROCESS

2.1 The author of this report was commissioned 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 Catherine:

- South London and Maudsley NHS Foundation Trust
- General Practice
- Croydon Adult Social Care
- Croydon Health Service
- Metropolitan Police

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 David Williams of the Metropolitan Police with representation from the following agencies:

- Croydon Adult Social Care (CASC)
- Metropolitan Police
- Croydon Health Services (CHS)
- Clinical Commissioning Group (CCG)
- South London and Maudsley NHS Foundation Trust (SLAM)
- CSAB Board Manager

Review Period

2.5 It was set out in the terms of reference that the period of time under review would be from 2016 to 2019. This period covered the first contact adult social care had with her relatives up until the time of her death.

Parallel Process

2.6 An inquest was held May 2019. The Coroner recorded the cause of death as unascertainable as there was no conclusive evidence of when and how she had died.

Family Involvement

2.7 Family members have met with the author and have supplied additional information. The author, at the request of the family, visited Catherine's flat.

Report Structure

2.8 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 Each agency provided the author with detailed chronologies of their involvement with Catherine. The following is a summary of the significant contacts extracted from these chronologies.

Events Prior to October 2016

3.2 She was first in contact with mental health services in 1974 when she has a diagnosis of Paranoid Schizophrenia. She had further contact with mental health services between 2002 and 2011 receiving both inpatient and community support. 2002 is an important date as it was the year that Catherine's husband died.

3.3 Records indicate that Catherine's last face to face contact with her GP practice was in 2014. It is recorded that they did on several occasions during 2016 send her routine re-call letters to which they received no response.

3.4 Catherine was first referred to London Borough of Croydon Adult Social Care in 1990 and again in 2003, 2004 and 2008 the latter was in respect of assessment as a hospital outpatient.

3.5 In June 2016 the GP practice received a letter from Forensic Nurse Specialist for the Fixated Threat Assessment Centre [1](FTAC). The letter informed the GP that they were concerned about letters Catherine had been sending to the Prime Minister. In them she stated that she had tolerated blackmailing, violence and constant lies for 45 years and was losing the will to live.

3.6 The GP response was to try and contact Catherine which was unsuccessful so they made referrals to Adult Social Services (ASC) and to the multi-disciplinary team. ASC have no record of receiving a referral from the GP practice.

3.7 On the 19th September 2016 police received a call from British Gas requesting assistance to gain entry to the property. The request was cancelled before as a decision was made that a Pay as You Go meter could not be fitted so the warrant was not progressed.

October 2016 to January 2019

3.8 In October 2016 a family member contacted the local authority by email seeking reassurance that Catherine was safe and well. They made further contact In November 2016, when family in Ireland were trying to contact her to inform her that her brother had died. There is no evidence of any follow up action at this time.

3.9 On the 27th October 2016 a family member also contacted the police stating that they had been trying to contact Catherine to tell her brother had died. Police visited the address twice with no response. On 29th October 2016 a family member contacted the police again stating 'not to bother' visiting as she would not open the door. They said that they would write a letter. It is not known if they did send a letter.

3.10 On the 28th October 2016 EDF Energy executed a warrant they recorded.
Customer on site and told engineer to go away. Croydon council contacted who advised to fill in a referral form. Referral form completed same day. Account follow up suspended.

3.11 In December 2016 the EDF Energy referral was received by ASC. The referral stated that Catherine would not allow them access to read her meter and that they were concerned for her safety. A client assessment was opened by ASC. A social worker visited Catherine's address but they did not make contact with her. They spoke to her tenant (shop below her flat) who stated that Catherine did not like strangers but that she was okay as he had seen her out shopping. A letter was sent to her offering support. A letter was also sent to her GP advising that Catherine may benefit from a review of her mental state. The case was closed to the ASC Centralised Duty Team.

3.12 On the 16th December 2016 the GP practice acknowledged receipt of letter from Adult Social Care. No recorded follow up action was taken by the GP.

3.13 In February 2017 Catherine's tenant raised some concerns with ASC in relation to a pest infestation, with the pest control not being able to obtain access to her flat. He stated that

[1] The **Fixated Threat Assessment Centre** (**FTAC**) diverts into treatment mentally ill people who stalk, harass or threaten public figures

she had history of mental health but had been stable since her last admission to hospital in 2008. She was also not collecting rent. A decision was made to make a home visit. The referral was actioned as an urgent request to Older Person North Team (OPN) but marked as priority 2. This was not a safeguarding referral. The case was not allocated until May 2017. A visit did not take place until 15th May 2017.

3.14 On 29TH March 2017 the GP practice conducted a review of Catherine's notes. This prompted a discussion at the GP practice Multi Disciplinary Team (MDT)[2] meeting. There are no notes to evidence the outcome of this meeting. The following day the GP practice sent a routine recall letter to Catherine for an annual health check.

3.15 In May 2017 the case was allocated to the OPN social worker. A visit was undertaken but no contact was made with Catherine. The social worker again spoke with Catherine's tenant who stated that there was no need to ring police as he could hear Catherine in her flat, could smell cooking and had seen her going out shopping. (This was the visit resulting from referral in February 2017.) The decision was made to take no further action. An email with the decision was sent to the team manager and advanced practitioner.

3.16 In August 2017 (three months later) a summary of the case notes were entered on the ASC electronic system (AIS) requesting closure. The audit closure request was rejected with the following comments

"*Case not closed as we need a SW to see her and check living conditions? Safety. It's possible that the landlord may own the property and is not repairing as they should; therefore possible risks may present*"

The case was then placed on a waiting list and was not reallocated so a visit as actioned by the manager did not take place.

3.17 On the 3rd November 2017 police attended Catherine's address as she had locked herself out. They found that she was scared to return home because she had been threatened and the flat was possessed. Police reported that her flat was inhabitable as she had no food, no heating and a fuel bill (electricity) for £6563. Police also had concerns about possible exploitation by the tenant. As a result Catherine was admitted to hospital due to dangerously high blood pressure and a psychotic episode. Catherine was detained under S2 Mental Health Act[3]. It was confirmed that she had not seen her GP since 2014.

3.18 Police had contacted Catherine's GP raising concerns about her. They believed she was acutely vulnerable and that she needed to be sectioned but she had declined to go with the London Ambulance Service or see the GP.

[2] A Multidisciplinary Team Meeting is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

[3] **Section 2** of the **Mental Health Act** allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.

3.19 The Adult Social Care Centralised Duty Team completed a safeguarding triage and a decision was made that the case did not meet Care Act 2014 Sec 42 [4]or well-being duty S1. The case was closed to the Centralised Duty Team. The case was already open on the OPN waiting list.

3.20 On the 13th November 2017 the GP practice highlighted Catherine's record as a vulnerable adult on their electronic system. Several attempts were made to establish contact with Catherine.

3.21 The hospital psychiatric ward Approved Mental Health Professional (AMHP) assessed Catherine and recommended a safeguarding referral should be made around possible financial exploitation by her tenant. At this stage the possible exploitation was not recorded as a crime. This referral was received by ASC Centralised Duty Team. The Centralised Duty Team commenced a safeguarding assessment and requested transfer from the Centralised Duty Team to the OPN team. The case was held on a waiting list.

3.22 On the 21st November 2017 a referral was made to ASC from the psychiatric ward. The case was allocated to a social worker who made contact with the Community Mental Health Team (CMHT) Care Coordinator. A best Interest meeting was held on the ward on the 29th /30th November 2017. The outcome was that Catherine was able to make decisions regarding living arrangements but unable to make decisions about financial arrangements.

Case notes stated that Catherine was suffering severe neglect prior to being taken into care. The Local Authority made the following plans:

- Request a Care Act Advocate.
- Request a MCA from ward.
- Follow up with debt collection agency and EDF energy.
- To complete a referral for Adult Safeguarding.
- To complete a safeguarding fact finding exercise.

3.23 On 1st December 2017, SLaM Occupational Therapy (OT) made a home visit and concluded that the flat was unsafe and work needed to be undertaken before Catherine could return. The allocated social worker stated that they would make a safeguarding referral. OT made the following recommendations:

- Need someone to be appointed to manage her finances and set up direct debit for her bill.
- To be offered a free fire safety check from local Fire Brigade and a smoke detector to be provided.
- Safety check of gas heaters.
- Gas hob and oven needs repair.
- Hole in bedroom ceiling needs to be repaired.
- CM to be encouraged to change carpets.
- Water in kitchen did not appear connected.
- Boiler to be tested.

[4] The **Care Act** 2014 (**Section 42**) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

There is no evidence that a new safeguarding referral was made by the social worker.

3.24 On the 21st December 2017 a further home visit took place by OT and the ward manager. This resulted in the discharge of Catherine being cancelled. The social worker liaised with the 'Staying Put Team'[5] to assist with repairs. They delivered heaters for Catherine's flat to the ward prior to her discharge.

3.25 On the 27th December 2017 Catherine was discussed at the ward round. She wished to go home. It was agreed at the MDT meeting that she would return home with support from Older Adults Home Treatment Team (HTT) and the CMHT Care Coordinator. On the 29th December 2017 Catherine returned home.

3.26 On the 2nd January 2018 the Croydon Finance Team commenced an Appointeeship[6].

3.27 On the 9th January 2018 the Mental Health Nurse contacted police as she had not seen Catherine since the first. Police officers attended and gained entry. They found Catherine (*safe and well*). She stated that she did not want the nurse informed but would contact her the following day. Police updated the nurse that she was safe and well. Police submitted a contact referral (MERLIN) to ASC.

3.28 On the 10th January 2018 an engineer attended the address but Catherine would not allow them entry to the flat.

3.29 On the 15th January 2018 the CMHT Care Coordinator sent an email to ASC requesting a meeting as Catherine was refusing access 'due to her delusions'.

3.30 A meeting was held on the 23rd January 2018 at the Mental Health Older Teams Base. A decision was made to discharge her from the Community Treatment Team following a seven-day check-up due to her noncompliance to treatment and lack of engagement.

3.31 On the 1st February 2018 a SLAM Consultant Psychiatrist raised concerns after she was asked to review the case by the social worker. She queried if Catherine should be readmitted to hospital due to her non engagement. She concluded that:
'There is very high risk of ongoing serious self-neglect and financial difficulties due to her inability to manage finances. Long term high risk from neglect.'

On the 12th February 2018 the GP practice undertook a routine review of Catherine's notes. No action was taken as they believed that she was still an inpatient at the time.

3.32 On the 19th February 2018 SLAM wrote to the GP practice to make them aware of

[5] Staying Put helps older, disabled and other vulnerable people who need advice and assistance to carry out repairs or adaptations to their homes.

[6] To apply for the right to deal with the benefits of someone who cannot manage their own affairs because they're mentally incapable or severely disabled.

Catherine's non-compliance with psychiatric medication. There is no documented evidence of any GP follow up. It is of note that the letter stated that issues such as maintenance of her property such as heating and electricity were "*thankfully resolved before her discharge ".* This was not the case.

3.33 On the 21st February 2018 a Local Authority Care Planning Panel[7] meeting agreed to fund repairs. It was agreed to set up a contingency plan for non-engagement. The panel did challenge why the case was with ASC and not Mental Health. The social worker explained they were a social worker in the Mental Health Older Adults team (MHOA). They also stated that a contingency plan was not possible because Catherine did not want it.

3.34 On the 1st March 2018, the Staying Put team confirmed to ASC that only minor works were carried out to repair the gas hob. Catherine had refused to allow checks on the central heating. They expressed concerns about what Catherine was doing for heating in the 'current climate'. It is not clear if anyone physically saw Catherine at this time.

3.35 On the 19th April 2018 there was an email sent by the social worker to the financial management officer. It stated that:
She (Catherine) has declined community treatment and she said she does not want to work with me and other! She has been living with her illness for a long time and it's very entrenched. She does not understand money and its value. She gets her shopping every day and gets the money from her tenant in the shop below. (£62 per week)

3.36 In April 2018 a GP practice nurse documented that Catherine was an inpatient at hospital and so was removed from the GP recall list. She was not in hospital at this time. They had no record of a discharge summary. This was incorrect. They had received a letter on the 19th February 2018.

3.37 On the 24th April 2018 the social worker contacted EDF Energy but they would not supply any information to the social worker due to lack of consent.

3.38 On the 15th May 2018 an audit closure was requested by the social worker to close the case to ASC. It appears that the allocated social worker then left the employment of the local authority. There is no evidence of supervision and no follow up with the finance manager.

3.39 On the 11th June 2018, 3rd July 2018, 17th July 2018 and 18th September 2018 the finance manager sent emails to the OPN team requesting allocation of the case so that they could continue with the deputyship.

3.40 The team contacted the financial manager by phone and advised "*to watch AIS for the case to be closed to xxxx (social worker).*

3.41 On the 15th October 2018 there was a further email from the finance department forwarded to the OPN Team. Once again it requested that the case needed to be referred

[7] Local authorities have 'funding panels' to which social workers have to present cases, in order to get agreement for the care support a person may need.

as it was still allocated to a care manager.

3.42 The case was allocated to a new OPN Team social worker on 30th November 2018. This was six months after the request for closure.

3.43 The social worker visited Catherine's flat on 10th January 2019. They got no response so they contacted the police who gained entry. Catherine's body was found at the address.

4 FAMILY VIEWS

4.1 The author met with some of Catherine's family members and their representatives at the commencement of the review. He also visited Catherine's home at the request of the family. The author was surprised to see that that the soiled bedding on which Catherine was found was still in place. As a result, the author made the police aware so they could liaise with the family.

4.2 The family provided the author with a number of documents, letters and photographs, including a letter to the Metropolitan Police setting out their concerns about possible crimes committed against Catherine. They expressed concern about the possible cause of death and the police investigation. They were informed that the SAR would not examine the post death investigation but the author would convey the family's concerns to the Metropolitan Police.

4.3 They stated that Catherine was close to her sister in Ireland but this changed in about 2015, when she stopped answering her phone and did not respond to letters or cards. When they made contact with her tenant they stated that they he was hostile. He (the tenant) stated that Catherine did not want contact with the family as they were trying to get her money. When a local relative did attend the flat, the tenant would not allow him to access Catherine.

4.4 After her death relatives searched the premises and they found that the last food wrapper was dated January 2018. They found no medication and no indications that the rent had been paid by the tenant for a long period of time. It was this income that she used to purchase food.

4.5 Their main area of concern was focused on why the services failed Catherine. The secondary area of concern was exploitation and the potential criminality of the tenant.

- Concealing Catherine's death.
- Financial exploitation.
- Possible theft of property.

Other Contacts

4.6 The author did try and contact the tenant but they failed to respond. They also contacted the local priest. There were suggestions that Catherine was a regular church attender. The priest stated that this was not the case he had never met her. He was able to confirm that during 2017 he was contacted by a priest in Liverpool, Catherine had regularly been donating as a member of the Guild of Sick. He had become increasingly concerned about

her state of mind following receipt of some unintelligible letters so requested that the local priest visit her to ensure that she was not in need of support. The local priest attended her flat but received no reply. He spoke to the tenant who assured him that Catherine would never answer the door but assured him that she was okay. He took no further action upon receipt of that assurance.

5 ANALYSIS OF EVENTS

5.1 This author reviewed information provided from a number of sources including the agency IMRs, family and panel discussions.

5.2 VB is a Croydon SAR the circumstances of which had some significant similarities to Catherine's case. VB died in February 2017 and her body wasn't discovered for a number of months. Learning from that review will be referred to in this report.

5.3 This case can be split into three periods of time. These are:

- October 2016 to 3rd November 2017 (Living at home).
- 4th November 2017 to 29th December 2017 (Hospital Inpatient).
- 30th December 2017 to January 2019 (Living at home).

November 2016 to November 2017

5.4 In October 2016 family members contacted the local authority social services via email. They sought reassurance that Catherine was safe and well having expressed concern regarding her current state of health. This was followed up in November 2016 by a second email from the family confirming the death of Catherine's brother and providing contact details of a family member. The family had also contacted the police in October 2016. Police officers made a couple of visits to Catherine's flat but received no response, the family then informed them not to bother they would send a letter.

5.5 The family's email requests are recorded as being sent to the ASC referral team but there is no record or evidence that any action was taken or that family members were contacted.

5.6 In October 2016 EDF Energy staff went to execute a warrant at Catherine's flat. They appear to have spoken with Catherine who refused them access to her flat. As a result EDF Energy suspended enforcement and made a referral to ASC highlighting concerns about the state of the property and outstanding debts. They also expressed concerns about the tenant. EDF Energy files record that this referral was made on the same day (28th).

5.7 As highlighted in the VB review, EDF energy's identification of safeguarding concerns was good practice and reinforces the benefits of agencies working with utility agencies to raise awareness of safeguarding.

5.8 The EDF Energy referral was not recorded by ASC until December 2016. In response to the referral a safeguarding assessment was opened. An ASC Centralised Duty Team social worker visited Catherine's flat however, they failed to make contact with Catherine. They spoke to the tenant and took his word as reassurance of Catherine's welfare. They recorded the comment that she often goes out "*doing well for her age*". The tenant stated

that he would raise any concerns. A letter was sent to Catherine offering her support. A decision was made to close the case with no further action being taken.

5.9 Whilst a safeguarding assessment was opened it was not completed. This was the pattern during the whole review period. During that time a total of four assessments were opened by ASC but none were completed before the case was closed. Safeguarding referrals should not be closed without evidence of contact with the subject of the referral.

Recommendation
Adult Social Care:
Opened safeguarding cases should not be closed until assessments have been fully completed with evidence of contact with the client.

5.10 There was no feedback to EDF Energy. It is good practice to provide feedback to authors of adult safeguarding referrals. There was also no feedback to relatives who made contact in November 2016. There is no evidence of any supervisory oversight.

Recommendation
Adult Social Care:
To ensure that referrers of safeguarding referrals are provided with feedback as to action taken.

5.11 It is of note that for the rest of the period covered by the review services involved with Catherine state that they have no details of next of kin so no relative was ever contacted. This was incorrect as social care and police had been supplied with a family contact. The interaction with the family was recorded on the individual agency systems. If adult social care or police had searched their systems for the name or address when they received future actions or referrals they may have identified that Catherine had family.

5.12 It has not been established why there was a delay of a month between the EDF Energy stating they sent the referral to being recorded within ASC. This delay was unfortunate. If it had been received in October 2016 links to the family requests might have been made.

Recommendation
Croydon SAB:
To recommend to all agencies that it is good practice, upon receipt of information to search their systems to identify previous involvement with that individual or address.

5.13 Despite closing the case the ASC social worker appeared to have still had concerns about Catherine's well-being. They stated in their letter to her GP practice (December 2016) that whilst ASC would not take any further action, she might benefit from a review of her mental state and well-being. However, they ticked the box marked 'no' on the assessment document that asked the question:
'Is the individual experiencing, or at risk of abuse or neglect'.

If they had concerns they should not have marked the box 'no' as they had not physically seen her, so were not in a position to have fully assessed the risk. The case should not have

been closed until this had occurred.

5.14 The next contact with ASC was in February 2017. The tenant himself raised concerns about pest infestation and Pest Control not being able to gain access to Catherine's flat. He also reported that he had been unable to contact Catherine and she had not collected rent. A decision was made to undertake a home visit, this was the correct action.

5.15 The ASC Centralised Duty Team identified the potential risks and made a referral to OPN team requesting urgent allocation. Whilst the case was marked urgent, it was placed on the Priority 2 list. The case was not allocated to an OPN social worker until May 2017 (three months later).

5.16 The placing of the case on the wrong priority list replicates the issue identified in the VB review. It is of note that this was around the same time as the VB case, so appears to confirm the failings in the system at that time. The case should have been managed within the safeguarding process, not a referral to workflow process.

5.17 When the social worker did finally undertake a visit in May 2017 they again failed to make contact or engage with Catherine but recorded that the tenant had seen her and that she was okay. In May and August 2017, the social worker made recorded requests on the electronic case recording system that the case be closed. In August 2017 the audit closure request was rejected by the Team Manager with the following comments:

"*Case not closed as we need a SW to see her and check living conditions? Safety. It's possible that the landlord may own the property and is not repairing as they should; therefore possible risks may present*"

The comments left by the manager about the possible risk because of living conditions were relevant given what was discovered a few months later.

5.18 The delay of three months between the referral and visit and a further three months delay between visit and supervision oversight of file, is unacceptable. What compounds the delay was that failure for the Team Manager's instructions to undertake a visit and contact Catherine to be carried out.

5.19 The delay on the OPN waiting list and supervision is understandable when the staffing level and the waiting list numbers are considered. The OPN team as of April 2019 had a waiting list of 1413 clients. It is presumed that the list was higher during 2017/18. The service only had two managers and a staff of more than 20.

5.20 With these high numbers it becomes a major risk to safety of vulnerable older individuals, if cases which fit the eligibility for safeguarding enquiry are placed on the waiting list. Changes to the OPN structure (to be detailed later in this review) might help with the waiting list, but may still lead to serious delays if immediate safeguarding intervention is required.

5.21 A major issue that runs through this case is the failure at any stage to undertake a Care Act 2014 Section 42 enquiry.

5.22 If the social worker had fully completed a safeguarding assessment on either of the two occasions their decision making would have been informed by the GP that she had not been seen by the surgery that she had mental health history and her accommodation was in poor condition. She should also have been seen. As the Adult Social Care IMR states:

"Professional curiosity and concerns for her safety and well-being alone would have required persistence to see Catherine before decisions were made that no further action is required"

5.23 The following extract from a [8]Care Knowledge article by Deborah Barnett 2017 describes decision making on Section 42 safeguarding

5.24 **Section 42 of the Care Act (2014)** *describes a safeguarding enquiry and identifies that a Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether action is required. The enquiries are to be conducted when the adult (Aged 18 or over) meets the* ***three-part eligibility test*** *for safeguarding and there is reasonable cause to suspect that the adult is in the Local Authority area (Irrespective of whether they are ordinarily resident there or not):*

1. *Has needs for care and support (whether or not the authority is meeting any of those needs),*
2. *Is experiencing, or is at risk of, abuse or neglect, and*
3. *As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

5.25 Catherine's circumstances on all occasions presented during this review period appear to fit the three-part eligibility test. A Section 42 enquiry would have identified that this was a complex case that requiring a multi-agency response. This would have provided an opportunity to have in place a multi-agency safeguarding plan.

5.26 Referring the case to a waiting list had a major impact on the action or lack of action taken. The ASC IMR confirms the following:

Safeguarding risks and concerns are best managed within the safeguarding process where a multi-agency approach is required but in Catherine's case, the safeguarding referral was work flowed as a referral to a waiting list and ended thereby closing off this opportunity.

5.27 This statement is important. Failure to undertake a section 42 enquiry with the urgency and focused approach that would have been brought to Catherine's case, led to a weak response to her compounded by significant delays.

Recommendation
Croydon SAB:
To be assured that cases that fit the Section 42 enquiry threshold are being progressed as

[8] Barnett 2107: Safeguarding Adults: Decision Making in Section 42 Enquiry: Care Knowledge

such and not being placed on waiting lists.

GP practice

5.28 Whilst ASC failed to make contact with Catherine's GP, the Practice also failed to take any positive action to contact her.

5.29 Catherine's GP acknowledges receipt of the ASC referral in December 2016. They recorded that the referral did not raise any safeguarding concerns. There is no evidence that the GP practice made any attempts to contact Catherine. Given that the Practice had not seen Catherine since 2014 and they had received concerns about her behaviour in June 2016, it is surprising that a review of her health and wellbeing was not undertaken.

It is recorded that the Practice sent Catherine routine recall letters in February 2016, April 2016 and a flu vaccination letter in September 2016, followed by attempted telephone contact when her telephone line was found not to be connected.

5.30 The use of letters was highlighted in the VB review and is applicable to the GP's and ASC response in Catherine's case. The VB review stated:

The ASC response was to send a letter offering an assessment as it was felt, at that point, that VB was a client choosing not to engage rather than any concern regarding self-neglect.

5.31 The Practice state that they would generally try to call patients if they fail to respond to three letters. It was known that she did not have a working phone so this was not an option. It is evidenced that she would not respond to letters so other options such as a face to face visit should have been considered.

Recommendation
GP practice:
To review the use of letters when they have had no contact/response from elderly individuals with a recorded mental health history.

5.32 Whilst no immediate action was taken by the GP practice, a Care Programme Approach[9] review of her file was undertaken in March 2017. Catherine was deemed to have unstable mental health and was not engaging. The plan was to review her case in a Multi-Disciplinary Team meeting (MDT). The outcome of this meeting is unknown as there are no recorded minutes of this meeting.

5.33 The General Medical Council's (GMC's) good medical practice states the following at Domain 1: Knowledge skills and performance[10]:

[9] The Care Programme Approach (CPA) is for people in England with severe or complex mental health problems and those who may need services from a number of agencies to support them.

[10] GMC Guidance Domain 1: Knowledge skills and performance
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance#paragraph-19

Clinical records should include:

a. *relevant clinical findings*
b. *the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
c. *the information given to patients*
d. *any drugs prescribed or other investigation or treatment*
e. *who is making the record and when*

5.34 Failure to accurately record the review outcome is in contravention of the GMC guidance. There are a number of occasions when Catherine's GP records are inaccurate. An example is an entry in April 2018 which states that she was an inpatient. She had been discharged in December 2017.

Recommendation
CCG:
GP Practices to be reminded about the need to accurately record patient information including review meeting outcomes.

5.35 Despite the findings of their review of Catherine's file there is no evidence that a GP undertook a visit to Catherine's flat or that they referred the case back to ASC. The following day the GP sent a routine recall letter for an annual health check. They had failed to establish her current mental health state and if she required any support or care needs.

November 2017 to 29th December 2017.

5.36 In November 2017 police attended Catherine's flat. She was locked out and scared to return home due to delusions. Police recorded that the flat was inhabitable and she had no food. There were also concerns recorded by police that Catherine was being exploited by her tenant. She was taken by the police and London Ambulance Service to hospital having been detained under the Mental Health act 1983 s 136 amended 2007 [11](DH2007).

5.37 Catherine's poor health and living conditions might have been identified earlier if she had been seen during 2017. It is of note that the tenant whose views had influenced the previous inaction was considered to be possibly exploiting her.

Police

5.38 As well as a good description of the poor conditions she was living in, they also recorded the following on police electronic recording system (CAD).

[11] Sec136 MHA 1983:If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—

(a)remove the person to a place of safety within the meaning of section 135, or

(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

Police were concerned that Catherine was potentially being economically exploited by Mr xxxx as he is only paying her £62 a week in rent which seems very cheap considering the location and it is her only income. As mentioned above Mr xxxx commented that there was nothing of concern which is what he told social services on a welfare visit for her back in December 2016 when she wasn't there. This man clearly didn't care about her if he thinks there is no concern considering her poor living conditions. At the time of contact Catherine only had £8 on her and no bank cards which is not a sufficient amount to be able to live. There was no food whatsoever in the fridge or cupboards which were falling apart and didn't work which lead officers to believe she was barely eating. She has no friends or family or next of kin. The recommendation was that Social Services should visit Catherine regarding her and Mr XXX.

5.39 Officers had recognised the possible exploitation of Catherine and whilst they sent a police contact (MERLIN) setting out concerns to ASC, there is no evidence that the police followed this up as a possible crime, either recording it as such or undertaking an investigation.

5.40 The Police IMR concludes the following:
One element that merits further exploration is the financial abuse marker on the Merlin Report from November 2017. It is unclear if this was followed up on and indeed, who would have responsibility for this action. This should have been the subject of further discussion as it may well have been an ongoing exploiting of Catherine and it has never been potentially addressed or explored.

5.41 Whilst the Metropolitan Police have in place child protection teams, the same is not as well established for specialist adult safeguarding, which means that expertise in investigating cases such as exploitation against Catherine is limited.

5.42 The case of exploitation should have been considered as a Section 42 enquiry led by ASC. The officers had identified a potential crime and therefore it should have been recorded and further investigated. At this point in time contact with Catherine was not an issue as she was an inpatient for a number of weeks. Exploitation was a theme that ran through the case but was never fully addressed.

5.43 Another concern is that officers recorded that she had no family. As has been previously set out, the family had been in contact with both police and ASC in 2016. A search of the police CAD system may have identified the previous action including family details. Having family contact details would have been important information for all agencies at that time and would have helped to involve them whilst Catherine was an inpatient.

Recommendation.
Metropolitan Police:
Suspected crimes should be recorded and investigated.

Hospital Emergency Department (ED)

5.44 The Emergency Department patient records recorded the circumstances as set out at 5.36. Her clinical records showed that she had formal diagnosis of paranoid schizophrenia. Catherine was not taking her antipsychotic medication.

5.45 Whilst the ED nurse (agency) noted that Catherine had significant psychiatric history there is no evidence that a Mental Capacity Assessment[12] (MCA) was undertaken as part of her initial assessment. Good practice would have been to undertake MCA at triage.

5.46 The ED triage assessment form contained Safeguarding Adult referral prompters. For reasons unknown, the nurse undertaking the initial assessment failed to complete that section. This is despite the detailed information from police and LAS that evidenced the level of risk faced by Catherine.

5.47 The CHS IMR states:
The initial nursing assessment did not appear to demonstrate the appropriate level of awareness of complexities of mental health illness and did not appear to recognise Catherine as a vulnerable adult.

5.48 After five hours Catherine was subject to a psychiatric assessment by the ED Liaison Psychiatrist. A formal MCA was undertaken and she was deemed to lack capacity.

5.49 Catherine remained detained under 136 MHA. Secure transport was book to transport her to a SLAM psychiatric ward for a Mental Health Act Assessment. Due to a delay police officers opted to take her themselves. She was discharged back to police. The ED record does not confirm that the police took her to a Place of Safety. There is no evidence that a referral was made to ASC.

5.50 It is evident from the information received that Catherine was very vulnerable and that a safeguarding referral should have been made whilst she was in ED.

5.51 Croydon Health Service and SLAM have in place a policy that described the threshold for interventions including referral for Section 42 enquiry.

The CHS IMR states:
It is not known the extent to which the agency nurse was conversant with this policy or whether they received up to date training

Recommendation
Croydon Health Services:
Emergency Department triage nurses including (agency nurses) to be reminded of the need to fully complete the safeguarding assessment process.

SLaM Ward

5.52 Catherine was admitted to a SLaM psychiatric ward from the Emergency Department under

[12] The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Section 2 of the Mental Health Act. Upon, admission to the ward Catherine was assessed by the Approved Mental Health Professional. This assessment was comprehensive and patient centred. They recommended a referral to ASC in respect of possible financial abuse by her tenant. They also recorded her poor living conditions and that she had not been seen by her GP since 2014.

5.53 This was the first comprehensive assessment of Catherine's health and requirements to be completed. It evidenced significant safeguarding concerns including possible exploitation. It was good practice for a safeguarding referral to be made to ASC.

5.54 Catherine engaged well. She made a noticed recovery and her Section 2 was rescinded. She remained an informal patient until her discharge on the 29th December 2017 to the care of the SLaM Older Adults Treatment Team.

5.55 On the 1st December 2017, in preparation for her eventual discharge, OH team made a home visit with Catherine and concluded that the flat was unsafe and work need to be undertaken before Catherine could return. The social worker stated that they would make a safeguarding referral.

OH made following recommendations

- Need someone to be appointed to manage her finances and set up direct debit for her bills.
- To be offered a free fire safety check from local FB and smoke detector to be provided.
- Safety check of gas heaters.
- Gas hob and oven needs repair.
- Hole in bedroom ceiling needs to be repaired
- Catherine to be encouraged to change carpets
- Water in kitchen did not appear to be connected
- Boiler to be tested

5.56 It is of note that in the summary of OH team home visit they note the following:

Catherine opened post and went to collect 3 weeks rent from shop. Tenant reluctant to give her any money but eventually gave £62 - one week of rent and advised her to return on Monday for the remainder.

This provides further information that enhances the potential for Catherine to be financially exploited.

5.57 A further home visit took place on the 21st and serious issues were still raised. The conclusion was that Catherine's discharge should be cancelled.

5.58 The ward facilitated a MDT/Best Interest Meeting [13] to which Catherine's social worker and Catherine's CMHT care coordinator were invited. It is of note that neither the SLaM Home

[13] 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.' (Principle 4, section 1(5) Mental Capacity Act 2005)When a person does not have capacity to make a decision, all actions and decisions taken by practitioners or their attorney or Court Appointed Deputy must be done or made in the person's best interests.

Treatment nor the care coordinator who were to oversee her upon discharge attended the discharge meeting.

5.59 The safeguarding concern about financial exploitation was discussed, an application for a deputyship application had been made and an Independent Mental Capacity Advocate (IMCA)[14] was suggested as safeguards. Unfortunately, the notes of these discussions appear to have been lost whilst being transferred from the hospital to the community setting.

5.60 Catherine had been formally assessed as not having capacity to make informed decisions about her finances, but was willing to work with professionals to improve her conditions, including moving to temporary accommodation. This was the first time that her voice was being heard in line with Care Act 2014 Making Safeguarding Personal[15] principles.

5.61 There is no indication that Catherine was being supported by any independent advocacy to ensure she understood what was taking place and to support her decision making. An IMCA was suggested at the Best Interest Meeting and the hospital appear to have made a referral to 'Advocacy for All'[16] just before Catherine was discharged. On the 11.01.2018 Advocacy for All sent an email to the hospital consultant stating:

Below is the email I sent previously on the 28.12.2017 and then resent on the 08.01.2018 having had no response. It was try to confirm the reasoning behind the original request.

It is not clear why the hospital had not responded whilst Catherine was still an inpatient. This was missed opportunity to have fully supported Catherine and ensured that she understood all aspects of her care. The IMCA was not progressed as the IMCA service confirmed that whilst they could be involved when the issue is accommodation, issues pertaining to a person's finances falls outside the IMCA remit.

Recommendation
Croydon SAB:
All agencies to be reminded about the importance of the use of advocacy to support the individual and to ensure best interest decisions are made.

5.62 Given the clear concerns about the safety of Catherine's accommodation exploration of alternative accommodation on a temporary or a permanently basis should have been

[14] The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

[15] **Making Safeguarding Personal** means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their **safeguarding** situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

[16] Advocacy for All is totally independent from statutory organisations and all other service delivery and is free from conflict of interest. AfA's culture supports Advocates to promote their independence with individuals, professionals and other stakeholders; Advocates will be free from influence and conflict of interest so that they can represent the person for whom they advocate.

considered as part of her discharge planning. There is no evidence that it was further considered despite Catherine's agreement of that option.

5.63 Her discharge was a pivotal time. A comprehensive discharge plan should have been produced but no evidence that this was done. There appears to have been a wrong impression by the ward staff that repairs to Catherine's flat would be completed before she was discharged. There is no recorded confirmation within SLAM records that work had been completed. The CMHT Care Coordinator expressed concerns that she was not consulted about the discharge.

5.64 Significant concerns were raised by the ward staff with the allocated social worker on the 21st and the 27th December 2017.

The ASC response on the 21st was for the 'Staying Put Team' to arrange for delivery of heaters to the ward and consideration of installing a Key Safe to the property. Their response to concerns raised on the 27th was to agree that 'Staying Put' would follow up on repairs on the 29th. Despite these concerns and no significant changes in circumstances Catherine was still discharged on the 29th .

5.65 These limited actions failed to address the immediate risks. It is difficult to understand why the delivery of heaters to the ward was considered an appropriate response and should have led to questions being raised. The discharge process failed to anticipate and plan for the possibility of Catherine failing to engage once she was discharged despite this being her response previously.

5.66 Having expressed serious concerns on the 21st and 27th there is no evidence that ward staff attempted to delay her discharge on the 29th. They should have considered an escalation of the case and potentially making an urgent safeguarding referral.

5.67 Her discharge was reviewed in the SLAM IMR, it states:

Although all professionals working with Catherine, whilst she was admitted to the ward, actively assessed risk to self with possible safeguarding in place post discharge, this does not appear to have been formulated into a discharge plan and followed through in the community.

A thorough assessment of her mental health should have been completed before she was discharged from SLAM with a clear contingency plan in place if she disengaged from services.

5.68 The December 2015 NICE[17] document sets out guidelines for hospital discharges.

[17] NICE guideline [NG27] Published date: 01 December 2015: *Transition between inpatient hospital settings and community or care home settings for adults with social care needs*

The principles include:

***Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital*.**

In this case it is not clear who the single coordinator was. There was a care coordinator in place which would seem to be the appropriate individual but they highlighted that they were not involved in meetings or the discharge planning.

***Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning*.**

This did not take place. There was an opportunity to get family involved but clinical records state no known next of kin. ASC had records of family from when they made contact in 2016.

The hospital-based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on the day they are discharged.

There is no evidence that the GP received a discharge letter within 24 hours. Letter received by Practice in February 2018, or that they were involved in the discharge planning.

From admission, or earlier if possible, the hospital- and community-based multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. For example:

- ***homelessness***
- ***safeguarding issues***
- ***lack of a suitable placement in a care home***
- ***the need for assessments for eligibility for health and social care funding.***

As evidenced previously, issues were highlighted but not effectively resolved before she was discharged.

5.69 Catherine's detention provided an opportunity for a well-planned multi agency intervention. Catherine made progress and the Section 2 was rescinded so her discharge was a pivotal point. Effective discharge planning should have ensured that she was safe and fully supported both in terms of suitable accommodation and her mental and physical health.

Recommendation
SLAM:

To ensure that discharges are in line with NICE guidance.

Adult Social Care

5.70 On receipt of the SLAM safeguarding referral the case was referred by ASC to the OPN team and the safeguarding action was closed on the 7th November 2017. The reason given was that she had been admitted on a S2 MHA 1983.

5.71 The decision not to continue the safeguarding Sec 42 enquiry process but to allocate to the OPN team was another missed opportunity to have commenced a multi-agency response to Catherine's situation, including police involvement to address possible exploitation. A Sec 42 enquiry would have helped ensure strong multi agency planning for her discharge. This is the second occasion that this action had been taken.

5.72 ASC received notification from the hospital requesting community support to facilitate Catherine's discharge. The case was allocated to an OPN team practitioner. Further information from the hospital indicated that Catherine was assessed as independent and a request was made for sheltered accommodation. A Best Interest Meeting was planned but no MCA assessment was shared with the social worker or requested by the social worker.

5.73 NICE Guidelines state:
In line with the Mental Capacity Act 2005, practitioners must conduct a capacity assessment and a decision must be made and recorded that a person lacks capacity to make the decision in question, before a best interest decision can be made. Except in emergency situations, this assessment must be recorded before the best interest decision is made.

5.74 Given the concern about Catherine's ability to look after her own finances and the proposed local authority action, the social worker should have visited Catherine in line with best practice and undertaken a specific MCA as decisions were being made on Catherine's behalf by the Local Authority. Decision making was not based on informed MCA assessments and was not in line with the Care Act 2014 Making Safeguarding Personal principles.

5.75 The OPN team social worker had an opportunity to have visited Catherine. She was an inpatient for a number of weeks, sufficient time to have completed a comprehensive assessment and action plan. All indications are that Catherine was happy to converse whilst in hospital. With the recorded information available about her health, mental state, condition of her accommodation and the indication that she was being exploited, escalation to safeguarding referral should have been considered and her return home stopped or delayed until either the accommodation was passed fit for her to live in or alternative accommodation found. It was indicated at the Best Interest Meeting that the social worker would make a referral there is no record of them doing so.

5.76 It is recorded that there were still significant concerns about Catherine's return to her flat and given her lacking capacity to handle her own finances, the concerns about the tenant exploiting her should have been highlighted. Evidence of his possible exploitation had been witnessed by the OH team.

5.77 None of these actions effectively made Catherine any safer. What is most concerning about

this case is the reality that at no time over the period under review did any ASC social worker speak with Catherine. This highlights not only failings by the individual social worker but the failure of the system of case management and supervisory oversight.

5.78 The decision to allow her to return to her flat, given that at that time the flat still did not have heating or hot water, does not make sense. She was still vulnerable at a high risk of self-neglect and still vulnerable to possible financial exploitation. No professional sought to delay or challenge the action.

GP Practice

5.79 Police contacted Catherine's GP on the 3rd November 2017 raising concerns about her. This was good practice by officers. They believed she was acutely vulnerable and that she needed to be sectioned but she had declined to go with the London Ambulance Service or see the GP. This was on the day she was sectioned. The GP subsequently received the Emergency Department discharge summary which stated that she was taken back into the care of police under section 136 of the MHA. It did state that the clinician advised that the GP should review Catherine's blood pressure.

5.80 On the 13th November 2017 the GP practice placed Catherine on the vulnerable patient list and sent her a letter inviting her for an appointment on the 8th December 2017. This was cancelled when the psychiatric ward informed the GP that Catherine had been admitted to hospital.

5.81 Knowledge that Catherine was in hospital provided her GP an opportunity to have visited her as they had failed to previously make contact with her. There is no evidence they considered this option or became part of the professionals' discussion in respect of the discharge plan. This was a missed opportunity.

30th December 2017 to January 2019

5.82 This covers the period between Catherine's discharge and the time when she was found dead. When reading through the chronology of contacts, the last time that Catherine appears to have been physically seen was in January 2018. When considering the state of her body it is possible that she died many months before the grim discovery in January 2019. Her case was still being held by ASC for the whole of this period.

5.83 Engagement with Catherine once discharged proved difficult when she returned home in December 2017. Whilst the plan by the Home Treatment Team and CMHT Care Coordinator was to visit her daily. They only managed to see her twice. This was no surprise given her previous history and was a factor that should have been taken into account prior to her discharge. Her disengagement led to the Mental Health Nurse from the Home Treatment Team contacting police who forced entry on the 9th January 2018. Police stated that Catherine was 'safe and well'. They sent a contact (MERLIN) to ASC. They commented that the flat was reasonably tidy and extremely warm but Catherine was complaining of being cold. She was sitting on the floor.

5.84 Given the concerns about Catherine's mental health, it would have been a good opportunity for the Home Treatment Team to attend with the police so once they had gained entry,

they could have spoken with Catherine herself. This would have ensured that a health professionals' assessment of her condition including her medication and mental health was made. The only assessment was that of police officers who concluded that she was '*safe and well'.*

Recommendation
Croydon SAB:
To recommend to agencies that when they raise concerns with police about an individual which may result in a forced entry to premises, where possible they should accompany officers.

5.85 The CMHT Care Coordinator requested a professionals meeting to discuss Catherine's case as she was no longer allowing access to her premises including workers there to repair property. They stated this was due to her delusions. The meeting took place and the case was closed to mental health services due to her non engagement. She was discharged to the care of her GP and ASC.

5.86 Given Catherine's mental illness history it has to be questioned why the ASC social worker did not escalate/challenge the decision by Mental Health to close their case.

5.87 On the 1st February 2018 an email was sent from a SLaM consultant to the social worker and the care coordinator. They had reviewed Catherine's notes in light of her non engagement.

They concluded "*there is a very high risk of ongoing serious self-neglect and financial difficulties due to her inability to manage finances.*

It also stated that:
My thoughts are that a joint review with the new consultant social worker and care coordinator is arranged for as soon as possible. I think this lady may require further inpatient admission, as although the risks to self are not immediate, without proper treatment and assessment there is a long term risk from neglect.

5.88 This email highlights serious professional concerns about the safety of Catherine. There is no record either in SLaM or ASC electronic case recording systems, to indicate that any action was taken by either the social worker or the CMHT Care Coordinator as a result.

5.89 The SLaM IMR states:
There appears to be a lack of documentation the Home Treatment's and CMHT management or senior nurses of Consultants psychiatrists on why re admission was not considered and reasons for discharge.

5.90 This was a major failing by the social worker and the CMHT Care Coordinator to act on this information. Catherine was left to suffer and eventually die, when immediate action,

including possible readmission could have been taken.

5.91 This was a clear indication that Catherine was likely to suffer serious self-neglect and should have resulted in a section 42 enquiry that could have explored opportunities of how to engage with Catherine, including the involvement with family. It was not followed and there are no indications that any professional escalated their concerns.

GP Practice

5.92 On the 19th February 2018 the GP practice received a letter from SLaM advising them that Catherine was referred to the Home Treatment Team. It stated that Catherine engaged HTT and there were no concerns about self-neglect. Issues relating to heating and electricity were addressed before her discharge. Catherine was non-compliant with medication.

5.93 This letter appears to have been the letter sent following her ward discharge. It does not indicate that SLaM had closed the case and passed it back to the social worker and the GP. There is no record of the GP practice taking any follow up action. An entry made in April 2018 states that Catherine was an inpatient and that the practice was unable to monitor her renal functions.

5.94 Again, the GP practice is not seen as a pivotal part of the long-term care/support in the community. Other than police contact in November 2017 there is no evidence that any other agency worker made direct contact with the GP to either involve them in the care planning process or to ensure that the GP was fully aware of the current position. The practice records evidence the lack of oversight they had of Catherine's situation at any given time.

Adult Social Care

5.95 On the 1st March 2018, the Staying Put team confirmed to ASC that only minor works were carried out to repair gas hob. Catherine refused to allow checks on the central heating. They expressed concerns about what Catherine was doing for heating in the 'current climate' [24 February – 4 March 2018 Beast of the East]. It is not clear if anyone physically saw Catherine at this time.

5.96 By the 1st March 2018 there was sufficient evidence to indicate that Catherine was at risk. She had not been seen since January 2018, she had not responded to engineers calling to undertake work and the psychiatrist had strongly expressed concerns. Despite this evidence no proactive action to ensure Catherine's safety was taken. This was potentially the last opportunity for an intervention. Nobody physically saw Catherine after this point and indication are that she may have at this stage either died or have been close to death.

5.97 This failure was compounded by the following action. The allocated ASC social worker contacted the Local Authority Finance Team and it was agreed that they would pursue a deputyship application. In January 2018 Croydon finance Team applied for an appointeeship. The social worker appears to have been unclear as to which applied, so he received advice on each order from 'Advocacy For All' in January 2018.

5.98 The Local authority funding panel agreed payment for repairs on the 21st February 2017.

They queried why the case was being held by OPN rather than Mental Health Older Adults. The social worker sent an email to their line manager but there is no recorded response.

5.99 There is again a failure of supervision and an opportunity to escalate the case. This failure was compounded when in May 2018 the practitioner requested to close the case to social services.

Client is not engaging with mental health or social care. Crisis plan: Client to call the police and to take her to XX ward.

5.100 This closure request was not well evidenced. The social worker had never seen Catherine. The crisis plan was also inadequate. Catherine was at major risk of harm and in all likelihood may already have died. Once again case management and supervision totally failed. It appears that the social worker left the authorities employment at this time. This possibly explains the reason for the closure request.

5.101 The case remained on the system with no further action taken until June 2018, when the Finance Team made an urgent referral as they had been unable to obtain the information required for the order. They were advised that the case was still allocated to the practitioner and that they would have to wait until it was un-allocated and 'to watch AIS.' (The social care electronic recording system).

5.102 The case was sent back to the OPN team for allocation. Despite the Finance team making several chase-ups the case was not allocated until the 30th November 2018.

5.103 Whilst there was still a delay the newly allocated practitioner did undertake a visit eventually obtained the support of police to gain entry to Catherine's flat in January 2019.

5.104 There was a major failure of the system, there was a lack of case supervision and oversight of waiting lists. There is no indication that her case was being supervised. Previous supervision actions where not undertaken.

6 SUMMARY OF ISSUES

6.1 The findings of this review are not unique to Croydon The Bray, Orr, Preston Shoot 2015 serious case review[18] findings on the challenges of self-neglect highlights many of the issues in Catherine's case

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 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

[18] 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

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.

6.2 The following section will briefly highlight some of the main issues raised by this case along with some changes that agencies have made that may address some of the issues.

Assessments and Case recording.

6.3 The review has highlighted a lack of holistic assessments of need and a failure to ensure accurate timely case recording. ASC social workers failed on four occasions to complete the opened safeguarding assessment, staff in the Emergency Department failed to complete the triage safeguarding assessment and the GP practice, who had not engaged with Catherine since 2014, failed to fully record why they placed her on the vulnerable person's list. Other GP's entries such as Catherine being still an inpatient in April 2017 were inaccurate and led to a lack of follow ups.

6.4 The Home Treatment Team and the CMHT Care Coordinator failed to clearly record the increased risks to Catherine. A thorough assessment of her mental state should have been completed before she was discharged, with a clear contingency plan in place in the event she disengaged again.

6.5 This failure to accurately assess Catherine's needs impacted on the effectiveness of decision making. In Catherine's case this led to the closing of safeguarding cases and ineffective discharge planning which placed her at significant risk.

6.6 If effective case management/supervision had been in place across agencies, then incomplete or inadequate assessments might have been identified and corrected. Good intrusive case specific supervision provides support to the individual caseworker, and enables the identification of complex cases so interventions can be introduced at an early stage. In this case even when a Team Manager in ASC refused to close a case and set out actions to be undertaken it was not responded to or challenged.

Safeguarding Section 42 Enquiries

6.7 It is evidenced that Catherine was a very vulnerable adult and should have been subject to a Section 42 safeguarding enquiry as early as December 2016. Early closure of the safeguarding process and placement on OPN team's waiting lists led to major delays both in 2017 and 2018. Delays that in 2018 removed the opportunity to have identified that Catherine might be suffering and provide her with support that may have reduced the chance of her dying alone and undiscovered for many months.

6.8 Whilst there were still opportunities for the OPN team to support her, once it is no longer considered to be a safeguarding enquiry the delay, the potential risk and care responses were lacking.

The ASC IMR concludes:
There were various opportunities to work effectively with different organisations particularly around adult safeguarding process, policy and procedures however, this was not utilised as the adult safeguarding assessment was closed whilst requests to complete a new adult safeguarding referral and fact finding were not followed up. As such the safeguarding intervention was not deemed consistent with the local authority procedures for adult safeguarding as well as the Care act Duty to promote the welfare of adults with care and support needs.

6.9 A major failing was the case management and supervision of the ASC Older Persons services. The high waiting list numbers (previously highlighted) were being overseen at the time by two managers. The allocation to the wrong list which caused considerable delay was significant in this and the VB case and was addressed in the VB report.

6.10 Action 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.

6.11 This might have ensured that the case was allocated in a timely way and may have ensured improved supervision. This is the rationale behind the change but there is a need to monitor how it has impacted on delays and improved assessment and care plan quality. It should still not be used in cases that should be subject to a Section 42 enquiry.

Multi Agency Working.

6.12 Catherine's case involved a number of agencies, social care, mental health, emergency services and GPs. These were the appropriate group of people to be able to support Catherine but they ultimately failed to work in a cohesive joint up approach.

6.13 What is evidenced in this case is the lack of coordinated multi-agency working. This is best demonstrated when Catherine was discharged and when a psychiatrist review of her case highlighted major concerns in February 2018.

6.14 There were a couple of professional meetings, one whilst she was an inpatient and when she failed to engage in January 2018. Neither result in a comprehensive multi-agency care plan. There was a lack of co-ordination no individual took on responsibility to ensure coordination. The GP does not appear to have been proactively involved at any stage.

6.15 Once again this failing is not unique to this case but is highlighted in the Bray Person-Shoot review.

Challenges of interagency communication and collaboration dominated here. Several SCRs noted the absence of overall ownership of any collaborative strategy. Practitioners operated in isolation within their own roles, failing to coordinate services even in circumstances where a case conference would have been warranted or where financial abuse required investigation. The absence of shared understanding, collaborative working or full multidisciplinary assessment meant that not all the risks in an individual's situation could be identified or addressed holistically, and it was unclear what key risks were, or who should take responsibility for issues such as capacity assessment. Professionals were confused about where responsibility lay between or even within agencies, and struggled to coordinate who would do what and when. The more agencies that became involved, the more marked was the failure to join up their efforts. Individual agency decisions, sometimes to limit interventions or responses, were taken in isolation. As one SCR notes, "no single agency or individual was directly responsible for what happened to 'X', but rather no statutory single agency that had contact with 'X' took responsibility for taking preventative and protective action".

6.16 A new process which may assist integrated working is the One Croydon Alliance. 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.

6.17 This is a good initiative and the Huddle is good practice that should support GP practice. Catherine's case would have benefited from such a process. However, looking at the circumstances there would still be a need for an agency to recognise that Catherine was at risk and therefore to be supported by integrated services.

Recommendation
Croydon SAB:
To be assured by evidence that One Croydon Alliance is being utilised and making a difference to outcomes.

Non-Engagement, Self-Neglect

6.18 One of the difficulties that faced workers was their inability to engage with Catherine whilst at home. This often proves to be a challenge for practitioners as they look to apply the six principles of adult safeguarding [19]of the Care Act 2014.

[19] **Six Principles of Adult Safeguarding**
Empowerment. People are supported and encouraged to make their own decisions and **informed consent**. ... **Prevention**. It is better to take action before harm occurs. ... **Proportionality**. The least intrusive response appropriate to the risk presented. ... **Protection**. ... **Partnership**. ... **Accountability**.

6.19 As with the VB case workers failed to work together to produce a plan of options to help improve her engagement. Her failure to engage was assessed as her choice. In Catherine's case there was an opportunity to engage with her whilst she was an inpatient. That provided an opportunity for agencies to have produced a contingency plan for her future non engagement. This did not take place and inevitably resulted in her resumption of non-engagement. In both cases failure to engage was hiding evidence of fatal self-neglect.

6.20 An article by Deborah Barnett: Safeguarding Adults: Self-Neglect and Hoarding Toolkit sets out the spiral of self -neglect[20]

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 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.

6.21 The behaviour described in this article is very relevant to Catherine's case. However, in Catherine's case services did demonstrate an ability to intervene in November 2017. Unfortunately, this ability was not demonstrated again.

6.22 Croydon SAB 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

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

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

6.23 Cases of self-neglect combined with hard to engage individuals are difficult to resolve and can create complex circumstances.

6.24 Croydon have introduced the Risk and Vulnerability Management Panel (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.

6.25 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.

6.26 This is an option for agencies to refer to and was also referred in the VB review.

Financial Exploitation

6.27 The issue repeatedly highlighted by the family was the risk to Catherine posed by her tenant. There was information to indicate that she may be being financially exploited. Despite it being recorded on referrals there is no evidence of any action to investigate the allegation that other than looking at the local authority taking control of certain aspects of her finances.

6.28 The police failed to record the possible crime or undertake any investigation. ASC did not refer the case to the police. When Catherine was discharged back to her home not only was the home still not fully fit to live in, there was no plan in place that would address the potential risk posed by the tenant. Exploitation of the elderly is a form of abuse and failure to have Catherine's case subject to a safeguarding enquiry, meant that no multi agency plan which would have included the police as leading on exploitation was produced.

6.29 Suspected crimes against the elderly or individual with significant mental health needs should be subject to investigation.

6.30 **Recommendation**
Croydon SAB:
To remind all agencies that suspected crimes against vulnerable adults should be reported to police (with permission where appropriate).

Case Escalation

6.31 All professionals working with adults must be able to challenge each other appropriately.

When they believe that others are not working well together and, as a result, the adult remains at risk, or what is thought to be an unacceptable level of risk, then escalation should take place.

6.32 There were several occasions when an escalation by staff of various agencies should have been considered. Prior to discharge from hospital, upon receipt of the psychiatrist's review and closure of case to SLAM. No challenge was ever made

6.33 If challenges had been made when concerns identified, then the case may have been reviewed and weaknesses rectified.

6.34 Whilst professionals should be aware of the need to challenge the lack of any local policy procedure does not help encourage individuals to challenge.

Recommendation
Croydon SAB:
To produce an escalation policy.

Croydon SAB:
To be assured that the VB SAR recommendations have been progressed.

Other Issues

6.35 As previous set out at 4.1 the author did visit Catherine's flat. He was surprised to see that the very soiled bedding on which Catherine was found was still in place. This clearly presented a health hazard and was very distressing for the family. When scenes of deaths which pose such an environmental health hazard police or the coroner's officer should ensure that the health hazards are cleaned and property such in this case the bedding removed.

Recommendation
Police and Coroner
To ensure that at scenes of death that pose environmental health hazards, arrangements are made for cleaning to remove hazard before the property is handed back to family.

7 CONCLUSION

7.1 Catherine was an elderly lady who despite being an open case to ASC died alone several months before her body was discovered. Catherine's case has many similarities to the VB case who also died alone and was undiscovered for a number of months. Both had a history of long-term mental health; both were difficult to engage when living at home and both had cut themselves off from their families.

7.2 Where the cases differ, is that in November 2017 Catherine was detained under the mental health and remained an inpatient for a number of weeks. This provided agencies with the opportunity to engage with her and to ensure that the discharge plan ensured that she was safe in respect of her health, her living conditions and free from possible exploitation. This opportunity was not taken and she returned back to a flat that was in poor condition. She

responded by withdrawing again and refusing to engage.

7.3 There was a further opportunity to have intervened in February 2017 when she disengaged for health services. Her case was reviewed by a Consultant Psychiatrist who identified that Catherine was at risk and suggested consideration for readmission as an inpatient. Unfortunately, no agency either health or ASC took any action upon receipt of the review.

7.4 There were opportunities for professionals to have escalated her case but they failed to do so. The case should have progressed as a Section 42 Safeguarding enquiry but this was not progressed. Relatives were not contacted despite them contacting the authority with concerns in 2016 and the police failed to investigate the numerous references to Catherine being financially exploited.

7.5 The last confirmed time any services saw Catherine was in January 2018, her body was discovered in January 2019. Given the state of her body and the dates on food it would appear that she died many months before she was found. This is a shocking indictment of services who failed to work with Catherine or her family to make her safe.

8 RECOMMENDATIONS

1 **Adult Social Care:**
Opened safeguarding cases should not be closed until assessments have been fully completed with evidence of contact with the client.

2 **Adult Social Care:**
To ensure that referrers of safeguarding referrals are provided with feedback as to action taken.

3 **Croydon SAB:**
To recommend to all agencies that it is good practice, upon receipt of information to search their systems to identify previous involvement with that individual or address including details of next of kin.

4 **Croydon SAB:**
To be assured that cases that fit the Section 42 enquiry threshold are being progressed as such and not being placed on waiting lists.

5 **Clinical Commissioning Group:**
To ensure that the GP practice reviews the use of letters when they have had no contact/response from elderly individuals with a recorded mental health history.

6 **Clinical Commissioning Group:**
GP Practices to be reminded about the need to accurately record patient information including review meeting outcomes.

7 **Metropolitan Police:**
Suspected crimes should be recorded and investigated.

8 **Croydon Health Service:**
Emergency Department triage nurses including (agency nurses) to be reminded of the need to fully complete the safeguarding assessment process.

9 **Croydon SAB:**
All agencies to be reminded about the importance of the use of advocacy to support the individual, Mental Capacity Assessments and to ensure best interest decisions are made.

10 **SLaM:**
To ensure that SLaM Discharge Policies reflect the most recent NICE guidance.

11 **Croydon SAB:**
To recommend to agencies that when they raise concerns with police about an individual which may result in a forced entry to premises, where possible they should accompany officers.

12 **Croydon SAB:**
To be assured by evidence that One Croydon Alliance is being utilised and making a difference to outcomes.

13 **Croydon SAB:**
To remind all agencies that suspected crimes against vulnerable adults should be reported to police (with permission where appropriate).

14 **Croydon SAB:**
To produce an escalation policy.

15 **Croydon SAB:**
To be assured that the VB SAR recommendations have been progressed.

16 **Police and Coroner**
To ensure that at scenes of death that pose environmental health hazards, arrangements are made for cleaning to remove hazard before the property is handed back to family.

Glossary of Acronyms

- Adult Social Care (ASC)
- Croydon Health Services (CHS)
- Clinical Commissioning Group (CCG)
- Community Mental Health Team (CMHT)
- Croydon Safeguarding Adults Board (CSAB)
- Fixated Treatment Assessment Centre (FTAC)
- Emergency Department (ED)
- Home Treatment Team (HTT)
- Independent Mental Capacity Advocate (IMCA)
- Mental Health Act (MHA)
- Mental Health Older Adults team (MHOA)
- Multi-Disciplinary Meeting (MDT)
- Occupational Heath (OH)
- Older Person North (OPN)
- Risk and Vulnerability Management Panel (RVMP)
- South London and Maudsley Mental Health Trust (SLaM)