Safeguarding Adults Review (SAR)

Learning from the circumstances of treatment of and support for

Mr O1

VERSION 14.0

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Lead Reviewer

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1. Introduction

This Safeguarding Adults Review (SAR) is commissioned by the Croydon Safeguarding Adults Board (CSAB) in response to the circumstances surrounding the support for and treatment of Mr O1 aged 87 who died on 15 May 2020.

Mr O1 was a White British man who lived with his wife and daughter in a privately owned house in the borough. In October 2018 he was found at home on the floor and was conveyed to Croydon University Hospital (CUH) by ambulance with pressure wounds. Mr O1 was admitted to CUH and at the time he was found to be in a critical state with and assumption that he had only a small chance of survival. Following his discharge from hospital, and in part due to the very cluttered house in which he was living, he was placed in a residential care home to recover from his wounds. Mr O1 expressed that he wanted to go home, and he left the care home after one month, in the knowledge of Croydon Adult Social Care (ASC).

Mr O1 returned home in early December 2018. However, he was not seen by any agencies until 5 January 2019, when the London Ambulance Service (LAS) and the Police visited, having been called out by his wife. He had been lying on the floor for what is thought to have been several weeks and had significant pressure ulcers (including Grade 4 Pressure Ulcers) across multiple areas of his body. He was taken to hospital and palliative care was being discussed. The Police started an investigation and ASC started a S42 (2) Care Act Enquiry.

It was noted that Mr O1 was the dominant person in the household. He expressed that he was responsible for decisions around whether to engage with authorities and it was apparent that no-one else in the household was prepared to oppose his word e.g., to call an ambulance until he was unconscious. This dynamic of control did change after his last stay in hospital in 2019 when Mrs O1 ("N") took more control.

Concerns have arisen over Croydon ASC's response to Mr O1 as well as to other members of his family prior to October 2018. Concerns have also been expressed about the arrangements for and the appropriate Care Act Assessments which should have taken place around the time he expressed a wish to leave the care home in December 2018 to return home.

Additionally, concerns have been expressed about the District Nursing service (provided by the Croydon Health Services NHS Trust) that he was receiving in the care home and that information was not transferred within that service in respect of his return home and the potential for ongoing service to meet his medical needs.

Further concerns had been expressed that Mr O1's GP had discharged him to a new GP (in the area of the care home) but that his original GP Practice did not transfer his care back when he returned home.

Mr O1, sadly, died, whilst living at Albany Nursing Home on 15 May 2020.

In summary key issues identified within this review are:

- **Self-neglect and Hoarding**
- **Coercion and control within familial relationships**

1.2 Mr O1 and his family – a pen picture

Mr O1 aged 87 at the time of his death in a Nursing Home in May 2020, lived with diabetes, experienced chronic pain, had a history of alcohol dependency and a past history of a heart attack. He lived in his own home along with his wife, N (aged 75) and his daughter E.

Mr O1's wife N explained that in his early life, Mr O1 worked as a BT telephonist and took early retirement to help support his daughter as she became more ill in 1986. She described him as always jolly, outgoing, and optimistic, though also said that he was a vain man, a 'womaniser', unfaithful since 1994; having had relationships with other women outside the family home. N and Mr O1 slept separately, and she remained with him to support their daughter who was becoming progressively unwell.

Towards the end of his life, Mr O1 was described by N as short tempered, aggressive, dependent on alcohol, drinking whisky excessively and smoked frequently. Whilst drunk, he had threatened his daughter and wife and there were lots of clashes in later years in the family home. Mr O1 was always unwilling for N to get help for them at home and N described having to feed him at home towards the end of his life.

N felt that if a nurse or someone had visited after his discharge from hospital, more could have been done for him.

N was 75 years old and had been referred to adult social care for an assessment of her own needs. She had been on a waiting list for assessment since 8 October 2018.

E had a diagnosis of schizophrenia and was known to the local NHS Mental Health service since 2014 - her case was closed in December 2019. E died in different circumstances, with Covid-19 and at the time living elsewhere (away from the family home) with her mother, on 1 April 2020.

Mr O1 died just over a month after his daughter E.

1.3 Statutory Information

This review is conducted in accordance with section 44 of the Care Act 2014 and the Croydon Safeguarding Adults Board Procedures. Section 44 (i-v) of the Care Act 2014 stipulates that a SAB must arrange a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and (b) condition 1 or 2 is met.

(2) Condition 1 is met if— (a) the adult has died, and (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if— (a) the adult is still alive, and (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

*(4) A (*sic*) SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).*

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— (a) identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases.

1.4 A decision to carry out a SAR was made by the Board and Terms of reference were agreed at a Safeguarding Adults Review Panel at its first meeting on 8 February 2021.

The independent lead reviewer was commissioned, appointed in December 2020 and following this at the first Review Panel, in February 2021, the SAR report activity commenced.

1.5 Statutory guidance on the conduct of SARs advises that the individual's family should be invited to contribute to the review. The author spoke with N about the Review, its purpose and approach, and invited her to contribute through giving a pen picture, describing Mr O1. Prior to the presentation of the final report to the Croydon Safeguarding Adults Board, the author spoke with N again about the findings and the proposed recommendations. N will receive a full copy of the report and will consider whether she would like it further anonymised, prior to its publication. N, at this stage is happy to support publication of the review.

2. Terms of Reference

The full terms of reference can be found in **Appendix 1** at the end of this Report.

2.1 The Timeframe to be considered within the Review was determined to be between 2014 when Mr O1 was first referred to Adult Social Care Services by Age UK to May 2020, when he sadly, died.

2.2 The **specific areas of focus** for the SAR are for the independent reviewer to consider:

1. Identification and learning for all agencies involved with Mr O1 around assessing risk.
2. Identifying how high risk cases are escalated within Adult Social Care.
3. How all agencies working with Mr O1 communicated with each other.
4. Examining social work practice and process when working with people who self-neglect and managing this practice where people are considered to have mental capacity.
5. Examining how practitioners assess risk for people using services and how this is practiced.

3. Methodology

3.1 The methodology adopted included:

- Gathering pertinent information from N, the wife of Mr O1

- Gathering information from local professionals and agencies involved in the SAR Panel and bringing reports and chronolated information from those organisations to be reviewed by the independent author.
- A review and analysis of all information submitted by agencies (identified in 3.3 below) in respect of Mr O1 and of additional information presented at a Learning Review (see 3.2 below).

3.2 Activities undertaken during the Review process have included:

- Presentation and review of information gathered at the Croydon Safeguarding Adults Board, Safeguarding Adult Review Panel which met on 3 occasions in February, April and July 2021.
- A telephone conversation with N
- A virtual meeting with N in Croydon ASC
- Delivery of a Learning Review (Practitioner Event) on 5 July 2021 to include all key staff who, and organisations which, had been delivering services to Mr O1. The purpose of this event was to outline what the review had found so far; to record the experiences of those working directly with Mr O1 up to 2020; to further develop the emergent learning in the light of those experiences and to discuss recommendations for changes that could prevent a death from similar circumstances happening in the future.

3.3 The following agencies have contributed to the Review:

- London Borough of Croydon Adult Social Care Services
- Croydon Health Services NHS Trust – District Nursing Services & Croydon University Hospital
- 2 Croydon GP Practices – Practice 1 Thornton Heath Health Centre and Practice 2 New Addington Practice
- South London & the Maudsley NHS Mental Health Trust
- Metropolitan Police – Croydon, Sutton & Bromley BCU

4. The time in scope & Key Events for all Agencies: 2014 to May 2020

4.1 Pertinent information from the Adult Social Care (ASC) records

2014 - Records in relation to Mr O1 go back to June 2014 – where a referral is made to ASC by Age UK following their identification of hoarding and severe clutter at his home.

An occupational therapy assessment was completed on 1 September 2014, and the family was placed on the waiting list for major adaptations to their property. The case was then closed in December 2014 at Mr O1's request. There is no evidence of follow through or a return visit by ASC Occupational Therapists prior to the case being closed.

Between September 2014 and July 2018

In July 2015 Age UK raised further concerns in respect of Mr O1's property, citing a leak in roof and electrics not working. On 7 July 15 an ASC Duty worker contacted O1 and suggests a referral to 'Staying

Put'. O1 stated that he had the issues in hand. The Duty worker also spoke to O1's brother who advised that repairs were arranged. The worker contacted O1 and was then advised that all is now fixed.

On 3 September 15 - LAS called to O1 and they raised further concerns about the property. O1 was not taken to hospital and the noted outcome of the contact with ASC was for information and advice only. It can only be assumed that no action was taken as there are no notes of actions on the case records.

On 15 November 2016, ASC received a Discharge Notification from CUH, which was subsequently cancelled as O1 had already self-discharged.

On 6 September 2017, a Carer's assessment was completed by SLaM in respect of the role both Mr & N had in relation to their daughter with mental health needs.

July 2018 Mr O1's was admitted to CUH in July 2018 (this was his first admission to hospital and followed a fall at home and his spending a long period on the floor, on a mound of plastic bottles). There was no other intervention or support being offered to the O1 family by ASC at this time. CUH described Mr O1's appearance as unkempt, and it was stated that he had not been taking his medication.

Whilst in CUH, Mr O1 contacted Age UK asking for help. In response to this, Age UK contacted ASC on 20 July 2018 asking for assistance with addressing the issues with Mr O1's home environment. The outcome of this contact was that the information was passed on to the OPN team for further action. The ASC Hospital Social Worker (SW) referred Mr O1 and his family to 'Staying Put' for a blitz clean at their home.

A joint visit was arranged by the ASC SW & 'Staying Put' to meet with N who confirmed that there was no hot water in the property. There was no Care Act Assessment to confirm the causal factors but 'Staying Put' advised multiple issues with the property. It was later reported that a CUH Occupational Therapist (OT) advised that Mr O1 had declined the blitz clean, and despite being advised of the risks associated with returning home, stated that he was willing to accept the risks and discharged himself on 22 August 2018 to return home. No Mental Capacity Assessment was completed. The suggestion was that funding the work to reinstate the property was the issue. It was noted that as soon as finances are discussed with Mr O1 this was a barrier. There does not appear to be any consideration whether Mr O1 had the funds to pay for the work.

The following day an ASC Duty Worker contacted 'Staying Put' to advise that the blitz clean has been declined but asked them to contact family again with a view to seeing if they would change their minds and be willing to accept help. A referral was also made to the ASC Community Team for urgent follow up with the 'L' family. On 27 July 2018, Mr O1 was placed on the ASC Older People North Team's (OPN) waiting list. ASC have subsequently acknowledged that this was not an appropriate action for an urgent case of self-neglect and in light of the information highlighted by the London Ambulance Service (LAS).

August 2018 – 'Staying Put' contacted N by phone on 8 August 2018, suggesting that she obtain a quote from another company. N responded that the quote was too expensive. ASC felt that it was unclear who was hoarding items at the property and who was 'in charge' or in control. This was demonstrated by N refusing access to ASC when Mr O1 was in hospital. She stated he would not want her to let them in when he was not there, and Mr O1 later confirmed that this would be his view. There is further evidence of N abiding by everything her husband requested e.g., Mr O1 would also refuse to allow his wife to call LAS and she did not override this until he was very poorly.

September 2018 - It was noted that on 7 September 2018, no further contact had been received from Mr & Mrs L to confirm agreement to the blitz clean. 'Staying Put' attempted to contact them and left messages by voicemail.

October 2018 – Mr O1 was again admitted to CUH on 8 October 2018 following another fall at home and long period on the floor. On this occasion LAS found him on floor covered in faeces, urine and maggots. London Fire Brigade (LFB) had to help move him. He was very unwell and disorientated. Clinicians at CUH photographed evidence of larvae attached to his body. He was severely dehydrated and had sores all over his body. Mr O1 had not eaten or drank for several days and whilst N said this was only for a few days, medical evidence showed it had been longer. The hoarding at the family home was recorded on the LFB House Clutter index score of 8-9. There were bags of rubbish everywhere, fire marks on the walls, the roof was said to be caving in with a hole in the ceiling and flies and maggots everywhere. It was reported that the kitchen was unusable. LAS and LFB completed referrals of safeguarding concerns to ASC.

The safeguarding concern was allocated to an ASC triage worker in the centralised duty team who had contact with Hospital SW to discuss the concerns raised. A decision was made at this time not to progress to a S42 (2) Safeguarding Enquiry as O1 was accepting the need for support and had agreed to a blitz clean.

On 8 October 2018, a worker from the OPN team went to visit N at home, though N did not open the door. This was followed through by a SW who telephoned N. N stated that she would not allow anyone in 'because her husband would not do so".

On 18 October 2020, 'Staying Put' contacted the Hospital SW again to discuss clear up/ blitz clean of the family home. This was followed through with a contractor visiting the property on 22 October 2018, though N refused cleaning of their front room. Mr O1, when he was seen by the hospital Social Worker agreed that on return from hospital, he would move into back room, described professionally as moving into a 'micro-environment. It was arranged for the Cleaning Contractor to return on 23 October 2018 with a plan for 'micro-living', and an initial clean of the hall and back room only.

On 23 October 2018, the Hospital SW in discussion with the Team Manager, agreed that the OPN team needed to follow up, by addressing the concerns in respect of the property and arrange for the home to be cleared up so Mr O1 could return home. Further, that the 'Placements Team' needed to arrange an interim placement for Mr O1 in a Care Home, upon discharge from hospital, prior to returning home.

On 25 October 2018, the Hospital SW emailed the 'Staying Put' team to confirm that an estimate has been received from a Contractor to undertake a 'blitz clean' to the property and the SW made a referral to the Risk & Vulnerability Management Panel (RVMP) for community follow up.

On 30 October 2018, the Hospital SW contacted 'Staying Put' team advising that Mr O1 is going to an interim care home placement; that a referral to the OPN team has been made to address the home environment and that the blitz clean is no longer required. The Referral to the 'Staying Put' team was then closed.

The Hospital SW left a message for N in respect of a plan for an interim placement for Mr O1 until the back room/hall in their property was cleared.

On 31 October 2018, the assessment following the referral of a safeguarding concern about Mr O1 is ended, and a decision is made that the case does not need to progress to a (S 42 – 2) Safeguarding Enquiry as Mr O1 is engaging with a worker; has accepted the need for help and agreed to a short

term placement until the work is completed at his home and he can return. It is identified there needs to be some long term work with him, as a protective measure and that there is a need for follow up by the community team.

November 2018 – On 1 November 2018, the Duty Team emailed the Hospital SW and sent an email to the OPN team to advise that the safeguarding concern has been closed. It was suggested that a referral be made to the OPN team for follow up, and a referral to 'Staying Put' in respect of possible sources of funding for a clear up at the family home. This was followed by an email from the OPN SW to the OPN Team Manager raising a concern about the case coming back without a 'blitz clean' having been completed; and a request to the OPN Manager to speak to Duty Team Manager. The OPN Manager responded that if the community teams were involved prior to admission the OPN team will need to allocate the case, but that they can try to delay Mr O1's discharge. No action was taken.

On 8 November 2018, Mr O1 was discharged from CUH and moved to Addington Heights Care Home for a short term placement on the understanding that the property would be cleaned, and he could then return home. Mr O1 was registered with the New Addington GP Practice on 9 November 2018 and seen by one of the GPs on 16 November 2018.

December 2018 - On 5 December 2018, the Hospital SW contacted the 'In Touch' team to ask if they have a budget to fund the blitz clean**.**

On 6 December 2018 – the Hospital SW visited Mr O1 at Addington Heights Care Home. The SW advised Mr O1 that his wife refused entry to the OPN Community Team Social Workers who attempted to visit N at their home. Mr O1 stated that he wasn't surprised as he was not present and also said that he wanted to return home and was being kept against his will. Mr O1 was advised that he had the mental capacity to make the decision to return home, though no Mental Capacity Assessment was undertaken. The case notes recorded 'I informed him that he was not being kept at Addington Heights against his will, since he had capacity to make his own decisions and was free to leave if he wanted, but that his home environment had not been resolved due to the reasons mentioned above.'

Mr O1 decided that he would return home on 8 December 2018.

On 7 December 2018 - Addington Heights Care Home contacted Thornton Heath GP Practice to advise that Mr O1 was returning home. They were advised that he was no longer registered and further advised that Mr O1's family would have to register him on his return home. It is unclear if this information was communicated to Mr O1. There was no record in the GP notes that Addington Heights Care Home confirmed to the Thornton Heath GP Practice that Mr L had returned home. In fact, as Addington Heights had permanently registered Mr O1 with the New Addington GP Practice, it would have been assumed by the Thornton Heath GP Practice that Mr O1's residence at Addington Heights was permanent. When Mr L returned home, neither is there a record at Thornton Heath GP Practice that they had been informed that he had returned home (and would therefore have needed to be registered again with the GP Practice). It should be noted that N was unaware of the issues regarding de-registering and the need for Mr O1 to re-register with his original GP. Though this would not necessarily have been communicated to her as it was assumed that Mr O1 had the capacity to understand this issue. However, it is not even know if this was communicated to Mr O1.

8 December 2018 - Mr O1 returned home.

17 December 2018 – The Hospital SW contacted Addington Heights Care Home and was advised that Mr O1 had self-discharged on 8 December, the hospital SW then closed the case.

18 December 2018- There is a note on the adult social care records data base (AIS system) for N following information received by her brother that he has concerns about the state of the property

and Mr O1's alcohol consumption. Reason for contact is recorded as 'information and advice'. There is no outcome on the contact. Case note by contact centre also details information provided by brother. No further action was taken.

January 2019 - On 7 January 2019 **-** Multiple safeguarding referrals were received following attendance at the property by LAS, LFB and the police. Mr O1 was taken to CUH in a critical state.

4.2 Pertinent information from the GP records

Since early May 2008 Mr O1 was registered at Thornton Heath GP Practice until November 2018. Mr O1 was attending and having his regular blood tests, diabetes management and 'Barrett's Oesophagus' reviews.

After September 2017, Mr O1 rarely attended the Thornton Heath GP Practice, despite letters and phone calls to make appointments for routine checks (including flu vaccinations).

However, with more robust partnership working across health and social care compliance outcomes could have been improved. The multidisciplinary 'huddles' set up in GP Practices are assisting in better coordination of care but consent and compliance with the Mental Capacity Act (2005) has to be considered by clinicians. If a patient does not consent to being discussed in a 'huddle', then this does not happen.

There is evidence also that Mr O1 did not attend hospital appointments and seemed to only go in for the pain management and emergencies after falls.

It was noted that due to the challenges with information sharing, the information held on the 'Cerner' information system in the CUH would not have the information recorded on the 'EMIS' system and vice versa therefore an integrated record may reduce recurrence.

In 2018 following a discharge from CUH, and admission for respite care to Addington Heights Care Home Mr O1 was registered in the New Addington GP Practice. Except for an entry in July 2018 that the discharge summary received from the hospital referenced issues relating to hoarding there is no evidence in the clinical record held by the GP.

On 8 December 2018, when Mr O1 discharged himself from Addington Heights Care Home and returned home, the New Addington GP Practice advised that Mr O1's family had to re-register him at the Thornton Heath GP Practice. The Safeguarding Enquiry had found no clear evidence of how New Addington Practice communicated this to the family or any other statutory partners involved with Mr O1 at the time. Their records showed that there was no GP contact from either the patient or his family between 8th December 2018 and 20th January 2019 when he registered at another GP Practice.

Mr O1 was next seen by NHS services on 5 January 2019 when LAS and Police visited and concluded that he had been on the floor for what is thought to be several weeks and had significant (including Grade 4) sores in multiple areas of his body. Mr O1 was readmitted to CUH and actively managed and treated. It should be noted that the presence of diabetes can have a negative impact on wound healing especially if poorly controlled. There is no suggestion that management of Mr O1's pressure sores were poorly controlled or treated.
On 22 February 2019 when his condition stabilised at the CUH, Mr O1 was discharged to Albany Lodge Nursing Home where he was registered with another GP Practice.

During April and May 2020, Mr O1 was frequently assessed via video by this new GP Practice, as per national Covid-19 guidance, and treated appropriately for pneumonia. The GP Practice documented

how, now he was residing in a nursing home, there was access to 24/7 clinical support, supplemented by a telemedicine service. Mr O1 recovered from pneumonia, though his health began to deteriorate in early May 2020. The GP notes describe well the interactions between Mr O1 and the GP.

4.3 Pertinent Information from South London & the Maudsley NHS Mental Health Trust

The IMR sets out initially that it was evident that there was self-neglect within the household and that a safeguarding adult concern should have been raised at an early stage in SLaM's involvement with Mr O1's daughter E. In July 2018 it was noted that Mr O1 stated that N is a hoarder - he said it was not safe to do a home visit for E as things were everywhere. It was never confirmed exactly who was doing the hoarding.

The evidence for this was taken from the presentation of E and her family at outpatient appointments as SLaM never gained access to the family home. The safeguarding adult process may have provided a framework to make enquiries into the extent of the self-neglect and the hoarding within the property. Periods of time elapsed between appointments where the patient and family were not seen.

SLaM states that within a context of evidence of self-neglect and plans to discharge E to the GP, a more assertive approach should have been adopted by the Primary Mental Health Team. A transfer to a team whose remit is to provide more intense support may have been a viable option and would have been appropriate action to address the complex issues. The Primary Health Mental Health team is a step down low intensity services provided in SLaM to facilitate discharge to the GP. It is a community service aligned to the main CMHT. E was not discharged to the GP until 2019.

Intervention provided by the Primary Care Mental Health Team aimed at transitioning from secondary mental health care to Primary care e.g., establishing medication regime, reviewing physical health in relation to side effects of psychiatric medication – prior to discharge back to primary care. E's erratic engagement made this a difficult task. Most of the intervention was establishing and trying to maintain engagement. The Team is also able to maintain and continue to treat some people who have complex physical and mental health issues where management in primary care may not be the best option e.g., complex diabetes aggravated by psychiatric medication.

The author of this report was informed by the Team Manager that there were concerns about E's mother in regard to her cognitive functioning. Mr O1 had identified N to them as a person who was hoarding. There was no documented evidence within SLaM that these concerns were progressed in any way or escalated to the appropriate service.

A zoning system (indicating level of current risk) exists within the team and there is no evidence that E's non-attendance and family resistance to home visits triggered a decision to move her from a green zone to an amber or red zone with appropriate targeted action. There was a system in place, but it was underused.

There were pockets of good practice and communication with the GP in terms of physical wellbeing regarding E's chronic physical health issues. There was evidence of thoughtful prescribing in terms of her physical health and indeed the family was offered family therapy. E's father declined family therapy. This decision was perceived to have been unfortunate by SLaM as this could have been a good opportunity to explore the family dynamics from an holistic perspective.

Following the incident in January 2019 when Mr O1 was found on the floor and extent of self-neglect gets escalated to SLaM, there was a rapid response from the mental health service including

assessment at E's temporary accommodation by a consultant psychiatrist. However, no mental capacity assessment was undertaken. This may have provided useful information about E's capacity to identify risk and seek help. A degree of interagency partnership working was established, and the mental health team were able to access E and her mother much more frequently. A transfer to the 'Promoting Recovery' Team was made and frequent purposeful monitoring was instigated up until the point of discharge to the GP.

4.4 Pertinent Information from the Croydon Health Services IMR

Mr O1 was known to Croydon Health Services since November 2016. The IMR gave full and detailed information of all services provided to Mr O1 by Community Nursing and the Croydon University Hospital.

November 2016 - On 18 November 2016, an Occupational Therapist (OT) completed an environmental home assessment. The OT found that there was no room for the wheeled mobility aid-Rollator Frame (RF) due to clutter and hoarding. The living room was inaccessible, and one was only able to stand in the doorway with absolutely no space to enter. The house was untidy with damp on ceiling and there was no carpet throughout. N appeared dishevelled wearing dirty clothes and there was evidence that she was self-neglecting too. The OT concluded that the house was 'scruffy' and in order to set up the living room with the necessary equipment for Mr O1 to use, it would require a blitz clean, then a commode. If Mr O1 was to have carers, he would need transfer equipment. The recommendation was for Mr O1 to stay put in hospital until a blitz clean and the living room was set up. However, Mr O1 threatened to self-discharge from hospital.

On 19 November 2016, Mr O1 was reviewed by the Physiotherapist (PT) who recommended for safeguarding adult referral to be raised for self-neglect. However, it is not clear whether a safeguarding adult referral was subsequently raised and whilst referrals to ASC can be written via an online link, there is no record in ASC that this was ever received.

On 21 November 2016, Mr O1 was reviewed by the trauma & orthopaedic Specialist Registrar and the risks of discharging himself from hospital against medical advice was explained. Mr O1 was also seen by the OT, and he did not want to discuss the environmental visit and its implications. The risk of returning to an unsafe environment, obvious risk of failing over the clutter and re-fracturing prosthesis or damage to the repair if he puts any more weight through the joints was explained. Mr O1 said he was prepared to take the risks and remained adamant that he wanted to self-discharge. However, he agreed to a plan for the OT to refer his case to 'Staying Put' to clear the micro space. A commode was ordered and was to be delivered to his home address within three days. Since Mr O1 was assessed to have mental capacity to make the decision to self-discharge, his wishes were respected, and he was discharged from the OT and physiotherapy case load. The discharge plan was to refer Mr O1 to community physiotherapy, to ASC and inform authorities that Mr O1's daughter, E, was a vulnerable adult living in an unsafe environment. A District Nursing referral was written for administration of (Deltaparin) injections used to treat and prevent clots. Medication to take away and a discharge summary was given to Mr O1, and he was discharged. It is not clear in the clinical record whether community physiotherapy and ASC referrals were raised.

December 2016 - On 6 December 2016, the hospital anaesthetist sent a letter to Mr O1's GP advising that he was booked to have bilateral lumbar facet joint injections for his chronic lower back pain and would keep the GP informed as to how he responded after the injections.

On 8th February 2017, Mr O1 was reviewed at the fracture clinic. X-rays of right femur and right hip did not show any abnormalities.

May 2017 - On 10 May 2017, Mr O1 attended a review in the pain clinic. He was given an epidural facet joint nerve block injection and the next review was set in six months.

August 2017 - On 10th August 2017, Mr O1 was assessed by the specialist falls/bones health nurse and concluded that bone health treatment was not required anymore.

September 2017 - On 27 September 2017, Mr O1 presented to hospital with history of a fall two days prior and sustained heavy facial bruising over the upper jaw. Mr O1 stated that he had tripped over his shoes on the pavement and fell forward his face. Computerised tomography (CT) scan of the head, cervical spine and face showed comminute fracture of the external nasal bone. He was subsequently discharged with follow up by the Ear, Nose and Throat surgeons at St Georges' Hospital. Mr O1 was given information on actions to take if his condition failed to improve, changed or if he was concerned about his health in the future and a Head injury advice leaflet given to him.

July 2018 - On 16 July 2018, the OT completed an environment visit at Mr O1's home, as he was at that time in CUH following a fall at home. The OT found the property in a poor state with evidence of extensive hoarding and clutter, with some rooms were inaccessible, and so recommended a blitz clean and micro-living downstairs with equipment.

On 19 July 2018, the OT completed a referral to 'Staying Put' for an urgent blitz clean to clear walkways in the living room and kitchen to accommodate hospital bed, armchair and a commode. A telephone call was received by the OT from the 'Staying Put' blitz cleaner who advised that he had been to Mr O1's property, but N had declined the set up on the ground floor.

On 20 July 2018, an email received from 'Staying Put' highlighted that their contractor had visited Mr O1's property and had found it in an extremely poor state with a great deal of hoarding in every room and some rooms were inaccessible. The contractor estimated a week's work costing £3000 to clear downstairs, upstairs hallway, bedroom, and bathroom. There was no access to get a hospital bed into the property and there was no clear space to place it. The OT later met with Mr O1 on the ward and advised him of the quote and time frame. Mr O1 threatened to self-discharge and declined the cleaning service. The OT explained that given the pressure injuries, a blitz clean was recommended to provide suitable access for a hospital bed. The OT reiterated that it would not be ideal to go back to a cluttered home due to increased risk of falls, pressure injury and poor personal/environmental hygiene, however felt that the patient could furniture walk if needed. He was subsequently discharged from the OT case load. There should have been an MDT meeting at this point to discuss next steps and minimising the risk to Mr O1 and his family.

A formal mental capacity assessment in respect of the blitz clean was performed by an elderly care consultant Doctor, who discussed the risks associated with returning home before the blitz clean was completed such as risk of falls, risk of infections from poor tissue viability and the ability to be able to facilitate potential carer visits. Mr O1 stated that he understood the practitioners' concerns but was

willing to take the risk. He was deemed to have mental capacity to refuse blitz clean and to self-discharge.

A memory assessment was completed with Mr O1 which demonstrated an Abbreviated Mental Test Score (AMTS) of 9 out of 10 showing that there was no impairment of memory or cognition.

Mr O1 proceeded to discharge himself from hospital against medical advice in the presence of his nephew. He demonstrated mental capacity to make that decision. He declined functional assessment, despite the high risk of exacerbating the pressure sores as he did not have a suitable bed or mattress in place at home. He declined a package of care, smoking cessation and alcohol support services. He also declined the District Nurses (DNs) referral for his clot prevention injections and blood glucose monitoring. He confirmed that he had a blood glucose machine at home. Mr O1 was deemed to have mental capacity to understand the risks of not accepting support/ equipment. He signed the self-discharge form against medical advice. The discharge summary letter was sent to Mr O1's GP clearly stated the on-going safeguarding concerns and requested for Mr O1 to be referred to the GP huddle and to podiatry. However, as per Mr O1's decision, the DNs referral was not sent as it was assumed that he was able to get to the surgery for his wound to be dressed. Consequently, Mr O1 was never followed up in the community by the nursing team, neither was he followed up by the GP despite safety concerns clearly highlighted in the discharge summary and the request to refer him to the GP 'huddle'. No safeguarding concern was raised at this point.

October 2018 - Following Mr O1's admission to CUH in October 2018 there is a note stating that collateral history was obtained from N via a telephone call. N confirmed that she was aware of her husband's poor condition and was also aware of the safeguarding referral made by LAS. She informed that a blitz clean was meant to have been done in July, but they could not afford £3,000 as they depended on social benefits, hence they refused. N stated that she was trying to clear out the house, but it was too much for her. She described her husband as very stubborn and did not want to come to hospital and she didn't know what to do.

The ASC notes evidence that Mr O1 did not have the funds to pay for the blitz cleaning at his property and this appears to be the main barrier for him not accepting help. In order for the work to be done enforcement action by the Council had to be taken so that a charge could be put on the property for the costs of this action. This could have been an option that was considered as a blitz clean was never going to be the solution given the poor state of the property which required huge amounts of work which Mr & Mrs O1 could not finance. They accepted the need for this to be addressed and agreed to the enforcement route.

On 16th October 2018, during a ward review, Mr O1 was informed that the Hospital Social Worker was working to secure funding for blitz clean and therefore it was important for him to remain in hospital. Risks associated with going back to a cluttered environment were explained and he was advised against self-discharge even though he had mental capacity in that respect. Mr O1 stated that he understood but was willing to go home once infection cleared even though blitz clean was not yet done.

8 November to 8 December 2018 at Addington Heights care Home - On 8 November 2018, the DN attended the Care Home for an initial face to face consultation with Mr O1 and completed an initial wound assessment for necrotic wounds on the right hand and heel. A management plan for daily dressings was agreed. Between 9 November and 8 December 2018 (when Mr O1 self-discharged from the care home) Community Nursing Services and the GP were closely monitoring Mr O1 at the Care home and taking all appropriate action including referral to a Tissue Viability Nurse. During this period Mr O1 disclosed to the DN about his complex home situation and described it as highly cluttered. He also spoke about his wife and daughter's ill health.

January 2019 – Notes from 5 January 2019, describe how Mr O1 was brought to hospital following a call to the local ambulance service by his family. It was documented that on arrival, skin was coming away from his body and his body temperature was below normal. The house was described as being in a "horrific state", with rubbish all over the place, mould, damp in all rooms and was rated by the London Fire Brigade as level 9 on the 'Clutter Score'. Mr O1 was bedbound. It appeared that Mr O1 had been given water from a cup where dead flies were seen floating. He was forced to stay on the floor because the daughter wanted to sleep on the only bed available in the house. The bed was reported as being covered in mould and dirt as well. N reported to have given Mr O1 whisky and reported compliance with medication. However, many medications were still in boxes. N reported that they could not get him up and they called another family member to help but Mr O1 was in too much pain, so was left on the floor. She stated that Mr O1 did not like hospitals. Note is made that a Safeguarding concern was raised.

4.6 Pertinent Information from the Police IMR

During the period in scope for this review Mr O1 was a victim of robbery in 2014; he called police in respect of a number of other issues in 2016 and 2017 and had also been a witness to a commercial robbery in 2008 and reported a fraud in 2007.

There are extremely thorough notes/ evidence in the IMR in terms of all the considerations Police gave to Mr O1 and his family on the number of occasions when they had contact with the Police. These considerations included perceptions of vulnerability and considerations of welfare or other concerns. N had called police in 2001, 2010 and 2011 to report a number of issues. There are no police records of E having come into contact or calling police at any time.

<u>Police notes of the circumstances surrounding Mr O1's admission to hospital in January 2019.</u>

Police received a call from Croydon University Hospital (CUH) reporting that Mr O1 had been admitted into their care via the London Ambulance Service (LAS) and that he was in a very serious condition. He was suffering from various pressure wounds believed to be caused by severe neglect. Police officers attended CUH and spoke to medical professionals who explained the circumstances of Mr O1's admission.

Police were initially unable to speak to Mr O1 as he was too unwell but in the early hours of the 6 January 2019, they attended his home address where they found N and their daughter E. They were both described as being in a dishevelled state with multiple disabilities. Officers noted that N appeared to be suffering from dementia and E appeared to have learning difficulties. The premises were

described as smelling strongly of urine, extremely cluttered with rubbish everywhere and evidence of hoarding. The incident was recorded as a crime and Merlin[1] reports were completed.

Police again attended the home address at 13:40 hours to check on the welfare of the occupants. Due to concerns, entry was forced under Section 17 PACE[2], N and E were inside, in appalling conditions. Adult Social care attended and assessed the property as inhabitable and arranged alternative accommodation.

There were early concerns raised by police regarding the level of multi-agency and professional support provided to Mr O1 on the lead up to his admission to CUH.

Police Notes following Hospital Discharge and admission to Albany Lodge Nursing Home

When Mr O1's condition improved and following his discharge to Albany Lodge Nursing Home, he was visited there by Police - he stated that he had little memory of his time prior to his admission to hospital and was not very forthcoming about his home situation and at times appeared confused. He was not happy with police being involved and felt that the situation was between his family and ASC to deal with the issues at home such as hoarding, personal hygiene and the general state of the property.

On 10 July 2019 the police investigation was closed as undetected by a supervisor and no further action was taken. The OIC concluded that there was no evidence to suggest that ASC or other partner agencies were negligent in their duties and that Mr O1's self-neglect was the main contributing factor in this case. N and E had no formal care responsibilities and were therefore not accountable, having their own complex needs. Sadly, on 15 May 2019 Mr O1 passed away and the cause of death was recorded as COVID 19.

5. Outcome of Safeguarding Adults Concerns and Enquiries

It should be noted that only one previous safeguarding concern had been raised in respect of Mr O1's family and this was in October 2018. That 'Concern' did not progress to a Safeguarding Enquiry as, at that time, Mr O1 accepted the need for support.

Safeguarding Concern and Enquiry in January 2020 The outcome clearly states, **"**In light of this failure to intervene in situations that are dangerous to the person concerned or to others it is my recommendation that neglect, and acts of omission is substantiated This lack of follow up and the missed opportunities when Mr O1 returned home appear to be the result of a systemic failure of practice and processes within Adult Social Care and therefore, I recommend that organisational abuse should also be substantiated".

Practice issues were identified within partner agencies:

- District Nursing Service – A referral for further district nursing input was not deemed to be necessary as Mr O1 appeared to be mobile and able to get to the GP surgery to be seen by the practice nurse. The Head of Community Nursing identified that the initial assessment completed by the District Nurses could have identified concerns about Mr O1's home environment. The nurses did not at any point ask why Mr O1 was in Addington Heights. 'B' feels that if the nurses had showed greater professional curiosity and made fewer assumptions, they may have been concerned about Mr O1 discharging himself. They would then have had a responsibility to make contact with Thornton Heath Health Centre to advise that Mr O1 had self-discharged and ensure that the practice was made aware of his need to be seen by the practice nurse. There is no evidence to suggest that the DN service was neglectful in their care of Mr O1. However, if they had undertaken the actions as suggested above this would have been viewed as good practice and may have improved the outcome for Mr O1.
- Addington Heights Care Home - The staff at Addington Heights agreed to contact Thornton Heath Health Centre to advise them that Mr O1 is returning home. They were informed that Mr O1 was no longer registered with them due to his change of address to Addington Heights. They were also informed that Mr O1 would need to re-register at the practice. It is unclear if this information was shared with Mr O1 prior to his discharge. There is no evidence to suggest that Addington Heights were neglectful of Mr O1. However, it would have been good practice for them to share the information about Mr O1 being de-registered with the DN service. The DN's could then have communicated with their health colleagues at Thornton Heath Centre and flagged up the need for follow up by the practice nurse.
- Thornton Heath Health Centre - Mr O1 was registered with the practice since November 1987. He had not been seen at the practice since 2016. Mr O1 was removed from the patient register on 12 November 2018 due to an address change and registration with Parkway Health Centre.

The NHS England Standard General Medical Services Contract 2015/16 document[3] sets out in chapter 13 the conditions for registration and de-registration. One of the conditions is when a patient registers with another practice. As Mr O1 did register with Parkway Health Centre there appears to be a valid reason for Mr O1 to be removed from the practice list. Following Mr O1 self-discharging the professionals involved failed to communicate with the practice and share with them the significant risks to Mr O1's health and the need for practice nurse follow up. If this communication had taken place the practice may have considered further actions, and these may have improved the outcome for Mr O1.

Recommendation regarding the outcome of the Safeguarding Enquiry and to reduce further risk:

Due to the lack of follow up and a number of missed opportunities it was recommended that both neglect and acts of omission and organisational abuse are both substantiated against Adult Social Care. As detailed a number of practice issues and learning from partner agencies who were also involved with Mr O1 have been identified.

- Adult Social Care - A recent restructure of older people services has resulted in the formation of 6 locality teams. This restructure has meant that each of the teams are smaller and presumably any

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

waiting lists are more manageable. Older people senior management to consider the following recommendations:

- Review the waiting list system in the locality teams to ensure that consistent and robust processes are in place to reduce the risk of an individual being on a waiting list where there are clear concerns around self-neglect and hoarding.
- Develop clear processes around the interface between hospital social work team and locality teams around case responsibility.
- Ensure that there is clarification around the process for self-neglect cases that are identified in the hospital and require follow up in the community to be identified and flagged up to the responsible locality team.
- Learning from this enquiry to be disseminated within team meetings.
- Individuals involved in this case to be provided with supervision which allows for critical reflection on the case.

The barrier to the blitz clean being undertaken and the lengthy timescale resulted in Mr O1 losing patience and returning home appears to have been due to issues with obtaining funding. In the future all the social workers in the hospital need to have a clear understanding of the process for obtaining funding for a blitz clean. If it is not possible for the hospital SW to carry out this work, there needs to be a seamless transfer to the relevant locality team. Other recommendations were also made at that time in terms of all community staff need to be conversant with the self-neglect and hoarding procedure, training for staff on self-neglect and hoarding; the contact team to complete a piece of work so that the team record contacts appropriately to include reason for contact and the outcome, all Social work teams to always ensure that clear information around the reason for temporary placement is undertaken and agencies are notified of risks posed if the adult returns home.

- District Nursing Service - the team requested to develop their professional curiosity and ask questions about an individual's home background; not to make assumptions and be thorough in their information gathering. It was also identified that there was a lack of sharing important information between the social worker, Addington Heights, CUH and the DN service. The Manager stated that if the DN's had been made aware of the home situation they may have been more concerned about Mr O1 returning home and as a result may have contacted his GP surgery to ensure that there was follow up.
- Addington Heights - The registered manager at Addington Heights has acknowledged that there is learning for them in this case. She accepts that staff should have followed up once they were aware that Mr O1 was no longer registered with Thornton Heath Health Centre and could have contacted the DN service who would then have had a professional responsibility to follow this up. The manager has also stated that she has advised staff to be more curious around the reason for admission for a short term placement and ensure that they are aware of potentially hazardous home environments.
- Thornton Heath Health Centre - Current NHS guidance allows practices to de-register patients who they have been advised have registered with another practice. This poses a risk to those returning home from respite care or a temporary placement who may not be aware that whilst they were in the placement, they have been de-registered by their own GP. This may result in vulnerable adults returning home without being registered with a GP and lacking the support from another to successfully complete the re-registration process.

6. Analysis of Key Events - Findings

6.1 The period leading up to significant contact with Mr & Mrs O1 in July 2018

During the period September 2014 to July 2018, there were a number of missed opportunities to engage well with the L family. During this time the hoarding issues might have been addressed by professionals through commissioning voluntary sector activity. Had a trauma informed approach been considered at this point, in work with the family there would have been many opportunities to support the family with changes in small steps which may have made their accommodation safer and contributed to their abilities to protect themselves. Indeed, work with the family at this stage might have identified the issue raised of a potentially coercive and controlling relationship which Mr L had with his wife and daughter; and when support could have been provided to help him understand and change his behaviours.

6.2 Intervention of Adult Social Care

When a referral was also made to the ASC Community Team for urgent follow up with the 'L' family on 27 July 2018, it was placed on the ASC Older People North team's waiting list. This combined with a previous home visit evidences a lack of professional curiosity in this matter which could have been developed, had a second visit been arranged to the family home by the Older People 'North' Team.

Adult Social Care and a Hospital Occupational Therapist visited the family home in August 2018 to assess what could be provided on Mr L's discharge from hospital. Support was declined and it was evident that professionals assumed that Mr O1 understood the risks. Use of a risk assessment would have been good practice and may also led to a requirement to undertake a Care Act Assessment.

When a worker from the OPN team went to visit N at home in October 2018 and was not able to gain access, and despite a follow up call by a Social Worker who telephoned N - receiving a response from her stating that she would not allow anyone in 'because her husband would not do so' - there was no further follow up, supervisory or management discussion nor oversight around this case. N also remained on the OPN waiting list. Given that at this point everyone is seemingly at risk in the household, there is no evidence that other professional advice was sought e.g., Environmental Health Officer and no Mental Capacity Act (MCA) Assessments were undertaken? Again, there seems to have been no professional curiosity applied about the possibility of a coercive and controlling relationship between Mr L and his wife.

Given that there is expertise in Croydon's ASC teams about self-neglect; ASC could and should have referred the matter to a 'funding panel' at the earliest in July 2018 and certainly at this point, as the ASC notes evidence that Mr O1 did not have the funds to pay for the blitz cleaning at his property and this appeared to be the main barrier for him not accepting help. There were other options which could have been considered – e.g., funding panel consideration or for there to be further case work with the family and these were not followed through. There is some evidence in the information provided for this Review by CHS that a discussion had taken place about funding, so it appears to be widely known that there is a process for consideration where individuals do not appear to want to fund essential services.

Later that same month, when the hospital Social Worker contacted 'Staying Put' team advising that Mr O1 was going to an interim care home placement; that a referral to the OPN team has been made to address the home environment and that the blitz clean is no longer required, the Referral to the Staying Put team was then closed. The rationale for the Social Worker closing the request for blitz clean (or indeed other support for the family about clearing their home environment) is not apparent as this was why Mr O1 agreed to the placement. Additionally, others in the family were substantially at risk. There is no evidence of a 'think family' approach, neither is there evidence of professional curiosity, especially as the daughter also had mental health needs. A clear plan should have been put

in place with coordinated conversation and agreed actions by all the teams involved with various family members at this point.

When the referral of a safeguarding concern about Mr O1 was closed on 31 October 2018, a decision made that the case does not need to progress to a (S 42 – 2) Safeguarding Enquiry – it was made on the basis of Mr O1 then engaging with a worker, accepting the need for help and agreeing to a period of short term care. It was stated that long term work with Mr O1 was needed as a protective measure with follow up by the community team. However, it is my belief that the Safeguarding concern should have remained 'open' until Mr O1 was able to return home and work commenced to enable wider engagement in clearing the property with consent, especially as he had terminated contact and support previously.

A referral back to the OPN team on 1 November 2018 was made following closure of the safeguarding concern for follow up, and to 'Staying Put' for possible sources of funding for a clear up at the family home. The OPN Social Worker then emailed the Team Manager raising a concern about the case coming back without a 'blitz clean' having been completed. However, no action was taken. This raises the issue that the team which works with vulnerable people at home have no narrative about the successes or otherwise of a blitz clean. Further that there was no evidence that a trauma informed approach might be more effective alongside support of a cleaning agency. Additionally, the matter seems to be caught up in process here and a person-centred approach is lost. Again, a MDT meeting might have better enabled more appropriate action to be taken.

On 5 December 2018, the hospital SW contacted the 'In Touch' team to ask if they have a budget to fund the blitz clean. Despite telling 'Staying Put' to close the request for the blitz clean the Social Worker was still trying to find funding. There was no discussion with the supervisor in respect of the correct channels to obtain funding and it is not known whether the Social Worker was aware that Panel decisions could be made to waive the need to charge for such service, in certain circumstances. There seems, on the evidence to be poor communication between the hospital social work team and the OPN community social work team.

On 17 December 2018 – The hospital Social Worker contacted Addington Heights Care Home and was advised that Mr O1 had self-discharged on 8 December, the hospital SW then closed the case. This points to both a lack of management oversight and delays in respect of the work with Mr O1 as he had left the Care Home to return home some 9 days earlier. This matter should have warranted a full discussion between the Social Worker and Manager given the complexities of this matter. Had this been the case, the Manager would have likely discussed a transfer of case and need for urgent allocation due to high level of risk and completion of a full Care Act Assessment.

Mr O1's brother had contacted ASC expressing concern about the state of his property and MR O1's alcohol consumption on 18 December 2018. However, the case records denote that the contact is recorded as 'information and advice', with no further contact outcome and there was no action taken. There was clearly inattention by the Contact Worker to the full records on the AIS system which would have included information about Mr O1, his admissions to hospital, the interim placement in the care home and self-discharge. This should have been escalated to the Contact Team Manager for further advice and intervention. The outcome record was inappropriate. It should be noted that Mr O1 was still 'open' to the OPN Waiting List and thus at the very least, the contact note should have been escalated to the OPN team.

There is evidence that throughout there were opportunities to engage with Mr O1; that he had some insight into his behaviour and If ASC and other agencies had put in the work and communicated well

across and between agencies; there would have been an opportunity to commence protective actions which might have meant that Mr O1 could have remained safely at home.

6.3 Intervention of GPs

There had been significant non-attendance by an elderly gentleman (Mr O1) with a number of co-morbidities which might have been followed through better, though it was noted that Mr O1 was often not agreeable to the GP visiting him at home. It was stated that overall Mr O1 would attend some GP and Hospital appointments but not all. There was no evidence at the time that the GP Practice had protocols in place which would enable a busy GP practice to identify people who were potentially at risk and difficult to engage and enable them to be more proactive to follow through.

Further a concern was identified that discussion could only take place at a GP led 'Huddle' if the patient had offered consent. This does not fit with the necessity to raise safeguarding concerns and it is possible that had MR O1 been the subject of a 'Huddle' discussion, safeguarding concerns in respect of MR O1 may have been referred earlier.

Overall, lack of consideration of mental capacity is an issue and if this had been considered and then a referral of a safeguarding concern been made to ASC at this point, there may have been a case for ASC to use inherent jurisdiction to protect Mr O1 from harm and at the very least this should have been considered and documented.

The fact that the GP with whom Mr O1 was registered when living at home, de-registered Mr O1 when he moved to temporary respite care at Addington Heights Care Home was in accordance with local procedures. The GP Practice was unaware that Mr O1 was only moving to the care home for a short term period. However, when the Practice advised, on being told that Mr O1 was returning home, that he would have to re-register, no-one took account of the fact that he would have needed proactive support to re-register.

On 7 December 2018 - Addington Heights Care Home contacted Thornton Heath Health Centre to advise that Mr O1 was returning home. They were advised that he is no longer registered and further advised that Mr O1's family would have to register Mr O1 on his return home. It is unclear if this information was communicated to Mr O1. There was no record in GP notes that Addington Heights confirmed to the Thornton Heath Health Centre that Mr L had returned home. In fact, as Addington Heights had permanently registered Mr L with their GP Practice, it would have been assumed by the GP Practice that Mr O1's residence at Addington Heights was permanent. When Mr O1 returned home, neither is there a record at Thornton Heath Health Centre that they had been informed that he had returned home (and would therefore have needed to be registered again with the GP Practice).

6.4 Intervention of South London & the Maudsley NHS Mental Health Trust

It is important to recognise that although Mr O1 was not receiving mental health services, his daughter, still living in the family home, was. It is good professional practice always to 'think Family' and this means that professional curiosity should extend beyond the person to whom a service is being directly provided. In this case the issue of hoarding and the unkempt property was absolutely an issue to be raised by SLaM professionals supporting E.

6.5 Intervention of Croydon Community Health Services and Croydon University Hospital

It should be noted that the CUH Discharge summary for Mr O1 did not specify that he was moving to Addington Heights for a temporary placement, which was the reason that he was registered with a new GP practice on arrival there. Neither was Addington Heights Care Home aware of the poor state of his property, and as a result this was not conveyed, nor did it feature in a discussion between the Care Home and the District Nurses. However, the Care Home was aware that the placement was short

term. Information provided as a part of the Discharge Summary was not comprehensive and environmental and safeguarding concerns not shared with the care home. This is an inadequate referral to the Care home, and does not reflect an holistic assessment, especially as the referral was for an interim placement.

On 16 July 2018, the OT completed an environmental assessment at Mr O1's home (he was at that time in CUH following a fall at home). Given that the OT found the property in a poor state with evidence of extensive hoarding and clutter, with some rooms were inaccessible (s/he recommended a blitz clean and micro-living downstairs with equipment); a Safeguarding concern should have been raised at this point and was not.

On 20 July 2018, an email received from 'Staying Put' highlighted that their contractor had visited Mr O1's property and had found it in an extremely poor state with a great deal of hoarding in every room and some rooms were inaccessible. However, following the OT discussion with Mr O1 he then threatened to self-discharge and declined the cleaning service; and was subsequently discharged from the OT case load. There should have been an MDT meeting at this point to discuss next steps and minimising the risk to Mr O1 and his family.

A formal mental capacity assessment in respect of the blitz clean was performed by an elderly care consultant Doctor, who discussed all the risks with Mr O1. This was good practice, though when Mr O1 stated that he understood the practitioners' concerns and was willing to take the risk, it would have been appropriate for a MDT meeting to have been convened to discuss concerns and agree what supports cold be put in place to minimise the risks further.

During MR O1's temporary residence at Addington Heights Care Home, Community Nursing Services and the GP were closely monitoring Mr O1 and taking all appropriate clinical action. During this period Mr O1 disclosed to the DN about his complex home situation and described it as highly cluttered. He also spoke about his wife and daughter's ill health. There is no record as to what happened as a result of this information from Mr O1 – again this would have been an appropriate time to convene a multi-disciplinary meeting.

6.6 Interventions by the Care Home

On 7 December 2018 when Addington Heights Care Home contacted Thornton Heath Health Centre to advise that Mr O1 was returning home, they were advised that he was no longer registered and further advised that Mr O1's family would have to register him on his return home. It is unclear if this information was communicated to Mr O1 or his family or indeed whether there was still a contact with Croydon Adult Social Care services where they might also have been informed. It is therefore important that all Care Homes commissioned to provide temporary respite care are required to ensure that residents have the necessary support to re-connect with the GP services or indeed to re-register (if appropriate) when they return home.

7. Learning Points – Key Issues presented by each agency.

7.1 Key issues identified by ASC.

At the time of Mr L's death, another Safeguarding Adults Review was taking place in Croydon in respect of similar issues about self-neglect. That SAR approved recommendations in respect of Adult Social

Care and its organisational systems. As a result, and at the start of 2019, Adult Social Care began making significant changes to practice in the Locality Adults Social Care teams, strengthening management capacity and beginning to reduce waiting lists for team action. This evidences actions which have already taken place, and which are in part covered in some of the recommendations in this Review. The detail of this is covered in Section 8 below.

- It was inappropriate to place an urgent case of a person's self-neglect on the OPN Team waiting list, despite safeguarding concerns being raised by the LFB regarding the state of property on Mr O1's admission and his subsequent self-discharge in July 2018.
- The OPN Waiting List was vast and could not be safely managed and/or prioritised.
- There was a lack of follow up when the Social Worker duty visit identified concerns with the property in October 2018**.**
- There was a lack of understanding by the Social Worker in the CUH Hospital Team of processes for securing funding for blitz cleans.
- There was inadequate sharing of information with Addington Heights by ASC and via the Hospital Discharge Summary. Addington Heights care Home was unaware of Mr O1's home environment and previous safeguarding referrals in December 2018.
- There was a lack of follow up by the OPN team when Mr O1 self-discharged home from Addington Heights in December 2018 despite the OPN Team Manager being aware of the need for action and accepting responsibility to follow up.
- Following discussion with the Contact Team the wrong outcome was recorded in notes which evidenced a further failure to act on information provided by the family – in December 2018.

7.2 Key Issues identified by the GP Practice.

<u>Learning for all agencies around assessing risk.</u>
From previous consultations Mr O1 had come in with his wife and it would have been good practice to know if he still had the continued support from his wife or a relative or carer. Prior to December 2018 his diabetes could have had better control but unfortunately due to the fact that he did not always attend appointments this was not achieved. The Practice advise that they respected Mr O1's rights and acknowledge that discussions held at the huddles across health and social care minimise the risks associated with this.

<u>Roles and responsibilities, opportunities for proactive joint working.</u>
The patient was referred to other teams not just in primary care but in secondary care as well. He was known to the complex care team. Patient had a lot of involvement from other agencies, but improved joint working could have contributed to better outcomes. On 22 February 2019 the GP had concerns about the quality and detail of the discharge summary from the hospital but there was no evidence to suggest that this was followed up. Good practice would have been liaising with discharging ward to raise their queries relating to the discharge summary and to use existing processes such as the quality alert system to encourage wider learning. There was also evidence that the clinical record held by the acute hospital was not updated with the new GP practice therefore there was a delay in receipt of the discharge summary.

<u>Managing high risk cases in the community – multi agency support/protection plans and contingency plans.</u>
The practice has regular meetings with multi-disciplinary teams where complex cases are raised and is effective in managing patients such as this. The effectiveness of the MDT is also dependent on the patient's engagement especially if they are deemed to have mental capacity. In this case patient seemed to prefer not to engage and chose when he wanted to be compliant. The presumption of

mental capacity was applied as the chronology does not reflect evidence of a formal mental capacity assessment and whether his wife has lasting power of attorney was not explored.

Mental Health and Self Neglect – approaches to long term planning.
The practice was not aware of any mental health issues or self-neglect. However there has potentially been missed opportunities to identify and highlight the risks associated with poor compliance to health needs. Self-neglect covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. (Care and Support Statutory Guidance, p.234). On 20 July 2018 the chronology highlighted that the discharge summary makes reference to hoarding which is an indicator for self-neglect or concerns relating to poor mental health. This was a missed opportunity for clinicians to refer safeguarding concerns relating to the hoarding which could have led to the involvement of adult social care.

To consider looking at structures and processes.
The practice team is very good at identifying patients who may be at risk of harm or need extra support. Patients are being signposted to link workers and self-help groups, and the wider MDT team (the community psychiatric team member, district nurse, community pharmacist, social worker, Age Uk etc). It presents an opportunity to intervene at a much earlier stage as another health professional who will have the skill set and knowledge of the resources that are available to support the patient is involved. Following admission in July, a referral for consideration of the huddle was made but Mr O1 did not respond. The GP Practice feels that Mr O1 would have benefited from a multidisciplinary approach for his care; he would have had a care needs assessment, the befriending service and more people to come in contact with him and report any symptoms that may have been there.

There is a view that it is difficult to know if the Practice could be infringing on a patient's privacy when they suddenly stopped responding to invites and there was no confirmation in the notes of a lack of capacity.

7.3 Key Issues identified by SLaM

Learning for all agencies around assessing risk
On a number of occasions appointments with the mental health team were missed by E as her father phoned to cancel them and would not permit home visits. A more assertive response may have been useful in order to investigate the risk at home. A 'think family' approach to risk management may have been useful where the patient was seen within a context of her family and ongoing risk e.g., hoarding and self-neglect. It is unfortunate that discharge to primary care was being considered at the same time as identifying evidence of neglect. A useful reflection, stated by SLaM is that the L family were close, and rarely 'allowed people in'. N was described as difficult and was always arguing with her daughter. Mr O1 always accompanied his daughter to her mental health appointments.

Roles and responsibilities, opportunities for proactive joint working.
It was identified in October 2018 that both E and her mother displayed signs of self-neglect, no consideration was given to raising a safeguarding adult concern and yet the concern could potentially have triggered a section 42 Safeguarding Enquiry. An enquiry may have prompted professional curiosity which appeared lacking for the most part. Mr O1 identified that his wife was hoarding; that the place was a tip, and hence did not want home visits – the extent of hoarding should have been pursued for fire safety reasons if nothing else.

Managing high risk cases in the community – multi-agency support/protection plans and contingency plans.

There was little evidence of multi-agency working in the years leading up to the incident where Mr O1 was found on the floor and admitted to CUH. Relatively good liaison with the GP in terms of physical health. Post incident there was much clearer evidence of joint planning and liaison.

Mental Health and Self Neglect – approaches to long term planning.
Absence of planning in regard to managing self-neglect. A missed opportunity to undertake a mental capacity assessment shortly after the incident occurred could have identified ongoing risk of self-neglect and forward planning for E. Slam understanding of her capacity to identify risk and seek help may have been useful given the circumstances.

To consider looking at structures and processes.
It would be useful to consider the circumstances that transfer to a more intense service would have been appropriate. Non engagement with the service and prohibitive access to the patient by the family e.g., not allowing home visits may have required a more assertive approach. A more fluid approach to responding to changing need would have been useful at an earlier stage.

A transfer to the 'Promoting Recovery Team' following the incident led to more intensive assessment and support until the point of discharge to the GP. The decision to discharge to the GP appeared to be clinically appropriate and was accompanied with the required discharge letter and recommended plan.

The manager for the Croydon Primary Mental Health Team has informed that they have implemented a system where if a patient does not attend a written pre planned appointment a home visit is triggered. This should go some way to ensuring that non-attendance is acted upon in a prompt and decisive manner.

7.4 Key Issues identified Croydon Health Services

Lack of understanding risk of self–neglect/hoarding
Mr O1's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the complexities with Mental Capacity Act 2005 especially with people who self-neglect. It highlights the difficulty of respecting an individual's right to choose yet respect autonomous decision making at the same time trying to keep them safe from harm.

All agencies must be persistent and creative when it is clear the cause of self-neglect is complex. In Mr O1's case it was not a lifestyle choice and had grave consequences.

However, there were many missed opportunities where professionals could have intervened in a timely manner. The evidence from this IMR suggests that there is an urgent need to have a coherent and consistent understanding of the risk and safeguarding implication of hoarding between and across agencies. Additionally, balancing patient's rights when they have mental capacity against duty of care when decisions pose a risk to self and others.

Poor Multi-agency working.
Practice in respect of Mr O1 has shown that no single agency could address his care and support needs. However, it appears nothing compelled or even required health and social care services to work collaboratively within and across their own provisions to provide direction and resolution and as a result, opportunities to intervene in an integrated way were missed as, CHS passed referrals to ASC rather than seeking practical help from ASC on the patient's behalf. If the MDT meetings were strengthened, this would have provided an integrated response to Mr O1's deteriorating situation.

There was a lack of management oversight and action.

This case shows that working with people with multiple and complex needs across agencies has to hinge on coordinated assessment, case management and working with the risk of harm together. There was lack of ownership – a leading coordinating manager who should have been tasked to over-see and kept the patient fully engaged to prevent the same risks which resulted in hospital admissions. Case management for patients with dual diagnosis such as Mr O1 could have offered better opportunities for person centred engagement and risk management. Involvement of the CHS safeguarding service would have strengthened case discussion/supervision, management oversight and follow up of Mr O1's case.

Lack of understanding the available legal rules and protocols.

Mr O1's case raises questions about the importance of understanding people who self-neglect but who have mental capacity to understand the risks but still choose to self-neglect, and considerations to be in terms of support needs. Mr O1 was believed to be making unwise decisions, declining blitz clean and returning home. It highlights the dilemma of respecting an individual's rights to private life at the same time duty to try to keep them and others safe from harm.

Lack of continuity, lack of follow up.

There was failure to follow through on decisions. Mr O1 had multiple safeguarding referrals sent to ASC but still the same agencies continued to raise the same referrals without querying the outcome of the previous referrals.

Lack of professional curiosity

There is evidence that all practitioners who came into contact with Mr O1 did not exercise concerned curiosity and challenge hence failed to explore family dynamics or to probe more as evidenced by the case of the District Nurses who did not ask why Mr O1 was in Addington Heights and did not ask about his home situation which was an important aspect of his care. Again, there was lack of concerned curiosity with the professionals who cared for Mr O1 in hospital as they never queried the outcome of the previous safeguarding referrals with the ASC.

Given that Mr O1 had mobility issues and sometimes spent days to weeks on long lie, there was lack of professional curiosity and challenge to find out who was buying him alcohol "was this out of love, or fear or oblivious to the fact that he was alcoholic. Was the wife and daughter alcoholic too?" All these concerns remained unanswered.

Poor communication

There is evidence of poor communication with the family though the family made some calls to the practitioners offering information they regarded as important for Mr O1's physical welfare. The family had every right to be fully informed about the progress of their loved one which would also have provided an opportunity to build a rapport and involve them in the patient's care. Once was established, it may have been easier to solicit N and E's views regarding treatment and discharge plans as it is evident in Mr O1's clinical records that the family were not involved until the very last admission in 2019 when N sought a placement for him. This may also have given N more confidence to know what to do in case of medical emergencies.

Failure to offer carer assessment.

Given that Mr and Mrs O1's relationship was estranged, and that E was struggling with her mental illness, and her behaviour was upsetting. It appears the family was not coping, yet the professionals

who were supposed to have helped them disregarded important information given by N. This case shows us the importance of engaging the patient and family members in the risk management process and plan which could have helped the practitioners in a way to gain an overview of family strengths, risks, relationships and needs. This could have mitigated the risks incurred by Mr O1.

Conformity to organisational procedure

In this case there was a sense of practitioners conforming to organisational procedures. Practitioners could have tried different approaches such as use of advocates or concerned others or maintained contact with Mr O1. CHS could have shared information with ASC for initial inquiries which means that regardless of whether Mr O1 had mental capacity or not, his behaviour though at the time might have appeared as an informed decision, the decisions were detrimental to the quality of his life and that of significant others, his well-being and safety and this should have been escalated to the ASC and guidance sought regarding people with capacity who refuse services and are at risk rather than conform to organisational procedures.

Failure to escalate.

It is evident in this case that there was failure to follow through on decisions. For example, the long term plans to refer for case management or to the GP huddle would have been a safety net against non-compliance. There was failure to escalate concerns with either CHS SGA team, senior managers for example the matron, who would have escalated to the relevant Head of Service, Director of Nursing/Safeguarding, Designated Safeguarding Lead for the CCG/NHS Trust and the CSAB Chair when Mr O1 self-discharged from hospital before blitz clean of his property was resolved and also when there was no outcome of the previous safeguarding referrals.

Non-engagement

There is evidence that Mr O1 disengaged with services as highlighted by discontinuing vital medications and refusing follow up services in the community. There was a range of interlocking factors that made it harder for Mr O1 to become and stay involved with services for example, his mobility issues, home environment, alcohol dependency and complexities of his physical health.

Lack of information sharing

There is evidence of good practice of information sharing as was indicated on discharge summary sent to the GP and to Albany Lodge Care Home on the 28 January 2019. The discharge summary explicitly stated that there was an-going safeguarding concern and what the concern was. However, there was no evidence of information about the on-going safeguarding concern on referral letters to the DNs and incontinence services.

It was also identified that there was a lack of sharing of important information between the Social Worker, Addington Heights, CUH and the DN service. She has stated that if the DNs had been made aware of the home situation they may have been more concerned about Mr O1 returning home and as a result may have contacted his GP surgery to ensure that there was follow up.

7.5 Key Issues identified by the Police.

Good practice has been highlighted in the use of the 'Merlin' system to record information about vulnerable adults. In particular it is important to note that following police contact with all members of the O1 family in January 2019 three separate Merlin reports were created so that each individual's needs could be assessed, and their safeguarding concerns documented.

Officers attending the CUH where Mr O1 had been admitted on 6 January 2019 and also attending the home used their own professional judgement and assessed that there were urgent safeguarding concerns, that N and E did not have the capacity to appreciate the full extent of the neglect against Mr O1 and that they were not in any immediate danger. They were left at the address with urgent referrals ongoing and subsequently a decision was reviewed by a supervising officer who deployed officers back to the home address. A crime scene was then established, and new accommodation was secured for N & E. This was good practice as the secondary risk assessment was made just a few hours after the initial assessment and concerns acted upon immediately.

From an MPS perspective this case highlights the importance of a joint multi-agency approach and the Police worked hard to obtain copies of and review all third party material in order to make an informed decision around a potential criminal investigation. Investigators commented upon concerns which were raised in respect of other agency reaction to the potential neglect of Mr O1 prior to police involvement. No criminal charges were laid, and it was agreed that the matter was for other agencies to scrutinise and comment upon. The parallel enquires relating to the Local Authority S.42 enquiry and the way in which multi-agencies worked together was felt to be good practice and enabled all agencies to reflect upon the circumstances of this case and where necessary make recommendations to deal with and implement change.

8 What has changed since 2020?

8.1 In response to an earlier safeguarding adult review and appropriate for referring to within this SAR, there have been considerable changes since 2020. The Head of Service for Older adults in Croydon has set out that:

- The **Integrated Care Network+ Multi-Disciplinary Team**: enables health and social care professionals to meet at least twice a week in each locality and discuss cases that require joint working, additional input, idea sharing and risk escalation.
- There is a **S42** (Care Act s42 Safeguarding Concerns and Enquiries) **Consultation Panel**: scheduled to meet each Tuesday to discuss cases social work teams think that the S42 team should take on for full enquiry (i.e. post initial triage). Ad hoc additional meetings can be scheduled as required if a case cannot wait.
- **All Self Neglect cases are now referred to the S42 panel:** even if the decision by the social worker and Safeguarding Adult Manager is not to progress to S42 (2) Enquiry. This gives another oversight on each Self neglect case.
- A **Risk and Vulnerability Management Panel:** meets monthly, chaired by the borough's Anti-Social Behaviour Team. This Panel has ability to help in some self-neglect cases from a housing, environmental health, London Fire Brigade and Police perspective
- **Waiting List management:** A tool developed in older people services, which enables managers and advanced practitioners to keep track of who is on the waiting list, how long have they waited, and the level of risk
- **MIND and "Clouds End"-** These are Agencies that can be commissioned for a more psychological approach to people who hoard, help reduce accumulation and declutter at individual's own pace. This service is commissioned several times a year on difficult cases where ASC is '*stuck'* with more traditional offers.

- **Safeguarding Oversight** – there has been a fundamental review of how safeguarding activity is tracked in real time by managers within adult social care

8.2 A Briefing is attached at Appendix 2 which sets out in more detail the changes which have been made over the last year to 18 months.

8.3 Following the Learning Review (detail in Section 9 below), some examples of good practice have also been identified and these are included at Appendix 3.

8.4 Thornton Heath medical practice have already as a result of the learning from this matter:

- Adopted the practice of putting major alerts on notes for mental health review for patients that are hoarding.
- Now make everyone aware of the fact that for the 'Huddle' meetings - if there are safeguarding concerns, the patient can be added without their consent.
- Look out for the triggers for a mental capacity assessment to be carried out.
- Continue ensuring that 3 contacts are always made for patients - which must be by different forms other than telephone or letter.

9. Findings from a separate Learning Review event on 5 July 2021

This section considers the comments made within the Learning Review - this was an event facilitated by the Independent Author, attended by all key partners who were involved in the provision of services to Mr O1, his wife N and daughter E. Notes from this event are included at Appendix 4.

It was agreed that the outcomes of the Review presented by the Independent Author had reflected appropriate findings and learning. All 21 participants felt that in similar circumstances this could happen again. However, there was absolute clarity and unanimity in respect of what happened, how practice could be improved and indeed that practice across many agencies has changed since the death of Mr O1. Key points included in the feedback included:

- The need for all to be clear about the process for GP registration and temporary resident support, for people on short term placements in care homes.
- The need for one agency to take overall responsibility for coordinating work in cases similar to that of Mr O1 and his family.
- That practice of staff who are working with individuals who are difficult to engage, needs to be supported with good quality safeguarding supervision.
- There needs to be better understanding of Information Sharing Protocols across all agencies, especially to enable discussion without consent where individuals may need safeguarding intervention.
- Improvements are needed to ensure better understanding of the application of the Mental Capacity Act.
- Embedding learning from this and other SARs is important, and this needs special attention where there is (currently) a huge turnover of staff. That this may need additional resources.

- Commissioners within ASC and the CCG need to have clear expectations of care homes in relation to facilitation of information handover for those receiving short term care or who are subject to Discharge to Assess protocols
- Commissioners need to review the offer of a wide variety of services which can be offered to people who self-neglect and hoard and to people who find engaging with statutory services difficult. Commissioners need to ensure that operational staff within the statutory agencies understand all the different services which can be offered and how to arrange them, following assessment of need.
- The new Integrated Care Network approach can offer opportunities for better joined up working across agencies.
- Important to note the Council's Section 114 Notice in 2020 and its impact of a 15% reduction in staff, and a knock-on effect on both the statutory and the voluntary sector; affecting funding and ability to recruit.
- All professionals should understand that safeguarding is everyone's responsibility.
- Supporting people who self-neglect needs a much greater degree of coordinated inter-agency support and activity.
- Agencies need to concentrate on improving good practice and not always bringing in new ways of doing things

10. What contributed to the effectiveness or lack of effectiveness of multi-agency responses?

Lack of effective multi-agency responses to Mr O1 and his family features significantly throughout this review. In my opinion this was caused by insufficient attention to systemic leadership across all partners at the time; or certainly to ensuring that front line practitioners had the ability and the systems which enabled them to work proactively together to share and manage risk for a family which touched a number of different agencies.

There were many opportunities, cited in this review, when a multi-agency or multi-disciplinary meeting could and should have taken place which may have ensured a better outcome with good preventative work going in to support Mr O1, N and E. In Section 7 CHS quite clearly have stated that "Practice in respect of Mr O1 has shown that no single agency could address his care and support needs. However, it appears nothing compelled or even required health and social care services to work collaboratively within and across their own provisions to provide direction and resolution and as a result, opportunities to intervene in an integrated way were missed as, CHS passed referrals to ASC rather than seeking practical help from ASC on the patient's behalf. If the MDT meetings were strengthened, this would have provided an integrated response to Mr O1's deteriorating situation."

Solutions presented to supporting Mr O1 were stop-gaps e.g., temporary residence in a care home whilst his home was cleared and the offer of a 'blitz clean'. No work was undertaken to try to understand the cause of some of the issues. Indeed, had practitioners been more professionally curious, there may have been the opportunity for partnership working with a trauma-informed approach to practice, which may have resulted in improved outcomes for the whole family.

Within the IMRs there was not a specific reference to whether the Human Rights Act had been considered. Specifically, whether the reasons for professionals not intervening in Mr O1's decisions to self-discharge (both from hospital and care home) and to decline any other suggested interventions, was because of MR O1's right to privacy and private family life. Neither was there

consideration of this in relation to Mr O1's right to life and the L family's right to live safely without fear, when subject to what may be described as coercively controlling familial relationships. This issue was picked up in the learning by Croydon Health Services (mentioned in the first paragraph of 7.4 on page 25).

11. A review of partnership and collaborative working

There was evidence from discussions at the SAR Panel and at the Learning Review, that at senior strategic level there is good partnership and collaborative working. However, the evidence from this Review, of the issues considered in respect of Mr O1 and his family, suggests that at the front line, collaborative working was not as good. Although, discussions and submitted documentation by Adult Social Care, showing changes which have taken place since 2019 shows that a good deal of work has taken place to create organisational systems which better facilitate collaborative working. The challenge, as safeguarding interventions across the system increase, and as resources available reduce, is to ensure that all partners in the local Croydon system regularly review the effectiveness of organisational structures and seek assurance that this facilitates good, professionally curious practice on the ground between staff and across organisations. Recommendations in this regard are set out below for the Croydon Safeguarding Adult Board (CSAB).

12. Recommendations for the Croydon Safeguarding Adults Board

<u>Learning for all agencies around assessing risk & risk assessing practice.</u>
The CSAB should take overarching responsibility for ensuring that that there is a shared understanding across all agencies on what constitutes risk within the context of safeguarding.

The CSAB is recommended to agree a single risk management strategy and protocol which is shared by all partners and sets out practical steps which front line practitioners in all agencies can take, when working with people who are at risk of harm, abuse and neglect. In particular:

- the strategy should focus on supporting those who have been assessed as having capacity to take unwise decisions.
- The strategy should have an ethos of 'Think Family' to ensure that when different agencies are working with individual family members, they consider and investigate the circumstances of others with whom the person lives.

<u>Escalating high risk cases within ASC.</u>
The CSAB should seek assurance that the measures put in place by ASC since the time when Mr O1 died are reviewed. In particular, it would be helpful to undertake an audit or deep dive into safeguarding practice to obtain assurance that risk management protocols and staff responses to working with people who are deemed to be at high risk, are effective.

The CSAB should also consider seeking assurance about high quality safeguarding supervision for front line practitioners across all agencies.

<u>Communication between agencies.</u>

The CSAB is recommended to consider that a focus of its Annual Peer challenge event should be an audit of multi-agency safeguarding practice to demonstrate the effectiveness of interagency communication.

This should also feature in work to analyse the outcomes for people of safeguarding interventions, with learning on what does and does not work from a customer perspective with interagency communication. This is key application of 'Making Safeguarding Personal' and should be used to address any future changes which may need to happen.

The CSAB should reinforce its Information Sharing Agreement, signed by all partners, and seek assurance that partners are also reinforcing this in individual agencies.

Practice of social work process and management of self-neglect where people are considered to have capacity.

There is evidence that the CSAB has done some considerable work on promoting good practice for working with people who self-neglect. This work must feature regularly as part of the Board's assurance. This is especially important as there has been a significant reduction in staffing and turnover locally within ASC. Programmes to both seek assurance and enhance legal literacy for practitioners on the Mental Capacity Act need to feature regularly and every partner organisation, not just ASC, must provide assurance to the Board that Training on the MCA and practice is continuously improving.

GP Registration for people who are vulnerable, at risk, and who may have fluctuating capacity, no capacity or be unable to take steps to self-register

The CSAB should seek assurance that there is acknowledgement of the complexities of GP registration within the current nationally agreed system and protocol. Further that all agencies within the area consider that people who are vulnerable are registered with a GP Practice on discharge from any service and where they are unable to progress this for themselves, are supported proactively in doing so.

The CSAB should consider escalating this issue with NHS England & Improvement and consider other measures where improvements can be made in this area through potential changes in regulation or protocol.

13. Recommendations for individual agencies

The quality of IMRs was particularly good for those that were submitted by partner agencies, such that the learning and recommendations already suggested by agencies should be included in this Safeguarding Adult Review. Additionally, the outcome of the Safeguarding Enquiry as set out at Section 5 above raises issues which chime with those included in the analysis of key events in Section 6.

The specific areas of focus for the SAR are:

1. Identification and learning for all agencies involved with Mr O1 around assessing risk.
2. Identifying how high risk cases are escalated within Adult Social Care.
3. How all agencies working with Mr O1 communicated with each other.
4. Examining social work practice and process when working with people who self-neglect and managing this practice where people are considered to have mental capacity.

5. Examining how practitioners assess risk for people using services and how this is practiced.

Thus, recommendations take account of these together with any other issues which have evolved in the course of writing this Review.

13.1 Adult Social Care

ASC did not submit information using the IMR format and thus the learning was not identified by the IMR author. ASC were, however, clear that the way services were organised at the time did not facilitate good integrated working with health services.

- ASC have reorganised the way services are provided recognising that improvements needed to be made in managing risk and waiting list management. It is recommended that ASC regularly review the waiting lists for services and provide assurance to the CSAB on how these are managed, and people are protected from harm, abuse, and neglect. (A briefing on current changes within ASC is provided at Appendix 2).
- ASC needs to address both internal communication within teams and external communications with other agencies, particularly when supporting people who may be deemed to have capacity to take unwise decisions and where they may self-neglect or come to harm. ASC should play a major part in developing the Board's Risk Management Strategy and Protocols alongside other partner agencies and evidence to the CSAB that the strategy and protocols are applied.
- ASC to provide assurance to the CSAB in terms of how high risk cases are escalated appropriately, and importantly achieve good outcomes for people to whom this strategy applies.
- ASC needs to provide evidence and assurance to the CSAB in terms of how the legal literacy of its staff is promoted and in particular how the application of the Mental Capacity Act improves through effective case outcomes and training and development for its staff.
- ASC identified that there needs to be learning to improve 'strengths-based practice'. It is recommended that ASC arrange specific learning and development for staff who undertake Care Act Assessments and that this should also feature in staff induction.

- ASC identified that there needs to be learning to improve the application of professional curiosity; to achieve this it is recommended that ASC assure the Board that time is available for assessment staff to critically reflect on their practice, for them to have the opportunity to develop these skills in professional supervision and team discussion.
- ASC Commissioners identified the need to review commissioning guidance for care homes where people self-discharge and to improve alternative offers for practitioners to recommend, when working with people who self-neglect and hoard. It is therefore recommended that ASC Commissioners, working alongside CCG Commissioners agree a joint commissioning strategy to support delivery; in particular that new commissioning offers are shared with operational staff.

13.2 GP Practices across Croydon

- GP Practices to have a more robust communication protocol with patients at risk where there are issues with non-compliance, non-attendance at appointments and other engagement issues e.g., consent for discussion at a 'Huddle'. If there is a safeguarding concern, then GP Practices must discuss the patient at a 'Huddle' or other appropriate meeting and refer a safeguarding Concern to ASC as appropriate.
- GP Safeguarding Leads to have oversight on the monitoring of compliance, particularly in respect to managing patients who do not engage and present significant risks.
- GP Practices to work with the CCG in respect of developing better integrated patient records across the borough.
- GP Safeguarding Leads to have assurance that all practices have a good understanding of the process for referring safeguarding concerns to Adult Social Care; that this assurance should be provided to the CSAB.
- GP Practices to ensure and provide assurance to the CSAB that for GP Safeguarding Leads there is adequate training and understanding by all practitioners about the application of the Mental Capacity Act.

13.3 SLaM

- SLaM should put in place a Self-Neglect Protocol with adequate training for all staff, which ensures that a proactive and preventative approach to addressing self-neglect is delivered.
- SLaM should review internal patient non-engagement protocols in the light of this SAR and review protocols in respect of issues raised about the family context for patients (similar to those identified in this review for E). In particular, SLaM to undertake a review of the internal zoning system and its impact on triggering home visits when patients do not attend appointments.
- To provide assurance to the CSAB that all SLaM staff understand how to refer Safeguarding Concerns to improve safety for patients and family members and that the internal safeguarding protocols should influence all other protocols such as zoning.
- To ensure that all actions taken in respect of safeguarding and non-engagement of individuals are transparent and actions are documented.
- A holistic 'think family' approach should be embedded into risk formulation identifying strengths and weaknesses within patients' support networks.
- To further develop the 'Think Family' approach to consider the impact of coercive and controlling relationships in domestic settings and to provide staff with effective learning in this specific area.
- SLaM to undertake an audit of identified Self Neglect concerns and the effectiveness of interagency planning to address risk, with the aim of providing assurance to the CSAB that self-neglect is identified and acted upon in an holistic manner.
- SLaM to commit to ensuring that safeguarding supervision is provided by borough safeguarding leads and that all staff are required to participate. Team Managers, in both one to one supervision or team supervision to improve competency in decisive, informed, and accountable safeguarding decision making.

13.4 Croydon Health Services

- All practitioners must understand organisational safeguarding protocols and policy at an agency level and must utilise support of the Safeguarding Team to follow up, escalate, be supervised and ensure seamless delivery of safeguarding adults at risk. Such assurance must be provided to the CSAB.
- CHS to ensure that placing a flag on patient's electronic record should be a standard operating procedure in all cases where patients self–neglect so that the practitioners are aware of these risks. This system should also be used to inform GPs.
- All practitioners who provide a direct patient service should have training in mental capacity assessments and guidance on how to respond to people, with capacity, who refuse services and are at risk and may be taking unwise decisions.
- All practitioners should receive safeguarding training according to the 'Adult Safeguarding: Roles and Competencies for Health Care Staff: Intercollegiate Document (2018)'. Safeguarding training should highlight cases of neglect and self-neglect and the impact of coercively controlling relationships within the family on the safety of all individuals.
- In respect of complex cases, all practitioners should seek appropriate internal legal guidance and/or advice from Croydon Adult Social Care Safeguarding team, especially where there may be a need for inter-agency coordination for multi-agency assessments and responses.
- CHS and the integrated safeguarding team should review its Safeguarding Toolkit to ensure that a self-neglect protocol is included. This protocol should include information on understanding hoarding what support can be offered to patients to begin to address this. This should be shared across the health and social care system in the borough with a view to developing a system wide protocol on hoarding to be used by all agencies.
- CHS should ensure that all its staff understand and are able to exercise professional curiosity in all cases, particularly where neglect or self-neglect is an issue. This is elemental to the practice of 'Making Safeguarding Personal (MSP)' and understanding of the toolkit of MSP and Health services should be used in training and in supervision for all practitioners.
- CHS must ensure that all clinicians are reminded to highlight on-going safeguarding concerns on discharge summaries; that all practitioners on Hospital Wards are reminded to highlight on-going safeguarding concerns in referral letters and handover reports.
- All Hospital Discharge plans should include full information, particularly where 'Discharge to Assess' is applied or a person is moved to temporary arrangements such as a care home, prior to returning home.
- CHS to ensure that the quality of information contained within patient Discharge Summaries is audited by a senior professional or clinician within the Trust.
- CHS to copy Discharge Summaries to Patient's GPs and in the case of discharge to a Care Home, for the attention of the local GP.

13.5 Croydon CCG

- In commissioning nursing or residential care home placements, the CCG must ensure that Discharge Summaries from other services are accurate, particularly in respect of whether placements are for the short term (e.g., respite care, Discharge to Assess) or

longer term. The CCG must ensure that care homes understand that GP registration for those in short term care should only be on a 'Temporary Resident' basis

- The CCG should work in tandem with commissioners within adult social care to develop any new commissioning strategies which will improve outcomes for people residing in care homes (who could be funded by the CCG or by ASC)
- The CCG should ensure that as the new Integrated Care System develops, there are effective joint working protocols which enhance all staffs understanding of safeguarding practice and the necessity to work together to support people who may be difficult to engage.

14. Glossary

Blitz cleans have in the past been means tested by Croydon ASC in that if the person has the means to pay for the service this was the expectation. Cases could be funded on a case by case basis if a Social Worker presented a rationale for funding to a senior manager.

CCG – NHS Clinical Commissioning Group

Cerner Information system – the system used for keeping medical records at Croydon University Hospital

Croydon Health Integrated Safeguarding Team (CHIST) – is a team within Croydon Health Services that specialises in addressing safeguarding concerns.

CSAB – Croydon Safeguarding Adults Board

CUH – Croydon University Hospital

EMIS system – the system used for keeping patient records in the GP Practices.

GP – General Practitioner

Grade 4 Pressure Ulcers - Grades qualify the seriousness of a pressure sore or ulcer and Grade 4 identifies extensive skin destruction, tissue necrosis* or damage to muscle, bone or supporting structures.

'In Touch' Team was set up to address concerns about very large waiting lists and growing concerns from those cases which were not being monitored or prioritised. The team worked through the waiting lists to review each case and decide what action needed to be taken. This team is now disbanded.

LAS – London Ambulance Service

LFB – London Fire Brigade

LFB House Clutter index – https://www.london-fire.gov.uk/safety/carers-and-support-workers/hoarding-disorder/

Merlin is the system the Met uses to record information about missing persons, children and vulnerable adults. This information is risk assessed, graded and if appropriate shared with Social Services.

'Micro Living' – The term micro living means to create a one room space for someone to live – e.g., it could be someone moving a bed downstairs, providing a commode if there is no downstairs toilet.

Older People North (OPN) Team is the Community Social Work team with responsibility for assessing and providing support for people over 65 years living in the north of the borough.

RVMP - is the Risk and Vulnerability Management Panel. Cases are presented when there are concerns in respect of the level of risk, often concerns about the state of housing and where the case requires a multi-agency response and coordination. Attendees include Housing, SLAM, Police, LFB, ASC. This is a multi-agency discussion and actions are agreed.

SAR – Safeguarding Adults Review

Section 17 (1) Police and Criminal Evidence Act 1984 offers a power of entry to Police who have genuinely held belief that entry is justified to save life or limb or prevent serious damage to property.

'Staying Put' Service is a council organisation which provides advice and assistance with the repair and adaptation of owner occupied properties. They have access to grants to undertake this work

15. References

a. Other Croydon Safeguarding Adults Reviews (SARs) where issues of concern were in respect of self-neglect

https://www.croydonsab.co.uk/about-us/safeguarding-adult-reviews/

SAR VB undertaken in February 2020 had recommendations also have resonance with the recommendations arising from this review:

- Croydon SAB: To be assured that GP practices do not deregister vulnerable individuals on the basis of non-contact only
- 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.
- Croydon SAB: To progress the proposed action set out in the self-neglect report.
- Croydon SAB: To raise awareness of and to monitor the use of the RVMP including audits to measure outcomes.
- Croydon SAB: To review the implementation and impact of the new Croydon Adult Support (Front Door) project.

Brian Boxall (Author of SAR VB) discusses an article in his report by Deborah Barnett in March 2019:

Safeguarding Adults: Self-Neglect and Hoarding Toolkit sets out the spiral of self-neglect 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. The Safeguarding Adults: Self-Neglect and Hoarding Toolkit; Careknowledge.com refers to social isolation and self-neglect being 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 and 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.

There are also many SARs commissioned by SABs across England where self-neglect is identified and where agencies in Croydon have the opportunity to learn from the

recommendations made. The forthcoming development of the SAR Library will provide an opportunity for similarly categorised SARs to be used in learning and development.

SAR Catherine undertaken in 2019-20 had some similar recommendations:

- CCG to ensure the GP practice reviews the use of letters when they have had no contact/response from elderly individuals with a MH history
- SLaM to ensure discharge policies reflect the most recent NICE guidance
- CSAB to be assured that the VB SAR recommendations have been progressed.

b. Examples of Good Practice and Guidance

The example below – although it relates to homelessness is helpful in that it shows how such an approach can support better engagement and better outcomes for people.

Katy Shorten and Lydia Guthrie on Trauma Informed Practice
https://www.local.gov.uk/psychologically-informed-and-reflective-practice-safeguarding-people-experiencing-homelessness-18

The link below is to CSAB Policies & Procedures which links to the Pressure Ulcer Protocol and Flowchart for use by professionals. It also refers to the Croydon Data Sharing Agreement for all SAB partners to adhere to in ensuring that information is shared about persons at risk with appropriate partners when a safeguarding concern is identified.

https://www.croydonsab.co.uk/information-resources/policies-and-procedures/

Sweeney A & Taggart D. (2019). *Trauma-informed approaches in adult social care*.

Adults being supported by mental health services often present complex behaviour patterns that have their roots in trauma and corresponding survival mechanisms. This workshop investigated trauma-informed approaches, assisted practitioners in developing different ways of supporting people, and helped individuals to understand and reframe their response to situational or relational triggers.

Wilkinson J. (2019). *Developing and leading trauma-informed practice: Leaders' Briefing (2018)*. Dartington: Research in Practice.

Repercussions of trauma experienced in childhood may persist through adolescence and into adulthood. The intention of trauma-informed practice is an increased understanding of the ways in which present behaviours and difficulties can be understood in the context of past trauma.

The approach offers a framework for a common set of values, knowledge and language across services (eg, social care, health, education, housing and criminal justice). Trauma-informed approaches (TIAs) can also be applied to understanding and protecting the workforce from secondary or vicarious trauma as a consequence of the emotional demands of their work.

16. Appendices

Appendix 1 - Terms of Reference for the Review

Croydon CSAB Safeguarding Adults Review **Terms of Reference – Case O1**

Governance and accountability

This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures (London ADASS April 2019); and
- Croydon CSAB SAR framework (2018)

SAR methodology
A traditional SAR has been selected as the methodology for conducting this SAR. Details of the methodology can be found in Safeguarding Adults Reviews under the Care Act: implementation support.

Specific areas of enquiry
The SAR panel (and by extension all contributors) will consider and reflect on the following:

17. Learning for all agencies around assessing risk.
18. Escalating high risk cases within ASC.
19. Communication between agencies.
20. Practice of social work process and management of self-neglect where people are considered to have capacity.
21. Risk assessing practice.
22. The SAR should cover the time period between 2014 - 2019.

This SAR will commence in **February 2021,** when the first Panel meeting will take place and will conclude within 6 months.

Chair and Membership of SAR Panel
A chair and panel membership for this SAR has been determined to oversee progress of the SAR:

Panel Chair – David Congdon and Croydon ASC; Croydon CCG; Croydon Health Services, Police; CSAB Manager

The review will seek to hear the perspectives of all key staff and volunteers and Mr O1's wife N.

Appendix 2 - Briefing on Localities / Front Door for Croydon ASC on improvements since 2019

Introduction

This is a brief paper to support the SAR process in respect to O1. The report sets out briefly the changes that have been implemented over the last couple of years which has led to a shift in culture and structures in Adult Social Care, especially in older people services.

Background

At the time of Mr O1s discharge from Addington Heights the Local Authority had a high waiting list across all areas in adult social care. This was in particular the case in older people services.

In response to an earlier SAR there had been:

- a full review of the waiting list;
- review of the prioritisation process; and
- development of the In Touch Team. The In Touch Team was basically introduced to monitor and review the waiting list.

Although initially this had an immediate impact it was recognised that this was not a long-term solution for the following reasons:

a) The original focus was on the current waiting list as of March 2017. However, behind it other cases began to build up.
b) The on-going increased activity at the 'front door', which had a number of consequences including, increase of cases to the older people teams, many cases sent through could have been resolved quickly if there was capacity to do this (either at the front door or within the Older People Teams).
c) The need to develop a more integrated approach both within the Council and across agencies.

It was felt that there needs to be a systems and cultural overhaul, which has led to a Localities / Community Led Support model underpinned by the Croydon Alliance.

Croydon Alliance

The development of the One Croydon Alliance put in place the foundations for the current Localities model. The One Croydon Alliance basically is a formal agreement to integrate services pathways between the NHS 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 a response to holistic and be timely with a focus on prevention.

Localities

A key step has been the move into a locality-based model where social workers are in 6 Locality teams aligned to the 6 Integrated Care Networks to enable closer working with the GPs and other services. The older people's social work teams were re-organised from north, south and reviewing teams to 6 integrated care teams and aligning other teams like the Occupational Therapy teams and financial assessment teams to work in a multi-disciplinary way. This has had the advantage of:

- developing a more integrated, multi-disciplinary approach focused on localities.
- more oversight and management – moving from 2 managers to 6 managers; and

- a locality focus on the waiting lists rather than 2 unwieldy waiting lists (North & South) each Locality team is responsible for their own waiting lists.

Front Door

As part of the Localities project there was a full revision of the access / 'front door' arrangements in Croydon. There were a number of ways to access services, which often led to 'hand offs' from one area to another and inconsistency in responses.

In order to simplify this process for the resident the Council brought together different teams that were involved in the first point of contact. This has encouraged a more multi-disciplinary approach to the person, looking at preventative options not always reliant on an adult social care service / package.

A number of models across the Country were explored, the model above was felt to meet Croydon's needs as it focussed on prevention and matched the ethos of Community Led Support.

Community Led Support in Croydon

It was recognised that any structural change needed to be underpinned by a shift in culture. This has been driven by the focus on community led support.

Community led support is a strength base model of social work focussed on conversations and engagement rather than mechanistic approach of assessment and care packages. It is the cultural foundation which underpins the Locality and front door model. Croydon have been embedding this model into practice for the last two years.

- For the first phase we had in place an implementation partner, 'National Development Team for Inclusion (NDTi)'
- There are 25 other NDTi CLS sites around the country with Croydon being the first London Borough.
- Community Led Support (CLS) brings innovation to how we deliver services, designed and delivered by practitioners alongside local partners and members of the community they are serving.
- Its not a new fad but respectfully builds on what is already working, joining up good practice and strengthening common sense, empowerment and trust.
- CLS assists organisations to work collaboratively with their communities and their staff teams to redesign a service that works for everyone, that evolves and is continually refined based on learning.
- All staff across ASC were involved in workshops regarding the design .
- Intially innovation sites, such as Thornton Heath Locality, were identified leading to an uptake across all Localities. Despite key challenges such as COVID and S114 this has still remained at the centre of Adult Social Care culture. In the last few months disability services have moved into a locality model underpinned by Community Led Support.

Waiting Lists

At the time of O1 being admitted into hospital the waiting list was nearly 1600 across all services in adult social care. With the implementation of the changes outlined above the waiting list was down to 640 by July 2019. By the end of February 2020, just prior to the first COVID lockdown, this had reduced to 147. As a result of the COVID lockdowns and the S114 reductions this has risen to 311 as of 20/6/2021. Waiting lists are now reviewed on a weekly basis by the Adult Social Care Senior Management Team

Challenge Panel

The Challenge Panel is another key monitoring system. Any case that is requiring a new support package or a change in a support package is presented to the daily Challenge panel which is chaired by The Director of Operations / Heads of Service and has been a key tool in driving up performance and ensuring that practice is of a good quality.

Adult Safeguarding

Over the last couple of years Croydon has developed a hybrid model, whereby safeguarding concerns are managed through the teams / front door and enquiries are undertaken by S42 Safeguarding team. This process works as long as the teams progress concerns. This was identified as an issue with 2 previous SARs where a concern sat on a caseload / waiting list and was not discussed with the S42 team.

Steps were put in place in line with the publication of the VB SAR to address, these were being implemented at the time of O1. These are:

a) A social work post converted to a *planning officer*. It was found that the systems reports were not always accurate and there needed to be capacity to trace and track safeguarding concerns across ASC. Weekly tracking takes place, so the safeguarding unit are aware of every concern / enquiry in the system.

b) As part of the safeguarding process there has been in place a *safeguarding consultation* where workers can bring cases for direction / decision. This was initially voluntary; however, this now has a compulsory element to it.
   - All self-neglect cases should go to safeguarding consultation.
   - All cases where a concern has been opened for more than 2 weeks comes to safeguarding consultation. These are picked up through the planning officer tracking cases and people are given an appointment to attend where a decision as to how to progress the case is made. If the appointments are not kept and there is a worry of drift the case is escalated to Heads of Service.

c) Heads of Service are given by the safeguarding unit, a weekly update on the progress of adult safeguarding concerns. The safeguarding team also review and will highlight to the Head of Adult Safeguarding any key areas of concern.

d) There is a daily meeting between Croydon Adult Support and safeguarding team to look at in-coming safeguarding concerns and agreeing next steps

Hopefully this has given an overview of some of the key changes in ASC which have improved performance and the outcomes for Croydon residents.

Appendix 3 – outcome of a learning Review in July 2021

The aims of the Learning Review were to:

- To outline what the review had found at that stage in the process.
- To listen to the experiences of those working directly with Mr O1 until his death in May 2020.
- To further develop the emergent learning in the light of those experiences.
- To discuss recommendations for changes that could prevent future similar circumstances.

Had anything been missed from the findings and if so, what clarifications could be added?

- There was a belief that at the time there was selective non-engagement.
- Clearly opportunities were missed in Adult Social Care, e.g., time on waiting list. Family owned their home; possibly would have been differences if they lived in social housing.
- Poss. could include mention of resources to help hoarders, e.g., MIND/LB Croydon Hoarding Project (not running currently) and others. (ASC)
- Confirmation that not all cases of respite require a change of GP. However, hospital discharge summary form has been updated so as to be clearer.
- There was still a lack of clarity as to which person/ organisation actually saw the hoarding.
- Commissioners need to be clear about what is required our care homes to send to GPs when people discharge themselves.

What factors influenced how they/their agency were able to work with Mr O1?

- No-one took overall responsibility – the obstacle was not about funding, more about finding a coherent approach.
- GP surgeries have procedures they follow for contacting patients.
- There had not been a District Nurse (DN) intervention as Mr O1 was seen at the GP Practice - DNs should enquire further regarding safeguarding when people are allocated respite beds and why they are being admitted to these beds.
- To note that Mr O1 was very in control and did not want any help, he was difficult to communicate with and staff need to ask for and to be supported to be professionally curious in such circumstances.
- There was a lack of communication across agencies especially why Mr O1 went into the care home. This led to different decisions being made. It is always Important to have the back story of an individual and a robust needs assessment, and to be aware of their mental capacity.

Do you think this could happen again in Croydon? What has changed?

- Many responded that it could happen again, and turnover of staff was referred to with one participant asking, “How do we embed the learning?”
- Improvements in ASC were referred to especially in terms of managing waiting lists and trackers and improved integrated working with health services. Importantly a move towards strength-based practice
- It was felt that the combination of mental health and mental capacity issues can be particularly challenging.
- It was felt that services can minimise risk through better application of coordinated discussion and professional curiosity.

- Staying Put team spoke about work they have been doing towards developing a hoarding strategy.
- SLaM rep spoke about a support group SLaM have been running elsewhere. It takes place at a Fire Station. People can drop-in for tea, cake and a fire alarm.
- Re sharing of information, SAR Author reminded the attendees of the Data Sharing Agreement in place across London which is in existence for the CSAB
- There is a need to highlight the impact of the local reduction in resources at the Council and the demand during Covid – the Council lost 15% of staff.
- It is often about implementation of good practice rather than new changes.

What further changes in systems, policy or practice are needed to minimise the risk of recurrence?

- The move to the new system of working of Integrated Care Network+ (ICN+) will be especially useful, with more integrated/multi-agency working.
- One person felt the issues in O1's case were not so much about complexity but more about things not being communicated between agencies.
- There is an issue that different agencies have different recording systems which professionals need to circumvent in complex cases.
- It was still felt non-engagement can be difficult to work with and more work was needed in this area.
- There are lots of things which can be done and offered in between depriving people of their liberty – such as thinking out of the box, doing the simplest of things rather than a complex intervention.
- Despite changes in local systems, need to recognise that its whole system change and so questions must be considered on discharge summary forms – is this permanent or respite?
- CHS Discharge Planning Process – checklist [care and support needs, mental capacity and concerns around safeguarding]
- ICN model provides the opportunity to work in localities so more joined up working. The ICNs have multi-disciplinary meetings 2/3 times per week and there are also Huddle discussions. Re Huddles there was a comment made that this case may not have been discussed at the Huddle due to the need for consent).

<u>If you could change two things as a result of this review, what would they be?</u>

- Communication e.g., If ASC, GP, SLaM had known what each other knew, things could have been different. Think ICN+ will help. However, still concerned about resources.
- Could be helpful to look again at the criteria for Huddles.
- Soft skills, professional curiosity, having discussions which empower people. "Signs of Safety" is a useful model.
- Making sure frontline workers actually speak to the person. (There may be many people/agencies involved but has anyone actually spoken to the person?)
- Gentle persistence and building trust.
- We have some examples of good practice. Could we use these to bring out some of the important lessons?
- Handovers between organisations need to improve.
- SLaM could have been more assertive within the home environment with regards to safeguarding. The Light Touch Team to be prompted to be more professional curious.

- All professionals to understand that safeguarding is everyone's responsibility, are we taking all cases to Challenge Panel? At supervision are cases gone through. The need to think as a family rather than the individual and how to use safeguarding.
- Commissioners need to review guidance in respect of self-discharge procedures and practice in care homes.
- Commissioning review and reflection on what is offered with regards to hoarding and how best to support people and for this to be communicated widely across the Health & Social care system.
- Self-Neglect needs more joined up and co-ordinated work in order to reduce those cases which fall between the gaps.

Other Discussion

- Need to implement good practice rather than bringing in new things.
- Important for CSAB Ind. Chair to continue to raise the matter of resources in her 1-1s with Chief Exec.
- Group all agreed there was evidence of coercion and control within this case which should have required further exploration.
- Recommendation for the CSAB to be included to reinforce the Information Sharing Agreements with all partners across the borough.
- SLaM has since had two safeguarding leads within the borough which has helped.
- There are examples of good practice taking place now which need to be included in the review.
- Examples given that Southwark has a Hoarding Policy and Lewisham has a social worker specialising in hoarding.
- Mention of the role of the Personal Independent Co-ordinators (PICs), these have been recruited through Age UK and more recently through MIND.

Appendix 4 - Examples of best practice on working with people who self-neglect and hoard Presented to CSAB on 6 July 2021

Case 1 (2017-2019)

Mr P is aged 90 now resides in care home. He was born in Guyana and attended school there. He fled Guyana fleeing prosecution by the then government for his political beliefs. Mr P worked on ships which took him around the world before he settled in the UK. He worked in the garment industry and was a trade unionist. Mr P married his first wife in 1958. It is not clear what happened to this relationship. He then had a long term partner who died a couple of years ago. They had 4 children together 2 boys and 2 girls, one girl is deceased.

Referral / reason for involvement
Referral received on 2/1/2017 from health visitor raising concerns of self-neglect and hoarding,

Summary of work undertaken:

Initial response was through case management - locality teams, several home visits over many months to build a relationship. Referral to mental health older adults due to exhibiting memory issues and paranoia, querying fluctuating mental capacity. Care Act assessment completed, identified needs around self-care and care of environment. Mr P declined any interventions. Family tried to help but Mr P remained very suspicious of anyone's intentions. There was evidence of declining health, falls and increasing paranoia. A S42 safeguarding enquiry was triggered. Consideration was given to a mental health act assessment, however on a welfare visit Mr P was found on the floor and was conveyed to hospital, in his best interest. A Deprivation of Liberty Safeguards (DoLS) assessment was undertaken in the hospital as he was objecting to his stay. A Best Interest meeting took place, and a decision was made to discharge him to a temporary placement. An application was made to the Court of Protection due to his objections – A plan was put in place to support Mr P to return home with a package of care and support services in place. The work entailed:

- Hospital visits, care home visit and visits to his property. Conversations with Mr P's sons and daughter and relatives.
- Court work and Court Reports
- Capacity assessments
- Best interest meetings
- An Independent Mental Capacity Advocate (IMCA) was involved throughout.
- Joint working with Environmental Health team and the Fire Service
- Joint working with Health
- Joint working with Older People Locality Team Social Worker
- Joint working with Care Home
- Joint working with the DoLS team
- Joint working with Best Interest Assessor

A multidisciplinary approach was critical to supporting Mr P and to manage and minimise risks. Mr P's health deteriorated during the life of the court case resulting in an order for him to remain permanently in a care home where he settled and is currently living with family members visiting.

Case 2 (2020/2021 - ongoing)

OVERVIEW & PRESENTING ISSUES:

SD is a 59 year old woman diagnosed with a history of bi-polar disorder (no current medication), diabetes, insulin dependent – administered daily by a District Nurse (DN), with oedema (swelling) in her legs and feet (currently taking water tablets). SD lives in a 1 bed self-contained flat within extra sheltered accommodation. There are historical and ongoing issues with hoarding – following a home visit, property observed as a clutter scale 6 or 7.

Due to clutter and her limited eye sight it had been reported that SD sipped/ingested cleaning fluid as she reported she accidentally thought it was her milkshake as they were both in similar containers/bottles.

SD is not always compliant with her medication e.g., water tablets, as she explained the medication hinders her going out or attending appointments/meetings – as she needs to use the toilet often. SD's history included being victim of domestic violence, marriage breakdown & children removed from her care – unresolved loss & trauma identified.

A safeguarding alert was raised for self-neglect – SD consented to this referral – she is at risk of fire, eviction, ill-health and falls. A referral made to the Fire Service and following their visit they raised the need for a referral for a mental health (MH) assessment. SD's GP is aware of the historical and ongoing issues with self-neglect and has also been requesting a referral to MH in order to assess SD's baseline in terms of her mental health. It is unclear as to how deterioration of MH may present.

Historically SD has been reluctant to engage with carers (presenting as agitated) however, some recent escalation in behaviours toward carers, with 2 recent incidents of being verbally and physically threatening to staff, e.g., threatening to throw hot oil on staff as they entered her property and on one occasion coming to the door with a knife in her hand. During initial visit, client reports she answered the door with a knife in her hand as she was making lunch. Incident reports were requested and provided by the extra sheltered accommodation service. Client expressed her views and wishes, and next steps have been considered in terms of ASC support/involvement.

ACTIONS TAKEN/PLANNED:

- GP made aware of non-compliance with medication and client's reasoning – GP was requested to explore and carry out a medication review & to consider referral to IAPTS or appropriate services for unresolved loss and trauma.
- Referral made to SIT – for sensory assessment & requested to provide aids/equipment to support client to identify hazardous products (in order to avoid accidental ingestion).
- MDT meetings with extra sheltered accommodation providers to share clients' feelings/views in regard to incidents reported – e.g., providers state client came to the door with a knife – client explained she was making lunch and felt the providers were intruding in her home and judging her by opening a window without asking/explaining.
- 1:1 meetings & MDT meetings carried out with providers/carers in order to discuss/explore issues, views, potential unconscious bias and how support maybe interpreted by client. Complexities of hoarding; client's social story and how this may be linked to behaviours discussed.
- ASC advocating for client in regard to preventing eviction – requesting to work together in order to address/explore underlying issues.
- Joint/multi agency risk assessment planned/developed in collaboration with client, provider/housing/carers, health, ASC and LFB.

- Referral made by ASC to the MH team for assessment as hoarding may be a result of underlying MH and deterioration. Baseline of MH requested.
- Plan to explore possible 1:1 DP worker skilled in working with adults who hoard in order to build relationship so as to support & progress in a direction and at a pace comfortable with client.
- Plan for client to set the pace in addressing risks (with the support of carers) e.g. agreeing for pathway from bed to door to be clear in order to avoid trip hazards. Plan to build on successful action with next steps e.g. pathway from bathroom to kitchen to be clear etc.
- Case presented to RVMP and to GP huddle.

CHALLENGES:

- MH referrals made by LFB, GP & ASC were all rejected, therefore ASC escalated to head of MH team/Principal SW for support, appealing for multiagency working.
- Client was historically supported by provider skilled in working with adults who hoard – unfortunately client did not engage and provider closed case; therefore DP to be explored with a DP carer from the same service (that previously closed the case).
- Case transfer may impact on building relationship and momentum of case.

LEARNING POINTS:

- Cases involving self-neglect and hoarding are time & service provision intense.
- Service provider fatigue & unconscious bias must be identified and jointly and non-judgementally addressed.
- Pattern of progress may fluctuate – no quick fix.
- Network meetings are key.
- Utilising available forums/panels are effective in holistic assessment/overview of risks and case direction.
- Challenges with engaging agencies exist – e.g., MH rejecting referrals from multi-agencies & providers closing cases due to client's non engagement – as such, problem solving & professional debate is vital.
- Building rapport and trust by including client in all aspects of involvement, and having open and transparent, repeated discussions with client re. wishes, feelings, views, risk & possible consequences/impacts; while working at client's pace, are imperative to supporting client to engage to affect positive outcomes.

Case Study 3 (2018 – ongoing)

Safeguarding concerns around self-neglect and hoarding raised by housing. Mother aged 85, primary carer for 2 adult sons with learning disabilities. Staunchly independent, resistant to any support or input from council teams, concerned that her sons may be taken away from her care. Neither son had been reviewed by health in many years. Initially case management however due to risk and non-engagement, S42 enquiry was triggered.

- Regular safeguarding risk management meetings involving all relevant professionals, housing repairs, Pest control, following up health needs.
- Building up a relationship, it helped that there were 2 social workers. One for each son and to go together – one to talk to mum and the other to talk and see the sons. And having an overview of the home etc.
- To really listen and try and to resolve the issues that were bothering mum. SW was fantastic at getting funding from charities for cookers, fridges, sorting out benefits.
- Persistent / regular visits – planning who and when and why
- Following up every visit and meeting with a letter to mum – outlining at the visit what actions we agreed on, what we had concerns about and the way forward – when we were visiting again. Being open and transparent
- Being honest and open about the meetings and also inviting her or a rep, even when she did not come. Being prepared to challenge.
- Knowing the law or finding out on breach of tenancy around environmental issues and not being frightened to use these for mum to agree with accepting help.
- Also around Mental Capacity Assessments and again knowing when to do them and who is responsible – particularly if there are any health issues
- One person co-ordinating /good communication.
- That ' professional curiosity'

<u>Clouds End Organisation</u>
A was originally from Clouds End – but she is self-employed and DP is being used. She works 15 hours a week and is flexible. Also, she has someone who can step in when she is not around – this was the clinch – they have a fantastic rapport and initially A spent time just getting to know mum and the two sons - so invaluable throughout Covid-especially when the day centre is closed. They have a great relationship and A is able to push mum to agree things as their relationship has developed. She is good at keeping in touch with us. She plays the "good cop"- while we are the "bad cops". However saying that mum will ring me when she is fed up and wants things sorted. She will ring the community LD nurse – when she needs cream or medication for her sons.

A is also very hands on with helping to decorate, gardening – putting a shed up with mum – playing games and getting the two men involved.
Mum is very independent and proud and wants to do things herself without anyone interfering, she is a good mum but hates interference and is very frail herself. However, mum is starting to sit back and asks for A's help. A is experienced, skilled and flexible.

It's about that 'good conversation'. It's hard to know what her sons want all the time, so this is work in progress and we use the knowledge of those that know them and what's in their best interest.

Things have taken a backward step due to Covid, however we would be in a worse position if we did not engage with them all and have A – she has continued throughout, shopping and monitoring. We are trying to get them all vaccinated – mum won't have one –so this again is work in progress and

Community LD Nurse is doing a great job with story boards and reassuring mum and considering best interest.
We are looking at A escorting J in the taxi and being at the day centre for a couple of hours a week.