# Buckinghamshire Safeguarding Adults Board

## Safeguarding Adult Review:

## Report of Adult FF Independent Review

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## Contents



## Appendices

## 1. Introduction

This Safeguarding Adult Review (SAR) has been commissioned by the Buckinghamshire Safeguarding Adults Board to review the circumstances and learning for agencies resulting from the death of Adult FF.

## 2. Background to the Review

2.1 Mr FF was an elderly Afro-Caribbean gentleman who lived alone at his home in High Wycombe, Buckinghamshire. Mr FF died at home in mid-November 2019, aged 94 years.

2.2 At the time of his death, Mr FF was living in unsanitary, rat-infested conditions with evidence of self-neglect. Several agencies were involved with Mr FF. However, Mr FF did not always accept the services offered and he did not fully engage with agencies. Mr FF was known to have a pacemaker fitted that was many years overdue for checking and renewal, but this was not resolved prior to his death.

2.3 Just before his death in November 2019, there were food parcels outside Mr FF's home that had not been taken inside by him. When the Social Worker made enquiries, she was told by other individuals that they had not seen him for some time. The Social Worker called Police 101 for a Welfare Check. Officers from Thames Valley Police arrived and gained entry to the property, Mr FF was found deceased at home in his bed. The cause of death was recorded as natural causes.

## 3. Review's Scope and Focus

The review has been set up to focus on the following areas:

- Effectiveness of partner agencies working together and undertaking escalation following appropriate assessment, analysis recording and information sharing.
- Consideration of the impact of different priorities, thresholds and remits of various agencies on addressing Mr FF's needs.
- Consideration of the quality of assessment, analysis and risk analysis of Mr FF's decision-making capacity and his capacity to then appreciate the consequences of those decisions.
- Consideration of current policies and procedures regarding self-neglect and safeguarding.

The timeframe set for the main focus of the review is from January 2019 to November 2019. There is also consideration of the service involvement from 2014 when there were already

serious concerns or indications of concerns about Mr FF's circumstances and his mental health.

## 4. Review Methodology

A Systems Practice Model has been used as the methodology for this SAR. It has focused on the actions and decisions of the individuals and agencies who were directly involved, to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken.

The focus has been on the team, the service, the agency as a whole and the collective actions of agencies together as well as the responsibility of individuals to act professionally and to work effectively.

The review has been conducted with due regard to the principles of fairness, impartiality, thoroughness, accountability, transparency and above all with a focus on the experience of the client.

The SAR has built upon the learning from the key events chronologies and Individual Management Reports from those agencies which were involved, and a practitioners' event to explore good practice, missed opportunities and learning.

The Review has therefore included:

- A review of the records relating to Adult FF
- Individual Management Reports and chronologies from each of the agencies who were involved with him.
- A Practitioner event led by the Reviewer.
- Initial family engagement was planned to take place through his daughter-in-law and possibly his daughter who works in the Local Authority.
- A brief report by the Independent Reviewer, focusing on learning rather than the events including:
    - A conclusion as to whether as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
    - Recommendations demonstrating responses to the Case and System Issues identified.

## 5. Profile of Mr FF and Family's Views

5.1 Mr FF's family have provided the Reviewer with more background information about him. There is a little background history in the agency records about him. It seems that Mr FF was divorced about 20 years ago and since then he had lived alone in the house. His wife died about 6 years ago having returned to the Caribbean. They had 5 children. Both he and his wife had emigrated from St Vincent to the UK.

5.2 He is described by his family as a very independent and strong-willed person who did not like to accept advice. He had two sons and three daughters. Mr FF was a member of the Methodist Church in High Wycombe, but he stopped attending about 2014 but his family did not know the reason for this. He was very involved with the church and a Pastor, so the family were surprised when he stopped going to church.

5.3 Mr FF worked at an engineering factory. He also works as a self-employed personal tailor at weekends from home. He enjoyed visiting friends and playing dominoes. His passion was cricket – he played for the High Wycombe team and travelled around going to matches.

5.4 In the main, it was one of his daughters-in-law and her husband, the elder son, who tried to keep in touch with him. They took him to stay with them over every Christmas holiday, including his last Christmas in 2018, for at least two weeks. Mr FF also used to go and stay regularly with a friend in Luton until 2018. On one occasion, on the way back to his home from his son's house, Mr FF opened the car door and tried to get out while they were still moving; according to his family, he seemed to be like a child again with no sense of danger.

5.5 The family took him food because they were concerned about his diet when he was at home. Mr FF was always adamant that his house was fine, but the family were worried about his declining state over the last four years. Over time and certainly by 2019, he was, in the family's view, making irrational decisions; he was also incontinent when staying with his son and refused to have a bath. He was a bit of a hoarder with a great deal of mess in the house. His hygiene deteriorated and he could no longer recognise what was dirty or what was unsafe.

5.6 Mr FF refused to go with his daughter-in-law to the optician even though his sight was failing. He did not want to go to the GP to get advice or to attend appointments for monitoring his cardiac pacemaker.

5.7 Mr FF's family believe his thinking was impaired. He was adamant that the house was fine. He spent most of his time out of the house. This has also been confirmed by the local PCSOs in the town centre who knew him well.

5.8 By 2019, the family believed he needed to leave the house and to be rehoused elsewhere because he was not functioning, had changed and was not himself. Mr FF was not thinking logically, and he could no longer recognise one of his daughters who lived locally. They tried to get him out and contacted services to help with this. At the beginning of 2019, his daughter-in-law made sure that both Adult Social Care and the Environmental Health Service could get into the house to see him.

5.9 The services did respond but the family feel that more should have been done sooner. It was, in their view, too risky for him to be living in that house. They were told that nothing could be done, and it all took too long. The family report that they were not given any advice about other options or steps they could have considered.

## 6. Agency Involvement

The following agencies were involved with Mr FF.

- Thames Valley Police – periodically throughout the period from 2014
- GP – throughout the period from 2014 but not regularly
- Private Sector Housing/Environmental Health – from 2019
- Oxford Health Foundation Trust – from April 2019
- Buckinghamshire Council Adult Social Care – from 2014 but not an allocated case and subject to assessment till January 2019
- Buckinghamshire Council Adult Safeguarding – from February 2019

6.1 Police records show that from 2004 and over the next 10 years, there were almost twenty calls made to the Police, mainly by Mr FF. These calls related to fears for his welfare, reporting incidents of anti-social behaviour in or near his home and, on one occasion, fear of a suspicious person. Police attended all of the calls relating to his fears for his welfare and the presence of a suspicious person. He was found to be safe and well.

6.1.1 The first significant concern from the Police about Mr FF which triggered a referral to Adult Social Care was in February 2014. This raised concerns about his poor living conditions and his arguing with neighbours.

- *No light in the house. All doors were separately locked, including internal doors.*
- *The house clearly needs some attention, does not look to have been cleaned in many years and Mr FF seems to live in one room (his bedroom upstairs).*
- *Mr FF believes that his neighbours are coming into his address and taking his tea-bags and his sugar (a regular occurrence) but cannot see how they are getting in, so has resorted to keep his items in his bedroom locked and secured. There is no damage to any of the doors or windows and there are no signs of forced entry. He believed also that his teabags and sugar were taken by witchcraft*
- *Clothes dirty and unkempt, the house smelt damp and dirty.*

The GP was contacted and Mr FF's daughter-in-law.

6.2 There was no further contact by services with Mr FF until 2016.

6.3 In early October 2016, the Police reported to Adult Social Care that the house was in a mess with discarded food and flies around. Mr FF was contacted by phone and he said he did not want services. His daughter-in-law was contacted who said that he was unlikely to accept help because he was very independently minded and convinced that there was nothing wrong about the way he was living.

6.4 Towards the end of October 2016, the Police went to the house following a burglary report. There were serious concerns shared about his safety and welfare.

- *self-neglect,*
- *no running water and an unclean bathroom,*
- *have no electric to his fridge, his ceiling is falling through,*
- *The floor is damp and he has holes in his shoes for which he is wearing plastic bags over them.*
- *His phone line has been disconnected and he seems to be having issues with his electric. Mr FF in denial seems to be in denial about his situation.*

6.5 A few days later Adult Social Care sent a letter to Mr FF as he did not answer a telephone call. Letter was sent to Mr FF offering an assessment.

6.6.1 Between 2017 and 2018, there was no service contact with Mr FF.

6.7 At the beginning of January 2019, the referral was made from Environmental Health to Adult Social Care following a concern raised by Mr FF's daughter-in-law. This referred to:

- *Rats living in his house and he is not looking after himself.*
- *The house smells and he uses a room in his house as the toilet.*
- *His house is like a tip and his front door does not even close.*
- *No human should be living like this. He needs help. What can you do to help him?*

6.8 According to the records, there was no response from Adult Social Care for 21 days which is outside the service expectation; there is no written explanation for the delay. Three weeks later on two consecutive days, an unannounced duty visit was attempted by the Adult Social Care Social Worker. The Social Worker could not gain access. On January 31st, an unannounced visit was completed by a Social Worker and Mr FF was seen and the concerns were noted. At the end of January 2019, there were several Police reports with similar concerns as well as concerns raised by a member of the public. There was a further Police report the next day which was shared with the Social Worker. For the rest of 2019 to the date of Mr FF's death the case was allocated to a Social Worker and Adult Social Care was directly involved.

6.9 At the beginning of February, the GP agreed to do a home visit but there was no answer. Two days later, the Social Worker gained entry and saw Mr FF. Such was the level of concern, that the case was progressed to a Safeguarding S42 Enquiry though this response appears to have been delayed. Between 25th February and 29th March, there is no recorded intervention or involvement in the Adult Social Care records.

6.10 Following a further Police report of serious concerns at the end of March, the GP was contacted by Adult Social Care as was Environmental Health. The GP agreed that a mental health referral was required though he wanted to see Mr FF first.

6.11 A joint visit was arranged with the Social Worker and GP on 1st April 2019. However, Mr FF refused to open the door. There was no further Social Work follow up during the next two weeks. Then a joint visit with the Mental Health Team (MHT) was arranged for 17th April. The day before there was a further Police report which stated - *"When we went into his house it took our breath away at how unkempt and disgusting it was."*

6.12 On 17th April Mr FF was seen briefly by the Social Worker and the Duty Worker from the Mental Health Team. There was just a short discussion as Mr FF left for lunch in the town. The Social Worker visited but did not see Mr FF on 26th April. In a telephone call on 29th April, the allocated MHT Coordinator agreed that the case required an urgent approach.

6.13 On 2nd May, the Older People's Mental Health Team (OPMHT) contacted the Social Worker to express concerns about the delay in making a referral to them. They said they would offer assessment. The OP Mental Health Team said that

*"they can assess his mental state at a later stage, but this should not be the basis of minimising the current risk. There appears to have been numerous engagements from Social Services for a long time- with serious risks being raised at all times. Family is also concerned. Safeguarding Team to consider urgent action."*

6.14 It is recorded at the Social Worker's supervision on 3rd May 2019 that:

- *The Social Worker will write analysis of work so far and considerations made such as capacity, risks, what options can be explored to try to support Mr FF.*
- *The Social Worker attempted tool kit with Mr FF who refused to look at. The Social Worker will complete without Mr FF to analyse.*
- *Professionals meeting to be booked after next visit. Consideration of referral to the Risk Assessment Multi-Agency Panel (RAMP)*
- *Cannot happen as this is being reviewed and no new dates organised.*

6.15.1 The Older People's Mental Health Team (OPMHT) assessment was completed on 10th May. Its findings were: -

- Risk of self-neglect remains high due to lack of insight and formal support networks. Social Services is aware of this.
- Risk to his physical health remains high due to the unknown state of his pacemaker but he denied any physical health issues or pain at the time of contact. The GP is aware of this.
- Risk of further deterioration of mental state is moderate due to evidence of memory loss but this has been progressive and is currently not having a serious impact on his wellbeing. He is not manifesting acute mental health symptoms at the moment.

- Risk of harm from others is not known but he has no door keys hence he leaves his door open when he goes out. It is not known how he manages his finances and other property.

The recorded outcome and recommendation was that Mr FF would benefit from urgent social care support in consideration of his severe self-neglect and the environmental risk to his neighbours. Safeguarding will be asked to look into this area.

6.16 It was not until 22nd May that a Professionals meeting was arranged for 10th June then changed to 12th June which does not seem to reflect the urgency suggested by the OPMHT.

6.17 In addition, a further referral was made to Environmental Health on 3rd June whereas previously in March there had been contact but no referral made.

6.18 On 12th June 2019, a visit by the Environmental Health Officer with Mr FF's daughter-in-law took place. They saw Mr FF who understated the problems and said that God was looking after him and that he was not worried. Mr FF agreed he would like grant support to get heating and a shower. He was advised that the house would first need to be cleaned and pest proofed, and he agreed to this. The conditions were described as follows:-

- *There were rats in every room*
- *It was not possible to get into the downstairs toilet and Mr FF had a bucket by the bed but there was urine everywhere in the house*
- *There was a tree growing through one of the windows*
- *The kitchen was unusable*
- *There was no heating*

6.19 The Professionals meeting was held on 12th June. It was attended by Adult Social Care, Police, Environmental Health and Mr FF's daughter-in-law. It was agreed to arrange a deep clean of the property to enable works to improve the heating and washing facilities.

6.20 On June 14th, the Environmental Health Officer returned with cleaners to clean the house downstairs. Mr FF said he did not want anything done. At that point, it was felt that nothing more could be done to resolve the housing squalor given his refusal of the preliminary cleaning and pest proofing which was required. The case was re-referred to the Safeguarding Adults Team due to his lack of engagement and concerns about his self-neglect.

6.21 There was further evidence of safeguarding risk to Mr FF on July 11th when the Environmental Health Officer contacted the Social Worker to say that that "there is information on social media about Mr FF approaching people and children inappropriately

in the high street, the information contains Mr FF's name and address. [The Environmental Health Officer] feels that these circumstances are putting Mr FF at risk and Environmental Health will be suspending all planned work at Mr FF's property due to safety and security issues". Work was put on hold while Adult Social Care looked into the possibility of respite for Mr FF as well as his capacity to live independently. A further safeguarding referral was made by Environmental Health on 31st July because of continuing concerns about Mr FF's welfare.

6.22 A further Police report was sent to Adult Social Care on August 9th. Mr FF was found disorientated in the dark.

6.23 On September 16th, there is recorded management oversight for the first time since May. "Concerns of self-neglect. Multi-agency safeguarding meeting arranged for 18th September with Fire Services, Environmental Health, Early Help, GP and Mental health."

6.24 On September 18th another SW visit was completed. "Case now allocated in the south team." A Strategy/Professionals meeting was held the same day. Action plan as follows - weekly welfare visits, Legal advice to be sought, Environmental Health report to be obtained. The Professionals meeting in September identified critical and immediate risks and proposed an urgent welfare decision by the Court of Protection.

6.25 On September 24th, the allocated Social Worker made a referral to Legal and IMCA. The case was allocated in the Legal Team on October 16th after being chased. The Safeguarding SW visited on September 27th but did not see Mr FF. The allocated SW visited on September 30th and saw Mr FF. On October 2nd the Safeguarding SW visited but could not get into the house so he spoke to Mr FF through the window.

6.26 The allocated SW made a referral to Appetito for meal delivery to Mr FF and she visited on October 3rd and saw Mr FF. On 10th October a joint visit completed with the IMCA and Social Worker. The case was allocated in the Legal Team on 16th October after chasing. On 18th October, the SW carried out a welfare visit – Mr FF was seen. The Police requested an environmental health check on property on 30th October.

6.27 On 11th November, the Police arranged a Professionals meeting for 3rd December at 11am at High Wycombe Police station. Adult SW wanted this meeting to be brought forward.

6.28 The urgency of the situation notes at the Professionals meeting held on 18th September was not followed up by urgent action. There does not seem to have been any welfare check visit completed between 18th October and 15th November.

6.29 The SW completed a welfare visit on 15th November. Mr FF was not seen though SW thought he was inside the house as the door was locked from the inside.

6.30 On 18th November Mr FF's daughter-in-law expressed concerns that she was unable to make contact with him. A welfare visit completed, unable to gain access. The Police were called, and Mr FF was found deceased in his bed.

## 7. Analysis of Agency Involvement

**Between 2014 and 2019, many serious and consistent concerns were raised by the Police, neighbours and Mr FF's family about Mr FF's safety and welfare.**

7.1 As early as 2014, there were concerns about Mr FF's safety and welfare. However, there was no visit to assess the situation and the risks to Mr FF. The GP was asked to visit, and contact was made with his daughter-in-law. This was not a proportionate response to what was clearly already a safeguarding matter with no suggestion that Mr FF's safety, welfare and mental health may have been affected. No contact was made with or referral to Environmental Health despite the dreadful conditions he was living in.

Between 2014 and 2016, according to the Adult Social Care records, he did not come to the attention of agencies.

7.2 In early October 2016, the Police reported to Adult Social Care that the house was in a mess with discarded food and flies around. Mr FF was contacted by phone and he said he did not want services. No visit or further action was undertaken.

Between 2017 and 2018, there was no service contact with Mr FF.

For more than 5 years, Mr FF had been living in deplorable conditions. His home was not fit for habitation and it was full of risks to his safety from the lack of basic amenities – heat, water and sanitary facilities as well as a major rat infestation in every room. It is unclear why the threshold for intervention by Adult Social Care was not regarded as having been met during these years. It seems that there may have been the perception that this was his 'lifestyle choice'. It may be that there developed, without any contact with him directly, a developing desensitisation from acting in relation to his well-known case, resulting in minimisation of need and risk and an unfounded optimism that it was not that bad really. There is research evidence that professionals may become desensitised to even extremely poor living conditions. Certainly, there was a challenge presented by Mr FF's lack of engagement when he was approached and this made it difficult for professionals to work with him but there does not seem to have been evidence that his mental health or decision-making capacity was being explicitly considered as far as his own safety and well-being was concerned. His family have commented that it was not clear to them that he had the capacity to appreciate the risks posed in his home and to keep himself safe.

**2019 – Concerns were recognised as serious**

7.3 At the beginning of January 2019, a referral was made from Environmental Health to Adult Social Care which very much restated the conditions which had been identified and noted both in 2014 and 2016. There had been no improvement.

- *Rats living in his house and he is not looking after himself.*
- *The house smells and he uses a room in his house as the toilet.*
- *His house is like a tip and his front door does not even close.*
- *No human should be living like this. He needs help. What can you do to help him?*

7.4 Despite these continuing concerns having been identified, and the fact that it was recognised that the threshold for Adult Safeguarding intervention had been crossed and that the situation was being managed on a multi-agency basis under the safeguarding framework. The response overall throughout the year lacked the urgency and sense of priority required.

7.5 It was not until 22nd May that a Professionals meeting was arranged for 10th June. By that point a very concerning mental health assessment had been completed which clearly stipulated the need for urgent action to safeguard Mr FF. It is unclear from the title of the meeting whether this was a strategy meeting held under the adult safeguarding procedures or a less formal bringing together of those involved.

7.6 There was a lack of an overarching thorough and robust risk assessment and planning from a safeguarding point of view.

7.7 There was some collaboration between the agencies, but it was not effective in delivering a prompt and appropriate response to addressing Mr FF's needs and to keeping him safe.

7.8 It is not clear how the safeguarding adults' procedures were being used to drive the planning and intervention required.

7.9 There seems to have been a general lack of management oversight of the planning for Mr FF and a lack of any sense of urgency to improve his circumstances. This was particularly important in this case when Mr FF was uncooperative and evasive. The professionals involved did not seem to be aware of the legislative options available to intervene to safeguard a person who is severely self-neglecting like Mr FF and who was placing himself at risk. In addition, within each agency until September 2019, there is no evidence of the application and understanding of the Mental Capacity Act and the need to consider the options adopting a "best interests" approach to take in relation to Mr FF's refusal to engage. Whenever an individual refuses services, it is important to consider mental capacity and ensure that the individual understands the implications and that this is documented in their records. This did not occur for Mr FF until just a month or so before his death alone in terrible living conditions.

7.10 Even after the mental health assessment of Mr FF had been completed in May 2019 and those professionals expressed extreme concern about the lack of intervention at pace to safeguard Mr FF, there remained delay and a lack of urgency. Of course, Mr FF's lack of engagement was a frustration, but it was not seen as it should have been as from someone who may or may not have had mental capacity, making unwise decisions or withdrawing from agencies but continuing to be at risk of significant or serious harm.

7.11 There is evidence of each agency carrying out positive intervention in this case. The Environmental Health service acted promptly to try and improve Mr FF's home conditions when they knew about him. However, he declined much of the service on offer, so the service withdrew without recourse to working collaboratively with other agencies to look at the risks to him and legislative options. The SW managed to get Mr FF to accept some delivery of meals to his home in his last few weeks. The Police and particularly the local PCSOs kept an eye on him in the town centre and reported concerns seen but again this was single agency activity and not drawn together into a multi-agency safeguarding process. It was not until the Practitioner Event, that others became aware of the extent of their knowledge and involvement with Mr FF. The Mental Health Team assessed his coping and capacity and they were very clear that he was highly at risk and pushed for intervention from June 2019. This did not lead to an effective multi-agency response. There was a lack of coordinated intervention and drive to deliver this across all the agencies involved.

7.12 The safeguarding procedures are for all agencies to operate in collaboration and to understand when and how they should be applied. However, the sense in this case is that Adult Social Care and the Local Authority's Safeguarding Team were responsible to act and were expected to lead. At the same time, there seems to have been no professional escalation process between agencies to drive required action and intervention when there is professional disagreement about the seriousness and/or urgency of action.

7.13 There was early information sharing about Mr FF, in relation to the previous and continuing concerns amongst agencies. However, the local Police and Environmental Health in particular were not entirely in the loop in terms of the assessment, planning and implementation of interventions. As a result, the activity tended to be unilateral with high expectations that Adult Social Care was leading the case.

## 8 Key Findings of the Review

8.1 This was a complex case. The issue about whether to intervene is difficult when the person is determined that they do not want agencies to be involved. The issue is to consider whether this gentleman's mental capacity was impaired and therefore whether he was able to act or not in his own best interests. His family are of the view that he did not have capacity to keep himself safe and well and that agencies did not take this seriously enough for far too long. Living in squalor with evidence of his self-neglect were clearly safeguarding issues and was related to his mental health capacity and was not in his best interests.

8.2 Mr FF's behaviour and problem with engagement displayed several aspects of self-neglect as identified in the research:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid self-harm
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

*(Manchester Adult Safeguarding Partnership –Resources, self-neglect)*

There is no question that he was extremely vulnerable and at risk.

8.3 There is evidence of positive multi-agency working and of information sharing in this case but there were significant delays in responses. The local safeguarding system did not work effectively enough to ensure that timely and decisive action was taken to safeguard Mr FF.

8.4 The safeguarding principles listed within the Buckinghamshire Multi-Agency Policy and Procedures were applied to some degree and practitioners sought to do their best for Mr FF. The way in which the principles were applied and interpreted were not always in his best interests and did not take sufficient account of the worries and concerns of his family about his safety and the circumstances in which he was living.

For example:

- Empowerment - People being supported and encouraged to make their own decisions and informed consent.
  Professionals did seek to empower Mr FF but there was insufficient questioning of whether he had capacity to make safe decisions for himself.

- Prevention - It is better to take action before harm occurs.
  However, there was little evidence of early intervention or effort to prevent further harm in this case.

- Proportionality - The least intrusive response appropriate to the risk presented.
  The least intrusive response was applied in Mr FF's case, but this needs to be qualified by also considering the high level of risk and his lack of capacity and the lengthy delay in there being full recognition of the seriousness of his situation.

- Protection - Support and representation for those in greatest need.
  There were efforts to support Mr FF but his adamant refusal, non-cooperation and (his unrecognised) lack of capacity frustrated this and alternative solutions were delayed.

8.5.1 The challenges presented by Mr FF made it difficult for professionals to work with him but this should have been overcome with all professionals working together at pace with a shared agenda and remit to resolve the safeguarding concerns for him.

8.6 It would have been helpful if practitioners had considered the Mental Capacity Act 2005 Code of Practice advice about individuals who refuse to cooperate and appear to make unwise decisions.

This would not necessarily have led to a conclusion that Mr FF lacked capacity. However, it would have indicated that further enquiries need to be made taking into account the person's past decisions and choices and their current context.

8.7 There was some involvement with Mr FFs family, but this could have been more effective if plans had been more regularly shared. In addition, it could have been considered that an independent advocate should be involved to provide another perspective on his wishes and feelings and his capacity to share these and to make appropriate decisions.

## 9. Conclusion

9.1 There was some positive practice in this case but there was also delay and indecision. Thorough and robust joint risk assessment and planning – including a clear shared safeguarding plan - is required with regular multi-agency review to support effective collaboration between agencies.

9.2 The current local Multi-Agency Safeguarding Adults Procedure does not provide for regular Safeguarding meetings/Case Conferences to be held or for the Safeguarding Plan to be shared and reviewed and this should be reconsidered.

9.3 Such self-neglect cases need to be higher up on all agency agendas in terms of urgency and, if information had been shared more widely, for example with Environmental Health at the earliest possible stage, then maybe more intervention may have been considered appropriate.

9.4 One of the most concerning aspect of Mr FF's case was an apparent lack of a consistent appreciation of and desensitisation to his lived experience in that smelly, dirty and unsafe house where there was no water, electricity or heat and the urgency required to resolve this to protect him. The facts are mentioned in the agency reports but not the impact on him as a person which is important as he was unable to recognise it himself.

9.5 There needs to be an increased shared understanding across all agencies of the legislative options available to intervene to safeguard a person who is self-neglecting with legal advice being sought at an early stage.

9.6 There was also a lack of clarity and agreed understanding about the need to apply and consider the Mental Capacity Act and Mr FF's level of functioning throughout the agencies' involvement with him.

## 10 Learning and Recommendations

10.1 Practice in self-neglect cases needs to be proactive not just a series of reactions to events. The Safeguarding Adults' Procedures are being reviewed by the Partnership and this case has shown the need for them to provide a clearer framework across all agencies.

The new interagency Safeguarding Adults' Procedures should explicitly provide professionals:

- with clear criteria defining the safeguarding thresholds including definitions for the level of risks identified and their appropriate intervention including compulsory intervention – this is not about descriptors of concern but about levels of safeguarding risk requiring intervention.
- with flowcharts to show this process of assessment, planning and decision making
- with the use of consistent language to safeguard individuals who self-neglect and who are as a result at risk in the community.
- with specific timeframes for responses and multi-agency intervention.
- to provide advice about how to escalate concerns beyond a single agency when there is delay and urgent concerns remain for that practitioner or agency.

10.2 There was a lack of consistency about the meetings held concerning Mr FF and his circumstances. These were also not regularly scheduled and there was no required agenda or clear multi-agency plan.

There needs to be:

- clear terminology/nomenclature for safeguarding meetings-
- Multi-agency safeguarding plans should be drawn up to ensure all agencies are clear about what is required.
- Following Strategy meetings and the making of multi-agency Safeguarding Plans, regular Safeguarding Conferences should be booked ahead to review progress and to update the Safeguarding Plan.

10.3 There was a lack of regular management oversight and this led to drift and delay in escalating and tackling Mr FF's deteriorating circumstances.

There should be at least monthly oversight of safeguarding cases - and preferably through a multi-agency process - of such high risk cases which have met the threshold of the safeguarding procedures and the safeguarding framework for there to be a safeguarding plan in place to enable practitioners and managers to challenge and reflect upon cases through their supervision process.

10.4 When an individual like Mr FF refuses services, it is important to consider why he might be refusing and steps that might be taken to promote his engagement. This will include consideration of mental capacity and safeguarding from the start and to ensure that the individual understands the implications of this and that this is recorded. At the same time, all professionals and agencies need to make a decision using the best interest decision making process when it appears that the individual is unable to make safe decisions for themselves.
There is a need to:

- Consider in training and supervision the Mental Capacity 2005 Code of Practice as follows:

  *2.11 There may be cause for concern if somebody:*

  *• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or*

  *• makes a particular unwise decision that is obviously irrational or out of character.*
- Develop some guidelines for working with individuals who appear to be difficult to engage; these should include consideration of mental capacity and cultural needs.
- Following this review, specific workshop training for practitioners is required to ensure they have information about the learning from this SAR and that they are clear about:
- The requirement to consider and apply thresholds for single or multi-agency involvement from supportive preventative safeguarding measures to formal adult protection.
- Full adult protection processes may be required if the risks are high, even if it is against the wishes of the subject.
- What they need to and can do together to promote the best interests of high-risk vulnerable adults.
- How mental capacity needs to be considered and assessed at the earliest possible stage and regularly

10.5.1 In this case there was a lack of consideration and assessment of a vulnerable adult's needs.

The assessments must include full involvement of the wider family and social context if this is judged by professionals to be in the individual's best interest or the public interest, even if the individual has not consented. However, consent should be sought whenever possible and the individual's capacity and cognisance should be considered, and advice sought.
This family involvement should include:

- regular updates with the family
- holding Family Group Conferences, if possible, to discuss options and to provide the family with full advice

**In conclusion**, it is for the local agencies to work together to address these recommendations. It is clear that there has already been some policy and procedural development in the County in relation to cases of self-neglect. It has been positive that in some aspects of this development, the Review has been able to influence these already.

This Review has not taken account of all that activity and it will be important for the Adult Safeguarding Board to check out the extent to which these new processes are effectively able to address these recommendations. Above all, there is a need for speedier and more proactive responses in such cases of extreme self-neglect working whenever possible with the individual but also with their extended family.

**Appendix A**

**The Care Act 2014 and Adult Safeguarding Duties**

- Care Act statutory guidance 2014 formally recognises self-neglect as a category of abuse and neglect – and within that category identifies hoarding.
- This enables local authorities to provide a safeguarding response, including the duty to share information for safeguarding purposes; the duty to make enquiries (S42) and the duty to provide advocacy, where a person has no one to advocate on their behalf.

**Safeguarding duties apply to:**

- any adult who has care and support needs (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of abuse and neglect (including self-neglect); and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The duties apply equally whether a person lacks mental capacity or not. So, while an individual's wishes and feelings are central to their care and support, agencies must share information with the local authority for initial enquiries to take place.
Enquiries may take place even when the person has capacity and does not wish information to be shared, to ensure abuse and neglect is not affecting others, that a crime has not been committed, or that the person is making an autonomous decision and is not being coerced or harassed into that decision. Safeguarding duties have a legal effect in relation to many organisations and the local authority may request organisations to make further enquiries on their behalf.

**The purpose of a Safeguarding Enquiry (S42) is initially for the local authority to clarify matters and then decide on the course of action to:**

- Prevent abuse and neglect from occurring
- Reduce the risk of abuse and neglect
- Safeguard in a way that promotes physical and mental wellbeing
- Promote choice, autonomy and control of decision making
- Consider the individual's wishes, expectations, values and outcomes
- Consider the risks to others
- Consider any potential crime
- Consider any issues of public interest
- Provide information, support and guidance to individuals and organisations
- Ensure that people can recognise abuse and neglect and then raise a concern
- Prevent abuse/neglect from re-occurring
- Fill in the gaps in knowledge
- Coordinate approaches
- Ensure that preventative measures are in place
- Co-ordinate multi-agency assessments and responses

**Appendix B**

**Safeguarding Adult Reviews (SAR) National Requirements**

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

"(1) A Safeguarding Adults Board must arrange for there to be 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 Safeguarding Adults Board, 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 Safeguarding Adults Board 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 Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board 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 Safeguarding Adults Board 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."

**The Care Act 2014 Guidance explains that the purpose of a Review is to:**

i. Develop learning that enables the Safeguarding Adults' Partnership future.
ii. Ensure that lessons are learnt, and lessons are applied to future situations to improve local practice, procedures and services together with partnership working to minimise the possibility of circumstances similar to this happening again.
iii. The purpose of the Review is not to apportion blame or hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and

Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

**The following principles apply to all Reviews:**

● there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

● the approach taken to Reviews must be proportionate according to the scale and level of complexity of the issues being examined;

● the individual (where able) and their families will be invited to contribute to Reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;

● the Buckinghamshire Safeguarding Adults Board is responsible for the Review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;

● reviews of serious cases will be led by individuals who are independent of the case under Review and of the organisations whose actions are being reviewed and

● professionals/practitioners will be involved fully in Reviews and invited to share their perspectives.

**Appendix C**

**Terms of Reference for the Safeguarding Adult Review of ADULT FF**

**1. Purpose**

- to involve agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future
- long-term development of competent and confident multi-agency practice, where staff have a better understanding of the knowledge base and perspective of different practitioners with whom they work
- to provide insights into underlying issues such as the impact of organisational culture on professional decision making
- to identify if any processes or systems need to be changed or developed in order to improve understanding in relation to the needs of adults at risk.
- to strengthen the accountability of managers in taking responsibility for the context and culture in which their staff are working and ensure that they have the support and resources they need.

**2. Case Reference details**

The client will be referred to as Client FF. All documentation will be anonymised as far as possible.

**3. Circumstances leading to the SAR**

Mr FF was an elderly gentleman who lived alone at his home in High Wycombe, Buckinghamshire. Mr FF was estranged from extended family but was supported by his Daughter-In-Law who resides in Birmingham and visited FF once a month.
Mr FF was living in unsanitary, rat-infested conditions with self-neglect and an element of hoarding present. Several agencies were involved with Mr FF however Mr FF did not always accept the services offered and did not fully engage with agencies Mr FF was known to have a pacemaker fitted that was many years overdue for renewal by medical professionals.

A Social Worker did not always receive a response when visiting Mr FF. Just before his death in November 2019, there were food parcels outside Mr FF's home that had not been taken in. When the Social Worker made enquiries, she was told by other individuals that they had not seen him for some time. The Social Worker called Police 101 for a Welfare Check. Officers from Thames Valley Police arrived and gained entry to the property, Mr FF was found deceased at home in his bed. The cause of death was recorded as natural causes.

**4. Agencies involved**

- BSAB
- Thames Valley Police
- Environmental Health
- Oxford Health Foundation Trust
- Buckinghamshire Council Adult Social Care
- Buckinghamshire Council Adult Safeguarding

**5. SAR Independent Chair**

DI Carl Wilson Thames Valley Police

**6. Panel Members**

| Name | Agency | Job Title |
|---|---|---|
| DI Carl Wilson | Thames Valley Police | Chair & Domestic Abuse Investigation Unit – Bucks |
| Amy Weir | Independent Consultant | Lead Reviewer |
| Vince Grey | BSAB | Business Manager |
| Ashleigh Coneron | BSAB | Safeguarding Practice Review Officer |
| Jenab Yousuf | Buckinghamshire Council | Interim Safeguarding Adult Lead, Adult Social Care |
| Amy Starsmore | Buckinghamshire Council | Private Sector Housing Team Leader, Housing and Regulatory Services |
| Tracey Ironmonger | Buckinghamshire Council | Service Director Integrated Commissioning, CHASC |
| Julie Dale | Oxford Health NHS Foundation Trust | Associate Head of Social Care |

**7. Lead Reviewer/s**

Amy Weir Independent Consultant

**8. Requirements**

The Panel, with the support of the Independent Reviewer/s will:

- Assist with the arrangements for the Review, including briefing and supporting their staff to engage in any individual discussions for the Review if required and attend the Practitioners' Review Day
- Identify the roles and responsibilities of each agency involved and analyse the extent to which the agency has met its responsibilities, identifying good practice and any issues with policies, procedures and practice
- Identify the culture and context in which the staff of each agency work, and analyse the extent to which they support effective practice

- Identify and analyse how well the agencies have shared information and worked together
- Report as findings good practice which should be shared and learned from
- Identify areas of improvement in individual agencies cultures, structures, policies procedures and practice to share and learn from.
- Report as findings any measures which could improve the effectiveness of joint work

In the above context, the Panel will note the extent to which the work of the agencies was

- Consistent with the principles of Making Safeguarding Personal
- Person centred
- Informed by needs and risks assessments
- Timely
- Adequate and appropriate
- Responsive to crises and risks

**9. The scope of the SAR**

The Review will cover the period 1st October 2016 to 18th November 2019.

**10. Additional Areas of Focus**

The circumstances leading to this Review require specific attention also to be paid to the following:

- Effectiveness of partner agencies working together and undertaking escalation following appropriate assessment, analysis recording and information sharing.
- Consideration of the impact of different priorities, thresholds and remits of various agencies on addressing Mr FF's needs.
- Consideration of the quality of assessment, analysis and risk analysis of Mr FF's decision-making capacity and his capacity to then appreciate the consequences of those decisions.
    - This should include possible links to his medical health and the possible impact of this on his mental health and capacity.
- Consideration of current policies and procedures regarding self-neglect and safeguarding.
- Initial family engagement will take place through the daughter-in-law due to the apparent estrangement from other family members.

**11. Methodology**

A systems Practice Model will form the method for this SAR. It will focus on the actions and decisions of the individuals and agencies who were directly involved, to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken. The focus is on the team, the service, the agency as a whole and the collective actions of agencies together as well as the responsibility of individuals to act professionally and to work effectively.

The Review will be conducted with due regard to the principles of fairness, impartiality, thoroughness, accountability, transparency and above all with a focus on the experience of the client.

The Reviewer will consider:

- Relevant policies and procedures – both local and national
- IMRs and chronologies from each agency
- Holding a Practitioner Event
- Consider holding interviews with individual practitioners

**12. Timeframe for the SAR**

The timeframe set for the Review is July 2020 to December 2020 because it is anticipated that the use of the Systems Practice Review Model along with a limited timeline and areas to explore should enable this Review to be completed within this timeframe.

**13. Timetable for the SAR**

- IMRs and timelines to be submitted - 19.09.2020
- First Panel meeting - 20.07.2020
- Second Panel meeting to identify possible themes – 19.10.2020
- First draft of the Report to be submitted – Week commencing 7th December 2020
- Third Panel meeting to comment upon first draft of the Report – Early January 2020
- Practitioner Event to be held – November 2020
- Fourth Panel meeting to finalise the Report – Late January 2020
- Report to be submitted to SAR Subgroup – February 2021
- Presented to the BSAB Executive meeting – March 2021
- Learning Event to be held – TBC

**14. Role of the SAR Subgroup:**

1. The Subgroup will agree any amendments to these Terms of Reference proposed by the Panel
2. The Subgroup will ratify the Report, with any qualifications as appropriate, and forward it to the Safeguarding Adults Board for adoption
3. The Subgroup will draft a multi-agency Action Plan to meet the Findings and Recommendations contained in the Report for submission to the Safeguarding Adults Board
4. The Subgroup will ratify, with any qualifications as appropriate, any internal Action Plans written by the agencies participating in the SAR

**15. Completion Date**

Scheduled for 31st December 2020, this date may subject to change due to COVID19 restrictions. This will be reviewed periodically by BSAB, Chair and the Independent Lead Reviewer

**Appendix D: Summary Chronology of agency involvement**

| DATE | | |
|---|---|---|
| 2/2/2014 | Police Report received by ASC | Duty contacted Daughter-in-law + GP |
| | Living in bedroom; dirty and unkempt; Mr FF accusing neighbours of stealing. | Mr FF refused support |
| 4/3/2014 | Tel message from Duty GP | |
| | Pacemaker fitted 2010; missed appointment 2013 | Concerns shared with GP. Said would contact NOK. |
| | | Case closed NFA. |
| 2014-16 | No contact with Mr FF. | |
| 3/10/2016 | Police report received; prop in a mess; food and flies. | Referred to Community Response and Reablement team for assessment. |
| 5/10/2016 | Referred to Community Response and Reablement team for assessment. | |
| 6/10/2016 | Daughter-in-law contacted. Said FF very stubborn. Refused offer of going to live with them in Birmingham. Visits him monthly. | |
| 20/10/2016 | CR and R contacted Mr FF by phone. | Mr FF declined assessment; agreed to receive info re services available. |
| 26/10/2016 | Burglary report – Police attended. Concerns re neglect and state of property. Lack of water, electricity, unsafe. | Mr F in denial |
| 31/10/2016 | Letter sent to Mr FF. Offered assessment because no phone. | |
| | | |
| 2016-2019 | No contact | |
| | | |
| 3/1/2019 | Referral from Environmental Health; rats; self-neglect; using a room as a toilet; front door does not close. “no human should be living like this”. | No immediate action |
| 24/1/2019 | Unannounced duty visit. | Unable to gain access. |
| 25/1/2019 | Further visit - unable to gain access | Police welfare visit requested. |
| 27/1/2019 | Another Police report with similar concerns. | |
| 29/1/2019 | Concerns from a member of the public. | |
| 31/1/2019 | Unannounced visit completed. | Concerns noted. |

| | | |
|---|---|---|
| 1/2/2019 | Another Police report with similar concerns. | Shared with allocated worker |
| 6/2/2019 | GP agreed to do a home visit | Completed? |
| 8/2/2019 | Welfare visit. Mr FF seen. | |
| 12/2/2019 | Progressed to safeguarding S42 enquiry | Allocated to Safeguarding SW |
| 25/2/2019 | Joint Visit with AEHT | |
| | | |
| 25/2 to 11/3/2019 | No case notes | No intervention to 29/3/2019 |
| | | |
| 11/3/2019 | Contacted daughter-in-law | No contact 11/3 to 29/3/2019 |
| 27/3/2019 | Supervision notes | MCA to complete |
| | | Ref to Environ Health + Fire Services |
| | | Liaise with GP re pacemaker |
| | | Complete self-neglect tool |
| 28/3/2019 | Another Police report. | |
| 29/3/2019 | Safeguarding concerns - hoarding and neglect - discussed with GP. | |
| 29/3/2019 | Contacted Environ Health | |
| 1/4/2019 | Joint Visit with GP. | No follow up 1/04 to 15/04/2019 |
| 15/4/2019 | Joint Visit with MHT arranged for 17/4/2019 | |
| 16/4/2019 | Another police report | |
| 17/4/2019 | Joint Visit with OPMHT - duty worker EJ. Brief cos Mr G left for lunch in town. | |
| 26/4/2019 | Visited and email to Daughter-in-law. Unable to see Mr FF | |
| 29/4/2019 | T/C with allocated MHT coordinator. | He agreed urgent approach required. Will visit and assess. |
| 2/5/2019 | OPMHT concerned re delay in making referral to MHT. | To be assessed. MHT want safeguarding team to consider risks. |
| 3/5/2019 | Supervision notes. (for Safeguarding SW) | To write up work so far and analysis, complete self-neglect tool without Mr FF. Profs meeting to be booked after next visit. RAMP not possible -under review? |
| April 2019 | No management oversight in ASC | |
| 10/05/2019 | OMHT assessment completed.<br>- high risk of self-neglect<br>- risk to physical health re pacemaker | Urgent social care support required. Safeguarding to be involved. |

| | | |
|---|---|---|
| | - risk of further deterioration of mental health- not yet acute<br>-risk of harm from others - door open | |
| 10/05/2019 | Joint Visit - with MHT worker | Mr FF not in |
| 22/5/2019 | Profs meeting arranged for 10/06/2019 | |
| 3/6/2019 | Ref to Environ Health - though contact as made March 2019 | Profs meeting rearranged to 12/6/2019 |
| 12/6/2019 | Joint Visit with Environ Health | Actions agreed |
| 11/7/2019 | Env Health - stating that info on social media re Mr FF approaching children inappropriately. | Env H suspending all work at house. Cos of safety and security issues. |
| | Contacted - will they continue work? | |
| 31/7/2019 | Email from Env Health | |
| 9/8/2019 | Joint Visit agreed with Fire Service for 19/8/2019 | |
| 19/8/2019 | Another Police Report | |
| May-Sept 2019 | No management oversight | |
| 6/9/2019 | Management oversight | Multi-agency safeguarding meeting set for 18/9/2019 |
| 18/9/2019 | Another visit completed. Strategy Meeting completed. | Allocated in south team<br>Plan<br>Legal advice<br>Weekly welfare visits<br>Env H report |
| 24/9/2019 | Ref to Legal and IMCA | |
| 27/9/2019 | Visit by SW - Mr FF not seen | |
| 30/9/2019 | Visit by SW - Mr FF seen | |
| 2/10/2019 | Spoke to him through window | |
| 3/10/2019 | Visit and seen | Ref to Appetito meals |
| 10/10/2019 | Joint Visit with IMCA and SW | |
| 11/10/2019 | Supervision and SW chased ref to Legal | Allocated in legal 16/10. |
| 18/10/2019 | Welfare check - seen. | |
| 30/10/2019 | Police requested Env Health check on property | |
| 18/10 to 15/11/2019 | No welfare check visit | |
| 11/11/2019 | Profs meeting arranged by police. On 3/12/2019. ASC asked for this to be brought forward. | |
| 15/11/2019 | Welfare visit completed. | Mr FF not seen. Door locked. |
| 18/11/2019 | Daughter-in-law concerned. | Police called and found Mr FF dead. |

**Appendix E: List of Agencies Involved and Key to Acronyms/Abbreviations**

**Agency**

Thames Valley Police – periodically throughout the period from 2014

GP – throughout the period from 2014 but not regularly

Environmental Health – from 2019

Oxford Health Foundation Trust – from April 2019

Buckinghamshire Council Adult Social Care – from 2014 but not an allocated case and subject to assessment till January 2019

Buckinghamshire Council Adult Safeguarding – from end of January 2019

Buckinghamshire Fire Service – one visit

**Key to Acronyms/Abbreviations:**

ASC - Adult Social Care
AST – Adult Safeguarding Team
CR and R – Community Response and Reablement Team
SW – Social Worker
EHO - Environmental Health Officer
OHFT - Oxford Health Foundation Trust
OPMHT – Older People's Mental Health Team
IMCA – Independent Mental Capacity Advocate
MCA - Mental Capacity Act
NOK – Next of Kin

## Appendix F: References


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Buckinghamshire Multi-Agency Policy and Procedures

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Manchester Adult Safeguarding Partnership - Resources – self-neglect

Office of the Public Guardian - Mental Capacity Act 2005 - Code of Practice (20007)
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