Brent Safeguarding Adults Board

Safeguarding Adults Review

Adult D (Sean) – Executive Summary

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1. Introduction and Background

This review concerns the death of Sean. At the time of his death Sean was 71 years old and living in LB Brent in a second floor one bedroom flat where he had lived on his own for about 20 years. It was rented from Network Homes. There had been a period of temporary housing for some time before this.

The scope of this Review covers the period of Sean's hospitalisation on 9 November 2016 to his death on 27 September 2017.

In November 2016 Sean was found when a gas engineer visited his flat. He was discovered in a very poor physical state. He was hospitalised with symptoms resulting from severe lack of nutrition and evidence of very poor personal care. On 11 November 2016, while in hospital, he was assessed as not suffering from a mental health illness by the hospital psychiatric liaison consultant. Following extensive cleaning and de-infestation by Brent Direct of his flat, Sean was discharged from hospital on 1 December 2016. A reablement package of care providing Meals on Wheels and twice daily visits by carers to support meal preparation was put in place (commissioned) by LB Brent. This package was subsequently reduced, following a review, to one visit a day to assist with meal preparation and shopping on 9 January 2017. The Meals on Wheels service was stopped. Sean was also being assessed for a possible move to supported/ground floor housing.

Following his return home and particularly during the period May 2017 to June 2017, Sean was reported to have declined to answer the door or allow access to the care agency workers and other professionals on a number of occasions. The care agency reported that Sean had accepted daily visits at the start of the service in December 2016 and up to April 2017 but then started to decline access in the 1st and 2nd week of May. He accepted visits again from 15 to 23 May but did not accept care visits after 29 May 2017.

Sean was last seen by a professional worker on 1 June 2017. The GP attempted a home visit the day before (31 May) but was only able to speak to him through the door. At the request of the GP, the Police carried out a welfare check on 1 June and saw and spoke to him although the inside of his property was not seen. The duty social worker also attempted a home visit on 1 June. The actual sequence of these visits is unclear.

On 8 June 2017 following the visit by the duty social worker on 1 June 2017 it was decided by LB Brent Adult Social Care to withdraw the care package and all contact ceased. This decision was on the grounds that the support was consistently being refused. Sean was deemed to have the capacity to make the decision not to engage with services. No follow up was planned though a letter was to be sent to him explaining the situation.

On 27 September 2017 following a neighbour's report, forced entry was made by the police into Sean's flat by the police and Sean was found dead. The post mortem was unable to provide a date of death or establish the cause of death as the level of decomposition meant that toxicology reports were not viable. An inquest hearing was held by the Coroner on 23 January 2018. The recorded cause of death was "unascertained".

2. Safeguarding Adult Review

This SAR was commissioned by Brent Safeguarding Adults Board (SAB) and managed by the Case Review Sub-Group.

Terms of Reference for this review were agreed by the Case Review Sub-Group on 17 January 2018.

This report is based on information provided from, interviews with staff in and a learning event involving:

- London Borough of Brent (LBB) Adult Social Care (ASC)
- Central and North West London NHS Trust (CNWL)
- Health Vision (Domiciliary Care Provider commissioned by LBB)
- Network Homes (Landlord)
    - Sanctuary Supported Living (service providing support to reassess housing options for Sean, commissioned by LB Brent Integrated Reablement and Rehabilitation Service)
- GP practice
- Imperial College NHS Trust

Terms of Reference

Consider in detail the events in the period from Sean's hospitalisation on 9 November 2016 to his death being discovered on 27 September 2017 to identify the actions and decision making of all professionals/agencies that were involved in those events, and to consider any outcomes having regard to:

a. Mental Capacity Assessments, with particular focus on executive capacity

b. Risk assessments

c. Agency and multi-agency practice and sharing of information in respect to adults who self-neglect

d. Medical assessments

e. Mental Health Act assessments

f. Practice response to issues of self-neglect

g. Consideration of any relevant legislation, for example Care Act 2014, Mental Health Act, and Mental Capacity Act

h. Safeguarding guidance (both London wide and for individual agencies)

i. Any other relevant policy or practice guidelines for individual agencies and any national advice or guidance

Review and outline the previous history of Sean and his involvement with health (including mental health), social care or community services to establish any other relevant information.

Specifically to consider the decision to stop the reablement care package to Sean on 8 June 2017.

The independent reviewer met with one of Sean's brothers and his wife on one occasion. They both spoke warmly and with much fondness and humour about Sean. Their descriptions of his life were insightful and painted a picture of a resourceful man with character and colourful attributes. The family's description of Sean written by them for the review is set out below. It is at the request of the family that the name "Sean" has been used throughout this report.

The Brent Safeguarding Adults Board independent chair met with one of Sean's brothers and his wife on three occasions.

The final review report was approved by Brent Safeguarding Adults Board in October 2019.

3. Sean

Sean was a white man born in November 1946. He was brought up in Ireland and referred to himself as being Irish. He had 8 brothers and sisters. He lived in a 2nd floor one-bedroom flat that was rented from Network Homes and he had lived there for over 20 years. He was very well known and recognised from his many years of walking the streets.

It is understood that Sean had worked on several building sites in the London area as a labourer and had done other manual roles with periods of unemployment. He never married or mentioned having any children.

From at least 2009 to 2013 Sean was treated by his GP for symptoms of depression. During this period a number of medications were prescribed but from 2014 Sean declined all medication, including anti-depressants.

He had a recorded history of heavy alcohol use, with a disclosed intake of 56 units per week in 2013. According to the GP notes this level of consumption reduced in 2015 and was recorded as zero at the point of emergency hospital admission in November 2016.

Sean was diagnosed in April 2015 with Stage 2 Chronic Obstructive Pulmonary Disease (COPD) for which he was prescribed inhalers.

When he was admitted to hospital in November 2016 he told staff that he had not seen two of his brothers, who had been living in England, for some years. It is recorded in the files that Sean was adamant that he did not want them (his brothers) to be told of his situation at that time.

Family Recollections of Sean

Like many young people before and since, Sean left home and family in Northern Ireland to seek work and experience in England. The second of 9 children he arrived in London aged 17 in the 1960s. All bar one of us siblings made the same journey at some point. Sean settled in part of North London - then known as the 33rd county of Ireland. It was home from home without "The Troubles".

Sean didn't flourish under the auspices of a Catholic education, and he left school without formal qualifications. So work meant manual labour in factories and building sites, joining the queues of other mainly migrant men who were waiting from the crack of dawn to be arbitrarily selected (or not) and transported to where the shovel and pick were needed. The publican of McGoverns was happy to cash the weekly cheque, and opened a dedicated counter for the service at 7pm on Fridays. The queue of thirsty men often snaked into the street and by the time a man's cheque was cashed it was already part spent and likely to be swallowed up in McGoverns' coffers before the night was out. Hard work followed by hard drinking.

Sean did get a break when he successfully applied for a job as postman, which suited him as a habitually early riser because he could then finish early, and he liked being out and about, exploring the streets and meeting people from all walks of life. Because work to date had been casual he'd cited his uncle, a successful tradesman back home, as referee assuming he'd go along with the white lie that Sean had worked in his shop. When Sean took part in industrial strike action his employers decided to scrutinise the strikers' backgrounds as a punitive measure. They contacted his uncle who refused to corroborate his nephew's CV and Sean was sacked. This was something of a turning point for him.

Sean grew increasingly disillusioned with the system which had kicked him in the teeth. He had an independent spirit and an attraction to the freedom that life on the streets without constraints and commitments seemed to offer, and he was comfortable in the company of other single men, often drinkers, who were living on the margins.

He was never street homeless but insecure housing and casual work interspersed with unemployment meant a precarious lifestyle for Sean, and he thrived on living on his wits. He became long term unemployed but he elevated resourcefulness to an art form. He walked for miles every day and took great delight in rummaging through skips and other likely spots where he retrieved everything from umbrellas to brooches and armchairs. He collected and stripped metal to sell on. He lived well on the food thrown out as waste by supermarkets and his vegetable rack was always well stocked. He was a keen proponent of recycling long before it became commonplace and, once he was in secure rented housing, his flat was full of interesting items and artwork, and plants he'd rescued and nurtured on.

Sean was generous and thoughtful in giving the treasures he'd come across to friends and family. Our mother took to writing poems in her later years, and he sent her a hardback blank page book inscribed with: "to ma, for your poetry, in other words, for better or verse".

Sean liked words and spent hours in libraries reading and doing crosswords. He was an avid Radio 4 listener savouring the satirical humour of his heroes, Spike Milligan and Willy Rushton. A gregarious person who was a well-known figure in the locality he'd talk to anyone. He observed a neighbour using a stick mirror to check underneath his car, a common sight in Northern Ireland. Curious he introduced himself. The Irish accent may have made the neighbour wary but Lord Russell, son of Bertrand as he turned out to be, was on friendly terms with Sean thereafter. He started corresponding with a Russian visitor he'd met on his walks in Hampstead Heath. His social network was extensive. My brother and I lived nearby and if we'd not seen Sean for a while we'd be sure to run into someone who recently had.

Sean lived through tumultuous times: the Cold War and espionage, Vietnam, student unrest, civil rights movements and the war in Ireland and IRA activity on the mainland. Conspiracy theories flourished, not without foundation, and Sean embraced some of these enthusiastically, at times obsessively. In later years conspiracy looked increasingly like paranoia and those of us closest to Sean had our concerns about his mental health. Contact grew less regular and sightings less frequent and then Sean stopped answering his phone or responding to letters or calls to his flat. Alcohol doubtless took its toll over the years and it is now clear that he was a troubled soul in the last few months of his life, increasingly isolated and alienated and expressing suicidal thoughts as well as paranoid ones.

His death came as a shock. The fact that his absence went unnoticed and his body lay undiscovered for weeks is distressing in the extreme.

Sean could be charming and witty though he equally courted controversy, and took some glee in overstepping the mark to watch the effect. He could be obstinate and difficult. He followed his own path and rejected many aspects of a conventional lifestyle and mainstream aspirations.

He set boundaries, but he was not beyond reach.

4. Analysis

In the years before the period under review there are a number of pointers to subsequent events. There was an emerging pattern of Sean not attending appointments when offered. Shortly before the period under review a summons was issued because the social landlord had been unable to ensure that the annual gas engineer check was completed. There were underlying physical and mental health issues that required some monitoring. Sean was a solitary man described as shy and reticent. He was a heavy smoker and used alcohol in some significant measure.

Time episode one

Sean was admitted to hospital on 9 November and discharged on 30 November. He was admitted with multiple physical health concerns. He had been living in uninhabitable conditions, with vermin infestation. He had been expressing suicidal thoughts. He had extensive weight loss and exhibited low mood, attributed to isolation/loneliness and related to housing. No mental illness was diagnosed and no mental health medication was thought necessary. An Adult Social Care assessment was completed and a care plan agreed – a meals on wheels service and twice daily reablement visits. His flat was blitz cleaned. Good liaison between the services and professionals involved is evident.

However, a safeguarding alert was considered by the hospital, because he was assessed as high risk on discharge, and an alert form was completed but this was not received by any other and represents a missed opportunity to coordinate a multi-agency approach to manage the risks of Sean's self-neglect. Mental Capacity was assumed. There is no recorded consideration of the risk of re-occurrence of his self-neglect or of further poor decision making as his care arrangements changed and that he would be less well supported than in a hospital setting.

The contextual aspects of his self-neglect or a strategy for dealing with this were not considered. This meant that the assessment or care plan did not appear to have considered Sean's situation in light of his lifestyle, kinship groups, family contacts and his interests. It is not clear who made any major inroad into getting to know Sean as an individual. The care plan had a rather narrow focus (primarily physical care). There was little consideration of his potential strengths and how these might be harnessed (Care Act strength based approach). There was little focus on mental health and emotional wellbeing, on promoting wellbeing more broadly.

The potential impact on Sean of the home clearance/clean up (in his absence) was not recognised (his personal possessions and space: the "invasion of his home"). There was no evidence of reference to policy or available practice guidance to support staff to carry out the care planning, with particular reference to the risk of self-neglect from a refusal of service.

There was no follow up/timescale, agreement(s) or co-ordination of the plan, including target dates or agreed timescales for potential rehousing options, social or community contact. It is not clear who was doing any follow up to establish a supportive relationship with Sean, seen as a critical factor in working with people who may self-neglect.

Time episode two

This covers the period between 1 December 2016 and 17 January 2017. Home services to support Sean began immediately after his hospital discharge. He was seen on 1 December by a community mental health social worker and discharged to the care of his GP. At a review on 10 December involving the hospital discharge and reablement teams, his mental capacity was considered, although this focused on his understanding of the care plan and not the future risk of reoccurrence

of self-neglect. Just before Christmas reablement visits were reduced to once daily. He is recorded as experiencing lower mood and slight paranoia but declined referral to local activities. He lacked motivation. His weight improved but there were initial signs of risks of returning self-neglect.

Longer-term follow-up by community mental health would have been advisable given the risks of future self-neglect and mental health decline. Concerns were expressed that Sean could not make use of reablement within six weeks but there was limited evidence of planning and relationship-building to attempt to mitigate future risks. There was a narrow focus on meal support and eating. A focus on rehousing and on linking Sean with social activities, part of wider wellbeing, was not progressed.

Time episode three

This covers the period 17 January to 31 May 2017. Reablement intervention concluded in January although it had been observed that the work was incomplete. The care and support plan continued but without an allocated social worker; the case was passed to the review team. A referral was made by the Council for rehousing in January and this was progressed in March with an assessment. Not all agencies, however, appear to have been aware of the importance placed on his being rehoused by psychiatric staff when he was last in hospital. A referral was made to the Irish Centre as Sean had no friends and was isolated but this was not progressed because of staffing issues at the Centre.

Sean's acceptance of the care and support package was patchy through, refusing access to the care workers, and this became more noticeable from May onwards. Adult Social Care and the GP were aware of this and there was liaison between the GP, police and a social worker. However, this would have been an occasion for convening a multi-agency meeting to share information and assess risks. No such meeting took place and there was no consideration of a safeguarding referral. This represents a missed opportunity in light of the care plan of January 2017 noting the risk of suicidal ideation, low motivation and declining mental health. This care plan does not appear to have been widely shared or used as the basis for subsequent planning and decision-making.

Time episode four

This covers the period 1 June 2017 to 27 September 2017. There was a police welfare check on 1 June initiated by the GP. There was no response until the police threatened to break down the door. Sean spoke to the police, appeared to be alright and they had no powers to pursue this any further.

On 1 June, the social work duty team attempted a home welfare visit because Sean had refused entry to care agency workers. There was no response. The duty worker contacted their manager in the Council who advised:

i. Client appears to have capacity to make decisions and to decline care
ii. That the care package should be cancelled
iii. That a letter would be written to Sean informing him that the care has been cancelled because of his refusal of care and that he should respond to social services when his circumstances change.

On 8 June there was an attempted visit by a care worker. Sean refused to open the door. An email was sent to Brent Customer Services at the Council stating that this was an ongoing issue. The same day Adult Social Care confirmed with the care provider the visit of 1 June and their decision to withdraw services, stating also that:

- Sean had capacity
- The Mobile Warden had spoken to him (through the closed door) and reported that he was fine.

On 21 June there was a telephone call to Brent Customer Services from Sanctuary Supported Living seeking information. This was passed to Adult Social Care Duty Team that exchanged information already referred to. At the point of cancelling the care services there does not appear to have been consideration of the work being carried out by Sanctuary Supported Living, though Sanctuary Supported Living tried to follow this up with Sean via contact with Network Homes on 8 July. On 3 August Sanctuary Supported Living wrote to Sean to inform him that LB Brent would not be using them for floating support from 1 September. Both Sanctuary Supported Living and then Elders Voice and also Network Homes made efforts to contact Sean but received no responses. One way of reducing the likelihood of this situation arising again is better communication based on a care plan and multi-agency discussions about what was happening and the inherent risks based, at least in part, on past evidence.

On 25 September one of Sean's brothers made contact with the Council seeking information about where his brother might be. On 27 September, after expressed concerns from neighbours, the Police forced entry into flat and Sean was found dead.

During this period agencies continued to work largely in isolation. For example, the decision by Adult Social Care to end commissioned services was made in isolation from other agencies. No-one appears to have considered what was likely to happen if care and contact was withdrawn.

There remained a lack of guidance on how to respond to repeating risks of self-neglect. There was no review of a risk assessment despite evidence of mental health decline and rejection of care worker visits. A further mental capacity assessment was not conducted and there is some evidence of misunderstanding of the requirements of the Mental Capacity Act 2005. No multi-agency meeting was convened, for example using provisions in section 42 Care Act 2014 to share information and agree a risk mitigation plan. It is potentially significant that, throughout the period under review no-one was allowed access to some rooms in Sean's flat.

5. Service Development

The duration of the review allowed the independent reviewer to meet with staff to explore immediate learning from the case and wider service developments. Since this case there have been both structural and operational developments. Adult Social Care is now formally linked with Housing in a Community Wellbeing Directorate. Adult Social Care and Commissioning have also been brought closer together and restructured to refine the monitoring of how services commissioned by the local authority are being delivered. Pathways have been developed to support planning, hospital discharge and review to ensure sound decision-making. There is a clear expectation that assessments will inform decision-making and that risk mitigation plans must be person-centred before cases are closed pending review. There is greater awareness of the role of Housing in supporting people at risk and a greater understanding of self-neglect and service refusal as safeguarding issues.

There is a protocol now actively in place for responding to situations where services are declined, which is being monitored. A system is in place for deciding which cases can safely be closed pending review, which is also being monitored. The robustness of care planning and review is being audited to ensure that decision-making considers risks, safeguarding and multi-agency involvement.

Self-neglect procedures are under development.

6. Conclusions and Recommendations

There are 5 major areas of learning and development based on the key findings of this report, as follows:

- Understanding and responding to self-neglect concerns
- Assessment and safeguarding
- Understanding and use of the Care Act 2014 and Mental Capacity Act 2005
- Role of commissioning and work with providers
- Multi-agency arrangements.

1. <u>Understanding and responding to self-neglect concerns</u>

Steps should be taken as follows:

i) A comprehensive multi-agency practice guidance and underpinning policy in relation to responding to self-neglect should be developed urgently.

This should include:

- a multi-agency document on thresholds (especially highlighting risk & safety and capacity)
- practice statements for anyone contracted to carry out blitz cleaning. .
- Relaunch of a simplified approach to "service refusal".

ii) All agencies dealing with self-neglect and hoarding should assess any individual concerned from an adult safeguarding perspective and use the multi-agency threshold document to raise an alert when appropriate.

iii) In any revisions of policy and practice guidance there should be overarching agreement covering all services/agencies and where appropriate specific detailed protocols for individual agencies or type of service, for example housing, hospital discharge, community care.

iv) To support the Transformation programme in developing the interface between the Brent Customer Services and Adult Social Care, guidance on use of safeguarding in situations of self-neglect/service refusal should be developed as a support for individual workers and decision makers.

2. <u>Assessment and safeguarding</u>

i) All standardised assessment or risk assessment documents currently in place must be completed to the fullest possible extent, covering all relevant tick box areas, though it is recognised that some areas may not be relevant. All aspects of wellbeing, as identified in the statutory guidance accompanying the Care Act 2014 should be considered.

ii) Where safeguarding concerns are apparent (to external agencies) and a referral is made, respective agencies should ensure that there is a delivery/checking mechanism in place to confirm that referrals have arrived and are being dealt with.

iii) Key staff should be made aware of the use of Section 42 of the Care Act 2014 as a means to bring together relevant agencies to consider risk and ways in which they can work together to engage with individuals.

3. Use and Understanding of the Care Act 2014 and the Mental Capacity Act 2005

i) The practical and contextual aspects of the Mental Capacity Act in relation to an individual who may self-neglect/choose not to receive services should be set out (preferably as part of the Self Neglect approach at recommendation 1). Risks should be fully weighed up alongside the consideration of capacity. This should be done in conjunction with the Mental Capacity Act 2005 Code of Practice.

ii) The important elements of using the Mental Capacity Act for health, social care and other professionals should be practical ways of exploring and understanding the interface between mental health disorders (using the Mental Health Act) and the diagnostic test for capacity based on an impairment or disturbance of the functioning of the mind or brain. Learning and development should also examine practical applications of the functional tests of the MCA (understand, retain, use/weigh-up and communicate) and the critical fact that all of those need to be set within the fact that capacity is both time (when the issues occur) and decision (what the decision is about) specific.

iii) The same should be set out in relation to the requirements of the Care Act 2014. This guidance must include practical approaches and responses with specific reference to Statutory Guidance.

4. Role of Commissioning and Work with Providers

i) The role of commissioning is integral to implementing an agreed and prioritised care plan. Commissioning managers should be made aware of the plan and have a direct interface with the appropriate key provider service.

ii) In Adult Social Care, Commissioners should be encouraged and supported to follow collaborative commissioning arrangements which should not be subsumed as primarily a mechanical contracting/financial task.

iii) Before any decision is made to fundamentally change a commissioned service for an adult with care and support needs, all involved agencies should be consulted and their views recorded. Unilateral decisions should be avoided. There should be an agreed protocol developed for this.

iv) The relationship between providers and commissioners needs further development. It should not only be "contractual" but where it applies to the care of vulnerable people a greater sense of partnership/collaboration is required, evidenced by:

- Clear plans (who, what, when and why)

- Sharing of information
- Jointly developed guidance
- Involvement of service user/carers in significant decision-making

5. Multi-Agency Arrangements

i. All agencies involved in providing any assessment material should contribute to the Care Plan that references other (key) documents. This should be set out by the primary agency responsible and be the basis for future decision making. There should be agreement about who is co-ordinating the care plan.

ii. Brent SAB, in developing procedures for working with cases of self-neglect, will engage with partner agencies in agreeing how multi-agency working is to be practised in Brent.