Cornwall and Isles of Scilly

Safeguarding Adults Board

Report of a Safeguarding Adults Review: Paul

Dr Paul Kingston & Emma Mortimer

Condolences:

This Safeguarding Adults Review was initiated as a result of the untimely death of Paul *[note: Paul is used as a pseudonym]* on 27th May 2016 aged 70.

The Authors and Panel Members would like to express their sincere condolences to all those who knew Paul and have been affected by his death.

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INTRODUCTION

1.1 Paul's Background

Sadly, very little is known about Paul by agencies providing him with care and support. He lived in a first floor flat in Cornwall, had undertaken farming work in his youth and had a forensic history, having been known to the criminal justice system since 1961 for a range of relatively low-level crimes that were largely related to alcohol use[1]. Paul reportedly had an adult daughter from whom he was estranged and who lives in Wales.

Paul's friend, Ms B provided him with daily support with his shopping and some general cleaning and meal preparation, but they apparently argued and the relationship ceased in January 2016; little is known about her by agencies that supported Paul in the last years of his life. However, as noted by Cornwall Partnership NHS Foundation Trust (CPFT), it was Ms B's departure that suddenly highlighted Paul's vulnerability and rapidly increasing inability to cope without support.

The Community Matron and AUKCIOS Support Worker who were most familiar with Paul of all the workers providing support described him as, '*a private person, especially about his family and finances*'[2].

1.2 Circumstances leading to this Safeguarding Adults Review

Paul was a 70-year-old man who experienced long-term physical and mental health conditions which included anxiety together with chronic and significant breathing difficulties. These impacted on his ability to manage daily living. His care and support needs meant he was unable to protect himself from the risks and experience of neglect and abuse. Paul lived alone in a Council-owned property and had no known family living in the region.

A referral was made to the Living Well team in July 2015 to support Paul with his social needs and isolation. An advocate from AUKCIOS subsequently visited Paul and helped him to apply for Attendance Allowance; this was completed in August 2015. A friend was supporting Paul at this stage that was helping him but in January 2016, the friend was no longer able to help and a referral was made (with his consent) to Adult Care and Support.

There were concerns at this time over the condition of his breathing equipment, about the condition of his home and about the reported dispute with his neighbours. All of these were impacting on his physical and mental well-being.

[1] Devon & Cornwall Police Individual Management Review IMR
[2] CPFT and AUKCIOS (IMR)

Paul began receipt of a care package that consisted of visits being provided by a home care agency commissioned by the Local Authority. His care plan commenced in March 2016 and was intended to provide support with shopping, cleaning the home and personal care.

METHODOLOGY

2.1 Legal context and parallel processes

Paul died on 27th May 2016. The Coroner advised that he had died from natural causes: a pulmonary embolism and bronchopneumonia.

A Safeguarding Adults Review is a duty on Safeguarding Adults Boards, set out at Section 44 of the Care Act (2014). Safeguarding Adults Boards must carry out Safeguarding Adults Reviews (SARs) when someone with care and support needs dies as a result of neglect or abuse *and* there is a concern that the local authority or its partners could have done more to protect them[3].

Paul was found at home by a care worker who attempted Cardiopulmonary Resuscitation (CPR) and sought assistance from Paul's neighbour, who reported her shock at the state of his home.
Safeguarding concerns were raised by AUKCIOS through the multi-agency safeguarding adults procedure. These concerns included identification of risks relating to the conditions in Paul's property, highlighting the presence of rancid food in the fridge and public health risks around the living room, which was the one room in the flat in which he lived. AUKCIOS noted that a bowl of faeces was found on the floor under his chair and that he was sleeping on the sofa. The AUKCIOS worker also questioned the fact that Paul stated he was paying for services for which he was not liable. Further concerns were raised about the general state of the living area, Paul not taking his medication and appearing grubby and unkempt. No personal care appeared to have been provided as part of his care and support plan.

Paul died twelve weeks after his care and support plan was put in place. There appeared to be no reviews of his care and support plan, no escalation of concerns, despite the significance of risks highlighted by the AUKCIOS worker and no apparent concern that Paul was showing some signs of self-neglect / neglect.

For these reasons, the Cornwall and Isles of Scilly Safeguarding Adults Board[4] decided to conduct a statutory Safeguarding Adults Review.

[3] Excerpt: Para 14.162 Care and Support Statutory Guidance (2016)

[4] https://www.cornwall.gov.uk/safeguardingadults

2.2 Safeguarding Adults Review: Overall Approach

This SAR was informed by analysis of:

- Agency chronologies of events, covering the period 01.01.2014 – 27.05.2016
- Agency Individual Management Reviews (IMRs)
- Discussions held at multi-agency Review Panel Meetings
- Consideration of information from the care services regulator, Care Quality Commission (CQC)
- Reflection on relevant legal duties and consideration of the efficacy of relevant agencies' adherence to those duties.

Even in the most difficult of circumstances there can be good practice; this SAR has sought to identify good practice as well as areas for development. Good practice is more than simply complying with expected standards of professional practice or legal requirements, but practice that has been considered to exceed those requirements. This review has identified significant areas of positive work that are reflected upon throughout this Review.

2.3 Review Principles, Hindsight and Positive Reflection

The primary purpose of this review is of learning lessons, it is therefore important that the Review is mindful of the application of hindsight; this comment in the Pemberton Domestic Homicide Review is applicable in any form of review, investigation or enquiry that has a scope over several years; "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[5]

Similarly, it is helpful to reflect on the statements contained in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[6]

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[5] A domestic homicide review into the deaths of Julia and William Pemberton, Walker,M. McGlade, M Gamble, J. November 2008 http://www.thamesvalley.police.uk/aboutus/crprev-domabu/crprev-domabu-whatdomabu/crprev-domabu-whatdomabu-howtvp/crprev-domabu-whatdomabu-howtvp-pemberton.htm (accessed 18.02.2016)

[6] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)

These principles have been borne in mind in the conduct of this Safeguarding Adults Review and in the writing of this Overview Report.

2.4 Agency Participation in the Safeguarding Adults Review

The following agencies participated in this SAR:

- University Hospitals Plymouth NHS Trust (UHP)
- South Western Ambulance Service NHS FoundationTrust (SWAST)
- Cornwall Partnership NHS Foundation Trust (CPFT)
- Cornwall Council Adult Social Care
- NHS Kernow Clinical Commissioning Group (CCG)
- Devon and Cornwall Police (DCP)
- A care agency
- Age UK Cornwall and Isles of Scilly (AUKCIoS)

2.5 Review considerations

The time period for the Review is from 01.01.2014 – 27.05.2016

This Review has focused its consideration on systems, decision-making and practice in Paul's circumstances by analysing the approach to safeguarding Paul in relation to each of the six safeguarding adults principles referred to in the Care and Support Statutory Guidance 2016:

1. Empowerment
2. Prevention
3. Protection
4. Proportionality
5. Partnership
6. Accountability

The Care and Support Statutory Guidance (2016) requires that all Safeguarding Adults Reviews should reflect consideration of these six principles[7]. This Review uses those principles to consider all aspects of Paul's experience and learning for Cornwall and Isles of Scilly SAB members.

[7] Care and Support Statutory Guidance (2016) Para: 14.166 '*SARs should reflect the 6 safeguarding principles'*.

CONTEXTUAL INFORMATION

3.1 Brief Timeline of Events

This brief timeline has been developed to provide key information about key events in Paul's life during the period under review (01.01.2014 – 27.05.2016)

Date	Event
28.05.2014	Paul started receiving support from community health services, particularly in relation to his need for ventilation support.
18.09.2014	Respiratory Service first visit to Paul.
September 2014	Paul referred himself to Cornwall Council ASC for '*proper help'* [8]
10.07.2015	The Community Matron from CPFT identified Paul's financial needs and referred him, with consent for advocacy support from AUKCIOS
21.07.2015	AUKCIOS Support Worker started visiting Paul.
07.08.2015	Respiratory health review undertaken, including consideration of the noise nuisance that was allegedly caused by the oxygen concentrator.
January 2016	Ms B, Paul's friend ceased support to him.
02.03.2016	Assessment of Paul's needs conducted by Cornwall Council Adult Social Care.
04.03.2016	Care Agency visited Paul for the first occasion as the start of the care package commissioned through Cornwall Council.
18.04.2016	Home Visit by Community Matron to review his respiratory condition; Paul *'still smoking in close proximity to the oxygen supply so advised, (as had been multiple times before)'*[9]. Telephone call made to Fire Service.
07.05.2016	The Care Agency contacted Adult Social Care Out of Hours Service and asked for permission to undertake an additional visit to Paul the following day, (a Sunday) to ensure he had, '*food, a drink and his urine bottle emptied*'. This was granted.
23.05.2016	The AUKCIOS UK worker expressed concern that Paul was not managing his medication effectively and that also that he was unwell. Joint visit with Community Matron arranged for 25.05.2016. Telephone call to the Care Agency to express concern.

[8] CC ASC IMR
[9] CPFT / AUKCIOS IMR

25.05.2016	Joint visit to Paul by AUKCIOS worker and CPFT Community Matron. Both expressed serious concern about the state of the room in which Paul living, including him defecating and urinating into a bucket / bottles, confused medication, using a dirty oxygen masks and eating mouldy, rancid food.
27.05.2016	AUKCIOS worker made a safeguarding adults referral as the manager of the Care Agency had not returned her call.
27.05.2016	Paul was found deceased by a care worker.

3.2 Paul's Health Needs

Paul had a number of health conditions at the time of his death:

- Anxiety and depression
- Chronic Obstructive Pulmonary Disease (COPD)
- Urinary continence difficulties

Paul was a tobacco cigarette smoker; impacting significantly on his breathing difficulties. While he had a history of alcohol misuse, he had stopped drinking alcohol.

3.3 Overview of Paul's care and support services

During the period under review, Paul received care and support from the agencies that are listed below, together with a summary of their role in respect of Paul and any additional relevant regulatory information, where available.

3.3.1. Care provision

Cornwall Council Adult Social Care commissioned the care agency to provide domiciliary care for Paul from 4th March 2016 onwards. The care package consisted of:

2 calls per day:

- 09.30 – 45 minutes
- Washing, showering, check fridge, make a snack, prompt meds, change bedding, make a snack for lunch
- 16.30 – 45 minutes
- Main meal and drink of Paul's choice
- 2 x hours 'domestic' at 18.30 every Tuesday and Thursday
- Cleaning flat, putting out rubbish, shopping, prescription collection, electric key money

The organisation was inspected by the Care Quality Commission (CQC) in January 2017 and was found to be unsatisfactory. The inspection summary read, '*During that inspection we found the service was failing to comply with Regulation 12 Safe care and treatment and Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to Regulation 12 Safe care and treatment, we found people's risk assessments did not identify and ensure risks were minimised. Staff administering medication and assisting people with their mobility had not always been trained to do so. Not all staff had been recruited robustly before commencing employment and some people did not receive visits at times they needed them*[10].'

By August 2017, when a further inspection was carried out by CQC, all concerns had been addressed, '*We found that all areas referred to in the warning notices had been addressed and Regulations 12 and 17 had been met…….All the people and relatives we spoke with told us they were very happy with the service. They felt safe and were very complimentary about their care workers and expressed confidence in the way the service was managed. Three people who had been out when we telephoned, phoned back because they wanted to record their appreciation. One person said, "I really hope they do well in the inspection. They certainly deserve top marks as far as I'm concerned!*"[11]'

3.3.2. CPFT Community Matron and Respiratory Service

Cornwall Partnership Foundation NHS Trust (CPFT) provides a wide range of services for the citizens of Cornwall. The CPFT website[12] advises that, 'Community matrons provide intensive support to people at home in order to help keep people well, help them improve their health and enjoy a good quality of life. They aim to prevent unplanned admissions or treatment or when a hospital admission is needed; to support a quick discharge'.

The Respiratory Nursing Service provides nurses who, '*assess and manage patients on oxygen therapy either in your own home or a community clinic: These clinics are run in conjunction with the Royal Cornwall Hospital and Derriford Hospital*'.

As noted previously, the services provided in the community were originally provided by Peninsula Healthcare and then after March 2016, by CPFT. The Foundation Trust is currently (02.02.2018) regarded as 'requiring improvement' by CQC[13]. The CQC noted, "*We rated Cornwall Partnerships NHS Foundation Trust as Good when we last inspected it. Since that time, the trust has acquired community services previously provided by Peninsula Community Health Community Interest Company. We recognise that it can be difficult to take on new services in this way.*"

Paul received Community Nursing and Respiratory Nursing Support at home during the period under review.

[12] https://www.cornwallft.nhs.uk/ accessed 05.10.2018

3.3.3 Devon & Cornwall Police

Devon and Cornwall Police is the territorial police force responsible for policing the counties of Devon and Cornwall, including the unitary authority areas of Plymouth, Torbay and the Isles of Scilly. The geographical area covered is the largest for any police force in England, and the fifth largest in the United Kingdom. The total resident population of the force area is approximately 1.5 million, with around 11 million visitors annually.

Paul had extensive contact with Police as both a victim and perpetrator of crime in his younger years, but in the period under review, he had four contacts, including the notice of his death. Two related to the disputes with his neighbour and another involved the RSPCA and allegations that were not concluded about him keeping poultry in a shed in poor conditions.

3.3.4 AUKCIOS

AUKCIOS provides a wide range of support services and activities for older people[14]. Of these, Paul received a service from the Home Support Team and from the benefits Advice Service.

3.3.5 Cornwall Council: Adult Social Care

Adult Social Care is provided by the Council in Cornwall. ASC provides support for adults with social care needs and assists them to find care and support so they can live as independently as possible in their own homes. This includes older people, people with physical disabilities or learning disabilities, and mental health service users.

Paul received services from Adult Social Care, which conducted an assessment of his needs and commissioned home care support to meet those needs. He also had concerns about neglect and self-neglect referred into the multi-agency safeguarding adults procedures, of which Adult Social Care is the statutory lead agency.

3.3.6 Cornwall Council Housing and Anti-Social Behaviour Service

Paul had been a local authority tenant for many years. He lived in a first floor flat and had difficulties with his neighbours with claims and counter-claims of anti-social behaviour. However, he was clear that he did not wish to move and liked living there[15], although he was on a housing list for relocation. Paul received extensive support with the concerns regarding anti-social behaviour and his neighbour disputes from his Housing Officer.

Local Authority Housing in Cornwall is managed through Cornwall Housing Ltd.[16]

3.3.7 GP Surgery

[14] https://www.ageuk.org.uk/cornwall/ accessed 06.10.2018
[15] AUKCIOS IMR
[16] https://www.cornwallhousing.org.uk/about-cornwall-housing/

Paul's GP surgery was based in Cornwall. The practice provides a service to approximately 8,800 patients of a diverse age group with a larger than national average population of patients over the age of 54. The surgery is currently rated as '*outstanding*' by the Care Quality Commission (CQC) following an inspection in July 2018, and was rated as '*good*' in 2015, at its previous inspection.

Paul received his medication via the surgery, which was delivered to his home and he saw his doctor on several occasions during the period under review.

3.4 Relevant information about agency structures

Community healthcare was provided by X Community Health until 1st April 2016, when X ceased delivery of those services and responsibility was moved to Cornwall Partnership NHS Foundation Trust (CPFT).

ANALYSIS: PAUL'S EXPERIENCE - SIX SAFEGUARDING ADULTS PRINCIPLES

4.1 Empowerment

The Care and Support Statutory Guidance that accompanies the Care Act 2014 defines 'empowerment' to mean, 'People being supported and encouraged to make their own decisions and informed consent'[17]. Further it is a significant element of the Act's requirement that all services working with adults with care and support needs should be empowering them to achieve their own wellbeing, focusing on the outcomes that they wish to achieve. The Review has therefore considered how Paul's needs were assessed and met and the overall approach of agencies to him as a person.

Assessment of needs

Local authorities must ensure that care and support needs assessment under the Care Act 2014 focuses on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve in their day-to-day life. The Care Act 2014 states that,

'*Care and support needs assessments should:*

- *involve the person and their carers in discussions and decisions about their care and support*
- *take into account the person's personal history and life story*
- *take a whole family approach*
- *take into account the needs of carers*
- *take into account the person's housing status, and where and who they want to live with*
- *be aimed at promoting their interests and independence*
- *be respectful of their dignity*
- *be transparent in terms of letting people and their families and carers know how, when and why decisions are made*
- *take into account the potential negative effect of social isolation on people's health and wellbeing'.* [18]

Cornwall Council Adult Social Care advises that when a needs assessment is undertaken the following will be considered:

'*Social care needs will be based on things you may need help with, such as:*

- *Making sure you eat well*
- *Looking after yourself*
- *Being able to move around your home*
- *Being able to look after your home*

[17] Paragraph 14.13 Care and Support Statutory Guidance 2016 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[18] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- *Having contact with family and friends*
- *Being able to access other community activities, such as work opportunities or education*
- *Emotional wellbeing and mental health*
- *Other caring responsibilities you may have*
- *Supporting your family and friends to care for you'*[19]

This Review has considered how well Paul's needs were assessed in line with this statutory duty and in line with the Council's commitments by setting out what has been found from information provided to the review within a simple table below. However, it should be noted that some the information provided to the review by Adult Social Care is limited about activity with Paul prior to 2016 and some, by its own admission is vague due to structural changes and the '*passage of time*'[20].

Care Act 2014 Duty	**Information received by the Review about the assessment**
Care and support needs assessments should:	
• *involve the person and their carers in discussions and decisions about their care and support*	There is no evidence that Paul was effectively involved in the assessment of need that took place on 2nd March 2016. It is this assessment that resulted in the care package provided. Please note the comments below regarding the statutory duty to provide advocacy support for people who experience '*substantial difficulty*' in participating in an assessment.
• *take into account the person's personal history and life story*	Given the paucity of information about Paul's life, other than that provided through the Police National Computer (PNC), it is likely that this was not taken into account at the time.
• *take a whole family approach*	Paul's estrangement from his family made this not possible.
• *take into account the needs of carers*	Paul's informal carer, his friend who had supported with shopping etc. for many years ceased that role at this stage, hence the referral to ASC. It would have been good practice to seek permission to talk to her

[19] Cornwall Council: https://www.supportincornwall.org.uk/kb5/cornwall/directory/advice.page?id=3bRx4nWPnlE accessed 17:33 04.10.2018

[20] ASC IMR

Care Act 2014 Duty	Information received by the Review about the assessment
	and establish whether there was scope for her to remain involved with the additional help that was being provided by the commissioned care package. Paul was identified as experiencing isolation and loneliness and supporting the reparation of this long standing relationship would have met his need for social contact.
• *take into account the person's housing status, and where and who they want to live with*	Paul stated he wanted to remain in his flat, but it was regarded as unsuitable and he was in fact on the housing list for relocation. It is unclear whether this information was considered as part of the assessment. There is no evidence that Paul's disputes with his neighbours were considered as part of the needs assessment.
• *be aimed at promoting their interests and independence*	Paul's care package was a suite of care aimed at providing him with shopping, food, home maintenance and personal care. There was no evident consideration of means of enhancing his independence.
• *be respectful of their dignity*	Paul's life was not dignified and there is no evidence that the assessment considered this challenge.
• *be transparent in terms of letting people and their families and carers know how, when and why decisions are made*	It not known how information was provided to Paul about the outcome of the needs assessment or indeed, if so, how we he was able to understand it, given his limited literacy.
• *take into account the potential negative effect of social isolation on people's health and wellbeing'.* [21]	As noted above, Paul was very isolated, he was lonely and described variously by the Community Matron and his AUKCIOS Worker as being *'down and depressed'*. There is no evidence offered to the review, nor that can be seen in the detail of the care package provided that this was considered in terms of Paul's wellbeing.

Cornwall Council ASC commitment:	Information received by the Review about the assessment
Social care needs will be based on things you may need help with, such as:	

[21] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Cornwall Council ASC commitment:	Information received by the Review about the assessment
• *Making sure you eat well*	Paul's care package was aimed at ensuring that he ate well; this was the purpose of the meal provision in the evening and at lunchtime.
• *Looking after yourself*	This part of the care package was the twice daily support with personal care.
• *Being able to move around your home*	Paul lived largely at the time of the assessment, and entirely by the time of his death in his living room. The ASC IMR notes that the assessment conducted on 2nd March 2016 noted that Paul did not enter his kitchen, and rarely his bathroom, yet the support plan that was derived from assessment required the care workers to tidy kitchen and bathroom, indicating a plan that bore little resemblance to the daily experience of Paul. It should be noted that when he died, the kitchen was, according to his neighbour who was appalled by the state of his main living room, '*immaculate*[22]'.
• *Being able to look after your home*	Paul's home was in a poor state; while it was exacerbated as he became frailer over the next twelve weeks up to his death, there is no question that it was not in a good state of cleanliness/hygiene at this point. For this reason, the assessment resulted in the care agency providing support around cleaning his home. The challenge was that Paul rarely allowed this; a factor that could, on the basis of information provided to this Review, have been predicted. There is no information about consideration of this risk when the assessment was undertaken, and contingency planning or proposals for addressing the risk.
• *Having contact with family and friends*	Paul was reportedly estranged from his family; it is not known to this Review whether or not Paul's relationship with his daughter was explored, but it seems unlikely, given the other issues that were not considered.
• *Being able to access other community activities, such as work opportunities or education*	Paul advised the AUKCIOS worker in March 2016 that he had not left the property for twelve months; there is no reason to imagine that he did not tell this to the ASC care coordinator. If he did, there is no evidence that it was considered an area of concern.

[22] ASC SAR Referral

Cornwall Council ASC commitment:	Information received by the Review about the assessment
• *Emotional wellbeing and mental health*	Paul was variously described by a range of professionals as being 'depressed' 'anxious' and 'down'. This was not new information; there is no understanding of this within the assessment process it appears to the Review.
• *Other caring responsibilities you may have*	N/A
• *Supporting your family and friends to care for you'*	As noted previously in consideration of the Care Act assessment duties, it would have been good practice to address Paul's loneliness and his former friendship with Ms B, but this did not take place.

The Care Act 2014 places a duty on local authorities (and those who have delegated responsibility) to' *promote a person's well-being'*. The Care and Support Statutory Guidance (2014)[23] advises that a number of principles must be adhered to when supporting a person. These include:

'*The individual's views, wishes, feelings and beliefs. Considering the person's views and wishes is critical to a person-centred system. ……Where particular views, feelings or beliefs (including religious beliefs) impact on the choices that a person may wish to make about their care, these should be taken into account'*.

In considering Paul's wishes and feelings, it is important to consider what is known about these. It is sadly true that information from agencies provided for this Review tells us very little about Paul himself. All that can be gleaned is the following:

- He liked a hot, cooked meal;
- He wanted to be clean and have a shower or a bath;
- He preferred to take things at his own pace, talking on several occasions about his dislike at being '*rushed by carers*'[24];
- To be helped with paperwork; he found bills and papers a challenge[25];
- To carry on driving; Paul advised the Community Matron on 11.07.2014 that he did not want medication for '*feeling very low, depressed and fed up' because he wanted to carry on driving*[26]

[23] Para 1.14 (b) Care and Support Statutory Guidance 2014
[24] Cornwall Partnership NHS Foundation Trust IMR
[25] Cornwall Partnership NHS Foundation Trust IMR

- His own bed to sleep in

There is no evidence that Paul enjoyed living as he did, nor that he wanted to die in what his neighbour described after his death as being such an *'undignified'* way[27].

Paul's mental health was not stable and he himself told the AUKCIOS worker at his first assessment visit in May 2016 that he experienced anxiety and depression. At the same visit he described his own 'goals' to be to, '*get out of the house and improve his quality of life*[28]'. As noted previously, he also described his mental health problems to the Community Matron at her visit in July 2016.

The assessment completed by the AUKCIOS worker sets out Paul's wishes and feelings in a person-focused way. The assessment describes how he feels about his situation and focuses on what his aspirations were, together with the proposed means for achieving them. The assessment is an example of good, person-centred practice.

It seems from the information provided to this Review that Paul did not disclose the level of anxiety and depressions that he discussed with the AUKCIOS worker to his GP. His GP reported to the review that he had developed anxiety '*secondary to a complicated court case*[29]*'* only in a period in 2013 – 14 and his other presentations focused on his increasingly challenging physical respiratory health problems.

As noted by Paul's GP, his mental health difficulties were related to the problems he experienced with his neighbours. These difficulties were exacerbated, Cornwall Housing's worker said when interviewed for this Review, by the *'intense level of scrutiny and criticism by his neighbours'.*[30] Paul's Housing Worker who had responsibility for dealing with the neighbourhood dispute was, despite his '*argumentative nature'* and frequent swearing and shouting understanding that his poor literacy placed him at a distinct disadvantage to his owner occupier neighbours. She tried to help him resolve the disputes, providing him with headphones so his could hear his television without neighbours complaining of noise. She also responded with compassion to his declining mental and physical ill health, which she identified as becoming worse from February 2016 onwards.

The Care Act 2014 advises that where a person, '*has substantial difficulty'* taking part in care and support planning[31] they must have support of an advocate.

The Care Act defines four areas, in any one of which, substantial difficulty might be found. These are:

- understanding relevant information
- retaining information
- using or weighing up the information (as part of being involved in the key process)
- communicating their views, wishes and feelings.

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[26] Cornwall Partnership NHS Foundation Trust Chronology
[27] Social Worker records Cornwall
[28] AUKCIOS record 16.05.2016
[29] GP Practice single agency report
[30] Cornwall Housing Interview Summary
[31] Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

This is not the same as a person lacking mental capacity to make relevant decisions as in the Mental Capacity Act (2005), it is broader and is necessary to enable someone with circumstances like those of Paul to participate in an assessment effectively; it is not about their cognitive (in)ability, but about a range of factors that hinder a person's ability to participate fully in the assessment process. This is the way in which someone like Paul is enabled to express his views and ensure the assessment focuses on his wellbeing, wishes and feelings.

Paul had a reputation; he was known to be challenging, (housing services referred staff in pairs to visit him because swore a lot) and he was known to be reluctant to accept services; although he was not entirely unwilling, as is shown by the fact he accepted home care services, a safe key system, regular visits from the Community Matron. In fact, this was not a man who totally refused to engage; this was a man who was anxious and scared. Certainly the four areas of '*substantial difficulty*' could all have been applicable to Paul. However, there is no evidence that Paul was provided with an advocate in line with the statutory duty on local authorities. Paul was provided prior to the assessment with an advocate at the request of the Living Well Service, but this was for benefits advice, not support during an assessment and the advocate did not provide support because that was not their role and they had not been asked to do so by the local authority.

The report of Paul's main carer from the care agency shows a level of personalised care that is entirely what is hoped for by the aspirations set out in the Care and Support statutory guidance; she described cutting his hair only at the point where he decided he, '*wanted it cut and was happier*'[32].

However, the agency for whom she worked has provided information to this Review that reveals in its tone and use of language an inappropriate approach to working with people; it refers throughout both the agency's chronology and report to Paul solely by his family name with no prefix or title; for example, were Paul's family name to be 'Smith', a sentence reads in the care agency's Individual Management Review as, *'[Smith] often declines to change his clothes….[Smith] does not, like food being taken out of his fridge'* . This reads as disrespectful and dehumanizing. It leads the Review to question the organisational culture of a service for adults with care and support needs that considers this appropriate language and it is far from empowering.

4.2 Prevention and Protection

The Care and Support Statutory Guidance defines 'prevention' as, '*It is better to take action before harm occurs*'[33]. Protection is defined as, '*Support and representation for those in greatest need*'.

The needs assessment conducted by the local authority has been analysed in earlier parts of this report. It has been shown that the assessment was focused on provision of service from the service 'menu' rather than considering Paul's needs and the prevention of harm. The

[32] Care agency IMR

[33] Paragraph 14.13 Care and Support Statutory Guidance 2016

Care and Support Statutory Guidance describes the duty on local authorities to have an outcomes-based approach to care and support that, '*should emphasise prevention, enablement, ways of reducing loneliness and social isolation and promotion of independence as ways of achieving and exceeding desired outcomes, as well as choice in how people's needs are met'*[34].

Cornwall Adult Social Care has highlighted[35] that Paul was referred for support from the local authority in January, April and May 2014. He declined help on the first two occasions, but the third was initiated by him and he therefore accepted an assessment of needs. This assessment concluded, using Fair Access to Care Services[36] criteria that he had 'moderate' needs. At that time Cornwall was operating a support threshold of '*critical and substantial need'* and he therefore did not meet the criteria for support. Adult Social Care has noted that this assessment did not take into account the concerns of other agencies who had made the previous referrals, (Paul's GP, Housing Worker and the Early Intervention Service) and did not consider undertaking a risk assessment before deciding that Paul did not meet the criteria. This was a missed opportunity to prevent harm.

The CPFT Community Matron team treated Paul from July 2014 and all its matrons had a clear focus on prevention of harm. Of particular concern, understandably was the significant risk posed by Paul continuing to smoke while using oxygen therapy. Community matrons spent considerable time trying persuade Paul not to use the oxygen when smoking. For example, on 23rd July 2014, it is recorded, '*discussed risks associated with oxygen, takes oxygen [mask] off but leaves it switched on. I have advised this practice must stop immediately and he must switch oxygen off otherwise a high risk off ignition*'[37]. This is a theme of the Community Matron Team's recording on each visit to Paul; a year later on 9th July 2015, it is recorded that, '*he is fully aware of the risk associated with smoking and using oxygen*'. There followed a gap in visits from the Community Matron to Paul On 18th April 2016, it is recorded that, '*Paul is smoking, when asked if he isolates his oxygen supply, he says he takes it off but it is not switched off as the concentrator is in another room, there is an oxygen cylinder in the room where he smokes'*. At this point the Community Matron proposed involving Cornwall Fire and Rescue Service and Paul consented. This was 21 months after the first identification of this significant risk of harm. While there is no doubt that the referral to a Fire Safety Officer was good practice, the fact that it took so long to do so, given the significance of the fire risk is concerning.

The British Lung Foundation states that, '*You should never smoke, including e-cigarettes, when using oxygen. The carbon monoxide in the smoke reduces the amount of oxygen that your blood can carry around your body. This makes the oxygen therapy ineffective. Oxygen also helps combustion, so it is vital that there is no smoking around oxygen. There is a risk of facial burns and house fires if you or someone else smokes in your home when the oxygen supply is turned on. If you continue to smoke while using oxygen, a risk assessment and a*

[34] Paragraph 4.13 Care and Support Statutory Guidance 2016
[35] Adult Social Care Individual Management Review
[36] Fair Access to Care Services Statutory Guidance 2003
[37] CPFT Chronology

medical review will be undertaken. It might be appropriate to withhold or withdraw oxygen therapy because of public safety or risk to others'[38].

The point raised about the public safety risk to others was especially relevant to Paul's neighbours who lived below his flat. However, there is no indication that a risk assessment was undertaken that considered this risk as well as those to Paul himself.

Paul described on many occasions the harm he felt he was experiencing as a result of the dispute with his neighbours. While this is seen by Paul's Housing Officer as being a dispute where both parties behaved in a way that made it intractable and beyond mediation, she also highlights the differences between them in terms of vulnerability and residential status, commenting that, '*the neighbours complained through many channels about him……..but due to his limited literacy, he could not complaint the same way [they] could'*[39]. The situation escalated beyond a 'neighbour dispute' to, according to Devon and Cornwall Police[40], reports of eggs being thrown at Paul's door, his locks being glued, sending a letter which Paul felt to be threatening. His Housing Officer noted that he declined in early 2016, visiting him in February and finding him to be '*frail and crying*'. She had the impression; she advised in interview for this Review, that he was feeling, '*very alone and defeated*'.
Devon and Cornwall Police have reflected for this Review on whether criminal action should have been taken against the neighbours and concluded not. However, they have not reflected on whether a safeguarding adults concern should have been raised in line with multi-agency procedures.

Cornwall Partnership Foundation Trust (CPFT) has also reflected on its services' contact with Paul and knowledge of the distress he was caused by his dispute with his neighbours and by their actions towards him. The author of the CPFT Individual Management Review comments that an early conversation could have been held with the local authority Adult Safeguarding Team and although there was a risk of him disengaging, this would have been good practice and could have allowed for multi-agency consideration of the range of risks, including those resulting from the dispute with his neighbours that Paul faced.

The Community Matron Team knew of the dispute between Paul and his neighbours and the impact upon him. The CPFT Individual Management Review comments that it was considered unnecessary to make a safeguarding adults referral about the matter because, '*Police were aware…and it was already being investigated by housing'. '*[41]. However, although both Police and Cornwall Housing were aware, neither was proposing the risks and harm be considered under multi-agency safeguarding adults procedures.

The Care Agency workers were very aware of the difficulties that Paul was experiencing from his neighbour; they were visiting him daily and he was vocal about the problems and his own distress. However, the Agency is clear in its Individual Management Review that

[38] British Lung Foundation https://www.blf.org.uk/support-for-you/oxygen/life-with-oxygen [accessed 21.10.2018]
[39] Cornwall Housing Record of Interview of Housing Officer
[40] Devon and Cornwall Police Individual Management Review
[41] CPFT Individual Management Review

there were, no safeguarding concerns, '*while he was alive'*[42]. However, on 29th March 2016, the care agency contacted the local authority Care Brokerage Team and reported him being distressed by neighbour complaints about his oxygen pump noise to the extent that he had stopped eating[43]. This is described in the Adult Social Care chronology where it is recorded as being '*good practice'*. However, the Review considers that this should have been expected practice and should have been raised through the safeguarding adults procedures. Again on 25th April, the Agency contacted the Adult Social Care Brokerage Team and stated that he had, '*received a threatening letter……they noticed his front door locks have been forced'.* This was not referred by the Agency into safeguarding adults procedures and was not interpreted as such by the local authority. In fact, all that happened, it seems is that the letter was saved on the electronic recording system and forwarded to Cornwall Housing. However, while Cornwall Housing was extensively involved in supporting and assisting Paul during this period, this letter is not referenced in its comprehensive chronology, indicating it was possibly not received. This was a missed opportunity to raise a safeguarding concern.

The response to this issue by agencies in contact with Paul indicates a deficiency of understanding of the Cornwall and Isles of Scilly SAB multi-agency safeguarding adults procedures and of their respective responsibilities.

Paul received extensive support from the Cornwall Housing Officer who, as noted previously, had a compassionate and sensitive understating of his difficulties and challenges. The Enforcement Team in which she worked with him to prevent harm, providing headphones to reduce the noise level experienced by his neighbours and in February 2016 referring him to Adult Social Care for support. It was this referral that resulted in an assessment of his needs and the provision of care through the appointed care agency.

AUKCIOS provided Paul with an advocate following a referral for support with claiming benefits in July 2015. He received a consistent prevention service from AUKCIOS from that date forward, receiving visits from a staff member and a volunteer from then until his death in May 2016. AUKCIOS has detailed the contacts that the staff member made with other services in an effort to provide him with care and support and prevent harm[44]. These are as follows:

- *'Early Interventions Service – 26.8.15*
- *Community Matron – 8.9.15*
- *Local Breathers Group – 18.9.15*
- *Respiratory Team – 2.11.15*
- *Air Liquide – 2.11.15*
- *Access Team – 12.1.16*
- *GP Surgery – 7.3.16*
- *Care Agency – 6.5.16'*

[42] Care Agency Individual Management Review
[43] Adult Social Care Timeline of Significant Events
[44] AUKCIOS Individual Management Review

The AUKCIOS staff member became increasingly concerned about Paul's wellbeing as his health deteriorated. On 5th May 2016, the AUKCIOS worker visited Paul and was very concerned about his situation, describing him as, despite his care package, sitting in a duvet covered in faeces, with 'rancid' food in the fridge and being, very unwell, unkempt and dirty. The AUKCIOS worker raised this with the Adult Social Care Rapid Response Team, whose role is to, '*provide immediate response and intervention to a social care crisis where there is a risk of admission to a care setting or where a significant increase in current support is required*'[45].

The manager advised her to speak with the care agency about her concerns. This she did the following day, questioning the care agency about their duty of care to Paul and their responsibility to call for medical assistance or report concerns to the local authority if he was unwell. It is recorded by the care agency[46] that the owner of the agency would call the AUKCIOS worker to discuss the concerns and this call took place; the agency reportedly agreed to meet with Paul and the AUKCIOS worker the following week. The Rapid Response Team visited Paul on 10th May 2016 and also met with the care worker from the care agency while they provided care to him. The result of this meeting was the agency being asked to follow the care plan more consistently and to bring forward a review of Paul's care. The Rapid Response worker noted that Paul had, '*declined a commode, he currently uses a bucket and a milk bottle*[47]'. It does not appear that using a bucket and milk bottle for elimination purposes was considered to be of any concern to neither the Adult Social Care team nor the agency and no action was taken to address this health risk or to protect Paul or others entering his home. The visit was concluded with a suggestion that Paul's care review '*might be brought forward*'. This did not take place because he died 17 days later.

The AUKCIOS service worked diligently with the Community Matron Team and on 24th May 2016, following several telephone discussions expressing concern about his wellbeing, the AUKCIOS worker, who remained very concerned, proposed a joint visit to Paul.

Both the AUKCIOS worker and the Community Matron were disturbed by the condition in which they found Paul, describing him as having a bowl of faeces under his chair, being confused about his medication, finding food dating back to 2013 in his fridge and describing him as, '*grubby and unkempt*'[48]. They both washed and supported Paul, throwing away a, '*huge bag of food*'. Paul told them both that he had not ever had a shower, despite this being part of his care plan and his shopping had not been done by the agency as required. As a result of this visit, it was agreed that the AUKCIOS worker would speak to the care agency again.
This call took place and was recorded by the care agency as follows[49]:
'*AUKCIOS called, she has attended P's home along with the Community Matron. They have got rid of a bin bag full of old food going back to end by dates of last year from his fridge, freezer and cupboards. They noticed (and disposed of) foods that were supposed to be*

[45] Cornwall Council https://www.cornwall.gov.uk/jobs-and-careers/work-in-social-care/adult-social-worker-careers/our-teams/ (accessed 25.10.2018]
[46] Care agency Chronology
[47] Care agency Chronology
[48] AUKCIOS Individual Management Review
[49] Care agency Chronology

frozen until cooked that had been left to thaw in the fridge. They have left 4 oxygen masks in the sink to soak. [AUKCIOS] said that carers really need to concentrate on managing P's shopping, as he has a lot of repeat foods in and ones that are going out of date, with this, carers need to use up food that is close to use by date before using new food. Nothing had been recorded in the care plan to say that any personal care had been offered, even if he declines, this needs to be done'.

The following day, 25th May, it was recorded by the care agency that,

'[Agency owners] informed of above. [Agency owner] said to draw up a food stock check form for the new care plan, and she will have [Agency owner] do the new care plan. Carers have been informed of what has been picked up and reminded of what they need to do and to remain vigilant. Asked [Care worker] to call office to clarify what we do shopping wise for him. Spoke to [care worker], she explained that a lot of the time, P will give her a list, she will check his stock and inform him that he already has said items/freezer is full etc, to which P becomes very agitated and rude towards her, [Care worker] said there is no arguing with him sometime so she ends up buying what he has asked for as she is worried about making him angry. I informed [Agency owner] and advised [Care worker] to record every time this happens so anyone looking into these things are in the know'.

It appears from this recording that the primary concern of the agency was avoidance of criticism at any later date. There appears little effort to modify the approach to enable a better relationship and service to Paul, nor any recognition of the less than optimal service for which it was commissioned, and consideration of Paul's wellbeing.

Two days later, the care agency had not responded to the AUKCIOS worker as required and showing tenacity for ensuring Paul's protection from harm, the AUKCIOS worker raised a safeguarding adults concern under the Cornwall and Isles of Scilly multi-agency safeguarding adults procedures. The same day, Paul was found deceased in his home.

Adult Social Care was unaware of Paul's death and appointed a social worker to visit Paul and conduct an enquiry in line with safeguarding procedures. She visited him at home on 31st May, having been unable to gain contact by telephone. When there, she met his neighbour, (with whom he had been in dispute for many years) who advised of his death, but also expressed shock at the state of his home and stated, '*although he was awkward and refused to work with carers, she still felt he died an undignified death*[50]*'*.

It is of concern that it took so long for a safeguarding adults concern to be raised about Paul's welfare; this Review has identified him experiencing distress from the dispute he had experienced from his neighbours and physical harm from the environmental circumstances that were not reported by the care agency commissioned to support him.

This Review has seen extensive reference to Paul's self-neglect in Individual Management Reviews and chronologies. Self-neglect is defined in the Care and Support Statutory

[50] ASC Chronology

Guidance as being about, *'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding*[51]*'*.

Paul's refusal of care and his lack of concern about the lack of hygiene in his environment suggests his circumstances meet this definition.

4.3 Proportionality and Partnership

The proportionality of agencies' responses to the clear risks of harm experienced by Paul has been identified as being too low. Risk enablement involves supporting individuals to identify and assess their own risks and then facilitating them to take the risks they choose; this was achieved for Paul by three different services who supported him.

The Community Matron Team identified risks of in relation to Paul throwing his door keys out of the window for anybody seeking access. She carefully discussed this with him and he agreed to a key safe.

The Housing Worker also identified risks for Paul in terms of his general wellbeing. In February 2016, she identified him as being, '*frail …….feeling alone and defeated*[52] and persuaded him to agree to a referral for care and support from Adult Social Care.

The worker from AUKCIOS worked sensitively and compassionately with Paul. She clearly identified the risks of his home environment and of the poor standard of care he was receiving from the care agency. Despite the lack of support from other agencies, she kept raising concerns. Regrettably when the concerns were finally acted upon, it was too late for Paul.

The person-centred approach in health and social care tries to involve the individual in the planning of their care and support and consideration of their own risk as much as possible; as this Review identified earlier in this report Paul was not empowered by a number of agencies, he had little or no involvement in his needs assessment and there was a consequent lack of effective risk assessment and management.

Partnership is key to effective safeguarding work. Multi-agency responses to addressing risk and harm enable a multi-disciplinary approach that involves a wide range of knowledge and expertise provides for achieving the best outcomes for people. This is particularly the case when individuals are at risk, apparently have capacity to make relevant decisions and are making unwise ones.

The agencies that were most involved in providing care and support to Paul were Adult Social Care, the care agency, Cornwall Housing, the Community Matron Team through CPFT and AUKCIOS. The Review has noted previously the actions of these agencies in empowering Paul, preventing harm and protecting him from harm. The Review has identified a high standard of partnership working between AUKCIOS and the Community Matron Team; the two worked together to a high standard and towards the conclusion of Paul's life were

[51] Care and Support Statutory Guidance 2016
[52] Cornwall Housing: Record of Interview

effectively joint case working. However, there is little evidence of partnership working elsewhere. It is striking that when the worker from AUKCIOS contacted the Adult Social Care Rapid Response Team, she was advised to contact the care agency herself, despite having done so on a previous occasion two weeks before and been effectively ignored. Adult Social Care defaulted their responsibility to pursue the care agency and request urgent action.

The Review has gained a sense of the AUKCIOS worker filling the gaps left by other, statutory agencies and working (with the exception of the Community Matron Team) in total isolation. The Review has no doubt that this was stressful for that practitioner and further, unhelpful to Paul.

4.4 Accountability

Paul is described by his GP[53] on 14th April 2016 as having capacity to decide not to attend hospital with his exacerbated Chronic Obstructive Pulmonary Disease symptoms. Given his COPD and noted occasional confusion a formal assessment of capacity may have been reasonable. Adult Social Care highlighted in its Individual Management Review that there was a lack of '*consideration of capacity, not even implied let alone specified and recorded*' in its systems and identifies it as an area for development.

Paul was a person who was not keen to accept services, (although he did do so on several occasions and also sought out support himself), and if his decline of services was accepted because he had mental capacity to do so, that reasoning required far greater explanation in agencies' recording. Defensible decision-making, where decisions are explained in terms of the scope of information considered, the reasoning behind the thinking and the 'adding up' to reach a conclusion is essential when working to support people in circumstances such as those of Paul. The care agency stated in its Individual Management Review submission to this Review that, '*he was very private, although he was neglecting himself, there was physically nothing the carers could do without going against his will'*. There is no reference to the requirements of the Mental Capacity Act (2005) in any of the reports received, nor consideration of whether those decisions albeit 'unwise' should have been potentially challenged by a formal assessment of mental capacity. This is replicated throughout agencies' contact with Paul, with the exception, as highlighted before, of his GP. It is also concerning that the care agency did not seek support from the local authority in responding to Paul's apparent rejection of services. That said, when the Adult Social Care Rapid Response service visited Paul with the care agency 17 days before his death, his use of bottles and a bucket for toileting was noted and his rejection of personal care acknowledged, with no apparent sense of concern. It is essential that agencies working with people who are at risk of harm yet reject services receive on-going support to understand and address, with the person, the risks they will encounter as a result of that decision.

[53] GP Individual Management Review

FINDINGS

Paul was clearly, from the information provided to this Review, a man who had well-defined views and who could be, in the words of his Housing Officer, *'feisty and up to a challenge*[54]*'*. He was embroiled in a dispute with his neighbour that escalated, he had mental health problems, experiencing anxiety and depression and his physical health deteriorated significantly over the last year of his life. His physical ill health, the symptoms of which were largely related to his respiratory problems had an increasingly detrimental effect on his day-to-day wellbeing and Paul grew more depressed as his physical health deteriorated. There is no evidence that there was any consideration of the inter-play between his anxiety and physical wellbeing and this indicates a lack of professional curiosity. With the exception of the worker from AUKCIOS, the Review has not seen any evidence of agencies considering why he was angry, why he shouted and further how this might be ameliorated to enable a conversation about risk and services that could address them.

The other concern for this Review in respect of Paul's capacity to make relevant decisions (assuming this was considered, but not recorded) is his decline in health, particularly his health in respect of his intake of oxygen and his increasing frailty.

The Review has seen a lack of consideration of Paul's dignity; this was exemplified by the care agency's use of simply his family name throughout the IMR and only serves to suggest a lack of respect for Paul.

The Review has identified a significant lack of partnership working throughout Paul's contact with agencies. There does not seem to have been a concern about sharing information, simply a lack of impetus for doing so. This can only lead to a conclusion that his 'feistiness' and refusal services influenced that impetus.

The Review reports an absence of joined up working in supporting Paul. Even though a safeguarding adults concern was raised the day prior to his death, the local authority did not seek to involve those agencies that knew Paul in consideration of risk and instead chose to focus solely on consideration of the agency's development and practice concerns; the entire focus was on the provider's failures, not on Paul's experiences.

There has been reference throughout this Review about self-neglect, but really it appears that Paul was not provided with optimal care by the care agency commissioned to support him and also by statutory agencies, in particular, the local authority. In hindsight, it is clear that Paul would accept help if it was offered in a way that suited him; the challenge for services was to work out what that was. The AUKCIOS worker and Community Matron did so, as did some frontline care workers.

Good practice in working with people focuses on understanding people's personalities, their histories, their likes and dislikes; this is what was incumbent on those services that worked with Paul.

[54] Cornwall Housing Record of Interview

In conclusion, the Review has found that Paul received an empowering and personalised response from individual practitioners from AUKCIOS, the Community Nursing Service, Cornwall Housing and one member of home care staff at the care agency. However, the organisational response to him from the statutory local authority Adult Social Care department and the care agency it commissioned to provide him with care and support did not achieve his empowerment, nor provide him with a personalised service that safeguarded his welfare nor his dignity.

LEARNING THEMES

- Quality safeguarding supervision – enabling reflective practice
- Risk assessment and management – frontline staff in direct care services having a consistent understanding of risk and a clear framework for response.
- Partnership working – valuing different agencies' knowledge and expertise and bringing these together in a multi-agency forum
- Focus on the person and require commissioned services to do – use the 'three conversation model approach recently espoused in Cornwall[55] where the approach to assessment is about having a 'conversation' based on what the person wants to address and change rather than what the system needs to know.

[55] https://lynromeo.blog.gov.uk/2017/12/04/the-future-of-adult-social-care-in-cornwall/

CONCLUSION

Lyn Romeo, Chief Social Worker has described the 'three conversations' approach to assessment that is now being followed in Cornwall Adult Social Care as providing a far greater level of strengths-based, restorative and personalised social care that would, without a doubt have impacted upon Paul in a significantly more positive way. As Ms Romeo comments in her fourth annual report[56], '*Care and support arrangements are worked out with and led by people themselves – there is no better way'.*

[56] https://lynromeo.blog.gov.uk/2018/03/20/from-strength-to-strength-on-world-social-work-day/

RECOMMENDATIONS

Recommendation	Agency Responsible	Method
Individuals who are reported to exhibit reluctance to co-operate with care, challenging behaviour and signs of self-neglect should be offered multi-disciplinary case conferences on a regular basis.	Adult Social care and other agencies	Case conference
An audit of individuals meeting the criteria above should be conducted to establish the resource required to provide optimal care to these individuals.	Adult Social Care and other agencies	Audit
The SAB should seek assurance that agencies are fully equipped to offer care and support for individuals who self neglect and are reluctant to cooperate with health and care agencies.	SAB	Audit and peer support
The SAB may wish to develop a task and finish group to establish if there are effective care pathways for individuals who self neglect and this group should also consider the interface with Mental capacity.	SAB	Task and Finish Group
The SAB should seek assurance that all agencies commissioning care provider services should check whether there are adequate quality assurance mechanisms in place to enable speedy withdrawal of contract should quality markers fail.	SAB and all commissioning agencies	Internal checks on contractual obligations and quality assurance methods.
The local authority should ensure there is a consistent referral system to the Fire	Local Authority	Policy and Procedure

and Rescue service for all individuals considered to self-neglect.		

Dr Paul Kingston and Emma Mortimer

Independent Reviewer

October 2018