LEEDS SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULTS REVIEW

MR A and MRS A

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Independent Reviewers

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Amended 11th July 2022 in relation to assessments for DWP benefits

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MR A and MRS A: SAFEGUARDING ADULTS REVIEW

1. OVERVIEW OF THE CIRCUMSTANCES THAT LED TO THIS REVIEW

1.1. Mr A's death at home, aged 50, was reported to the Police by his wife late in the evening of 11th March 2017, with his death being confirmed by paramedic staff in the early hours of 12th March 2017. He was found in bed surrounded by piles of household waste, his body severely neglected, emaciated and decomposed. He had significant pressure ulcers on his back, buttocks and legs and there was evidence of small animal predation (such as inflicted by a rat) following death. His cause of death is recorded at autopsy as renal failure and suspected sepsis due to pyelonephritis and an infected pressure ulcer, and coronary artery atheroma.

1.2. With a medical history that included osteoarthritis, lymphedema, hypertension, anxiety, deep vein thrombosis and musculoskeletal problems, Mr A had been in severe pain and poor health for many years. After becoming unable to work in 2008 he spent increasing amounts of time in his bedroom. He followed a drug regime prescribed by his GP. For a number of weeks before he died he had not moved from his bed. He and his wife occupied different rooms and communicated by mobile phone; she brought food to his room, along with bottles and puppy pads for his toileting needs, which once used he placed in plastic bags by his bed.

1.3. Mrs A, aged 45 when her husband died, has physical disabilities arising from congenital conditions involving facial and jaw asymmetry, congenital dislocation of the hips, bilateral talipes and torticollis. These have necessitated ongoing operations and treatment since childhood and over many years, including in 2002 a hip replacement. In 2007 she had a transient ischaemic attack and in 2017 a road traffic accident, leaving her with persistent muscular-skeletal pain and limited, painful mobility. A fall in 2013 resulted in a damaged coccyx causing numbness in her legs. She also suffers from fibromyalgia, high cholesterol, asthma, supraventricular tachycardia, migraines, poor sleep patterns and low mood. She sees her GP regularly and follows a medication regime.

1.4. After Mr A's death, it became apparent that the conditions in Mr and Mrs A's home were squalid, with hoarded materials, accumulated waste, evidence of rodent infestation and animal faeces (they kept dogs and chinchillas). For some time before Mr A's death there had been no hot water and the only heating was through electric radiators. Their landlord, Leeds Federated Housing, had been concerned about the deterioration of their home and garden since 2011 and had attempted unsuccessfully to engage Mr and Mrs A in securing improvements and in allowing gas safety checks to take place. Following unsuccessful attempts to conduct the annual gas safety check in August 2016 the Housing Association, at various points in the autumn of 2016 and early months of 2017, contacted the Environmental Action Team, the Fire & Rescue Service, the Police and Adult Social Care. They also initiated legal action themselves in order to gain access for the gas safety check. An injunction relating to this had been granted but not yet acted upon when Mr A died.

1.5. Following Mr A's death, West Yorkshire Police made a referral to the Leeds Safeguarding Adults Board, requesting a Safeguarding Adults Review (SAR).

2. THE STATUTORY DUTY TO CONDUCT A SAFEGUARDING ADULTS REVIEW

2.1. The Leeds Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

2.1.1. An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and

2.1.2. There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

2.2. Board partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[2]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

3. THE REVIEW MODEL

3.1. On 24th October 2017, following the SAR referral from West Yorkshire Police, the Leeds Safeguarding Adults Board determined that a SAR should take place to explore concerns about how the agencies involved had worked together in Mr and Mrs A's case. Independent reviewers were commissioned in December 2018, with the review starting in March 2019. The delay in commissioning the reviewers has been explained as due to the volume of business being conducted by the SAB.

3.2. The review covers a 2½ year period, between 31st October 2015 and 28th February 2018. The approach chosen was a review model that involved:

i. Chronologies of involvement from all agencies who provided services to Mr and Mrs A during the period under review. In addition, the reviewers asked agencies to identify and summarise any information that they considered significant regarding their involvement with Mr and Mrs A prior to the review period;
ii. Thematic analysis of the learning themes emerging from the chronologies and from agencies' subsequent responses to the reviewers' questions;
iii. A learning event involving discussion with practitioners and operational managers from agencies involved with Mr and Mrs A, including those who had met them, with the purpose of seeking their perspectives on the events of the case, to ensure that the review's analysis and recommendations were informed by those most closely involved;
iv. Drafting of a report for Leeds SAB to inform its planning, implementation and monitoring of relevant actions across the safeguarding partnership.

3.3. The SAR's terms of reference include a focus on the following matters:

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(5), Care Act 2014

i. Agencies' understanding of Mr A's self-neglect and the risks arising from it, and their responses to these;
ii. Mr A's dependency on prescription medication and how well this was considered, understood and mitigated against;
iii. How well agencies who had contact with Mrs A identified and communicated risk, escalated concerns and worked to build trust to understand and support her;
iv. The extent to which agencies understood the relationship between Mr and Mrs A and its impact on their actions as individuals;
v. How agencies responded to Mr and Mrs A's lack of engagement;
vi. The rigour of information-sharing and communication within and between services and agencies working with Mr and Mrs A;
vii. The quality of partnership and collaborative working between services and agencies working together to support Mr and Mrs A;
viii. The extent to which practice conformed to agency and SAB procedures and reflected evidence (from research and SARs elsewhere) on 'what good looks like' in working with self-neglect.

3.4. The reviewers received chronologies and where necessary additional information and/or documentation from the following agencies:

Department for Work and Pensions	The DWP reassessed Mr A's incapacity benefit for transition to Employment & Support Allowance in November 2016.
Leeds City Council Adults and Health	Adult Social Care had no involvement with Mr A. In 2008 and 2010 Mrs A received occupational therapy services for the purpose of providing aids and adaptations. Adult Social Care were briefly involved with Mrs A following her husband's death.
Leeds City Council Environmental Action Service	The Environmental Action Service had contact with Mr and Mrs A in 2011 following concerns about noise and waste, and again in December 2016 in relation to the external conditions at the property.
Leeds Community Healthcare NHS Trust	The Trust's Musculoskeletal and Spine Fit Service provided clinic-based community healthcare services to Mrs A but did not have contact with her during the period under review.
Leeds Federated Housing Association	Since 1997 Mr and Mrs A had held an assured tenancy for an adapted bungalow provided by the Housing Association.
Leeds Teaching Hospitals NHS Trust	Mr A received medical treatment on a number of occasions historically. During the review period, in November 2016, he was investigated for a queried stroke/TIA. Mrs A received treatment from a wide range of departments over many years but during the review period she did not attend the two appointments scheduled with the Trust. Following her husband's death she was seen in A&E and reviewed overnight.
NHS Leeds Clinical Commissioning Group (GP surgeries)	Mr A saw his GP 6 times during the period under review; he also did not attend some appointments. Mrs A saw a GP regularly, although her contacts were less frequent during the review period until after her husband's death.
West Yorkshire Fire and Rescue Service	The Fire & Rescue Service attempted to visit the property to conduct a Home Fire Safety Check in December 2016, following referral from the Housing Association.

West Yorkshire Police	A PCSO visited the property in February 2017 following a request from the Housing Association to undertake a welfare check and to assist with a referral to Adult Social Care. After Mr A's death, the Police were actively involved in investigating the circumstances of his death.

3.5. One of the reviewers, accompanied by a representative of the SAB, met with a local Councillor who had brief contact with Mrs A and with the Housing Association in early March 2017.

3.6. Representatives of the SAB had a number of meetings with Mrs A and her father. One of the independent reviewers, accompanied by a SAB representative, met with Mrs A and her father during the review process. Their information and views have been taken account of in the review. A further meeting is scheduled at which the same independent reviewer will discuss the review's conclusions and recommendations with them.

3.7. It was known that Mr and Mrs A have an adult daughter but a decision was taken not to involve her, or Mr A's father, in the SAR.

4. CASE CHRONOLOGY OVERVIEW

This account has been created from the chronological information submitted to the SAR reviewers by participating agencies. Its purpose is to establish a clear narrative understanding of events as they unfolded over time.

Background information

4.1. Mr and Mrs A married in 1991 and lived in a Leeds Federated Housing Association adapted bungalow, holding an assured tenancy since 1997. Mr A's mother shared the property with them until she died in 2001. In 1997 Mr and Mrs A began to foster the daughter of neighbours, adopting her in 2001. Mr A also had one child from another relationship with whom he had no contact.

Events during the period under review

4.2. Leeds Federated Housing Association historically had numerous contacts with Mr and Mrs A as their tenants and since 2011 had held concerns about the deteriorating state of their property. Gas safety checks (a legal requirement) were undertaken annually. At the October 2015 check, the gas service engineer reported that although the safety check had taken place inside the property, the flue could not be checked due to overgrowth of bushes in the garden. The engineer also noted worsening untidiness inside the property and the presence of rat poison, although the engineer did not consider the condition of the interior to be at a level causing significant concern. The Housing Association made attempts to secure Mr and Mrs A's engagement in remedying the situation[3].

4.3. On 5th November 2015, the Housing Association visited and although no access could be gained they noted a deteriorated external state of the property, with a car

[3] Mrs A's view is that there were many missed opportunities to open a welfare pathway from this point onwards.

and caravan in disrepair and many bins and boxes full of rubbish. A further visit on 20th November to discuss the property condition was cancelled by Mr A, who advised that his father had had a heart attack and he would be unable to keep the appointment as he was travelling South.

4.4. On 11th December 2015 Mr A attended his GP surgery for a medication review. He attended again on 30th December 2015 for blood tests. His weight loss of 14-stone was noted and discussed, with Mr A stating that this was intentional and arose from healthy eating.

4.5. On 7th January 2016 Mr A's GP carried out a further medication review. Mr A was not in attendance. On 17th February 2016 the surgery offered smoking cessation advice by phone.

4.6. The Housing Association made a further unsuccessful attempt to make an appointment in January 2016; there was then an 8 month gap before they made further contact with Mr and Mrs A.

4.7. In August and September 2016 the Housing Association's gas contractor delivered 3 letters advising Mr and Mrs A that a gas service was required[4], none of which received a response. The Housing Association also in August wrote to them about the condition of the garden, advising them also to seek support from Adult Social Care. On 12th September the Housing Association sent a legal warning letter and on 23rd September gave notice of intention to seek possession on the grounds of the overdue gas service. This was followed up in the following weeks by a phone call and two further letters giving a garden warning and breach of tenancy warning, and notice of a referral to the Fire & Rescue Service due to accumulation of items in the carport. On 21st October 2016 the Housing Association sent a solicitor's letter warning of legal action if no access was granted to carry out the gas service, and on 3rd November sent a further warning letter in relation to the garden. During this period, the only contact from Mr A or Mrs A was an email from Mrs A on 26th October 2016 reporting a missed green bin collection.

4.8. Between July and October 2016 Mr A's GP sent him three appointments for medication review, but he did not attend. As a consequence his prescription repeats were changed to monthly. On 19th October the surgery had telephone contact with him to request his attendance for a subsequent review.

4.9. On 11th November 2016 Mr A visited the GP surgery complaining of right-sided weakness. He was referred to Leeds Teaching Hospital Trust for review of a suspected stroke/transient ischemic attack. He was seen in A&E, where a CT scan and blood tests were performed. The hospital advised his GP that he had taken his own discharge against medical advice. The GP surgery wrote to Mr A requesting his attendance at the surgery on 17th November, but Mr A did not attend. Telephone contact took place to discuss smoking cessation. The GP received and reviewed the provisional brain CT scan report on the 28th December 2016, which indicated that there was no acute intracranial pathology, i.e. there was nothing on the scan that would explain the symptoms Mr A had experienced.

[4] The Gas Safety (Installation and Use) Regulations 1998 require a landlord to ensure that any gas appliances in a property are checked annually.

4.10. In November 2016 the Department for Work & Pensions (DWP) reassessed Mr A's incapacity benefit (which he had received since 2008) for transition to Employment & Support Allowance (ESA). DWP had only postal contact with him but a face-to-face medical assessment was carried out on 30th November 2016 by Centre for Health & Disability Assessment (CHDA) at the request of DWP. This identified the extent of his physical health challenges and their impact on his pain levels and mobility. DWP concluded that Mr A had limited capability for work and he was placed in the Support Group category of ESA, excusing him from work-focused intervention and face-to-face or phone contact unless he requested it.

4.11. On 5th December 2016, the Housing Association requested that Environmental Action Team visit the property in relation to the overgrown garden and combustible rubbish under the carport as well as a caravan in disrepair. An Environmental Action officer visited on 14th December and spoke to Mrs A at the door. She advised the officer that they had had a leak recently and were merely storing the damaged items under the porch. The officer advised her that any waste would need to be cleared.

4.12. A further letter by the Housing Association to Mr and Mrs A on 5th December 2016 requesting access to check the condition of the property and to arrange a gas service, followed up by an attempted home visit, again received no response.

4.13. On 14th December 2016 Mr A's GP undertook a medication review; Mr A was not in attendance.

4.14. On 14th December 2016 the Fire & Rescue Service, following the referral from the Housing Association, attempted to visit for a Home Fire Safety Check. Mrs A opened the door but declined the visit. The exterior of the property was observed to be unkempt but no further concerns were recorded by the officer.

4.15. The Housing Association continued to attempt visits (22nd December 2016, 5th, 10th, 18th, 24th January) receiving no response. In early February they contacted Environmental Action, who advised they would not be taking any action due to potential mental health issues and the vulnerabilities of the tenants. They advised the Housing Association that the principal responsibility lay with them and advised them to contact Adult Social Care. Environmental Action records indicate that the Housing Association were to clear the rubbish.

4.16. Acting on Environmental Action's advice, on 2nd February 2017 the Housing Association contacted Adult Social Care but were advised that a referral could not be accepted. (The Housing Association understood this was because it could not be accepted from them as an agency, but Adult Social Care records indicate it could not be accepted in the absence of consent from Mr and Mrs A.) Adult Social Care advised the Housing Association to request a police welfare check.

4.17. The Housing Association contacted the Police on 3rd February 2017 and requested that the Police carry out a welfare check and refer Mr and Mrs A to Adult Social Care. On the first visit on 4th February 2017 by a Police Community Support Officer (PCSO) there was no reply, but a neighbour reported having seen Mr and Mrs A go out earlier and that they had seemed fine. On 5th February a second PCSO visited and had a conversation on the doorstep with Mrs A, who opened the door only by inches leaving no view into the house. Mrs A herself appeared pale and unkempt; she did engage in conversation, stating that her husband had suffered a

stroke in November and now spent a lot of time in bed. The officer checked, and Mrs A confirmed, that she knew to call an ambulance if she had any concerns about him. She stated that she was herself not a well woman and took prescribed medication, but she refused the offer of medical assistance. On the state of the property, which the officer observed to be very untidy externally, with the garden overgrown, items accumulated in the carport and a caravan in poor condition, Mrs A stated they had had a flood, which had been reported but not yet attended to. She stated that she had no family nearby and no one to help her since her husband had fallen ill.

4.18. The PCSO concluded there was no reason to believe the couple was at imminent risk of serious harm or that urgent intervention was required, but that they needed some assistance. The PCSO undertook to try to make some referrals and left a phone message for the Housing Association requesting a call back to discuss this. A combined sequence of absences from work meant that the PCSO and the Housing Association did not have contact with each other for several weeks. Calling the Police in the officer's absence, the Housing Association was advised that that the PCSO had intended to make a referral to Adult Social Care, but in following this up with Adult Social Care on 27th February the Housing Association was advised that no referral had been received. The Housing Association sought an update from the PCSO on 8th March and advised him that Adult Social Care had not received a referral.

4.19. On 2nd March 2017 the Housing Association received a call from a local councillor (made with Mrs A's permission) in relation to the legal action for the gas safety check. The Housing Association understood from the councillor that the condition of the property was bad – this being based on what Mrs A, who had contacted the councillor via social media, had told her. Mrs A was claiming to the councillor that the state of the property was due to visitors who had stayed there for 3 months the previous year. She had told the councillor that they had been making attempts to clear up and had been trying unsuccessfully to contact the Housing Association. The Housing Association advised the councillor that they were not seeking possession of the property at that stage but were seeking to enforce the gas safety check, and that Mr and Mrs A needed to self-refer to Adult Social Care for support. They understood that the councillor would make this referral. The councillor's recollection, however, is that the Housing Association were to resolve matters and based on her experience of them she trusted them to do so.

4.20. On 3rd March 2017 the Housing Association obtained an injunction to access the property for a gas service to take place; the injunction was delivered by hand on 6th March. A lock change appointment was booked in anticipation that entry would need to be forced; this triggered Mrs A to seek clarification via the Housing Association's online customer portal and on 9th March the Housing Association's repairs team rang and left a message for her explaining why this appointment had been made.

4.21. Late in the evening of 11th March 2017, Mrs A reported to the Police that she had found Mr A deceased in his bed. His death was confirmed by paramedics in the early hours of 12th March 2017. Mrs A had last spoken to him two days previously, the same day that he had a phone conversation with a friend. She has stated that between 9th March and late evening on 11th March she did enter his room to let both dogs out but does not recall speaking to Mr A. While he was dependent on her for

food and other practical necessities, she recalls food and bottled drinks being in the room following a shopping delivery so she was not expecting food to be requested.

The period following Mr A's death

4.22. The Police initially took Mrs A to the Police station and subsequently to hospital for medical checks, following which she stayed with a friend and then with her father and his wife. Two Rottweiler dogs and two chinchillas were removed from the property and accommodated in kennels. A forensic post-mortem took place on 13th March 2017.

4.23. Adult Social Care had phone and visit contact with Mrs A in the days following Mr A's death and on 16th March 2017 a multi-agency meeting took place, involving Adult Social Care, the Police and Leeds Federated Housing Association. Adult Social Care made arrangements for Mrs A to receive her medication but no other care and support needs were identified.

4.24. The councillor who had discussed Mrs A's situation with the Housing Association earlier in March heard of Mr A's death from a friend of their family. Being aware that Mrs A needed somewhere to live, the councillor on 12th March sent an email to some of her elected member colleagues and to members of staff in Leeds City Council and West Yorkshire Police, drawing attention to the case and asking them to check their last involvement with Mrs A. The councillor advised Mrs A to work with Adult Social Care and Leeds City Council Housing.

4.25. The Police investigation into Mr A's death continued until the final post-mortem report was received, following which the investigation was concluded, with no criminal charges being brought.

4.26. The Housing Association attempted to bring the property back to a habitable standard. They also liaised with Leeds City Council Housing Options Team to support Mrs A's re-housing claim. Mrs A did not, however, feel well-treated by the Housing Association during this period. She remains of the view that the Housing Association did not intend to make the house habitable, leaving no alternative but for family members to clear the property and help her find suitable accommodation. She ended her Housing Association tenancy on 29th October 2017 and was rehoused by Leeds City Council.

4.27. The Police maintained contact with Mrs A, initially in respect of her welfare and the care of her pets and subsequently in relation to concerns expressed by her and her family about the conduct of the investigation, the appropriateness of their actions and compensation claims for items of property reported by her as missing from her address or seized by police and not returned.

4.28. During this period Mrs A has experienced mental ill-health, has had counselling from a specialist domestic abuse support agency and has also received cognitive behavioural therapy. She registered with a new GP practice in October 2017; her GP undertook a medication review and referred her to the Leeds Community Chronic Pain Management Service and to Rheumatology. She claims disability benefits and has a mobility car. She receives support from her father, who is a strong advocate for her interests, and her mother, who does her shopping and visits twice weekly to clean.

5. THEMED ANALYSIS

The following section addresses the learning themes arising from the SAR reviewers' integrated analysis of the information submitted by agencies and the perspectives of practitioners and managers who attended the learning event. It sets out key learning about how agencies understood Mr and Mrs A's situation, what they knew about their relationship, health needs and mental capacity, how risks were assessed and managed, the nature of interagency communication and case coordination, and the extent to which practice conformed to procedural expectations and good practice indicators. It thus addresses the key questions embedded in the terms of reference for the review.

5.1. Understanding of self-neglect and recognition of risks arising

5.1.1. Only the Housing Association identified significant potential risk in Mr and Mrs A's situation. Their awareness was triggered by concerns for the state of the property, arising from their role as Mr and Mrs A's landlord, but their response was to seek the support of other agencies to explore and manage the risks arising, with referrals to Environmental Health, Fire & Rescue, Adult Social Care and the Police. However, these referrals did not trigger explicit risk assessment by any other agency. Adult Social Care declined to open a referral, and although the other agencies did carry out visits they got no further than the doorstep and Mrs A's refusals to engage with them were taken at face value on each occasion. This was despite visible evidence (from both the state of the property and from Mrs A herself) of significant risk factors.

5.1.2. Thus the agencies lacked information about the true state of the conditions in Mr and Mrs A's home, about how they were or were not managing in the context of their physical and mental health, and about the nature of their relationship. From the reviewers' analysis of agencies' contributions and of the perspectives of those attending the learning event, there are a number of contributory factors here.

5.1.3. Healthcare agencies had worked on the basis of clinic/surgery-based contacts with both Mr and Mrs A, and this would not be an unusual pattern of contact for these services. The conditions in the home were therefore simply not visible to them, and the picture that both Mr and Mrs A presented in their respective clinic/surgery visits did not trigger questions that might have led to a fuller understanding of their living circumstances. More concerning perhaps, healthcare agencies do not appear to have asked questions about how both were managing at home in the light of their complex health conditions. This absence of a holistic approach, while it prioritised attention to their medical conditions, failed to broaden understanding of their situation.

5.1.4. Health personnel saw Mr and Mrs A on an individual basis and indeed this would again be line with standard practice. There was thus no point at which their relationship might have been observed. Mrs A had historically referred to 'having a domestic' with her husband when cancelling an appointment for a minor surgical intervention, and on another occasion in the context of a healthcare appointment with her GP she made reference to her relationship with her husband being strained. But the nature of their relationship was not the primary purpose of these health consultations and further questions were not pursued. Both her GP and the community healthcare trust were aware that

Mrs A suffered from low mood but this was seen to arise from issues with mobility and sleep rather than from her relationship. It is only since her husband's death that Mrs A has referred to the last years of their relationship being extremely difficult, causing her to become withdrawn and depressed. She has described very difficult communications between them during the final months of his life, after he took to his bed. But by this time their own withdrawal, combined with agencies' lack of curiosity about their living conditions, meant that difficulties in their relationship were not visible to anyone who might have been in a position to provide support.

5.1.5. In relation to knowledge and understanding about Mr A's health and in particular his use of medication (raised in the terms of reference for this review) surgery systems for the issuing of repeat prescriptions enabled medication to be issued despite Mr A missing his appointments for medication review. The surgery has stated that Mr A was not dependent on his prescription medication, but it is clear that they had limited contact with him on this matter. The last time his medication was reviewed in his presence was December 2015. Equally, when Mr A discharged himself from hospital in November 2016 against medical advice and then failed to attend a GP appointment, the surgery does not appear to have carried out any follow up. In discussion at the learning event, the view was expressed that there was no expectation for a GP to make a home visit following non-attendance at the surgery, in the absence of any concern about mental capacity. But other participants considered there was a need for a more proactive approach by surgeries in following up on missed appointments and that in this case such an approach could not only have enabled the GP to probe Mr A's health difficulties more fully but also would have led to the GP having more understanding of the home circumstances. They considered that either a pause in medication until Mr A attended an appointment or a home visit to check on his circumstances would have been an appropriate step for the surgery to take and would have demonstrated a greater degree of professional curiosity.

5.1.6. The lack of knowledge and understanding about Mr A's health was compounded by a further significant factor. On 30th November 2016 Mr A was medically assessed, face to face, by an independent assessment company CHDA for the purpose of informing DWP's decision on his Employment and Support Allowance. This assessment revealed the very extensive difficulties he faced, including the fact that he stayed in bed all day and every day because of severe pain, leg swelling and mobility difficulties, had dizziness and poor balance and muscle wasting in his upper and lower limbs. But DWP did not share the report with Mr A's GP (it is not the DWP's practice to do so) and despite the evidence the report revealed of the challenges Mr A experienced from pain and immobility, DWP made no notification about these difficulties to any other agency either. The CHDA medical appointment appears to be the last time anyone saw Mr A before his death 3½ months later.

5.1.7. Mrs A's surgery noted a drop in Mrs A's surgery and clinic attendance between 2014 and 2016, In this period she was asked to make appointments to attend the GP practice 13 times for a medication review, which she failed to do. She failed to attend on a further 2 occasions for other routine reviews and checks. During this period she had a total of only 4 contacts with the GP surgery compared to an average of 9 times a year in previous years. The CCG has commented to this review on the absence of professional curiosity in relation

to this change of pattern. Participants at the learning event, noting the more general fall off in contacts with a range of agencies, commented that it can be difficult to spot changes in a pattern of contact and that IT systems could be more helpful here in alerting practitioners to the accumulation of missed contacts.

5.1.8. Because the change in pattern of contacts was not questioned in respect of either Mr A or Mrs A, it is difficult to identify what might have been happening in their lives or their relationship during this period. Mrs A told the reviewers that she did not tell anyone else about the state of the property because of embarrassment and that neither her mother nor her father knew about it at the time, which her father has confirmed. However, she also said that she had been asking for help from the Housing Association for years, for example about drainage and sewage after a local school had been built, and about the boiler. She denied that she did not answer the door, saying that no-one knocked and she did not always look in the outside letterbox. She disclosed a 40% hearing loss in her left ear but denied that this might have meant that she missed knocks at the door. She also stated that for the last 18 months before Mr A's death she had only gone out to see the doctor. She stated that she had let the gas engineer into the house and the boiler was condemned. The gas supply was not disconnected because he could not check the outside vent because of the state of the garden. He did not return and there was no heating or hot water from October 2016.

5.1.9. It seems likely that there was significant deterioration in Mr A's health and Mrs A has described him as a proud man who did not easily seek help. Mrs A said to the reviewers that, although Mr A was a hoarder and lived in one room, she had been able to maintain the house until around 2015 when her physical ill-health worsened. By 2016 she had hit "rock bottom" and the house was "chaos". She said her OCD meant that as the house was a "mess" her head was also a mess. She did not know where to start. She described being physically and mentally low because of the way she was living. She stated that the car port was "not too bad", with materials stored in containers.

5.1.10. While Mrs A suffered low mood that could clearly have impacted on her ability to manage the house, it is clear also from her testimony that her relationship with Mr A was at times under strain. It may have been the case that the dynamics of their relationship showed patterns of dominance that made it difficult for her to act independently. The CCG has commented on an absence of professional curiosity on the part of Mrs A's GP practice when she disclosed to them the strain in her relationship with her husband. Mrs A has told the reviewers that Mr A had always spent time on his own but had increasingly given up and become more argumentative after his mother died in 2001. She described him as manipulative, argumentative and violent but she made excuses for him.

5.1.11. Most likely it was a complex combination of factors that affected Mr and Mrs A's ability to care for themselves, each other and their home and also their willingness to accept help. But this remains pure speculation – we simply do not know for sure what contributed to their withdrawal.

5.1.12. Services who did attempt to visit Mr and Mrs A at home in the last few months of Mr A's life appear (with the exception of the Housing Association)

to have made only one-off attempts to do so. This lack of persistence can of course reflect standard expectations on service pathways and workload pressures, but other factors are potentially influential too: the notion of respect for individual autonomy and lifestyle choice, and a failure to recognise warning signs that might indicate a need to ask more probing questions.

5.1.12.1. The Fire & Rescue Service, visiting in December 2016, noted that the house was unkempt and were concerned at the accumulation of fire risk materials they observed outside the home. While recognising that the Service does not have legal powers to enter a private dwelling (a point made at the learning event), they might have probed further about conditions inside, particularly as they were in possession of information from the Housing Association that Mr and Mrs A had shown hoarding behaviour. Equally, having been unable to carry out their own fire safety check they could have requested the involvement of other agencies, but did not do so.

5.1.12.2. The Environmental Action Team, confronted with evidence in December 2016 that there was waste at the property that needed to be cleared, did recognise that Mr and Mrs A had vulnerabilities, and this recognition was one factor in their decision not to take enforcement action. But they did not themselves probe further into conditions within the home, or trigger any direct action to seek support for Mr and Mrs A, merely passing responsibility back to the Housing Association.

5.1.12.3. Adult Social Care had no contact with Mr and Mrs A, becoming involved with Mrs A only after her husband's death. This review has heard two explanations for the refusal by ASC to pursue a referral from the Housing Association in December 2016. The Housing Association believe they were told that a referral could not be accepted from them because they as an agency did not have the status to make such a referral. The Adult Social Care record of the call refers to the reason being an absence of consent to the referral from Mr and Mrs A. Either way, the advice given was to request a welfare check from the Police to verify the circumstances. It is not clear what this advice was intended to achieve, given the Housing Association were referring known concerns. Learning event participants were clear that Adult Social Care should have accepted the referral, and the Police have commented to this review that requesting their own involvement merely served to delay progress of the enquiries Adult Social Care needed to make.

5.1.12.4. In relation to the absence of consent from Mr and Mrs A, if this was the reason for not accepting the referral this would be an erroneous interpretation of the requirements of the Care Act 2014, the statutory guidance to which[5] states clearly that consent is not a pre-requisite where abuse and neglect (including self-neglect) are suspected. Participants at the learning event were clear that consent to a referral to Adult Social Care is not required where there are safeguarding concerns and considered that the ASC Contact Centre would be required to take such a referral in the circumstances described. It may be the case that Contact Centre staff failed to recognise Mr and Mrs A's situation, as

[5] DHSC (2018) Care Act 2014 Statutory Guidance. London: Department of Health & Social Care.

described by the Housing Association, as self-neglect and therefore falling within the remit of adult safeguarding, but even if this was the case learning event participants considered it should have been clear that Mr and Mrs A's situation indicated the presence of needs that required an Adult Social Care approach to be made to them.

5.1.12.5. When visited by the Police in February 2017, Mrs A was explicit about her own poor health and indicated that following his stroke her husband spent a lot of his time in bed. But having offered medical assistance, which was declined, the officer did not probe further about the implications of her health for how she managed in the home, despite evidence that conditions were poor. Mrs A's explanation that they had had a flood that accounted for the possessions piled up outside appears to have been accepted at face value, and although the officer concluded that some assistance was necessary and undertook to arrange a referral, no referral was made.

5.1.12.6. It is also the case that the officer did not see Mr A but relied on Mrs A's description of his welfare. Greater persistence and insistence, on that or subsequent days, may have resulted in greater awareness of the conditions in which Mr A was by then living. To undertake the welfare check effectively would have required fuller enquiries into Mr A's welfare to be made, along with more proactive engagement with the need to make onward referrals. The Police, in the course of this review, have themselves identified learning here:

- that the Police should have ensured that Mr A was seen and his welfare was physically checked;
- that, given the PCSO had no lawful authority to gain entry to the premises to undertake the welfare check, it may have been more appropriate for a police officer to have attended or accompanied the PCSO, because where assessment of a person's vulnerability and their need for intervention is called for, this should be undertaken by a warranted officer whose training equips them to undertake this task;
- that a safeguarding referral should have been made to Adult Social Care.

They have reflected that the allocation of a PCSO to undertake the task reflects the control room supervisor's recorded view that this welfare check was not an appropriate role for the Police. It was therefore not seen as a priority call and could be undertaken by a relatively junior member of staff. This last point is explored further in the section on interagency collaboration.

Nonetheless, the Police have also concluded that, on the basis of the information they had about Mr and Mrs A, the powers of entry under the Police & Criminal Evidence Act 1984 would not have been applicable.

5.1.13. Lack of persistence also characterises some of the Housing Association's attempts to resolve issues relating to Mr and Mrs A's accommodation. After January 2016 there was an eight month gap in attempts to resolve the situation, notwithstanding the warnings that had previously been issued.

5.1.14. Mr A's visibility faded quickly after his hospital attendance and DWP medical in November 2016. There is no mention by any agency (other than CHDA for the DWP assessment) of having seen him since that date, which was some four months before he died, and indeed Mrs A's account indicates that after January 2017 he did not leave his bed[6]. It is clear however that there were numerous occasions during the ensuing months on which agencies visited the house; greater professional curiosity or persistence by any one of those agencies might have brought his circumstances to light. All visitors to the house, however, accepted Mrs A's perspective on their situation.

5.1.15. Equally, more decisive and earlier action by the Housing Association to remedy the gas safety check issue might have brought things to a head before the final decline in Mr A's health. The Housing Association's action in March 2017 to secure an injunction that would enable them to access the property did trigger some action from Mrs A, who contacted a local Councillor. The Councillor then contacted the Housing Association, reporting Mrs A's claim that visitors had caused the property to be in such poor condition and that she had tried without success to contact the Housing Association. The Housing Association the following day obtained an injunction to carry out the gas safety check, but even then did not take action under the injunction before Mr A's death 8 days later.

5.1.16. It is hard not to conclude overall that agencies simply did not worry enough to prompt them seeking to learn more about Mr and Mrs A and the conditions in which they were living or to take timely action. As a result, the professional and interagency system had insufficient knowledge of 'the person' in respect of them both – their individual history, the implications of their health conditions and mental health, their use of prescription medicine, the dynamics of their relationship – and showed insufficient professional curiosity to remedy that lack of knowledge. Participants at the learning event were clear that no-one really appreciated what life was like inside Mr and Mrs A's home and questioned whether the right questions had ever been asked in agencies' contacts with them[7].

5.1.17. A key question here is what measures can be put in place to enable practitioners to use a greater degree of professional curiosity in the context of busy and pressured workloads. Participants at the learning event suggested that organisational demands are such that it is very difficult to spot the cases in which further scrutiny is warranted. Two agencies commented that Mr and Mrs A's home, judged from the exterior, did not stand out as significantly more neglected than others, although the Housing Association did consider its condition more extreme. Nonetheless learning event participants advocated a culture of thinking 'what is the worst that can happen here?', as well as better support for practitioners to know how to persist with curiosity in the face of a client's reluctance to engage. With a higher level of risk awareness stronger and more persistent efforts to see Mr A could have been made.

[6] This account is contradicted by a neighbour who is reported as having told the PCSO that they saw both Mr and Mrs A out in February 2017 (see section 4.2.16).

[7] Mrs A is of the view that there should be a legal duty to report and act on situations such as these.

5.1.18. It is important to consider whether practitioners on the front line are sufficiently well trained and supported in identifying risk, particularly in the context of self-neglect. The Fire & Rescue Service and the Environmental Action Service have both indicated that all fire prevention officers and environmental action officers had had safeguarding training, but this did not result on this occasion in safeguarding risk being recognised or referred as such. No mention has been made of a specific focus on training in self-neglect, which as a newly-defined form of abuse and neglect[8] may well be less familiar to practitioners. The Police have identified that while the PCSO conducting the welfare check had had some training in responding to vulnerable adults it has not been possible to identify what this comprised. Beyond routine first aid and self-defence training the PCSO had had no regular refresher training (other than in mental health) since joining the force. The Police have noted to this review the need for the Police to consider the role and deployment of PCSOs in safeguarding-related enquiries, and whether and what additional refresher training should be made available to them as part of the Force's newly developed programme for experienced PCSOs.

5.1.19. Attendees at the learning event considered there were issues of confidence on the front line that need to be addressed to ensure staff have knowledge and feel empowered to use it, and that supervision and escalation pathways are used to discuss situations of risk. They also wished to see prioritisation of training in recognising self-neglect and assessing the risks it poses, particularly in the context of refusal to engage.

5.2. Responding to reluctance to engage and service refusal

5.2.1. It is clear from the foregoing analysis that despite evidence that might have given rise to concerns about safety across a range of issues (health, household management, fire risk, gas safety checks, public health, wellbeing) Mr and Mrs A's reluctance to engage was not effectively challenged. The exception to this were the actions of the Housing Association from August 2016 onwards, when concerns about the missing gas safety check prompted renewed attempts to contact and support Mr and Mrs A, both about that matter and about the general deteriorated state of the property.

5.2.2. One possible explanation for the general acceptance of Mr and Mrs A's disengagement and service refusal is the lack of awareness of risk. As explored above, practitioners did not know enough about the conditions in which Mr and Mrs A were living, and therefore simply did not worry enough to persist or seek solutions. But other features are also apparent. Participants at the learning event drew attention to Leeds SAB's current focus on "Hear My Voice" – seeking out the voice of the adult at risk as a priority in all safeguarding work. They questioned what should happen if that voice is saying "go away",

[8] Prior to the Care Act 2014, abuse and neglect was limited to circumstances involving a third party – i.e. an abuser. Paragraph 14.17 of the Statutory Guidance to the Care Act (first issued by the Department of Health in 2014 prior to the Act's implementation and updated annually since then, the latest version being 2018), explicitly includes self-neglect as a form of abuse and neglect. It brings an individual within the realm of adult safeguarding if they have needs for care and support, are experiencing or at risk of abuse or neglect and as a result of those needs are unable to protect themselves from the abuse or neglect: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

highlighting an apparent contradiction between respect for autonomy and the provision of safeguarding. This is a constant theme in SARs elsewhere[9].

5.2.3. Autonomy as a principle is deeply embedded in codes of professional ethics and in legal rules – respecting it is in many circumstances both the morally right and the lawful thing to do. But sometimes a complex situation requires a more nuanced understanding of the factors that can lead an individual to decline help, and here it is necessary to show more persistent curiosity about apparently autonomous choices that may in fact be far from 'chosen'. It is also important to consider whether the choice is a capacitous choice. However, the pressures on agencies providing services in a context of severe financial and time constraints can predispose practitioners to take reluctance or refusal at face value and to walk away rather than persist in building relationships that with time might enable fuller exploration of an individual's situation. In these circumstances, it is not perhaps surprising that the level of Mr and Mrs A's self-neglect remained under the radar. But the comments of participants at the learning event indicate a need to consider how staff can be supported to develop skills and confidence in persisting with attempts to engage, while also 'hearing the voice' of those with whom they work.

5.3. Mental capacity

5.3.1. When people in high risk situations are reluctant to engage with offers of support or attempts to keep them safe, a key question for practitioners to consider is whether that decision is being made with mental capacity. Of the agencies involved here, only the Teaching Hospitals Trust explicitly considered this question – here in relation to Mr A discharging himself following his hospital attendance with a suspected stroke in November 2016. Even here, no mental capacity assessment was carried out. This review has sought comment from all agencies on the reasons for the general absence of explicit attention to capacity, and two principally emerge.

5.3.2. First, some agencies have stated that there was simply no cause to question Mr or Mrs A's mental capacity because their explanations appeared reasonable. Taking mental capacity as a starting point is certainly in line with the Mental Capacity Act 2005, section 1(2) of which sets out the principle that in relation to any specific decision "*a person must be assumed to have capacity unless it is established that he lacks capacity*". The principle means that the presumption of capacity can only be overturned if the test set out in sections 2 and 3 of the Act has been applied. However, in this case there is no evidence that practitioners even considered whether they could justifiably rely on the presumption of capacity when faced with Mrs A's refusal to engage on the doorstep. Such an omission would not be unusual. The House of Lords Select Committee post-legislative scrutiny of the Mental Capacity Act [10] heard extensive evidence that caused it to conclude that: "t*he presumption of capacity … is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk*

[9] See Braye, S., Orr, D. and Preston-Shoot, M. (2017) 'Autonomy and protection in self-neglect work: the ethical complexity of decision-making', *Ethics & Social Welfare*, 11, 4, 320-335.
[10] House of Lords (2014) *Mental Capacity Act 2005: Post-Legislative Scrutiny - Select Committee on the Mental Capacity Act 2005*. London: The Stationery Office.

of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice". But the omission is certainly ill-advised in circumstances where an individual's decision leaves concerns of the nature being addressed here unresolved.

5.3.3. While there may well have been no evidence to prompt practitioners, when talking with Mrs A on the doorstep, to conclude that a mental capacity assessment was needed, it would nonetheless have been preferable (given the conditions that practitioners could observe for themselves) for them to have made and recorded an *explicit* judgement that it was justifiable to rely on the presumption of capacity.

5.3.4. The second rationale given for not conducting a capacity assessment is that undertaking such an assessment is either "beyond the remit of the agency" or that "staff are not qualified to make a mental capacity assessment". The agencies who advanced these reasons are agencies whose services would engage the question of whether an individual has capacity to make a decision relating to that service. It is therefore of concern that mental capacity assessment is not seen as something with which staff could and would, if necessary, engage.

5.4. Information-sharing, communication, partnership and collaborative working between agencies

5.4.1. There was a striking lack of partnership and coordination between the agencies involved with Mr and Mrs A. With the exception of the Housing Association, agencies appear to have considered and fulfilled only their own role and responsibilities[11], working on their own terms without reference to others. Having done so, they either withdrew without further communication to others or handed back the problem to the Housing Association. Thus:

5.4.1.1. Environmental Action Team, the Fire & Rescue Service and the Police all visited Mr and Mrs A's house in response to requests from the Housing Association, but without information-sharing or reference to each other.

5.4.1.2. Environmental Action did not communicate the outcome of their visit on 5th December 2016 back to the Housing Association or make any referral to any other agency, despite their concerns about Mr and Mrs A's possible needs. It was not until February 2017 that the Housing Association sought an update from Environmental Action and learnt that no enforcement action would be taken due to their perception that Mr and Mrs A had vulnerabilities, including possible mental health problems.

5.4.1.3. The Fire & Rescue Service believe that the officer who attempted to undertake the fire safety visit on 14th December did inform the Housing Association of the outcome, but neither the Fire Service nor the Housing Association have a record of this notification and it appears there was no

[11] Mrs A is of the view that even the Housing Association did not fulfil promises that were not fulfilled, particularly in the period following Mr A's death.

further discussion between the agencies of the need for a fire safety check.

5.4.1.4. Adult Social Care declined to become involved when approached by the Housing Association, advising the Housing Association to request a welfare check by the Police, as explored in an earlier section of this report.

5.4.1.5. The Police PCSO did not action their intention to explore onward referrals to request support for Mrs A following their doorstep discussion with her on 5th February 2017 about the difficulties she was facing, despite recording in the log that they would do so. This action was still outstanding by the time Mr A died weeks later. The log of the visit records that the PCSO intended first to discuss the situation again with the Housing Association, and indeed on the day of his visit he left a message requesting a call back. In following this up but unable to reach the PCSO, the Housing Association were advised by the Police office that a referral had been made to Adult Social Care (as the intention to do so is what was recorded on the log). But learning from Adult Social Care that no referral had been received, the Housing Association renewed efforts to contact the PCSO again in early March. It was not until 8th March, just 3 days before Mr A's death, that the two made contact by email. Even at this point, when the Housing Association staff member stated that Adult Social Care had not received a referral, it seems the PCSO did not act on the intention to refer concerns about Mr and Mrs A.

5.4.1.6. There appears a lack of clarity about the outcome of the telephone discussion between the Councillor and the Housing Association in relation to the Housing Association's legal action to secure a gas safety check. The Housing Association believed, from the discussion, that the Councillor was undertaking to make a referral to Adult Social Care (although none was in fact made). The Councillor's recollection is different; from her experience of working productively with the Housing Association on other cases she trusted that they would resolve matters. She also recalls offering Mrs A help with organising cleaning the house, since Mrs A had stated that she needed help with this, but it is unclear how this help was to be secured.

5.4.2. Agencies' understanding of each other's roles may not have been accurate. It is not clear, for example, why the Housing Association had not made earlier attempts to refer Mr and Mrs A to Adult Social Care, given the scale of their concerns. And although they logged the call as having been made to the Council's Vulnerable Adults Team, participants at the learning event clarified that there is no team by this name, and that all calls are routed through a Contact Centre. Participants at the learning event considered that clarification should be provided to agencies of the referral pathways into Adult Social Care, as well as information about the referral system works, the differences between s.9 and s.42 duties[12], and what information agencies should provide

[12] Section 9 of the Care Act 2014 provides the local authority's duty to undertake an assessment of care and support needs if an individual appears to have such needs. Section 42 is the local authority's duty to conduct a safeguarding enquiry where an individual with care and support needs is experiencing or at risk of abuse and neglect (including self-neglect) and as a result of their needs is unable to protect themselves.

in order to ensure effective triage of referrals. Some participants felt there was a need for an advice line that other agencies could access, but others felt this was not the way forward as all enquiries should be considered as potential referrals. More broadly, it was agreed there was a need to improve mutual understanding between agencies of the scope (and limitations) of each other's roles in relation to self-neglect.

5.4.3. When, in response to the Housing Association's referral in February 2017, Adult Social Care advised them instead to request a Police welfare check, it is not clear how or why Adult Social Care saw this as a viable alternative to their own involvement. The Police Control Room supervisor, receiving the request on a Friday, did in fact record at the time that the situation appeared more a matter for social services and the gas safety team than for the police. They concluded that a further discussion with the Housing Association was necessary the following Monday, but that if staffing allowed a PCSO would nonetheless carry out the check over the weekend. Learning event participants considered that for Adult Social Care to advise requesting a Police welfare check in the circumstances described was a misuse of Police resources. They were not the right agency to be requested to visit here; the situation was potentially already in the hands of the right agencies. The Police have raised in this review the need for them to ensure greater clarity between the Force and its partners about the role of the police, and to ensure officers are enabled to challenge inappropriate requests for police assistance that may, as in this case, delay safeguarding of the individual concerned.

5.4.4. In some cases an absence of information-sharing contributed to relevant agencies not being aware of the circumstances in which Mr and Mrs A were living. For example:

5.4.4.1. The absence of Adult Social Care involvement was a major factor in this situation remaining under the radar. It must be questioned why there were no referrals to Adult Social Care from health agencies, in the light of their knowledge of the Mr and Mrs A's health conditions and the difficulties they posed. Equally, why there was no referral to Adult Social Care from either CHDA or DWP in the light of the medical assessment in November 2016, which identified the circumstances in which Mr A in particular was living.

5.4.4.2. CHDA, in carrying out a face-to-face medical assessment with Mr A, did not provide details of this to Mr A's GP. While this was in line with their usual practice, it did mean that Mr A's GP surgery was not sighted on the true extent of his difficulties.

5.4.4.3. At the time of their visit in December 2016, Environmental Action identified that Mr and Mrs A had vulnerabilities, including possible mental health needs, and for this reason did not consider it appropriate to pursue enforcement action. However they did not act on their concerns by making a referral to any appropriate agency, merely advising the Housing Association to do so.

5.4.5. At the learning event, participants discussed the potential role of agencies beyond the public services that might call at a home, for example, postal delivery personnel, online order delivery companies and utility companies.

They felt that 'reliable tradespeople' should be connected into safeguarding through the SAB's community outreach work.

5.4.6. No agency attempted to convene a multiagency discussion that could have facilitated collective engagement in problem-solving and shared ownership of responsibility. The Housing Association in the autumn of 2016 held back from pursuing their own legal enforcement route, due to concerns about Mr and Mrs A's physical health and possible mental health issues. But they attempted to secure a solution by making piecemeal referrals to other single agencies rather than calling a multiagency conference. They were the agency best sighted on the extent of the problem and could have triggered such a discussion, but so too could Environmental Health, following their observation of the vulnerabilities that existed in Mr and Mrs A's situation. Learning event participants felt that better understanding was needed across agencies about how to call a multiagency meeting; indeed the Housing Association clarified that they were not aware of the mechanism for doing so. Participants at the learning event also considered that joint visits to Mr and Mrs A would have been an appropriate approach, creating a stronger sense of shared responsibility and reducing the silo working that was evident.

5.4.7. Learning event participants did comment that multi-agency working and information-sharing were now much improved, but they considered that the improvements were patchy rather than with all agencies. Specific mention was made of ongoing difficulties making referrals to mental health services. They suggested that a regular pattern of multiagency meetings would be helpful – meetings at which situations involving vulnerable adults could receive attention from the range of agencies attending (regardless of whether safeguarding action was being taken or not). This would obviate the need to call specific meetings for individual cases and would facilitate multiagency consultation.

5.4.8. They commented that there was too much distance between agencies, both in this case and in general terms. In particular, they felt there was a need for stronger engagement with housing associations – listening to their concerns and trusting their perspective. They questioned how SAB policies and learning are cascaded through to housing associations and considered that the Leeds City Council Housing representation on the SAB needed to forge stronger links with the wider housing sector across Leeds.

5.5. Procedural and legal literacy

5.5.1. Participants at the learning event placed emphasis on the need for legal literacy – knowledge of available legal powers and duties across the interagency network, and the ability to judge when those power and duties might be used. Yet within the agencies' responses to Mr and Mrs A's situation there is evidence that practitioners did not have accurate understanding of some legal matters.

5.5.2. The response by Adult Social Care to the referral from the Housing Association is one example, in which the absence of client consent was given as a reason for not accepting the referral. Some participants at the learning event had experience of Adult Social Care giving this as a reason for not accepting a

referral in other cases also. In fact, as explored above, consent (although desirable) is not required when safeguarding concerns are present.

5.5.3. Participants at the learning event questioned whether Contact Centre staff have enough training and support. In relation to any situation being referred to them, it is important that they are able to show sufficient professional curiosity to enable an accurate understanding of the circumstances to emerge and to be able to match that to legal powers and duties, even if referrers don't initially use specific words that facilitate the triage task.

5.5.4. It seems Mr and Mrs A's circumstances were not recognised, by Adult Social Care or any other agency, as evidence of self-neglect that could require a safeguarding response, calling into question familiarity with and adherence to the changes brought about by the statutory guidance to the Care Act 2014[13], with its inclusion of self-neglect within the circumstances that constitute abuse and neglect.

5.5.5. A further legal matter was a reported belief that powers of entry only apply when life is at risk. This may have been an interpretation of the grounds on which the Police may enter premises for the purpose of "*saving life or limb or preventing serious damage to property*[14]". But it omits consideration of other powers available under mental health, public health and housing legislation, indicating a need for clearer guidance to those involved in safeguarding on possible routes to securing entry. Indeed participants at the learning event called for greater clarity and guidance here. Equally important was recognition that sometimes, in the absence of legal powers, gaining entry requires persistence and creativity, and practitioners need further guidance of strategies to be employed.

5.5.6. Also on the legal front, some participants at the learning event expressed some disquiet about confidentiality and consent to information-sharing between agencies in a situation such as this, referring both to the perceived constraints both of the legal rules on data protection and of professional codes of confidentiality. Participants felt that clear guidance was needed on the expectations for sharing information and in what circumstances it could or indeed should be lawfully and appropriately shared despite the subject being unaware of this or having declined consent.

5.5.7. In terms of procedural literacy, some learning event participants felt that the SAB had given little guidance or support to agencies when safeguarding policies had been introduced. While some agencies have given assurance to this review that all staff had received safeguarding training and would have been aware of the safeguarding procedures, the Police have identified that the PCSO undertaking the welfare check on Mr and Mrs A on 5th February 2017 had no knowledge of either the West Yorkshire Police Safeguarding Vulnerable Adults Policy or the West and North Yorkshire and York Safeguarding Adults Multi-Agency Policy and Procedures. This, alongside the comment of learning event participants, highlights a need for stronger dissemination strategies, both by the Board and within individual agencies.

[13] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[14] Section 17(1)(e), Police & Criminal Evidence Act 1984.

5.5.8. Some learning event participants questioned whether self-neglect cases are correctly routed, sharing a perception that self-neglect tends not to be dealt with through safeguarding pathways. This review notes that the Leeds SAB does not have specific guidelines or procedures relating to self-neglect, although this has been identified as an important area for development. The present expectation is that if such cases enter safeguarding they are dealt with through the generic safeguarding pathways set out in their procedural guidelines[15] (although in those procedures no specific mention is made of self-neglect). The Board's adult safeguarding policy statement[16] does contain a short section on self-neglect, which also signposts readers to research that supports good practice[17]. However, the policy notes that self-neglect may not always prompt a response with safeguarding procedures and sets out indicators of when a safeguarding response could be indicated. Only one of the three criteria given, however, reflects the statutory guidance to the Care Act[18]; the remaining two do not have foundation in the legal rules. In addition, no guidance is given on what alternative routes may be pursued in cases where safeguarding is not indicated.

5.5.9. The PCSO who conducted the Police welfare check in February 2017 did not record an Adult at Risk occurrence under the West Yorkshire Police Adult at Risk Niche[19] Occurrence facility, which provides a means of recording non-crime vulnerability. He has stated in this review that he was not aware of the facility, although recognises that creating such an occurrence would have been advantageous here. The log of his visit was created by the control room operator from a call by the PCSO; it recorded that the PCSO was to submit a referral to Adult Social Care. In fact in the call the PCSO said Mrs A had asked for help so he was going to try and make some referrals for her (without specifying to whom), but he intended first to discuss the case with the Housing Association. After the PCSO's initial message back to the Housing Association requesting a call, delays in the two agencies contacting each other resulted in no discussion taking place and no referral being made. The Police have indicated to this review that had an Adult at Risk occurrence been created, supervisory scrutiny would have taken place. Without it, once the log was closed there was no process in place to ensure the identified action was

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[15] Leeds Safeguarding Adults Board (2019) *Citizen-Led Multi-Agency Safeguarding Adults Policy*.

[16] Leeds Safeguarding Adults Board (2019) *The Leeds Approach: Citizen-Led Multi-agency Safeguarding Adults Procedures*. https://leedssafeguardingadults.org.uk/Documents/Safeguarding/LSAB%20Multi-Agency%20Policy%20%28April%202019%29.pdf

[17] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.

[18] DHSC (2018) *Care and Support Statutory Guidance*. London: Department of Health & Social Care. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Paragraph 14.17 states: "*It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support*".

[19] Niche is the Force's primary recording database and is used to record a wide variety of incidents from serious crime to lost property. Reports on the database are referred to as Occurrence reports.

completed until the original caller re-contacted the police nearly a month later and the log was re-opened[20].

5.5.10. The Police have noted to this review that there is no prescriptive requirement for officers to use the Adult at Risk Niche Occurrence facility and that it is not supported by guidance on its use. Equally, it is not referenced in the PCSO initial training on Public Protection, Vulnerable and Intimidated Persons. Use of Adult at Risk occurrences varies across districts and it is common for none to be created even where concerns about a vulnerable adult exist. Thus in being unaware of their existence, the PCSO was acting in common with many of his colleagues and was not in contravention of any directive, as none exists. The Police have also commented that in Leeds no use is made of the standard form for direct referral to Adult Social Care[21], with referrals being made by free text email. They believe consideration should be given to what further guidance is issued to staff, both about the use of Adult at Risk occurrences and also referral processes to Adult Social Care, to ensure that effective processes are in place and consistently applied across the Force.

5.5.11. A final procedural matter relates to escalation. The Housing Association in this case made persistent efforts to engage others in supporting Mr and Mrs A but appeared to meet an impasse at every turn. These were, perhaps, missed opportunities to escalate their concerns. Participants at the learning event raised the question of how agencies might escalate concern about how any one agency responded to a referral or request for involvement from another, indicating that the channels for such communication were not clear.

6. CONCLUSIONS

6.1. This concluding section summarises the learning that has emerged from the SAR. In addition it maps the review's conclusions against the model of good practice in self-neglect - "What good looks like" - derived from research and SARs conducted elsewhere[22]. The following benchmarks provided by this model have informed the analysis of this case:

6.1.1. Direct work with adults at risk should comprise proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills. When faced with service refusal, there should be a full exploration of a person's history and what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss, trauma, fear and shame often lie behind such refusals. Repeating patterns should prompt close

[20] Mrs A questions why the Police were not more proactive in contacting adult social care or other relevant sources of support.
[21] Form 263
[22] Preston -Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice', *Journal of Adult Protection,* 21, 4, 219-234. Learning from other reviews includes a serious case review published by Leeds SAB in 2009, known as Mrs P, an older person who died in a house fire.

enquiry and, where indicated, detailed assessments of risk, care and support needs, mental capacity and mental health.

6.1.2. The work of professionals and agencies engaging directly with adults who self-neglect should be characterised by inter-agency communication and collaboration, coordinated by a lead agency and key worker. The approach to information-sharing should be comprehensive so that all agencies involved possess the full rather than a partial picture. Any referrals should provide as much information as is relevant, paying close attention to relevant legal rules. Multi-agency meetings are helpful to pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options. Safeguarding enquiries and use of policies and procedures can also support multi-agency working together. Recording should be thorough.

6.1.3. Organisations supporting the work of the professionals involved should provide supervision, access to advice from legal, mental capacity and mental health specialists, and close oversight of cases where risks are significant. Workforce and workplace issues, such as staffing levels, training, organisational cultures and thresholds, should be addressed.

6.1.4. The contribution of the SAB is to ensure that there are policies and procedures for working with adults who self-neglect, with audits conducted to monitor effectiveness. Learning from SARs should be disseminated and its impact on practice tracked.

6.2. In relation to Mr and Mrs A's case under review here, as detailed in the preceding analysis there seems to have been a long period between 2011 and 2015 in which deteriorating conditions in their home came to the attention of the Housing Association but did not reach a threshold at which enforcement action was warranted. It is not clear whether this deterioration was triggered by specific events, declining health or relationship difficulties, or a combination of these. No signs were picked up through the routine contacts that both Mr and Mrs A had with health services and the Housing Association continued only intermittently with attempts to engage and support them, and did not escalate their concerns.

6.3. It seems that 2016 was a pivotal period during which Mr and Mrs A became markedly less visible to the agencies involved with them. Both consistently missed appointments with their health practitioners. And between January and August 2016 the Housing Association had ceased efforts to contract them about the state of the property, having been told in December 2015 that Mr A was going South as his father had had a heart attack.

6.4. It was the serious breach of health and safety that occurred through Mr and Mrs A's failure to allow access for a gas safety check in August 2016, plus concerns about the condition of the property, that led to renewed efforts on the part of the Housing Association to seek entry and enforce compliance. When their attempts to find a remedy were frustrated, the Housing Association made repeated efforts to engage other agencies, calling in the Fire & Rescue Service, Environmental Action, Adult Social Care and the Police.

6.5. However, this review has found that a series of 'fault lines' are evident in what took place during this period. None of these in themselves can be said to have led to Mr

A's death in March 2017, but it clear that there were opportunities for action that could have changed the course of events.

i. Lack of professional curiosity and persistence on the part of agencies who had contact with Mr and Mrs A throughout the period under review;
ii. Acceptance of their explanations at face value during late 2016 and early 2017;
iii. Failure to pursue contact with Mr A himself after November 2016;
iv. Lack of recognition of Mr and Mrs A's self-neglect as a safeguarding issue and failure to recognise the risks inherent within their situation;
v. Poor communication and information-sharing between agencies;
vi. Failure to convene a multiagency discussion, resulting in lack of joint ownership of the perceived problem and an absence of shared strategy for intervention;
vii. Failure by Adult Social Care to accept a referral;
viii. Absence (until very late in the process) of enforcement action in the part of agencies empowered to take it.

6.6. A change in any one of these aspects of the agencies' work could have changed the outcome of the case. Yet all are, to some extent, understandable within the context of the custom and practice of how the services are organised and provided, and the very clear and successful attempts Mr and Mrs A made to remain off the radar. It is therefore at organisational and strategic level that changes need to be made to reduce the risk of similar circumstances arising again. Participants at the learning event were clear that the circumstances found in this case could arise again. In their experience, non-engagement was a common problem, and they were not confident that the changes made by agencies since Mr A's death (which are set out in Appendix 1) would prevent a similar unfolding of events[23].

6.7. The review also finds that Leeds SAB has provided insufficient leadership on self-neglect. This was almost certainly the case at the time when this case was unfolding, which was in the early days of Care Act 2014 implementation, and would not be out of step with safeguarding adults boards elsewhere. This procedural vacuum and possibly also absence of training may have contributed to agencies having insufficient awareness of self-neglect, the risks arising from it and the potential pathways for intervention. But this procedural vacuum remains and therefore gaps in knowledge, understanding and procedure may still persist.

7. RECOMMENDATIONS

7.1. In line with the terms of reference for this review, the recommendations that follow are intended to contribute to improvements in how agencies respond to individuals where there are significant levels of self-neglect. The recommendations are designed to stimulate measures to strengthen future interagency safeguarding practice. In addition some individual agencies, in their submissions to this review, have set out changes they have already implemented within their own organisation. These changes are listed in Appendix 1.

[23] Mrs A herself has expressed concern that as a disabled person who lives relatively independently, she is nonetheless, in her view, unsupported beyond the input of her parents.

7.2. Arising from the analysis undertaken within this review, the reviewers recommend that the Leeds Safeguarding Adults Board should:

7.2.1. Review and strengthen its membership in terms of links with housing associations, utility companies and trades people;

7.2.2. Produce and disseminate multiagency procedures for working with people who self-neglect, ensuring that such procedures:

- draw on the 'What good looks like' model derived from research and SARs;
- include guidance on agencies' respective roles in self-neglect work, and on working with people reluctant to engage, identifying and assessing risk, addressing mental capacity;
- include criteria and mechanisms for sharing information, convening multiagency meetings and escalating concerns about partnership working;

7.2.3. Commission multi-agency training on self-neglect, ensuring that such training includes:

- Recognition and understanding of self-neglect and its status within adult safeguarding;
- The exercise of professional curiosity;
- Working with people reluctant to engage;
- The importance of mental capacity assessments;
- Approaches that contribute to successful engagement and intervention;
- Legal literacy (including powers of entry and information-sharing);
- Multiagency case coordination;

7.2.4. Discuss with partner agencies how additional flexibility can be created within their organisation's standard workflow expectations (for example, standard timescales for assessment and for a case remaining actively open) in order to facilitate practitioners making and maintaining contact over longer periods with people who are reluctant to engage;

7.2.5. Seek assurance from each partner agency that all staff are aware of and able to exercise their responsibility for identifying and if necessary testing mental capacity in relation to decisions relevant to that agency's functions;

7.2.6. Request that Adult Social Care provides clarification for all partner agencies of referral pathways for actions under the Care Act 2014, in particular care and support needs assessments under s.9 of the Act and safeguarding enquiries under s.42, along with an indication of the kind of information that referring agencies need to provide in order to assist accurate triage of referrals;

7.2.7. Seek reassurance by means of a single agency case file audit from Adult Social Care that the questions of consent is not a barrier to acceptance of referrals where there are safeguarding concerns;

7.2.8. Request that Adult Social Care consider how the learning from this review can be embedded in training for Contact Centre staff;

7.2.9. Request that West Yorkshire police provide for partner agencies clarification on the circumstances in which welfare checks are considered appropriate;

7.2.10. Request that West Yorkshire Police consider the role and deployment of PCSOs in safeguarding-related enquiries and what additional training may need to be provided;

7.2.11. Request that West Yorkshire Police considers the need to provide further guidance and training to its staff about the use of Adult at Risk Niche Occurrences and about referral processes to Adult Social Care, and considers how and when information on identified vulnerability is made available to other agencies;

7.2.12. Seek agreement with DWP at both local and national level on strengthening information-sharing with GPs and referral pathways to other agencies such as Adult Social Care when DWP or their agents identify potential care and support needs and/or circumstances in which safeguarding action may be necessary;

7.2.13. Request that the CCG audits GP surgeries' compliance with its expectations (under its repeat prescribing policy) that surgeries have their own policy on non-attendance for medication reviews;

7.2.14. Request that partner agencies consider how recording systems can be modified to enable practitioners and managers to identify patterns of non-engagement (such as missed appointments);

7.2.15. Discuss with West Yorkshire Fire & Rescue Service the need to advise the Home Office that, where there are safeguarding concerns, there is a gap in law and advocate for Fire & Rescue Services to be given powers to enter private dwellings;

7.2.16. Provide regular briefings as a means of disseminating learning from this and other SARs and of raising awareness of its policies and procedures;

7.2.17. Audit how learning from this SAR has impacted upon agencies' practice one year on from dissemination of the learning.

APPENDIX 1

CHANGES IMPLEMENTED BY AGENCIES IN RESPONSE TO LEARNING WITHIN THEIR OWN ORGANISATION

1. Leeds Federated Housing Association

i. The Housing Association has changed the tenancy sign-up process to ensure that any mental capacity issues in relation to tenancy can be identified.

ii. The Housing Association now has safeguarding workflow on their system and safeguarding e-learning is undertaken by all new staff.

2. NHS Leeds Clinical Commissioning Group

i. The process whereby GP surgeries issue repeat prescriptions has been an important area of learning. Leeds CCG has issued a repeat prescribing policy, which includes statements about best practice for medication reviews. (Leeds CCG (2018) Repeat Prescribing: A Template for Process Mapping and Compliance Checklist.) The repeat prescribing policy assumes that patients attend for medical reviews and collect repeat prescriptions. It does not offer advice regarding patients who are non-compliant in these respects. The CCG has stated that it is the responsibility of individual practices to have a policy that deals with non-attendance.

3. West Yorkshire Fire & Rescue Service

i. If the Service was refused access to a property despite telephone agreement, as happened here, this would be referred back to the referrer.

ii. The Service now has a more robust reporting and recording procedure. They have protocols with Adult Social Care and the Community Health Trust about referrals and joint work.

4. West Yorkshire Police

i. While West Yorkshire Police has made no changes to policy or procedure directly as a result of Mr A's death, work has been undertaken to improve the Force's response to adults at risk. Historic practice has been for officers to make reports of concerns re vulnerable/at risk adults to local safeguarding units with the expectation that these units would triage the report and make any necessary onward referrals to other agencies. This has applied in both child and adult safeguarding. The Force has sought to change this practice and now expects officers attending incidents to make those referrals themselves directly to the appropriate service without tasking this to the safeguarding unit. In order to facilitate this the Force has over the last two years developed a Public Protection Notice (PPN) 'app' on officers' Galaxy mobile data devices which will allow them to populate a third agency referral form and email this directly to the agency without routing the referral through the local safeguarding units. Additionally, once created, the referral form will automatically create a Niche occurrence, recording the circumstances and the referral. This will entail the creation of new occurrence types: PPN Non-crime Adult and PPN Non crime child. This has been

part of a national police project and has consequently been subject to extensive consultation to ensure its national applicability. However, a West Yorkshire pilot is about to commence in the Wakefield and Calderdale Districts and it is hoped that this will result in the adoption of the process across West Yorkshire. The introduction of the PPN will require its incorporation into policy and the amendment of the current Safeguarding Adults Policy. It will also require publication of the new process to all staff and guidance on vulnerability and thresholds for referral and an accompanying training programme. This is currently in hand as part of the pilot and will be subject to evaluation before further roll out.

ii. The lack of refresher training provision for PCSO staff was recently identified in a Domestic Homicide Review. A programme is currently being developed by the Force's Corporate Services Department and training staff which will meet this need for refresher training for PCSO staff who have more than five years' service, which it is intended will include information in respect of responding to vulnerability.

5. Leeds Teaching Hospitals

i. As a result of this and other reviews, routine enquiries are now made for every patient in the nursing specialist assessment. Questions are asked about whether people feel safe at home, or afraid of anyone, and whether they would like help. The assessment is updated weekly and/or when there are significant changes. This system will also be applied with respect to outpatients. Training is being provided for staff and an audit will monitor the impact of this new approach.