SAFEGUARDING ADULTS REVIEW

Report in respect of Adult P

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Acknowledgements

I should like to thank all those who contributed to this Safeguarding Adults Review (SAR), particularly during a more than usually difficult time for everyone.

Although first contacts with me (reviewer/author) for this Review were in September 2019 the main work for preparing the Report has taken place during the period of the Corona-virus pandemic and there have been no face to face contacts since February 2020. Covid-19 and the restrictions that have been necessary have placed a number of more urgent requirements on staff so information flows have been delayed and my (SAR author) availability has been affected by increased caring responsibilities.

1.	**Introduction and reason for this Safeguarding Adults Review (SAR)**
1.1	Adult P, a white British man, 67 years of age, who was known to some Doncaster agencies as an adult with some vulnerabilities, was found at 3pm on 4th January 2019 on the floor of his home in Edlington. He had lived on his own in the house rented from St Leger Homes of Doncaster Ltd Housing since 2013.
1.2	Two Doncaster Council staff, including a member from the Council's Stronger Together Team and one from the Wellbeing Team, who knew him well, had called at his home several times to try and make contact and also asked at shops where he was known if he had been seen that day. They called South Yorkshire Police (SYP) who gained entry and staff from Yorkshire Ambulance Service (YAS) confirmed his death at approximately 4pm as he was 'displaying rigor mortis'.[1]
1.3	Information from the Doncaster Coroner's office on 11th March 2019 recorded that Adult P died a 'natural' death as a result of pneumonia and ischaemic heart disease. As there was a finding of a natural death a Coroner's Inquest was not required. This was, however, an unexpected death. He was seen at home by a consultant community physician/geriatrician, a social worker and two community nurses in the week before his death. All had concerns about him but not about any immediate life threatening health issues.
1. 4	A number of agencies had increasing contact with Adult P in the last few months before his death. Concerns had been raised about his poor nutrition and personal presentation both in public places (partly undressed and dirty, sometimes from faecal matter) and at his home when answering his door. His living conditions were also unhygienic, posed heightened fire risk, and were generally deteriorating. In a few weeks before his death a diagnosis of Diogenes Syndrome began to be suggested.[2]
1.5	Concerns were also being raised about his capacity to make informed

[1] Rigor mortis is the result of the death of cells in the muscle fibers of the human body, which leads to chemical changes in those fibers that cause shortening, or stiffening, of the muscles...rigor mortis begins to set in one to two hours after death. ... rigor mortis is evidenced in small voluntary muscles, such as the jaw and neck. It eventually spreads throughout the entire body, from the neck down. It usually reaches its peak at approximately 12 hours after death. A body generally remains in full rigor for 12 or so more hours before the stiffening subsides and completely dissipates by the 36-hour mark.
https://inpublicsafety.com/2019/02/how-rigor-mortis-can-help-indicate-time-of-death/

[2] Diogenes syndrome (DS) is a behavioural disorder characterized by domestic filth, or squalor, extreme self-neglect, hoarding, and lack of shame regarding one's living condition [1]. The approximate annual incidence of Diogenes is 0.05% in people over the age of 60 [2]. Affected individuals come from any socioeconomic status, but are usually of average or above-average intelligence [3]. It is often associated with other mental illnesses, such as schizophrenia, mania, and frontat temporal dementia [4]. While no clear aetiology exists, it is hypothesized that it may be due to a stress reaction in people with certain pre-morbid personality traits, such as being aloof, or certain personality disorders, such as schizotypal or obsessive compulsive personality disorder [5,6]. There are suggestions that an orbitofrontal brain lesion may lead to such behaviours [7], while others state that chronic mania symptoms, such as poor insight, can lead to such a condition [4].
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4016666/

	decisions about his self care and also protecting himself from others. A Mental Capacity Assessment[3] completed by a social worker a few days before his death, confirmed that he lacked capacity in some areas critical to his wellbeing. Some staff also identified that they believed he was being exploited and potentially put at risk by another adult, also identified as vulnerable. A 'Planning' meeting chaired by a senior social care practitioner, and attended by staff from Police, Social Care, Wellbeing and Stronger Communities met on the day prior to his death, and recommended a range of further assessments.
1.6	The circumstances of his death, concerns about his identified vulnerability, including possible exploitation by another person, and the fact that he had been known to a number of agencies with safeguarding responsibilities, led to a referral for a Safeguarding Adults Review (SAR) to be considered by the Review and Learning sub group of the Doncaster Safeguarding Adults Board.
1.7	The Review and Learning sub group agreed at a meeting on 7th March 2019 that a SAR should be undertaken as he was an adult known to a range of agencies; was described as having complex behavioural issues and self-neglect in relation to his living environment; and there were questions about his capacity to care for and protect himself.
1.8	Information from hospital records held by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) stated that in 2002 Adult P suffered an "extensive life threatening brain injury that required neurosurgery". It is suspected that the brain injury, particularly as he got older, may have resulted in him having difficulties in information processing, though he was described as 'cognitively intact'. A CT scan undertaken after a hospital attendance for a fall following a 'dizzy spell' in 2015 identified that his head injury in 2002 had resulted in 'chronic changes to the brain'.
1.9	The RDaSH records from 2002 describe Adult P as having been employed as a coal miner. It is believed that he had 3 siblings and had a female partner from 2002 to 2013. He had also given information that he lived with his mother and cared for her until she died. No agency was able to provide any current contact details of any relatives and his funeral arrangements were organised by DMBC.
1.10	Adult P was supported from time to time by his neighbour, described by some staff as 'his informal carer', until she became unwell and Adult P's needs and difficulties in accepting advice and other support increased. She continued to raise concerns about him, particularly potential exploitation by others. However, after advice from agencies about her own vulnerability, it was agreed that it would not be in her best interests to be invited to contribute to this Safeguarding Review.

[3] Mental Capacity Act 2005 and Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

2.	**Purpose of and Methodology for this Safeguarding Adults Review (SAR)**
2.1	The Statutory Guidance to the Care Act 2014 Act states that Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect[4], whether known or suspected, ***and*** there is concern that partner agencies could have worked more effectively to protect the adult.
2.2	The purpose of a SAR, as described very clearly in the Statutory Guidance is so "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[5].
2.4	There is no single prescribed method to conduct a SAR. The Statutory Guidance places emphasis on local decisions with a focus on 'what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected'.
2.5	I was appointed as a self employed, independent person[6], with substantial experience of safeguarding adults work and conducting similar reviews, to chair and lead the Review and provide a report for the Doncaster Safeguarding Adults Board.
2.6	The methodology agreed for this SAR is what is referred to as a 'hybrid' model. It involves production of a 'critiqued chronology'[7] from each agency which had relevant contact with the person(s) who is the subject of the SAR. This information is then combined into a full case chronology. It requires the participation of practitioners from all agencies involved with the person in a 'sharing and learning' event with the appointed reviewer(s); an invitation to family/significant others to meet with the reviewer(s) to share information and perspectives to enable organisational learning to prevent future deaths/harm to other 'at risk' adults.

[4] Neglect does not need to be intentional to considered for a SAR
[5] Care and Support Statutory Guidance to Care Act 2014 published 24th March 2016 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
[6] I 'independent, author' have never been an employee of any organisation in Doncaster or of any of the organisations providing services to Adult P.
[7] A critiqued chronology sets out dated events/contacts and agency actions/interventions that are 'assessed' in terms of expected agency practice compliance by the chronology author.

Review Panel

2.7

Name and role	Organisation
Shirley Williams-Chair and Author	Independent self employed
Angelique Choppin, Safeguarding Adult Board Manager, Interim Chair	Doncaster Safeguarding Adults Board (DSAB)
Shabnum Amin, Learning and Development Manager	Doncaster Safeguarding Adults Board (DSAB)
Kathryn Anderson-Bratt, Head of Safeguarding and Quality	Doncater Metropolitan Borough Council (DMBC)
Helen Allen, Team Leader Safeguarding Adults Hub	Doncaster Metropolitan Borough Council (DMBC)
Ailsa Benn, Principal Social Worker	Doncaster Metropolitan Borough Council (DMBC)
Julie Jablonski, Housing Safeguarding Partnership Manager	St Leger Homes
Pat Johnson, Safeguarding Adults Nurse Specialist	Doncaster Bassetlaw Hospital NHS Foundation Trust (DBTH)
Charlie Cottam, Nurse Consultant	Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
Leah Denman, Deputy Designated Nurse Safeguarding Adults and All Age Individual Placements	Doncaster Clinical Commissioning Group (DCCG)
Sarah Morton, Safeguarding Officer	SY Fire and Rescue (SYF&R)
Jo Wade, Case Review and Policy Officer	SY Police (SYP)

2.8 **Terms of Reference**

The timeframe to be examined for the SAR was agreed by the Doncaster Safeguarding Adults Board Review and Learning sub group to be from 1st January 2018 to Adult P's death on 4th January 2019. It was also agreed any significant information relevant to Adult P prior to the start of the agreed timeframe would be requested from agencies which had been identified as having had some involvement with him.

2.9 The objective of the SAR, as set out by the Review and Learning sub group was, "to identify multi-agency learning around the care, support and safeguarding of an adult male and the circumstances leading to his death". A group of 10 questions/areas of exploration[8] was identified by the sub-group members on the basis of the original information collected to consider whether a SAR should be undertaken. As the independent reviewer and author of this SAR report I have grouped the questions/areas of exploration into 6 broad areas for consideration:

1. Staff compliance with individual agency and the South Yorkshire Safeguarding Adults Policy and Procedures and including those relating specifically to self neglect.
2. The appropriate use of timely mental capacity assessments

[8] See appendix 1 for full details of the questions

	taking into account evidence of fluctuating capacity and balance of risk and choice and the level of professional curiosity about those choices. 3. Recording and sharing of information across agencies and use of multi-disciplinary meetings. 4. The quality of the support and services offered to Adult P and others who had concerns about him. 5. The impact of Adult P's mental and cognitive health, on his willingness to accept support and professional decision making including consideration of legal options. 6. Whether practitioners were working in a person centred, assertive and proactive way, taking into account that some of his decisions may have been the result of undue influence.
	Family/friend involvement in the Review
2.9.	The purpose of meeting family members/relevant others as part of a SAR is to enable them to share information that they believe pertinent to the Review; have their concerns and views taken into account; and identify any suggestions for improvements in systems and practice they would like to come out of the Review. Most relatives want to see that improvements will be made so that some of the negative things their relative experienced will not be repeated.
2.10	However, there was very little verifiable information about Adult P's background held by any agency. Although it is believed that he had 3 siblings, and a sister was believed to live in Retford, no agency had a current address for any of them. Some staff, who attended the practitioners' meeting, did have information that Adult P had lived with a female partner from 2002 to 2013 but again no agency had any contact details. It is believed that he moved from Conisbrough to Edlington when this relationship ended, but in the period under review no staff were aware of any family/friend contact so it has not been possible to involve any family in the Review.
2.11	Adult P had a next door neighbour who had provided him with some practical support, and who expressed concerns about his wellbeing to some agencies. There was discussion at the Practitioners' event about a meeting being arranged for me (SAR reviewer/author) to meet with his neighbour. However, after contact with St Leger Homes, the housing provider, and some of the other staff who had met the neighbour, the advice was not to contact her, as she was seen as quite vulnerable. The Review had also run into the Covid-19 restrictions by this stage.
	Practitioners Involvement – meetings and additional information
2.12	The Statutory Guidance to the Care Act 2014 states, "professionals should be *involved fully* in reviews and invited to contribute their perspectives *without fear of being blamed for actions they took in good faith".*

2.13	Doncaster adopted the good, and SCIE SAR Quality Markers[9] supported practice of bringing together practitioners who had contact with Adult P and/or those with some responsibility for quality assurance and staff development in relevant agencies. The purpose is for staff to share their experience and consider what might have been done differently that could have provided better outcomes for him and for others they/their agency might work with in the future.
2.14	The practitioners' event with the SAR author took place on 20th February 2020. 9 staff attended from a range of organisations, which had some involvement with Adult P as well as 2 Doncaster Safeguarding Adults Board (DSAB) staff. **Attendance** • Shirley Williams - Independent SAR Reviewer/Author • Dr Cheng Looi – Community Physican/Geriatrician (DBHT) • Ian Warhurst Police Community Support Officer (SYP) • Julie Bibby - Stronger Communities Officer (DMBC) • Richard Mills - Well Being Officer (DMBC) • Judith Metcalfe - Housing Officer St. Leger Homes • Helen Allen - Advanced Practitioner, Safeguarding Adults Hub (DMBC) • Sarah Gleadall -Team Leader Community Mental Health (RDaSH) • Melanie Brown Community Mental Health Nurse (RDaSH) • Kim Goddard - Lead Professional Safeguarding Adult (RDaSH) • Shabnum Amin - Safeguarding Adults Board Manager (DSAB) • Niall Werrett-Garfitt - Partnership Support Officer (DSAB)
2.15	Adult P's GP was sent a list of questions by the SAR author, which was followed up with a booked telephone discussion. A face to face meeting before Covid restrictions were imposed was also held with a safeguarding social worker who became involved with Adult P in the last few weeks of his life. She had visited him on two occasions shortly before his unexpected death to carry out a mental capacity assessment.
2.16	There have been no additional Review/Investigation/Inspection reports made available to the Review author, though there have been some further information and clarification exchanges by email with staff from a number of agencies.

9 https://www.scie.org.uk/search?sq=Sar+Quality+Markers - in order to access the Quality Markers you may need to register (free) with SCIE

3	**Key information, events, and interventions**
	Significant information, events, and interventions prior to January 2018.
3.1	Whilst there was some suggestion at the beginning of this Review that Adult P was regarded as a 'learning disabled' man, further information shared at the Practitioners' meeting suggested that the subdural haematoma brain injury requiring neurological intervention in 2002, may have resulted in him having difficulties in information processing[10], though his other cognitive skills appeared 'intact'.
3.2	In February 2013 Adult P registered at the Nayar GP Practice. He was diagnosed with an under-active thyroid[11] and as having a B12 deficiency[12] and was prescribed appropriate medication.
3.3	In 2013 Adult P was referred to the Doncaster Council's Wellbeing Service[13] as he was struggling with various aspects of his life and had particular difficulties with his benefits. His Wellbeing Officer described him as a "gentle proud man who did not always accept support but was open to discussion ... was known in the local community... and was generally bright and cheerful," at least until the last few months of his life.
3.4	In July 2015 his GP patient file records that Adult P had a fall following a dizzy spell. A CT scan on 15th July at Doncaster Royal Infirmary indicated no new concerns, though the 2002 injury had resulted in 'chronic changes to the brain'.
3.5	On 8th November 2016 his GP file records that a Wellbeing/Mental Health assessment was carried out that described Adult P as mildly cognitively impaired. Wellbeing staff seemed to have become aware of his previous head injury at this stage and recorded that "he was very susceptible to the (negative) influence of others". He had a positive relationship with his next door neighbour but this began to break down in the months prior to his death.

10 "Information processing impairments may not be immediately obvious when communicating with the brain injured person; these impairments may be a 'hidden' disability. However, markedly slowed responses can be very noticeable in some people following ABI.

Problems arising from information processing impairment may be incorrectly attributed to the person being uncooperative, difficult, de-motivated or even challenging. There may be a significant discrepancy between the person's communicative performance in a quiet environment, during one-to-one communication or during assessment sessions when compared with their performance in other, more communicatively demanding social situations. Therefore, other people's expectations of the person's ability to manage social situations may be unrealistic if they are based on the person's performance in less demanding situations".
https://www.acquiredbraininjury-education.scot.nhs.uk/

11 https://www.nhs.uk/conditions/thyroiditis/

12 https://www.nhs.uk/conditions/vitamin-b12-or-folate-deficiency-anaemia/treatment/

13 "**The Wellbeing Team was created on the principle of ensuring that all residents of Doncaster have access to support, guidance and advice about problems and issues they may be experiencing, and to also maximise the individuals independence within the community regardless of any medical condition, physical disability, or mental health difficulty" (Description as at 22.09.2020)**
. **https://www.doncaster.gov.uk/services/get-involved/wellbeing**

	Significant events and interventions January 2018-July 2018
3.6	From January 2018 a Doncaster Council's Wellbeing Officer, who had known Adult P since mid-2017, and a Doncaster Council's Safer Communities Officer began to visit Adult P at least once a month for 'check up' visits. His neighbour was raising an increasing number of concerns about him, particularly in relation to his personal presentation and the state of his house.
3.7	Adult P was described as 'chatty' and didn't refuse to discuss agency staffs' concerns but did not accept that he needed to change anything, repeating phrases like: "This is my choice; I choose to be/live like this; the way I live and am is OK with me". The Wellbeing Officer did, however, have concerns about risks associated with his smoking and cooking, and made a referral to South Yorkshire Fire and Rescue Services (SYFR) for a home safety check.
3.8	Towards the end of April 2018, two SYFR Community officers visited Adult P and were allowed to carry out their check. They recorded that he, "appears to have mental health issues". They were concerned about signs of self neglect; he was dirty as were his clothes and furniture; there were unopened Nomad boxes (these are pharmacy pre-acked medications that assist people needing to take multiple tablets daily); and his bed was broken and supported on bricks.
3.9	Fire risks were identified in relation to unsafe smoking as there were a significant number of cigarette burns on his mattress; and unsafe (deep frying) cooking practice. There were, however, linked smoke alarms and a heat sensor in the property. The SYFR officers gave Adult P some safety advice and fire retardant bedding.
3.10	The SYFR staff had information that his neighbour did his washing and helped him out but she had withdrawn some of that support. SYFR made a referral to Doncaster Safeguarding Team about their general concerns in relation to his living conditions and lack of self care.
3.11	On 23rd April the Wellbeing officer also raised a concern with the Safeguarding Team identifying concerns over Adult P's appearance and visible self neglect; he 'chose' not to wash, he had declined to seek treatment for an arm injury, and he "seemed confused at times". Support had been offered but he declined any help. A section 42 enquiry[14] led to setting up a face to face meeting with a safeguarding social worker.

[14] ***Section 42 Care Act 2014*** ***(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—(a)has needs for care and support (whether or not the authority is meeting any of those needs),(b)is experiencing, or is at risk of, abuse or neglect, and(c)as a result of hose needs is unable to protect himself or herself against the abuse or neglect or the risk of it.***

https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

3.12	On 8th June 2018, as a result of the concerns, a Safeguarding social worker visited Adult P accompanied by the Wellbeing Officer. The Wellbeing Officer had spoken to the neighbour, who expressed concerns about Adult P but she is reported as saying, "he copes OK". The Safeguarding enquiry was completed but not taken forward to a full safeguarding investigation. However, the social worker did refer the concerns to the senior practitioner on 12th June for consideration for Doncaster Self Neglect/Hoarding Risk Management Process (SNARM)[15] although there is no record of any action at that stage.
	Significant events and interventions August 2018-October 2018
3.13	During August and September Adult P was visited and assessed by a number of staff as concerns about his health and welfare were shared across agencies.
3.14	A further referral was made to Adult Safeguarding from the Wellbeing Officer and the Communities Officer in August 2018, and a duty social worker visited Adult P on 22nd August. The referrers had been alerted by Adult P's neighbour because of her increasing concerns. On visiting the staff observed that he had lost weight and he and his home were very dirty. He answered the door to the social worker in an undressed state and with faeces down his legs and he wouldn't let the social worker in.
3.15	The social worker sought senior staff advice and phoned Adult P's GP who said he had not seen him for 3 years as he "refused engagement" but a visit would be made that week. Safeguarding staff at this point seemed not to have information that Adult P had experienced a serious head injury/brain trauma.
3.16	On the same day Adult P's GP file records that a health visitor visited him at the GP's request. The main concerns from the health visitor on this visit were about the dirty state of his home; he appeared to be 'hoarding'[16] deodorant cans; there was food on the floor; and the fridge wasn't working.
3.17	On 23rd August 2018 the GP confirmed to the social worker that a welfare check had been done and he would make a referral for assessment to mental health services and also to the district nursing service to do some blood tests.
3.18	On 24th August 2018 a nurse from RDaSH visited Adult P and with his consent (the chronology provided for this review notes 'Informed consent obtained') the nurse took Adult P's blood pressure (no concerns identified) but she was unable to take a blood sample due to

[15]Doncaster Multi-agency Procedure Self-Neglect and Hoarding (2017) https://dscp.org.uk/sites/default/files/2019-05/Doncaster%20Multi-agency%20Procedure%20Self-Neglect%20and%20Hoarding.pdf

[16] There was no evidence from other staff that Adult P 'hoarded' though others did note his unopened Nomad medication

	'unsuccessful attempts at venous access' (couldn't find a suitable vein). There is no record of any concerns relating to unopened medication and the home conditions did not raise serious concerns.
3.19	Adult P agreed to a further visit, which took place on 29th August but taking a blood sample was again unsuccessful. On this occasion Adult P was described as 'bottom half naked with dirty hands'. An exchange is recorded with the GP that Adult P would need to go to hospital for a blood sample to be taken but "he is unable to go to hospital (by himself) and had no one to take him". It is unclear whether he did attend hospital, but there is information that he began to be visited by Community Nursing staff to administer B12 injections.
3.20	Over the next few days Adult P had a number of contacts from health and social care agencies and information was shared and cross referrals were made between agencies: • He was visited by a different social worker, who recorded that Adult P was 'unkempt'[17] but said he did not want any support. The social worker requested that the case be allocated to a 'named' social worker so that a consistent worker could keep contact with Adult P. • His GP visited and found him in 'a very unkempt state', neglecting himself, faeces on his body and sheets, unshaven, dirt and food everywhere. However, the GP did not identify any low mood or thought disorder. He described him as, "articulate ... seemed to have good short and long term memory". • His GP made a referral for assessment to RDaSH Mental Health Older People's Service attaching a copy of the CT scan taken on 15th July 2015 which identified chronic changes to Adult P's brain resulting from the subdural haematoma experienced in 2002. • Two mental health nurses visited Adult P and carried out a number of assessments, including a 'Falls' assessment. They concluded, as had the GP, that Adult P had no mental health problems either organic or functional but there were environmental issues including no gas or hot water making it difficult for him to wash. He had poor daily living skills and poor diet. They made referrals to SYFR, Wellbeing Team, and St Leger Homes. • They noted that Adult P had said he felt well supported by the Wellbeing Officer. • An Approved Mental Health Practitioner (AMPH) made contact with adult social care staff and gave information about the previous brain injury, which possibly explained Adult P's functioning at a 'suboptimal' level for the past 16 years and combined with aging of his brain could explain why he was no longer able to self-care effectively, rather than he was 'choosing' not to care for himself.

[17] Unkempt is a word often used in describing people who are believed to be visibly self neglecting – its literal meaning is 'uncombed'.

3.21	During this period it also seems Adult P had 'fallen out' with his neighbour because she had reported concerns about his deteriorating self care to the police, and raised the possibility of him being exploited. SYP have no record that such a report was made at this stage and it has not been possible to interview the neighbour for this SAR.
3.22	On 3rd of September the Community Mental Health Nurse Team Leader contacted the Wellbeing Officer to share the findings from their assessment and subsequent conversation with St Leger Homes staff. The Wellbeing Officer said three safeguarding referrals had been made about Adult P but he had not been allocated to a social worker. The nurse advised the Wellbeing Officer that Adult P had a brain injury but did not present with mental health problems, and therefore, mental health were not the appropriate agency to be involved with him.
3.23	On 6th September 2018 the social worker who had visited him in August was allocated as named social worker to Adult P but no visit took place until 8th November. On information exchanges between adult social care and mental health services it is reported that there was a backlog of referrals for adult social workers and the service was under pressure.
3.24	On 27th September 2018 SYP staff visited Adult P to carry out an Adult Protection Investigation. There had been complaints from neighbours that he was standing at a window naked where he could be seen by children. When they visited he answered the door naked with faeces down his legs and smeared on walls. He seemed unconcerned and did not see any issues for himself or for others in his appearance or his home conditions. As there were concerns that Adult P was putting himself and others at risk with his behaviour a vulnerable adult form was submitted to partner agencies.
3.25	During this period Adult P experienced financial problems as he was moved from Employment Support Allowance (ESA) payments to his old age pension. The Wellbeing Officer provided Adult P with some help to sort the problems but Adult P was reluctant to receive further help as he didn't want to, "cause a fuss".
	Significant events and interventions October 2018-December 2019
3.26	There were signs of Adult P increasingly struggling to manage his personal hygiene and living conditions from mid-summer but by October the Wellbeing Officer noticed that he also seemed unhappy and was not going out very much, which was unusual for him.
3.27	Looking back on this period during the SAR the Wellbeing officer believed this deterioration coincided with Adult P being 'targeted', along with other older people in the area, by an unnamed individual, who was believed to have his own vulnerabilities. The Wellbeing officer and other community staff believed some of the items that appeared to be 'being

	stored' in Adult P's house may have been stolen by this person, whom Adult P initially described as his friend. It is also suspected, and Adult P later confirmed, that he began to 'borrow'/steal money from him but Adult P did not want any action to be taken, and at that stage the concerns were not reported to SYP. There were issues about Adult P not paying his gas bill and it being cut off, though he was receiving sufficient income to pay his bills.
3.28	In early November SYFR staff did a 6 month follow-up visit to Adult P and assessed that the fire risk had increased. There were burn marks on his bedding and he was not using the 'fire-resistant throw' they had given him. There was evidence of chip fat all over his floor and furniture but he told them he didn't have a chip pan, though a pan of fat was visible to them. He was dirty and only wore a jumper. He said he had no gas because he couldn't pay his bills; he didn't have hot water so he didn't wash himself. His heating was electric so the house was warm but very dirty. SYFR reported their findings to the Wellbeing Officer including that they were unsure about Adult P's capacity to make decisions about how he lived given some of the ways he had answered their questions.
3.29	On the 8th November 2018 a safeguarding social worker and the Wellbeing Officer visited Adult P. He was 'dishevelled', dirty, naked from the waist down, and appeared to have lost weight. An area of his sofa was covered in faeces. He said he had money stolen from him by a man who lived in the flats, but did not want to report this to the police. He confirmed he had received his 'Winter Warmth' payment, but had no hot water as his gas had been turned off, but said he didn't want any support. The two staff held a meeting after the visit where it was agreed that the SNARM 'Tool' would be completed given the rising level of risk, as well as a Care Act community care assessment undertaken.
3.30	Adult P's GP was contacted and a further referral to psychiatric services was made from the Safeguarding Hub social worker. By the end of November the response from the psychiatrist repeated what had been said in August that a Mental Health Act assessment was not warranted and that the appropriate legal route to assess/support Adult P was set out in section 2 of the Mental Capacity Act 2005 as he had suffered a brain injury.[18]
3.31	The psychiatrist suggested that "Diogenes syndrome could be a factor" and made reference to Adult P's "brain damage, which may have impacted on his mental capacity and ability to maintain his own care and support needs".

[18] "For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind ***or*** brain".
https://www.legislation.gov.uk/ukpga/2005/9/section/2

3.32	On 30th of November the safeguarding manager requested that a locality team manager ask a social worker to complete a community care assessment prior to consideration of Adult P's risks and needs using the Self Neglect Risk Management (SNARM) process.
	Significant events and interventions December 2018 to Adult P's death 4th January 2019
3.33	Concerns began to build from a number of agencies throughout December 2018 and visits to Adult P and multi-agency meetings began to take place. On 10th December the Safeguarding social worker and the Wellbeing officer visited Adult P to begin the assessment process for the SNARM.
3.34	On the 13th December SYP attended Adult P's house with a staff member from Doncaster Council regarding the concerns raised that Adult P was being financially exploited. Adult P did not want to discuss the potential exploitation and did not give any name. On arriving at the house Adult P was found partially naked covered in faeces. At that time they found Adult P to be in a vulnerable state, covered in faeces and were unable to enter the house to make further enquiries. A vulnerable adult form was submitted to Safeguarding service due to the condition of Adult P.
3.35	On 16th December 2018, the staff member from St Leger Homes visited Adult P but was unable to get a response.
3.36	On 20th December 2018 the Wellbeing officer and the Safeguarding social worker visited Adult P again. He told them that he was physically afraid of the person he had previously described as his friend and believed he had been taking money from him. An initial mental capacity assessment was undertaken by the social worker This was focused on Adult P's understanding of his care and support needs. It was noted that Adult P's fridge wasn't working. The social worker got some grocery shopping for Adult P.
3.37	Later on 20th December a meeting was held between the Wellbeing Officer, his manager, the Safeguarding social worker (an Advanced Practitioner), and a social worker from a locality team. It was agreed that they would Inform the Police (CID) about the 'friend' and make a referral to the Vulnerable Persons' Panel (VPP)[19], and refer to Doncaster Case

[19] ***Level 2 Refer to Vulnerable Persons Panel (***doncasterccg.nhs.uk)
Where a case has been progressed at Level 2 and a multi-agency self-neglect or hoarding meeting has failed to address serious concerns and risks the case can be escalated to the Vulnerable Person Panel for multi-agency consideration and action. The Vulnerable Persons Panel (VPP) will bring together a range of agencies / services in order to provide an opportunity for escalation of issues relating to cases involving self-neglect or hoarding where serious concerns and risks are present;
 interventions have not proved effective or have hit barriers;
 and there remains serious concerns around the adult at risk.

	Identification Meeting (CIM)[20], and request that his gas be reconnected. There was also discussion about a further referral to mental health services and to neurological services, and plans put in place for a SNARM meeting on 3rd January 2019.
3.38	A meeting also took place with St Leger staff, South Yorkshire Police (SYP) and the Doncaster Complex Lives Team. Whilst, Adult P had said he was afraid of this person and his neighbour was also concerned about his presence, but there was no conclusion from that meeting that Adult P had been targeted by this adult. However the adult, who had been homeless and then supported by the Complex Lives Team, was moved before Christmas to a property outside Edlington.
3.39	On the 24th of December, following an urgent referral from Adult P's GP, a consultant community physician specialising in older people's health, made an unannounced visit to Adult P at home (she had been unable to contact him by telephone and he told her later that his phone wasn't working). Her subsequent letter to the GP described that she had knocked on front and back doors for some time and that when Adult P finally opened the door he was not wearing his pants and appeared to have dark brown smears on his skin and clothes. He said he had just woken up and agreed she could visit again at a later time after she told him she had come to do a Medical Review at the request of his GP.
3.40	Prior to Adult P opening the door she had looked through the windows and noted that there was "some dirt on the sofa and tables and carpets though, the floors and work surfaces were clear (i.e. not untidy). There were no unwashed plates/cutlery etc in the kitchen. There were small collections of cigarette butts on the table. There was no obvious sign of hoarding. The front and back of his property was generally clean and tidy".
3.41	On the 27th December the Consultant Community Physician visited again after 11am, and Adult P, again without any pants on, eventually opened the door. She described him as thin, with uncombed long hair and in much the same faeces soiled condition she had noted previously.
3.42	He agreed to an examination; had no problems with pain, breathing or heart rate; seemed steady enough with his walking about his house; had no problems with his waterworks but said he struggled with his bowels. He said he had not had his breakfast but would get some cereal and that he did his own shopping, though she felt he was somewhat vague about that.

[20] CIM is a Doncaster Case Identification Meeting usually Multi-Agency between DMBC Communities, SLHD Estates, South Yorkshire Police + occasionally other Agencies-general focus is around Anti-Social Behaviour (ASB), Low Level Crime, Neighbour disputes, Environmental Issues etc.

3.43	She was concerned to note that there were “two big piles of Nomads and boxes of tablets stacked on his bookshelf. The Nomads were from different dates as far back as late 2017. He said he took his statins every day but could not actually confirm when he had last taken them. He allowed her to remove all the medication and return it to the pharmacy except for one pack (still dated many months previously) that he said he would be using. He said the Wellbeing Service was helping him to sort his phone out and made no objection to her contacting the Wellbeing Officer and showed her a slip of paper with his phone number on.
3.44	In the letter to the GP date 28.12.2018, one day after her visit, she set out her findings from her visit and also a plan, “to continue approaching things very, very gently with him (Adult P)”. She wrote “He is not exhibiting hoarding behaviour as is classically associated with Diogenes syndrome, although his self-neglect, etc is a worry. I am very concerned about his memory and I would like to check into this further to see what we can optimise”.
3.45	She noted that he agreed to a referral for routine blood tests, weight test and a ‘full set of observations’. She also requested “his medications be stopped for now...as he had not been taking it... she had concerns over accidental overdose when he does remember...information needed on his eating and a diet that helped with constipation should be encouraged rather than prescribing more medication.”. She also recommended a multidisciplinary meeting be arranged in the next few weeks and a CT brain scan referral made.
3.46	On 27th December the Safeguarding social worker and the Wellbeing Officer also visited Adult P and carried out a further mental capacity assessment (MCA). The assessment confirmed that he did not have capacity with regards to meeting his care and support needs and that a Best Interests meeting was needed.
3.47	There is information that on 3rd January 2019 further information was received by Safeguarding that “there was an adult (presumed to be the person Adult P was afraid of) in the community who posed a risk to safeguarding”. A referral is said to have been made about that adult to the Vulnerable Person’s Panel.
3.48	On 4th January 2019, the Wellbeing Officer and the Communities Officer visited Adult P at 9.30am with the aim of checking up on him and doing some shopping for him. They couldn’t get an answer and during the course of the day they checked with Doncaster Royal Infirmary to see if he had been admitted to hospital, visited two local shops, where he was well known, to check if he had been seen, talked with his neighbour, and finally phoned for police support.
3.49	The police managed to enter the property by breaking a window and found him at 3.42pm lying near the window. The ambulance arrived 7 minutes later and confirmed his death and that rigor mortis was already

	evident.
3.50	The record from the Ambulance staff is that they were told “Patient last heard Thursday 3rd at approx 05:45am by neighbours, shouting and banging. Adult P was found naked from waist down, abrasions to both knees, lower legs and both buttocks were very red. He had cable wire under both arms and loose around his neck but there were no ligature marks.”
3.51	The Wellbeing Officer describes giving information to the police and leaving the property at 5.45pm and in my (review author) request for information following the Practitioner’s event the Wellbeing Officer reported, “the property as being sealed off as a crime scene.”
3.52	The Wellbeing Officer reported that when they were trying to find Adult P he had spoken to his neighbour who said she had heard someone knocking loudly on his window at 5am but as it went quiet she assumed whoever it was had been let in. It was also reported that statements were given to the police, and that the death was regarded as suspicious at first.
3.53	In their chronology the RDaSH Single Point of Access team states, “On the 4th January 2019 we received a telephone call from SYP to inform of Adult P’s death, which they believed was in suspicious circumstances”.
3.54	4th January 2019 Information requested and received from SYP during the SAR process stated that, police “attended the property after being alerted that he could be seen on the floor and not answering door. Entered by an open window and found door locked from inside. Male cold to touch and not breathing – ambulance staff called and confirmed death. No suspicious circumstances, body removed and Council secured the property”.
3.54	No relatives were identified and Doncaster Council arranged his funeral.

4	**Findings and Analysis**
4.1	The Practice Guidance developed by the Social Care Institute for Excellence (SCIE) to assist agencies carrying out Safeguarding Adult Reviews (SARs) as required by the Care Act 2014, suggests that a SAR is needed to achieve understanding of the following[21]: 1. What happened? 2. Were there any errors of problematic practice and/or what could have been done differently? 3. Why did those errors or problematic practice occur and/or why weren't things done differently? 4. Which of those explanations are unique to this case and context, and what can be extrapolated for future cases so become findings? 5. What remedial action needs to be taken in relation to the findings to help prevent similar harm in future?
4.2	Section 3 of this Report sets out some of the known key events and practice interventions in Adult P's life, while section 4 draws together the findings in relation to professional practice and the organisational context in which some of that practice took place, and whether things could have been done differently and potentially have led to better outcomes. Section 5 will identify areas to be considered/recommended for remedial/improvement action.
4.3	On the basis of initial information provided to DSAB there were a number of concerns identified as needing further information and analysis of events. This was in order for agencies and the Board to learn and take improvement action where findings identified that inadequate safeguarding practice and/or organisation errors/system barriers to good safeguarding practice, might have prevented Adult P's statistically early death. The 6 concerns below encompass the questions posed in the Terms of Reference.
	Key concern 1: Did practitioners comply with individual agency and South Yorkshire Safeguarding Adults Policies and Procedures (developed and adopted by the Doncaster Safeguarding Adult Board), including those relating to self neglect.
4.4	Whilst this SAR has not examined all the detail of the Safeguarding Adults Policy and Procedures, there is no evidence that there were any obvious errors in staff/agencies following procedures. As the methodology for conducting this SAR did not require agencies to submit individual management reviews (IMRs) and as agencies did not on the whole provide a 'critiqued' chronology it is difficult to be certain. However,

[21] www.scie.org.uk/safeguarding/adults/reviews/care-act

	It is evidenced that at least 3 safeguarding concerns were raised from different agencies between the end of April and December 2018. The first 2 did not proceed to a full safeguarding investigation but discussion did take place about referral through the 'Self Neglect and Risk Management' (SNARM) process on 12th June, though it remains unclear what happened to that referral.
4.5	Whilst Adult P was receiving some support from his next door neighbour, particularly in relation to his laundry, he was not identified as a high risk adult though he had some care and support needs that fell within the remit of receiving intermittent support from the Wellbeing Service. His Wellbeing worker was well known to him and responded to specific concerns and kept in regular, if initially infrequent, contact. It is unclear exactly when his neighbour's support ceased, but by April 2018 evidence of his inability/lack of motivation to take care of himself and his surroundings and manage safe relationships with others began to build up.
4.6	Between April and November 2018 he was seen by a number of professionals, including his GP, mental health workers, community nurses, 2 social workers, fire prevention officers, community staff as well as his Wellbeing Service officer. However, the urgency of the risks posed by his deteriorating situation does not seem to have been recognised by all agencies until late in 2018, when the risks associated with his home conditions, personal presentation, and low mood, (identified as probably the result of exploitation by another adult male) began to be more visible.
4.7	The signs of accumulating risks associated with the professional description of self neglect that indicated the need for safeguarding action included: • his gas was disconnected as he hadn't paid his bill and so had no hot water; • increased fire hazards were visible and fire safety equipment was not being used; • human excrement covered his furniture, including where he sat on his sofa; • excrement was visible on his hands and his often unclothed lower body; • he had lost weight, hair was uncut and he had a generally 'unkempt' appearance; • he was not taking prescribed medication; • he was not letting some staff into his home and even when offered help to sort out his gas bill he was reluctant, saying "I don't want any fuss"; • he was being visited/potentially exploited by another vulnerable adult; • his informal support network had broken down
4.8	Whilst he initially seemed unconcerned by these signs of deterioration

	and was regarded as a generally happy person, his Wellbeing Officer noted that he became increasingly unhappy, and was not going out into the community. His neighbour raised more concerns, particularly about him being 'targeted' by a local man, and he also eventually confirmed the suspicions of his Wellbeing Officer by telling him that he was afraid of this man, who he believed to have been his friend, but had stolen money from him.
4.9	There are some concerns about the slowness of professional responses to the emerging picture towards the end of 2018 of his heightened risks, particularly as there was a record in early 2016 that he "was susceptible to the influence of others". In the last week of April 2018 a safeguarding concern was sent by SYFR and by his Wellbeing Officer but he was not visited by a social worker until 8th June. On that visit the social worker identified that Adult P would benefit from a consistent/named social worker. This indicates understanding of good practice, particularly for people identified as neglecting themselves but allocation did not take place until 6th September and even then no social worker visit took place until 8th November. Information provided in the Adult Social Services agency chronology for this SAR indicated that there was a backlog of referrals during this period due to staff shortages.
4.10	A Safeguarding Planning meeting that took place on the 3rd January, the day before Adult P's death, was still referring to the need for an allocated social worker, and for other assessments to consider his levels of risk.
4.11	It is unclear whether there were any agency time targets specified between referral and action taken to visit someone with Adult P's identified risks, or escalation processes in place when there were staff shortages. At this stage Adult P's risks were not being identified as critical, though they were escalating.
4.12	Identification of and response to adults deemed to self neglect is a much researched area of professional practice[22]. Research papers from the 1950s refer to "social breakdown in the elderly...rendering the 'sufferers' offensive to Society". As well as being potentially dangerous for the individual's health and well being, visible evidence of vulnerabilities can lead to harassment and exploitation by others. It can also lead to public health issues from heightened fire risk, vermin, and general deterioration of property.
4.13	However, in spite of numerous reports and recommendations of what works well to support people who appear to self neglect, this continues to be seen as one of the most challenging areas of practice by staff from health, care, fire prevention and police agencies.

[22] Preston-Shoot, M. (2019), "Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice", *The Journal of Adult Protection*, Vol. 21 No. 4, pp. 219-234. https://doi.org/10.1108/JAP-02-2019-0008

4.14	A very recent finding in a report from experts in the field of safeguarding adults examined 231 Safeguarding Adult Reviews from 2017-19 and found that 45% of reviews described self neglect as the major factor in the reason for the review being commissioned by Safeguarding Adult Boards. However, referrals of safeguarding concerns relating to self neglect appear to be comparatively low.
4.15	This research reports that the region of Yorkshire and Humberside has a comparatively low percentage of referrals for Care Act section 42 safeguarding enquiries but a comparatively high number of SARs. This possibly indicates that self neglect concerns are not being responded to early enough as needing scrutiny through a safeguarding lens as well as a care and support process.
4.16	Whilst there needs to be caution about drawing conclusions from the data in this recent research, in my experience front line workers, particularly from community based agencies, often recount that their concerns about increasing risks to an individual don't get over the 'high bar' and/or are not acted on promptly enough by other professionals with specific safeguarding responsibilities.
4.17	Referral through the SNARM process was being discussed in early June 2018 but it appears no action was taken, nor was there evidence that a multi-disciplinary meeting was convened so the opportunity for all those involved with Adult P to consider evidence of increasing risks, such as attention to fire safety, storing up medication, having mental health issues and seeming confused on occasions was missed.
4.18	By November there was sufficient information available to identify that Adult P was not willing/able to care for and protect himself. It seems he couldn't be referred for consideration through the SNARM process until information was available as the result of a mental capacity assessment. The Safeguarding social worker did not begin to undertake a capacity assessment until 20th December – this was completed on 27th December. As referred to in section 4.10 there was what was described as a Planning Meeting on 3rd January but decisions seem to be made that Adult P required more assessments rather than a protection/safety plan.
4.19	Whilst some research by the Social Care Institute for Excellence suggests that "the development of Self Neglect Policy/Protocols can support decision making and may reduce the consequences of self neglect, (it cautions) that the evidence base is 'thin'. Creating new processes/forms to be completed and additional hurdles for front line staff and first line managers, needs to be viewed with caution if they seem to be replacing multi-disciplinary team meetings that may be able to be convened more quickly.
	Key concern 2: Did practitioners make appropriate use of mental capacity assessments taking into account evidence of fluctuating

	capacity and balance of risk and choice and the level of professional curiosity about those choices.
4.19	Prior to April 2018 there is no evidence within the agreed timeframe for this SAR that any professional considered that Adult P might lack capacity to make decisions about how he lived his life. There were however, concerns about whether he had a full understanding of the risks for him and potentially for others that were inherent in the way he was living. In November 2016 his GP patient file records that a Wellbeing/Mental Health assessment was carried out that described him as 'mildly cognitively impaired'. He had difficulties with his finances and was not living a healthy life but he wasn't coming to the attention of public agencies, including his St Leger Homes landlord. Social landlords are often one of the first agencies to be alerted to evidence of self neglect.
4.20	He was receiving support from his neighbour, particularly with his washing and he usually accepted visits from his Wellbeing Officer, and significantly was still able and willing to give the phone number of that officer when the community physician/geriatrician visited him in late December 2018.
4.21	Some areas of his behaviour seem not to have been explored, particularly in relation to his understanding and/or willingness/ability to remember to take his prescribed medication. In spite of not being seen by his GP for over 2 years he was collecting prescribed medication that subsequently was discovered in his property unopened – some dated back to 2017.
4.22	Towards the end of April 2018 his neighbour began to be more concerned about him and his Wellbeing Officer referred him to SYFR for a fire safety check, which he accepted. In their report the fire officers recorded that, "Adult P appears to have mental health issues". In the same month the Wellbeing Officer recorded that "Adult P seems confused at times". Neither report specifically mentions mental capacity but both indicate possible issues, though there is no evidence that an assessment of any specific capacity area was being identified and 'tested'. Global concerns recorded as mental health issues and confusion are not sufficient given that a mental capacity assessment (MCA) requires specificity about what decisions the person may be unable to make [23].
4.23	Adult P was certainly a person with some brain impairment due to his traumatic injury, which was reasonable for him to be considered for doubts about his capacity (Stage 1 of the MCA[24]). He had some behaviours that would be unacceptable in most cultures, particularly in relation to his personal care. However, without an assessment no

[23] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance
[24] https://www.legislation.gov.uk/ukpga/2005/9/section/4A

	conclusions could be drawn as to his capacity to choose to ignore that he was covered in his own excrement and whether he had understanding of the impact on his health and social contacts of not being able/willing to clean himself and/or seek help if he was unable to control his bowels.
4.24	In June 2018, whilst there was a safeguarding referral in response to his deteriorating personal and living state, there was no recorded consideration of a MCA. Subsequent visits in August, including from a health visitor, who was concerned about evidence of hoarding deodorant cans, the significance of which does not seem to have been explored, and the state of his home, did not indicate concerns about his capacity, though a referral for a mental health assessment was made to RDaSH by his GP. His GP had visited him at home and described him as unkempt...faeces on his body...dirt everywhere, although he also noted that he was "articulate...seemed to have good short and long term memory". In the recent 231 SAR analysis report, the authors comment on a SAR report where the finding reflects some of the issues practitioners from all disciplines can struggle with, "It was easy to overestimate comprehension and overall cognitive ability, particularly in the presence of verbal skills".
4.24	By November 2018 agencies were becoming more concerned and in their report following a second visit, the SYFR reported that they were "unsure about Adult P's capacity to make decisions about how he lives given some of the ways he had answered our questions".
4.25	The issues of capacity to make decisions about how he lived were not followed up but a referral was made again to mental health services for a general mental health assessment. He was judged not to fit the criteria for mental health services as he did not have a treatable mental illness. When he was re-referred again in December 2018 advice was given by the psychiatric team that he would be eligible to have a mental capacity assessment as his capacity to carry out decisions to care for himself safely (executive function) was likely to be affected as a result of his brain injury in 2002.
4.26	It wasn't until 20th December that a formal process to assess his capacity was carried out. On 27th December the social worker's assessment confirmed he did not have capacity with regards to his care and support needs and a Best Interests meeting was planned for early in 2019 but Adult P died before it could take place.
4.27	Towards the end of December, following referral from his GP, he was visited twice by a community physician/geriatrician. Her letter to the GP after the substantive visit identified concerns about Adult P's memory and a plan to carry out cognitive tests in early January "I am very concerned about his memory and I would like to check into this further to see what we can optimise". She does not appear to have had concerns about any specific areas where he might lack capacity, but one of the tests in undertaking a capacity assessment would be to "understand,

	retain, use and weigh information relevant to the decision". Her identification of memory loss might have indicated that he was unable to retain information.
4.28	Whilst Adult P was cross-referred amongst a number of agencies/teams in the latter half of 2018, he was not the subject of a full assessment as to whether his articulate and chatty presentation was matched by behaviour that indicated that he recognised the serious consequences of his behaviour and was able and willing to accept support to assist him in avoiding or at least mitigating those consequences.
4.29	In their feedback SYFR demonstrate their understanding of the complexity of mental capacity. They did not make direct referrals to safeguarding but did refer internally to their district high risk co-ordinator who sent their concerns to the Wellbeing Service. They described Adult P's presentation as not unusual to them, and were concerned about his and others "executive capacity i.e. to anticipate and then make the relevant decisions to act at a time when they need to act to keep themselves safe". This is particularly pertinent where action to prevent, and if necessary, manage a fire is needed.
4.30	Without prompt action to carry out a thorough mental capacity assessment it appears that it was not procedurally possible to set up a SNARM meeting. Such a meeting might have been able to consider whether Adult P was actually *self* neglecting.
4.31	The use of the terminology self neglect suggests that the person is in some way wilfully not taking care of themselves, and Adult P's insistence that he chose to be and live as he did was difficult to challenge. This would be regarded as appropriate professional practice whilst he appeared to be cheerful and managing to eat and go into the community and do his shopping. It is less easy to understand that his noted deterioration, being covered in faeces, living in an unsafe environment, and being fearful, were informed choices.
4.32	It is of note that in August 2018 the Approved Mental Health Practitioner (AMPH) made contact with adult social care staff and gave information about the previous brain injury, which possibly explained Adult P's functioning at a 'suboptimal' level for the past 16 years and combined with aging of his brain could explain why he was no longer able to self-care effectively, rather than he was 'choosing' not to care for himself.
	Key concern 3: Was there effective recording and sharing of information across agencies and effective use of multi-disciplinary meetings?
4.33	The Wellbeing Officer and the Communities worker appeared to work together to support Adult P. Appropriate referrals were made to SYFR and information was shared. Referrals were made by social workers to Adult P's GP and to RDaSH. Once his GP became aware of the growing concerns about Adult P's self neglect he visited him and passed

	information to the Mental Health services in RDaSH.He also referred him for blood tests to community nursing, and then in December to the physician/geriatrician for a full assessment.
4.34	What didn't seem to take place were any meetings that could be called multi-disciplinary, involving all the agencies who had some contact with Adult P during the last 3 months of his life, until the day before his death. An MDT might have avoided the issues over whether he was at risk because he had mental health problems; there may have been greater clarity of information and prognosis in relation to the possibility that he could continue to live a risk managed independent life; and a mental capacity assessment may have been carried out earlier. A safeguarding planning meeting was held the day before Adult P died.
4.35	It is also concerning that information about the appearance in Adult P's life of another adult male, who had identified difficulties of his own, was not regarded with greater suspicion.
4.36	Adult P's neighbour raised a number of concerns about this man and there was visible evidence that he was storing 'items' in Adult P's house and suspicion by the Wellbeing officer and subsequently the social worker, that he was obtaining money from Adult P. It had been recorded in 2016 that possibly as a result of his head injury, Adult P was easily influenced by others.
4.37	The person who was identified by Adult P to the Wellbeing officer and the social worker in December 2018 as taking money from him and of whom he had become afraid was discussed in December at a Doncaster Case Identification Meeting (CIM). It was not accepted that he had committed any offence against Adult P but he was moved to other accommodation outside Edlington, although he was seen in Edlington on the day before adult P died.
4.38	In my experience as a Safeguarding Board Chair and as the author of several SARs it is not unusual to discover the presence of someone who has an interest in/is 'helping' as 'a friend' a person who is identified by neighbours and/or agencies as living in a state of personal and environmental neglect. The motive is often financial, believed to be a widely under reported area of abuse. It is in the abuser's interest to encourage refusal by the vulnerable person to accept support from public agencies.
4.39	A safeguarding led MDT meeting prior to the Case Identification Meeting (CIM) where Adult P's safety was the key discussion in relation to this man, might have led to different conclusions about his ability to protect himself, and whether stronger protective action could have been taken earlier. Some practitioner staff, Adult P's Wellbeing officer in particular, as well as his neighbour were concerned and had been for some time about Adult P's exploitation, though adult P did not want any action taken.

	Key concern 4: The quality of the support and services offered to Adult P and others who had concerns about him.
4.40	The creation of a Wellbeing Service in Doncaster would generally be regarded as an area of good agency practice compliant with the Wellbeing Principles set out in the 2014 Care Act[25]
4.41	The service Adult P received from the Wellbeing Service from 2013, particularly in relation to his finances and intermittent support seems to have been welcomed and appropriate to his needs and wish to remain independent of services. His needs increased in 2018 when he appears to have had a disagreement with his neighbour/informal carer and she felt he was becoming "too much" for her. The Wellbeing Service and the Community Service began to visit him more frequently as both his personal presentation and his home conditions deteriorated.
4.42	Appropriate referrals were made and carried out for fire safety checks. He received advice and fire risk prevention equipment and in early November SYFR staff did a 6 month follow-up visit to Adult P and assessed that the fire risk had increased and raised a safeguarding concern. Once his GP became aware of the level of risk identified by other agencies, he became actively involved with Adult P – making referrals to physical and mental health agencies. The assessment by the community geriatrician was speedy and comprehensive.
4.43	There appear to have been some difficulties with timely adult social care involvement with Adult P, reportedly due to the volume of work for staff and the priority assigned to Adult P. I am unclear whether his identification as someone who refused care interventions also contributed to this delay, particularly as the Wellbeing Officer was accepted by Adult P and had oversight of his welfare.
4.44	When doubts about his capacity to care and protect himself became more urgent the safeguarding social worker/senior practitioner became involved and a mental capacity assessment was completed fairly quickly given that the activity took place over the Christmas period. A planning meeting was scheduled for early in the New Year but Adult P died the day after it had taken place. There was nothing reported in any assessments shared for the SAR that Adult P was in immediate danger of dying and there seems to be no evidence of any suicide ideation.
4.45	It seems Adult P had no involved relatives or concerned friends. Whilst I have very little detail about Adult P's neighbour it does appear that she was being an 'informal carer' in providing practical support and whilst she was involved Adult P was seen as 'coping'. Even after she felt unable to continue to provide him with practical support she demonstrated her

[25] https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/how-is-wellbeing-understood.asp

	concern about his vulnerability by contacting agencies about his deteriorating personal and home conditions.
4.46	Her concerns about her strong suspicions about exploitation by another person, towards the end of his life confirmed by Adult P, seem not to have been heard and explored with sufficient curiosity about events she regarded as indicators of exploitation. There is no indication in any of the reports that there was any formal recognition of her caring role and supports offered to her to continue that role with Adult P.
4.47	There is not a great deal of evidence that Adult P refused support and interventions from people, even those he had not met before but not unreasonably it would be on his terms. Community nurses were able to try to take blood samples: he was cooperative with the community geriatrician and agreed she could remove his out of date Nomads: he allowed the fire officers to carry out 2 risk assessments; he allowed the GP and 2 mental health workers into his house; and cooperated with the safeguarding social worker by giving her the money to shop for him.
4.48	What is striking is that there seems not to have been any discussion and consideration of the impact on him of his personal history, the life he lived as a miner, his family/important relationships, his hopes and fears and what activities he liked to do. There is no information that he was referred to any voluntary sector agencies or to join any groups, though there is no evidence that he wasn't a sociable person. Greater attention to him as a person, and support to find someone else like his neighbour may have produced better outcomes for him.
	Key concern 5: The impact of Adult P's mental and cognitive health, presenting behaviour and lifestyle choices on proposed interventions and decision making including consideration of legal options.
4.49	Concerns about Adult P's presenting behaviour began to be shared in April 2018 and became more serious in October 2018. Referrals were being made to other agencies for assessment and staff began to view Adult P through a safeguarding lens rather than as a man with some issues who needed support. As no immediate harm was identified as a result of Adult P's self neglect and Adult P was not routinely refusing support the need for legal interventions outside consideration of his mental health and latterly his mental capacity were not identified.
4.50	There seems to have been some confusion about the reasons for his referral to RDaSH mental health services in September in 2018 and again later in the year. This may have been as a result of a lack of knowledge about his traumatic brain injury in 2002. He was visited and assessed by two mental health staff but judged not to fit the criteria for their services as he did not have a treatable mental illness; his behaviour assessed as likely to have been as a result of his brain also being affected by his age as well as his previous injury. Advice was given about

	assessment of mental capacity and also a referral to neurology was planned.
4.51	Again what might have had led to better outcomes for Adult P would have been swifter action to fully assess all his risks and his needs within some form of multi-agency meeting between mental health, physical health and social work professionals.
4.52	Adult P was a 'known' vulnerable person to local police support officers, and had been visited when he was reported in an undressed state at his window in September 2018.
4.53	Police officers did attend with the Wellbeing Officer on 13th December when there some concerns being raised about potential financial exploitations but due to his presentation, the state of the property, and his unwillingness to discuss any exploitation, they did not interview him, but did submit a vulnerable adult referral form. The fact that a mental capacity assessment was not undertaken sooner may have contributed to this matter not being investigated more thoroughly at that time.
	Key concern 6: Whether practitioners were working in a person centred, assertive and proactive way.
4.54	There is little information about Adult P's background and the impact on him of the loss of his employment and partner and family relationships following his major traumatic life changing head injury in 2002. The injury itself appears not to have been known at least by Council wellbeing/care agencies when Adult P moved to Edlington and began to have some support in 2013.
4.55	His neighbour began to withdraw support, particularly in relation to his washing. His Wellbeing worker described him as confused at times, and made a number of referrals to other agencies but there seems to have been no evidence of any real curiosity as to why the deterioration was taking place, particularly in why he was covered in faeces
4.56	The open visibility of excrement on his body is unusual even for people who are regarded as self neglecting. Did he have bowel problems - was he unwilling to manage his toileting appropriately or in fact was he unable to do this? Did he often appear with his lower body uncovered at his door because he couldn't manage his bowel problems? He admitted to having bowel problems in his discussion with the Community Geriatrician a few days before he died but no agency appears to have been having exploratory conversations with him before then. Was the hoarding of deodorant cans a clue that he did have concerns about his faecal odour and it wasn't all a matter of 'choice'?
4.57	In relation to safeguarding was he an adult at risk of abuse and neglect, including self neglect? The research base as well as even lay and professionals' experience, would answer yes to that question. His

	presentation would have predicted that he had a high risk of being targeted as easy prey for abusers.
4.58	An expert and long experienced psychologist, Professor Hilary Brown, describes that, "adults who self neglect do not make a specific decision not to care for themselves, but instead they will experience a gradual slide into non-action." I would add that it is not unusual for staff working with those identified as self neglecting to find themselves on a similar slide. It is widely recognised that identifying and being able to work effectively with people exhibiting self neglect behaviours, particularly when accompanied by service/support refusal is an extremely difficult area of work. It needs curious, vigilant, and well supported practice for staff to constantly collect and weigh up the evidence that the gradual slide is not approaching the cliff edge for the individual and for themselves.
4.59	The fact that social work staff were not able to become involved quickly with Adult P when concerns were identified by the Wellbeing Officer, could have contributed to the delay in identifying/confirming Adult P's lack of capacity to care for and protect himself, and swifter protection to be put in place.
	Good Practice
4.6	There were a number of areas of good practice by staff and also systems of support that indicated knowledge of what works well with people who have indicators of self neglect. • The Wellbeing Service, through an experienced and person centred staff member who built a trusting relationship with Adult P, offered low level, practical and 'checking on' support to him and other adults with a range of vulnerabilities that were below the threshold of needing social work/safeguarding interventions. This support continued in a joint working relationship after social work/safeguarding staff became involved. • There was Identification of the need for continuity in a named social worker to build a trusting relationship with Adult P • SYFR responded efficiently and sensitively to their referral to check out Adult P's fire risk and did a follow up visit identifying a raised level of concern. • The Community physician/geriatrician carried out a thorough assessment and demonstrated compassion and persistence in engaging with Adult P, and identified a detailed plan of action to further assess and support him.

5.	**Conclusions**
5.1	Examples of deaths associated with self neglect continue to be very common in Safeguarding Adult Reviews. Research into case reviews prior to the Care Act also indicated the high number of deaths where a finding /evidence of self neglect have been key factors. The dangers of self neglect that result in death are often only beginning to be treated seriously just before a death occurs.
5.2	Research into self neglect describes the risk identifiers for self neglect as a complex interaction of physical, mental, societal, personal and environmental factors. Lists vary but often include the following and are pertinent to Adult P: - Living alone with no known close relationships - Unemployed with few identified activities - Limited economic resources - A traumatic event(s) like Adult P's serious head injury in 2002. It is not known if that resulted in him losing his employment as a coal miner, often described as employment that endowed community status and forged strong friendships - Diminished social networks - Someone who never quite 'fits' health, particularly mental health, and social care support services criteria - Wearing 'fierce independence' as a 'badge of honour' whilst care and control over self and environment is visibly deteriorating
5.3	There are examples of good and compassionate practice by individuals in their work with Adult P and significant investment in developing cross agency systems to learn from and improve practice in protecting people who self neglect. However, some of that policy and procedure development may have become too complex to navigate in everyday care work, particularly when demand for social work support in particular exceeds timely prioritisation of work with people identifying as self neglecting.
5.4	Little is known of Adult P's early life so it is unclear if he had risk factors for self neglect before his head injury. Good practice in working with people identified as self neglecting is said to start by trying to understand the meaning of self-neglect in the context of each individual's life experience. Sadly that doesn't appear to have taken place or perhaps not recorded and being identified as important information to find ways to mitigate Adult P's own harmful neglectful behaviours.

	Recommendations and Considerations
1	It is clear from reading Annual Reports from the Doncaster Safeguarding Adults Board from the last three years that a significant amount of work has been devoted to staff development in the area of self neglect. New training courses have been developed including learning from a good practice case that was featured in the 2018-19 RDaSH Annual report.[26] The recommendations that follow should build on that good work.
2	DSAB should consider commissioning a multi-agency staff development event, including all agency practitioners, using this SAR as a case example. The purpose would be to update staff on research into identifying and risk mitigation of life threatening self neglect; to test out the clarity of the SNARM process and its relationship to Safeguarding and Mental Capacity assessment processes; and to engage front line staff in developing any changes for improving practice in identifying and supporting adults who may be neglecting themselves.
3	All partner organisations should provide evidence to the Board that they have a programme of staff training/development that includes practice-based workshops on use of the Mental Capacity Act (MCA). Workshops in relation to MCA should be regular, brief and 'case based'. Opportunities to fully understand the distinction *and* connection between decision making capacity and executive function capacity and the balance of rights under the Human Rights Act (ECHR) need to be included.
4	Given some of the findings in the recent research from Professor Michael Preston-Shoot and colleagues, DSAB, should consider as part of the Board quality assurance programme an audit of a sample of cases where self neglect is identified but not referred to safeguarding to identify good practice and areas where greater scrutiny is required.
5	DSAB should seek assurance from health partners that where an adult has had any serious head injury that regular health checks are undertaken and procedures are in place that where there is non-compliance with health checks a referral for further enquiries should be made given the evidence of greater risk of additional cognitive impairment as a person ages.

[26] In 2018-2019 work was undertaken with J, where there were concerns about self neglect. The aim of the support was to use strength based interventions to with J who was willing to accept support.
www.rdash.nhs.uk › safeguarding-children-and-adults-

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6	Adult P had no family members or close friends 'looking out for him', but he did have a concerned neighbour who was sometimes referred to as his 'informal carer'. Neighbours are often essential supporters of people living alone and need recognition as potentially part of the 'team' around the at risk person. Partner agencies, particularly housing, social care and health agencies should review their policies and procedures for identifying and offering support to non family unpaid 'carers' as well as family. This is particularly relevant during the Covid-19 pandemic.
7	Adults who live in ways that are not supported by generally accepted cultural norms - for example appearing half naked at their door, being covered in personal excrement, and being unconcerned about their living conditions, are 'at risk' adults, particularly as they are likely to be targeted and exploited by others. All agencies need to encourage and provide training and support to staff to find ways in engaging with people and to be persistent in their curiosity as to why self neglect seems to be taking place. Often self neglect is the result of a traumatic experience earlier in life, so practitioners need to understand a person's history to provide the right support in the present.
8	The DSAB should consider its relationship with third sector/community based organisations which may have been able to offer Adult P more activity/interest based support. Whilst it is possible that workers did know more about Adult P's likes, dislikes, interests, and aspirations there is no evidence that this information informed strengths based assessment giving opportunities for protective factors to be developed.
9	The DSAB should seek a review of its SAR process, particularly in relation to requirements for, and quality of critiqued chronologies from all relevant divisions of partner agencies and the use of efficient electronic platforms to communicate with SAR authors.

Appendix 1

10 questions/areas for exploration agreed Doncaster SAB subgroup

1. The internal policies and procedures followed and at the relevant times.
2. SY Safeguarding Adults Policies and Procedures followed.
3. The adult's mental capacity assessment, timings of this and recording.
4. The impact of fluctuating mental capacity considered the services response to this.
5. Recording of decisions and assessments.
6. Information sharing between agencies.
7. The services and support offered and available.
8. The impact of the adults mental health, presenting behaviour and lifestyle choices on proposed interventions and decision making
9. The response from agencies involved in timely and appropriate manner.
10. 10 Agencies working in an assertive and proactive way, giving consideration to legal options