SAR HARRY July 2022

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Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

Contents

1. Introduction and reason for review

1.1 In March 2021, the Waltham Forest Local Safeguarding Partners agreed to a recommendation from the One Panel to undertake a Safeguarding Adults Review (SAR) for Harry, a 68-year-old man who had died in a fire at his home in January 2021.

1.2 Harry was known to several partnership services and the information presented at panel suggested potential indications of neglect as well as questions regarding how effectively services worked collectively with him and it was agreed that the SAR criteria was met.

1.3 The One Panel agreed that Harry's circumstances met condition 1 in line with Section 44 of the Care Act 2014:

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if

a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) Condition 1 or 2 is met.

Condition 1 is met if

a) The adult has died, and
b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.4 The purpose of a SAR is to "promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect." *(Care and Support Statutory Guidance, October 2018, 14.164)*

1.5 The purpose of a SAR "is not to hold any individual or organisation to account". Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council etc. *(Care and Support Statutory Guidance, October 2018, 14.168)*

1.6 The One Panel, in conversation with the Senior Responsible Officer and the Lead Reviewers, agreed the focus and lines of enquiry for this SAR initially as the following:

- Are our partnership responses to self-neglect adequate?

- Is our practitioners 'professional curiosity' sufficient when presented with self-neglect?
- What were the barriers that stopped practitioners working together with Harry?
- What was the impact of COVID 19 on practice?

2. Review scope and methodology

2.1 This review was undertaken using a hybrid methodology that takes a systems approach and is based on the following principles:

- Avoidance of hindsight bias. That is understanding how different professionals saw the case as it unfolded whilst trying not to be influenced by the knowledge of the outcome
- Providing adequate explanations for the practice encountered - appraising and explaining; and
- Understanding how the specifics in this case can be used to generate wider understanding.

2.2 This approach provides a framework for considering the influences on practice by people. It helps us understand not only why things happened the way they did, but also looks beyond into the "how", aiming to examine the wider factors that influence practice, practitioners, and organisations at any time.

2.3 To reflect the multi-disciplinary nature of Safeguarding Adults Reviews, the SAB appointed as the reviewers, Tim Stubley (Team Manager, Adult Safeguarding and DOLS Team, London Borough of Waltham Forest) and Samantha Chessa (Designated Professional: Safeguarding Adults, NHS North East London Health and Care Partnership) to co-ordinate and complete the review process and prepare the final report and recommendations. Gill Nash (Head of Settings and Workforce Safeguarding, London Borough of Waltham Forest) was appointed as the senior responsible officer for this SAR.

2.4 A multi-agency, multi-disciplinary review panel was established to consider and examine key issues in relation to Harry's death.

2.5 Chronologies of involvement from all agencies who provided services to Harry prior to his death were collected, this was then collated into a single integrated chronology.

2.6 Review workshops considered the integrated chronology, the issues, and themes, which were subsequently considered in detail by the authors of this report.

2.7 Relevant documents and information such as assessments, case notes, policies and procedures were considered against professional practice. Discussions took place where necessary with key persons and organisations involved in Harry's care.

2.8 In order to consider if the circumstances and experience of Harry were unique to either Harry and/or to Waltham Forest the authors undertook:

- A review of fire related SARS

- A review of the document 'a national analysis of Safeguarding Adult Reviews (SARs)'

2.9 The agencies involved in the review were:

Agency	*Represented by*
Barts Health	Safeguarding Adults Named Nurse from Whipps Cross Hospital
LBWF	Adults Safeguarding Team Complex Care Team
London Ambulance Service (LAS)	LAS Safeguarding team
London Fire Brigade	Borough Commander
NELFT	Operational Lead ICT South
Waltham Forest Clinical Commissioning Group (CCG)	Safeguarding Lead Named GP for Adult Safeguarding Waltham Forest & East London CCG
Unique Care	Registered Manager

2.10 Two review workshops were held with attendees' representation as per above. The review workshops considered and explored:

What happened	Any errors or problematic practice and /or what could have been done differently?	Why those errors or problematic practice occurred and/or why things weren't done differently?
Which of those explanations are unique to this case and context, and what can be extrapolated for future learning and service improvements?	Missed opportunities	Key Themes
What went well? What could have been done better? Why could have it been better?	Did we work collaboratively?	
Are there any unique/ standout issues to this case?	Anything else of note	

2.11 Key themes and issues emerged from the workshops which can be summarised as follows:

- Duties relating to safeguarding, review and assessment may not have been enacted upon appropriately by the local authority.
- Housing may not have been suitable and may have presented a health and safety risk.
- Fire safety may not have been considered in a joined up and cohesive way. There may have been missed opportunities to address fire safety concerns.

- The need for formal support around excessive alcohol consumption was not recognised or addressed.
- Risk assessment may not have been carried out appropriately or in a joined-up way.
- Services' engagement with Harry was ad hoc and sporadic and non-engagement could have been approached in a different way.
- Agencies working with Harry did not have joined up policies and procedures
- Use of language appears to have been hostile

2.12 This review appraised the practice that Harry had received against the key themes and issues and emphasis given to considering how issues were addressed under a multi-agency and multi-disciplinary lens.

2.13 In exploring areas of practice through identifying what worked well, what good practice would look like and encouraging reflection we are able to develop our understanding at a systems level of how multi-agency safeguarding partners work together and where there is scope for improved practice.

2.14 The reviewers approached a number of key managers involved in the care and support of Harry, including the Manager for Adult Care Management Team and representatives from care agencies working with Harry.

2.15 We thank all those involved in the review for their honesty and support in ensuring that the review process focused on learning and improving practice.

3. About Harry

3.1 Harry was a 68 year old white British man who died in a house fire at his home on 25 January 2021. His cause of death was due to inhalation of smoke and combustion products and burns sustained during an accidental fire, the cause of which was ignition of a towel which had fallen on a fan heater.

3.2 His death was treated as non-suspicious. Contributory factors were found to be related to his poor health, poor mobility and at the time of his death he was severely intoxicated. [1]

3.3 Harry rented a room from his friend David who was effectively a 'live in' landlord. David was in the property at the time of the fire and escaped the building following a failed attempt to get Harry out. David was treated for smoke inhalation and is believed to have made a full recovery.

3.4 Unsuccessful attempts were made to contact David and gain his views for input into this SAR, by using records on file.

1 (Source Coroners Report)

3.5 Harry was a single man who had no children. It is understood from a social worker within the hospital team that he had previously been living in Majorca where he had been trying to set up a business after selling his property in Epping. It seems this had not gone to plan due to issues with his business partners that resulted in a significant financial loss which led Harry to being forced to return to the UK. Upon arrival into London, with no money and no friends or family to call upon, it appears that Harry turned to David who agreed that he could stay with him for a few days. Harry had been a chef and is reported to have previously worked with David many years before.

3.6 Harry reported at the time of assessment to the hospital social worker that he ended up staying with his friend and paid rent for the room allocated to him in the flat. It seems that David had agreed to him staying longer until he was able to sort himself out.

3.7 It was further reported that David also supported him with his shopping, meal preparation and managing his correspondence.

3.8 We are unable to verify the nature of the rent paid or if a tenancy agreement was in place, however it seems this most likely was an informal arrangement.

3.9 It is also unclear as to the role that David performed as a potential informal carer and the level of reliance that Harry had on him as his health began to decline.

3.10 This appears to be a significant question as initially Harry staying with David was a temporary arrangement. Unfortunately, we have been unable to contact David for clarification during the process of writing this review.

3.11 From the records available Harry had multiple contacts with his GP and community health teams. In addition, he attended appointments at hospital and had engagement with the London Ambulance Service on multiple occasions due to falls within the property.

3.12 Harry had a formal diagnosis of COPD initially diagnosed in 2008 and recorded as deteriorating over an 8-year period, being identified as severe in 2016. He also had hypertension, bilateral cataracts (worse in right eye) and urine retention.

3.13 Harry's mobility was poor; he struggled to transfer and mobilize and was house bound. It is unclear whether this was due to general health deterioration or whether this was due to his diagnosis of myoneural disorder in 2014 which is defined as a chronic auto immune neuromuscular disorder characterised by muscle weakness.

4. COVID 19

4.1 It is important to recognise that in January 2020 the United Kingdom experienced the beginning of the Covid 19 pandemic, which resulted in non-essential contact restrictions being implemented on the 16 March 2020 and the first Lockdown being legally in place from the 26 March 2020.

4.2 We recognise that Covid 19 presented an extraordinary set of circumstances that had not been previously experienced and resulted in a fast-paced introduction of a new way of working. There was rapidly changing information provided from governmental departments and agencies that would have been involved with Harry's care would have been affected in a significant manner.

4.3 Nationally Safeguarding concerns dropped markedly during the initial weeks of the first Covid-19 lockdown period, only to return to and then exceed expected levels in June 2020. The trend of safeguarding enquiries showed a similar decline during the initial weeks of the Covid-19 lockdown period and upturn in June 2020, although the June upturn was not as great.

4.4 In Waltham Forest, as per nationally there was a strong correlation between lock down and reduced numbers of safeguarding referrals. It is of note that in December 2020, when Harry was probably in the greatest need, self-neglect safeguarding adults concerns reported were significantly lower than after lockdown.

4.5 The Briefing: *Adult social care and COVID-19 'Assessing the impact on social care users and staff in England so far (Karen Hodgson, Fiona Grimm, Emma Vestesson, Richard Brine)* notes that in addition to more than 30,500 excess deaths of those living in care homes during the pandemic, there had been a significant loss of life within the domiciliary care sector, with mortality increasing by 225%. The report notes that a significant number of the deaths were non covid related and may be related to the impact of isolation, reduced social care services and difficulty in accessing health care.

4.6 Various strategies were implemented to help support and maintain core service provision during COVID across social care teams these included enhanced one to one supervision of staff, regular team check ins via Microsoft Teams and operational team meetings. The structures sought to contain individual and team anxiety to provide delivery of service within the pandemic.

4.7 Health and social care team leaders have advised that the impact of COVID was felt across teams individually (illness, loss, anxiety) and collectively, noting additional work pressures associated with COVID for example, welfare checks on residents identified as shielding, communicating with residents, provision of safe services while not increasing risk of infection.

4.8 It is noted that prior to the pandemic the service was already dealing with increasing vacancies in both community & hospital services, and requirements for care had already outstripped the capacity, due to an increasing aging population, increasing demands especially for our very complex patients

4.9 There are reports that the impact of COVID on the community staff was very noticeable, these include:

- Some services were stepped down and staff redeployed to bridge gaps in the most needed areas, which lead to delays in care as waiting lists increased.
- That general practitioners were not seeing patients face to face, which caused an increase in the referrals to the Rapid Response Team and other community staff.
- That some staff were shielding due to medical conditions.

- It is noted that in areas where a great many numbers of staff are from high risk backgrounds, this leads to additional staff shortages, increasing sickness numbers due to shielding and isolating
- The emotional impact was noted. Staff were sad, overworked and broken, some talked about leaving the profession, and others retired.

4.10 Remote working and increased provision of telephone assessments may have impacted on the quality of information provided to practitioners who may have ordinarily carried out face to face assessments. They were now more reliant on the information provided by individuals via a telephone encounter.

4.11 It is of note there were no easements of key statutory duties, agencies were having to adapt to fit in new ways of working, whilst under extraordinary strain and pressure.

4.12 Harry's initial assessment took place on 11/12/2019 to aid discharge from hospital which was just prior to the first wave of COVID. We think it highly probable that COVID had a significant impact upon practitioners' ability to review the care package as pressures may have been elsewhere. This is evidenced anecdotally by accounts given by health and social care colleagues who also note a reliance on telephone reviews.

4.13 The authors note that practitioners when working with people who self-neglect are encouraged to '*walk alongside'* and use '*professional curiosity'*. *W*e note that early when Harry needed this approach the most it was compromised given the impact of COVID and new ways of working.

4.14 The authors are mindful of the unprecedented circumstances that professionals and service users alike found themselves in. Whilst it may not be possible to be precise about impact, it is probable, as evidence by the testimony given and research that COVID may have a significant effect upon the ability of practitioners to work with Harry upon the onset of COVID. Managers responsible for the key teams working with Harry, have identified that there were rapid changes and organisations were having to rapidly flex services in line with governmental guidance and also from an organisational standpoint where staff were being redeployed which in itself posed a risk.

5. Summary of the integrated chronology 2013 – January 2021

5.1 Chronology of key events and interventions: (Condensed from the Integrated Chronology)

Date	*Contact with services including reason for referral/contact and any risk identified*	*Outcome*
2013	NELFT Podiatry for foot health	Discharged after 12 months as no response received from Harry. No onward referrals or feedback to other agencies.
2015 – February 2019	No contact with services. Unclear as to where Harry is living.	N/A

Date	*Contact with services including reason for referral/contact and any risk identified*	*Outcome*
March 2019	GP – including contact with practice nurse Harry contacted the practice on multiple occasions indicating poor sleep, increasing use of alcohol and negative impact of health deterioration No risks were documented	Zopiclone was prescribed with caution advised when taking but not clearly indicated in notes. Advised to drink warm milk in evenings to help sleep and to take sleeping tablet 1 hour before bed Referral sent to single point of access 25/3/2019
April 2019	NELFT - Seen by Community Respiratory Team Referral offered to Falls team, District nurses and social services. Assessment noted smoking history	All referrals declined by Harry – indicated in notes he had capacity. Following assessment, it notes no signs of hoarding or self-neglect and no potential fire risk noted. No onwards referral. In GP notes indicates that Respiratory nurse will refer to Falls team – lack of consistency between recorded entries.
	GP – concerns for Harrys poor eyesight and spoke with respiratory nurse	GP to make referral to ophthalmology
May 2019	GP Practice Nurse indicated Harry doesn't require home oxygen following discussion with Respiratory Nurse. Harry requests antidepressants due to long term isolation. No risks identified.	Referrals made to ICM, Social Prescribing for befriending
	Barts Health - Harry seen at cataract clinic	Harry indicates he is happy for short notice surgery
June 2019	GP - 2 x Telephone Consultation with GP – indicates swollen painful legs No risks identified	Advised to call team following day. Call 2 days later and furosemide prescribed – advised if worsens to call for ambulance or out of hours team. Following call, practice nurse emails ICM to request blood tests and review by community matron regarding painful swollen legs
	GP - Harry indicated on the 19th & 20th that he was experiencing side effects from furosemide	Arranged a plan to put in place support with follow up the following week. Unclear what the outcome was
	Adults Social Care - Social prescriber referral received	Harry referred to Good Gym on May 20th – was awaiting a match with a volunteer
	GP – Group consultation. Harry discussed at ICM – plan agreed to visit,	

Date	*Contact with services including reason for referral/contact and any risk identified*	*Outcome*
	assess for falls risk and possible onward referral	
	NELFT - Referral received to Community Matron service	Ten attempts made to contact Harry between June & August 2019. Documented Harry did not 'truly engage' – either too busy to talk on the phone or could not agree a meeting date Fed back to the GP. Matron documents joint visits are considered when there is a noticeable risk to health or if agreed during MDT – this was not considered at the time.
	GP - Consultation where blood results indicate high ferritin and low folic acid. This is an indicator of large quantities of daily alcohol. No risk identified in notes	Prescription issued. Referral made to community matron regarding physio /OT and review of legs. No further action re alcohol consumption and risk
July 2019	Barts Health - Attended pre op clinic for eye surgery. Disclosed that he drinks a bottle of wine a night, unsteady on feet and requires one person to assist	Surgery performed 2/8/2019
22/07/2019-19/08/2019	GP - Harry declines ICM visit. Harry informed he is crawling up the stairs on all fours. Notes indicate that Harry stated if he feels he needs help he will contact the team. Number given	Harry is discussed on 3 separate occasions with the outcome that he is discharged from the community matron service. Community matron states Harry has been given the number to call when he was ready to be fully engaged.
October 2019	GP - Telephone consultations indicating episodes of diarrhoea – likely gastroenteritis. Further concerns regarding bilateral ankle swelling	Advised to reduce fluids to 1 litre a day
	NELFT - Community teams unable to contact Harry throughout Oct & Nov 2019. No risks considered	No escalation. Telephone calls and voicemails left on phone
November 2019	GP - Further telephone consultations indication constipation, poor appetite, and additional concerns regarding not being able to sleep	Harry requests further sleeping tablets
	LAS - Call received from Harry to LAS advising he had fallen from bed. Attended Whipps Cross Hospital. LAS reported poor living conditions	LAS raise Safeguarding Concern
	Barts Health - Harry attended the Emergency department. Following a fall where he sustained a head injury. Reported to be in an unkempt state	No escalation of risk following this disclosure. Discharged with a zimmer frame, and the offer of a 3 times daily

Date	*Contact with services including reason for referral/contact and any risk identified*		*Outcome*
	covered in faeces. 6 falls in the last 12 months as a result of legs giving way. Lives on the 1st floor. Ascends stairs on hand and knees. Reports struggling with meals and personal care. Also indicated he is taking zopiclone and drinks half a bottle of wine		package of care, Harry agrees to one call a day. Reviewed by ED therapies and referred to community therapy team. Referral states that he is a non-smoker
3/4/5 December 2019	NELFT - Attempts made by community therapy team to reach Harry, phone calls unanswered and voicemails not returned. No risks identified		No evidence in referral that there were difficulties in contacting Harry
December 2019	GP - Telephone encounter - Fall 1 week prior, experiencing headaches since the fall. Dressing has not been changed. No risks identified		Referral to Rapid Response
	NELFT Rapid response - Notes indicate there is a long period of positive engagement between Harry and this team. He is reported to have advised the property was untidy, he had poor eyesight. Rapid response attend to deal with multiple lacerations to his body following falls.		Care was shared between this team and rapid response with multiple attendances but no evidence of onward referral or escalation of concern.
	Adults Social Care	Safeguarding concern raised by care provider following a fall regarding self-neglect and Harry living in a poor environment covered in faeces	Concern raised through MASH. Not deemed a safeguarding concern, case closed as referred for case management
		Care package reviewed and increased. One off deep clean of property completed	
		Care agency changed	Original agency unable to provide long term care.
February – March2020	GP - Recurrent telephone consultations with Harry and community teams. No risks reported		No escalation and visits were carried out to address tasks required
May 2020	NELFT - District nursing team attended multiple times between 5th – 27th May, all indicate Harry has mental capacity to consent to treatment and wound care. No reports regarding the state of the property or risk of fire. No risks identified		No escalation. Care delivered as per task allocation.
29/05/2020	NELFT - Community Nursing Team leader attends Harrys property, reports Harry has mental capacity to consent to care and treatment.		Referral made to social services who advised they had tried to make contact with Harry on 2 occasions that week unsuccessfully.

Date	*Contact with services including reason for referral/contact and any risk identified*	*Outcome*
	Escalates concerns to social care and requests a reassessment and a further review of finances as Harry states he cannot afford new bedlinen. Reports the room is untidy and unclean with faeces on the pillow and used urine bottles. The bed is stained with urine and cigarette ash.	No reports of fire risk or that a safeguarding concern had been considered. Case manager raised her concerns and advised these would be shared with the allocated worker.
29/05/2020	LFB attended a fire at Harry's home. Crews found him on a commode in a bedroom on the first floor. He had dropped a cigarette into the bowl of the commode which had ignited the toilet paper in the bowl. He was unable to get himself up from the commode, so he was assisted with getting dressing and being put on to his bed.	
June 2020	Adults Social Care - Case considered an urgent review. Social worker attempts to speak with district nurse but reported that no contact made. It is unclear if further attempts were made.	
2/6/2020	Adults Social Care - Referral received from London Fire Brigade Risk of harm noted	Referral sent to allocated social worker Shared with allocated worker
3/6/2020	Adults Social Care - Allocated social worker makes contact with Harry who advises friend/landlord (David) is back. It is unclear when David went away or for how long. No risk identified – risk is considered diminished	No further action
5/6/2020	NELFT - Case load holder attended Harry and noted the room had not been cleaned as planned by social services	
24/6/2020	Adults Social Care - Harry requests support 3 evenings a week to help prepare food	
July -August	NELFT - Between these dates Harry is visited by community teams and no reference to the property of concerns re risk are documented	Not escalated
11/8/2020	NELFT - Visited by community staff nurse who reports property is again unkempt/untidy.	No documented escalation – missed opportunity Reports meeting was uneventful, and Harry was left comfortable
13/08/2020	LAS - Attended property, carers on scene and report Harry fell the previous night	Harry rang back and cancelled the ambulance stating he did not need it and the request was actioned.

Date	*Contact with services including reason for referral/contact and any risk identified*	*Outcome*
September – October 2020	NELFT - Multiple attendances to carry out wound care, reported to be uneventful and no concerns raised	
13/11/2020	NELFT - Community staff nurse attends and finds Harry sat in the chair smoking. Carer had not arrived. No reports of fire risk, no risk assessment	Staff nurse rang the agency and advised Harry the carer had been caught up on an emergency and would attend
17/11/2020	NELFT - Harry visited by respiratory nurse to review nebuliser machine. Records state room smelt of smoke. No risk assessment or documented concern re fire risk	
19/11/2020	Adults Social Care - Allocated social work attempted to complete review but it is reported no contact is made by him to Harry	Social worker spoke to care provider who advised Harry is ok and more receptive to help.
21/12/2020	NELFT – integrated care management meeting held, the multi-disciplinary team agreed that the community matron will try and engage with Harry again. This would include a joint visit with district nurse	Harry agreed reluctantly to falls referral. 3rd party encounter from community matron advised noted weight loss, house in a poor state and continuing to smoke.
25/01/2021	NELFT - Discussed in ICT meeting. Reported by staff that Harry is no longer getting along with landlord/friend David. Home remains unkempt with faeces around the room and he continues to smoke. He wanted to be considered for extra sheltered housing. Social worker confirmed there has been no contact with Harry for some time	Community matron will try and engage with Harry, refer to therapy team and arrange a joint visit with social worker
25/01/2021	Third Party Encounter by Community Matron - Documented that following visit the house is in total disarray, faeces everywhere, Harry is not eating, still smoking. Struggles with transfers, keen to move to sheltered accommodation or care home. Community matron to email social worker	
25/01/2021	LAS - 999 call received at 00:26 from the London Fire Brigade requesting an ambulance to Harry's property. Reports of a fire in the flat and persons reported to be on fire.	On attending and examination Harry clearly had injuries incompatible with life, full incineration. Recognition of life extinct at 01:13

6. Findings and analysis 1: Safeguarding response

6.1 **A multi-agency safeguarding response that seeks to prevent self-neglect and stop it quickly when it happens was not always enacted as per policy process and guidance.**

How was this finding evident?

6.2 Case notes and integrated chronology show several occasions where there were concerns that indicated the extent of self-neglect was such that Harry was placing himself and potentially others at risk and there may have been a risk of serious harm or death. There are numerous examples i.e.

I. Throughout the duration of community health contact there continues to be recognition that the situation is deteriorating with reports that the room was untidy and unclean and there appears to be "faeces on the pillow, full urine bottles in the room, which he refused to let the nurse empty for him, his bed was stained with urine and cigarette ash."

II. There are in addition contacts with the London Fire Brigade who attended Harry's property in May 2020 to deal with a low-level fire. The referral appears not to have been processed correctly but the concern was passed to a social worker. There were also attendances at the property by the London Ambulance Service due to falls with significant injury and attendance to A&E where assessments were completed but not fully considered to the level of risk. It is of note that on the day of the fire Harry had been visited by the case load holder from the Community Health team and there were no reports of fire risk.

III. On the day of Harry's death, a home visit was completed by a community matron. It was reported that his house was 'in total disarray, there was faeces everywhere and he was not eating. It was further reported that he continued to smoke and to struggle with transfers from bed to chair. It seems that he had stated that he wished to move from the current property and be placed in sheltered accommodation. From the document provided there was no record that these concerns were escalated in line with the level of risk identified, however it was documented that an email would be shared with the social worker regarding the requested move.

IV. Harry's care agency raised a safeguarding concern on 10 December 2019 to advise that Harry had experienced a fall sustaining a deep cut to his head but refused to go to hospital. Additionally, it was reported that Harry was refusing to accept support and is therefore self-neglecting and his environment is poor (faeces in buckets and urine in bottles).

V. The concern identified a high risk of fire in the environments and a cluttered state. A deep clean and occupational therapy intervention was recommended. The concern was not progressed to a section 42 and safeguarding enquiries were not completed; however, it is to be noted the concerns were not ignored but dealt with by care management.

VI. Following a fall, the London Ambulance Service (LAS) attended the property and found Harry in an unkempt state covered in faeces following episodes of diarrhoea. He had a laceration to his head and 'lots of old bruises to both arms'. He reported having six falls in the last 12 months because of his legs giving way. He further reported climbing the stairs to his first-floor room on his hands and knees. It is reported during this discussion that he said he was struggling with meals and personal care. He reports having no carers and smoking and prior to the fall he had taken zopiclone and had drunk half a bottle of wine. As a result, a safeguarding concern was submitted by LAS to the local authority however this safeguarding concern does not appear on records.

6.4 We note that the above examples provide a level of evidence that Harry was self-neglecting to a significant level.

Analysis

6.5 The authors feel it is important to recognise that self-neglect can be a difficult area for practitioners to navigate and there is a fine balance to be achieved between respecting a person's self-autonomy and function and enacting or fulfilling statutory safeguarding duties. Whilst we have identified several occasions when a safeguarding response may have been desirable there may in some circumstance be finely balanced arguments as to why this was not necessary and proportional.

6.6 The authors recognise there may have been a multitude of other reasons why a safeguarding response was not progressed. There may have been uncertainty around escalation routes. Workers may have not recognised the issues they are dealing with equate to safeguarding issues and when formal safeguarding interventions should be considered. Self-neglect may have built up over a period and workers may have become normalised to Harry's situation. Related to COVID that there were significant pressures upon all services working with Harry and this may have meant attention was focused elsewhere. It is also known that due to lock down professionals were visiting less and were more reliant on telephone contact and remote visits. We know Harry experienced challenges with telephone contact.

Why does it matter?

6.7 Whilst safeguarding interventions may have allowed a more formal process for issues around non-engagement and self-neglect to be addressed, it is important to recognise that the most desirable situation would have been that successful interventions would have prevented safeguarding thresholds being met in the first instance.

6.8 A reoccurring theme of this review is that professionals working with Harry assumed that Harry had mental capacity to receive or decline care and support. It appears judgement was made that he was making an unwise decision concerning his living arrangements. We note that if capacity is assumed or tested then it should not negate a professional's responsibility to escalate or exercise a degree of professional curiosity.

Systems level learning

6.9 There has been recognition that in this case, systems process and threshold for safeguarding interventions were applied inconsistently across the organisations working with Harry and as such further training and support is required across the partnership to embed and strengthen safeguarding practice. If this is not undertaken the implications across the system may be a continuation of missed opportunities and poor outcomes for service users.

6.10 We feel it is important to recognise that whilst we consider there were some occasions when safeguarding interventions should have progressed and they may have served the purpose of addressing some of the issues being raised particularly around risk assessment, there were missed opportunities to work with Harry, which may have minimized the need to raise to safeguarding in the first place. We consider that there were potentially lost opportunities for intervention which may have prevented issues of self-neglect becoming apparent and had early interventions brought together all the different people that are providing support to plan how to provide the best possible care and interventions we feel this may have prevented escalation.

6.11 There may be additional work required to support collaborative working, including updated guidelines, shared language and definitions, integrated systems, better process and greater understanding of roles and responsibilities.

7. Findings and analysis 2: Assessment and support planning

7.1 Assessment and support planning should have greater consistency across specialisms. Assessments and outcomes should be shared. Assessment should be of an appropriate depth and include the consideration and identification of risk.

How was this finding evident?

7.2 Social Care – Harry was referred to social care in December 2019 from hospital A&E concerns being raised about the state of his accommodation and his wellbeing. The initial assessment took place on 11/12/2019 to aid discharge. Considering pressures on beds and the need to discharge Harry from hospital, this intervention seems appropriate. However, the initial assessment was not updated through review or reassessment. Subsequently the social care assessment is not reflective of needs and does not consider or address housing issues, health problems and impact, nor the possibility of Harry drinking excessively. It did not capture or enable any understanding of social background (commentary regarding social background was taken from case notes), did not consider risk, or Harry's concerns and his wishes for the future.

7.3 Health - Within health assessments there were a variety of contact and approaches. These include telephone and face to face contacts, during the face-to-face contacts, there was some recognition of risk but there was no co-ordinated response to this and worsening of his living environment which resulted in discussion or referral to social care colleagues. However there does not appear to be evidence of onwards escalation.

7.4 Whilst we recognise that there were a variety of health professionals involved, it is evident that they were working with Harry largely in isolation from one another and Social Care. Again a 'team around the person' approach would have strengthened assessment and intervention. Accordingly, we cannot see evidence that outcomes of assessment were shared across organisations.

7.5 We note that Harry may have benefited from specialised health intervention for example counselling, psychological support, and interventions around alcohol consumption.

7.6 It is of particular concern that although it was widely known that Harry was a heavy drinker, this was not recognised in assessment and subsequent intervention.

7.7 A common theme across health and social care is that the outcome of assessment and interventions were not commonly shared across all agencies working with Harry.

7.8 Assessment does not consider or evaluate risk across a multi-agency lens.

7.9 There appears to a recurrent theme that David would offer support; however, we are unable to be certain of the nature of this support and if he was willing to support. We note a carers assessment should have been considered. There is no reference on case notes to suggest that anyone contacted David or gathered his views.

7.10 Through the period under review, mention is made that Harry was thought to have mental capacity to make his decisions. On social care files there is no evidence of a Mental Capacity Act (MCA) assessment being undertaken, i.e. you either have capacity or you lack capacity. Research (*Dong and Gorbien*) highlights that it may be more helpful to consider decision-making capacity as a '*spectrum rather than a dichotomy'*. Applying this thinking to Harry's situation, practitioners should be alert to the subtle ways that capacity can change and be impacted. In Harry case, given the evidence of alcohol misuse, consideration might have been given to how his capacity may fluctuate according to his alcohol consumption.

Dong, X. and Gorbien, M. (2006) 'Decision-making capacity: the core of self-neglect', Journal of Elder Abuse & Neglect, vol 17, no 3, pp 19–36

7.11 MCA assessment may have enabled greater insight and understanding of risk, thus informing risk assessment and management.

Analysis

7.12 On a systems level we consider the recurrent theme within the assessment and support planning process is of missed opportunities to escalate concerns, a lack of professional curiosity, joined up working and a lack of risk assessment.

7.13 It is evident from the chronology that staff felt that Harry had mental capacity around key issues, thus formal capacity assessments may not have deemed necessary.

Why does it matter?

7.14 Had assessment been more accurate, updated and included multiple views, interventions may have been more focused and the support reflective of need. Had statutory responsibilities with regards to reviews been met and reviews completed, this would have brought attention, under a multi-disciplinary lens, the many issues that Harry was experiencing. Had risk been considered in more detail this would or should have led to more detailed and considered risk assessment.

Systems level learning

7.15 This relates to the need for a more collaborative joined up multiagency approach to assessment especially in relation to risk and recognition of escalation points.

8. Findings and analysis 3: Awareness of fire risk

8.1 Practitioners need a greater awareness of the risk of injury or death from fire. This needs to be supported by multi-agency policy and process for intervention when fire risk is identified.

8.2 Fire risk was identified on multiple occasions. Risk was not always shared across agencies.

8.3 There is a theme throughout that there is a lack of escalation process and no clear or agreed protocol in place to discuss, escalate or refer into.

8.4 Attempts made to address concerns were disjointed and on one occasion dangerously inadequate (See below, from 8.11)

8.5 There was no consideration of additional fire safety equipment such as fire-retardant blankets, or sprinkler systems.

8.6 There is no joint recognised interagency policy or process for recognising or escalating fire risk which includes the fire service.

How was this finding evident?

8.7 Concerns regarding fire risk were raised within a safeguarding referral received on 10/12/2019 from Kare Plus.

8.8 Subsequently a referral was made to the LFB for a Home Fire Safety Visit on 12 December 2019 by the allocated social worker.

8.9 LFB carried out a Home Fire Safety Visit (HFSV) on 21 January 2020. The outcome report indicates that LFB practitioners did not consider Harry a person at risk and did not annotate the report in the appropriate place to suggest as much.

8.10 The authors have discussed this intervention with the LFB, and it is difficult to fully determine the rationale as to the decision made. It appears that Harry may not have been deemed as a person at risk if there was no evidence within the property, e.g., indication of burn marks on the carpet etc. It was noted that detection equipment was in place within the property, however a question asked is, was this sufficient to protect Harry and those living within the property and in surrounding areas?

8.11 On 29 May 2020 the LFB attended a fire at Harry's home. Crews found him on a commode in a bedroom on the first floor. He had dropped a cigarette into the bowl of the commode which had ignited the toilet paper in the bowl. He was unable to get himself up from the commode, so he was assisted with getting dressed and being put on to his bed.

8.12 A 'safeguarding referral' was made that was forwarded on 2 June 2020 and reported as being received on the same day.

8.13 Case notes refer to a 'referral' being received from London fire brigade in June 2020.

8.14 It is of note that this referral is not on Mosaic (the council's recording system) and we have been unable to determine precisely how it was processed. However, it was somehow communicated with the allocated social worker whom case noted a response to the referral.

8.15 Records show that the social worker made a telephone call to Harry who reported that the fire alarm was triggered because he was unable to clear his ashtray and that the risk was now resolved because his friend David would be able to help.

8.16 The social worker then determined the risk to be no longer present; his rationale was that David was able to mitigate concerns. There is no evidence that this was discussed with David and that David agreed that he could mitigate any risks. Again, there are assumptions being made about David's willingness to be involved and take on caring responsibilities.

8.17 It is of note the when the case note is cross referenced by the fire report it does not capture what happened and that there was an actual fire.

8.18 There are no records with regards to the other agencies being made aware at the time.

8.19 There is no mention of this event in the integrated chronology which includes notes from social care, the GP and NELFT. There appears to be no follow up or fire safety visit made by the fire service based upon the risk.

8.20 If we cross reference Harry's circumstances with the LFB risks assessment document he would have been at high risk of fire based upon his limited mobility, use of medication, poor vision, cluttered environment, use of alcohol, that he smoked in bed, and a previous fire had occurred.

8.21 It is noted from the coroner's toxicology report that at the time of his death Harry was severely intoxicated and had been reported to have taken medication (zopiclone) that

may have exacerbated the effects of alcohol consumption, thus potentially contributing to his death.

8.22 Within the health context there are inconsistent approaches to recognition of fire risk. There are limited references to fire risk, which came from two sources namely the respiratory and district nursing teams. Both indicate that Harry was a smoker however in the early assessment in 2019 there is a report that there are no concerns regarding self-neglect or fire risk.

8.23 Latterly the case load manager within the district nursing service documents on two occasions that the property is untidy and unclean, and that Harry continues to smoke.

8.24 There is recognition of fire risk however no documentation of a fire risk assessment, referral to the London Fire Brigade for a home safety assessment or escalation through a safeguarding concern.

Analysis

8.25 There is an absence of any multi-agency policy around fire risk, a lack of fire risk assessments and agreed multi-agency protocols. This is despite there being mechanisms in place to provide interventions around fire risk, for example fire safety checks. Thus, there is no clear escalation policy or process. It is the authors view that a joined-up approach with the London Fire Brigade is required to refer individuals at risk in a timely way.

8.26 The authors note that fire risk is not considered specifically by practitioners in health and social care when training to become qualified or post qualification. Given that fire deaths of vulnerable adults are by no means an isolated occurrence (See section 14) a greater emphasis needs to be placed on giving both social care and health professionals training.

8.27 It is of note that fire safety risk in not an issue that is considered specifically in either social care or health-based documentation. It is highlighted earlier in the review that consideration of fire risk and assessment has been inconsistent between practitioners involved in Harry's health and social care journey. This is further compounded by the absence of a fire risk assessment tool, which would not only identify the level of risk but would also highlight pathways to escalate concerns for action

Why does it matter?

8.28 Harry died in a house fire and had professionals been more aware of fire risk; had there been joined up risk assessment and intervention and agreed multiagency policies to support intervention around fire safety this may have been prevented. There were multiple missed opportunities across all services to address risk and the concerns recognised.

Systems level learning

8.29 This relates to all agencies involved in the care and support of vulnerable people having joined up systems and process in place that ensures when fire risk is identified an agreed multi-agency approach is enacted that seeks to assess and mitigate risk.

9. Findings and analysis 4: Unsuitable housing

9.1 Housing may not have been suitable and presented health and safety risks

How was this finding evident?

9.2 We understand Harry rented a room in a property owned by his friend David. This was initially a short-term arrangement on his return to the United Kingdom, however it then appears to have become more permanent.

9.3 We are not clear about the nature of Harry's tenancy and whether there was a tenancy agreement in place, however it appears this was an informal arrangement.

9.4 There are multiple accounts that the accommodation was in a state of disrepair and that Harry lived in a state of squalor.

9.5 Harry was unable to mobilise around his home or easily leave the property due to the steps leading up to the entrance. The social care assessment does not address or consider housing as an issue, nor does there appear to be any interventions around this.

9.6 Harry's views were not recorded in relation to his housing needs and wishes on the social care assessment.

9.7 Enquiries have been made to LBWF housing who have advised they have no records of a referral being made and there are no records of referrals on other agency records either.

Analysis

9.8 On an individual level there appears to be failure to take account Harry's housing situation and work with him to improve the situation. Unfortunately, there is a failure to recognise or address these issues within social care assessment. There were multiple entries within health records indicating poor cleanliness with the home environment.

9.9 We note that right before his death he disclosed to the community matron that he wanted to be considered for sheltered housing.

9.10 We note no occupational therapy or physiotherapy assessment took place to consider suitability of the environment or considerations for adaptations to be made.

Why does it matter?

9.11 Harry was living, often in a state of squalor and unable to mobilise around his home. Whilst his wishes or views are not recorded in relation to this it can be said with certainty that his housing situation and environment was unsuitable on multiple levels.

9.12 That Harry was unable to mobilise around his house may have had an impact upon his ability to escape or be assisted to escape from the fire that consumed him.

9.13 We believe his tenancy was informal and subsequently he would have had few and little protection.

9.14 Amongst the many professional visiting there appears to have been a lack of recognition that Harry housing situation was unsuitable and there appears to be no attempt to escalate the issues or to work with Harry to find more suitable housing.

9.15 On a points-based system we believe that Harry would have been a priority for rehousing had the system and the professional working with Harry escalated this appropriately.

9.16 Professionals working with Harry may have not considered it to be their responsibility to escalate.

Systems level learning

9.17 This relates to professionals working with Harry having greater awareness of housing issues, a knowledge of how to escalate housing issues, linked to a multi-disciplinary risk assessment process which can where necessary incorporate housing risks/issues.

10. Findings and analysis 5: Impact of prescribed drugs and excessive alcohol consumption

10.1 Practitioners need greater awareness of the impact of prescribed drugs and excessive alcohol consumption and when there may be a need for formal support around this

How was this finding evident?

10.2 It is evident from the integrated chronology that Harry was drinking to excess. There are reports that he was consuming up to two bottles of wine a night. At the time of his death, it was confirmed by the coroner's report that he was severely intoxicated with ethanol in his blood being recorded as 174mg/100ml this being more than twice the drink drive limit.

10.3 Harry informed various professionals of his alcohol consumption.

i. 14 & 25/3/2019 Practice nurse – Harry discloses he drinks between half to 2 bottles per night, which is becoming earlier and wakes with a desire to drink –

advice given to "try drinking warm milk to help with sleep and to take sleeping tablet 1 hour before".

ii. *15/7/2019 Barts Health Eye Clinic Pre assessment – During the assessment Harry indicates drinking a bottle of wine a night and requiring assistance of one person as he is unsteady on his feet*.

iii. *14/12/2020 Podiatry – Assessment undertaken, and Harry advises that he has a couple of glasses of wine with meals*.

10.4 There appears to be no further assessment or discussion with Harry regarding his alcohol consumption or the reasons why he is appearing to be dependent on such volumes per night.

10.5 There appears to be a lack of professional curiosity about concerns that Harry was experiencing. The social care assessment for example does not consider that Harry may be drinking to excess and subsequently there are not focussed interventions or support plans to address this.

10.6 It is also recognised that there was a lack of discussion with Harry as to whether he would like help with his drinking.

10.7 There also appears to be a lack of medication review regarding his prescribed zopiclone and short-term trial of diazepam.

10.8 It is of note that there is no reference within the documentation reviewed that indicates, health, social care, or domiciliary carers are concerned or recognising that Harry may be intoxicated or experiencing effects of alcohol or combination of alcohol and prescribed medications such as zopiclone e.g., increased sleepiness or worsening of his breathing during contacts.

10.9 There is also no reference to identification of drinking paraphernalia e.g. bottles, glasses, or other items within the flat. During contacts staff do not refer to any concerns or disclosures by Harry regarding his alcohol consumption.

10.10 Social Care and NELFT assessments did not recognise there to be any issues with excessive drinking and there is no reference or consideration or referring to drug, alcohol or counselling service.

Analysis

10.11 Whilst Harry did disclose his drinking habits to a few people working with him we note that Alcohol addiction is not always obvious, people developing alcohol addiction might themselves not recognise there is a problem and / or seek to hide or downplay the problem. It appears that where problems were recognised there was little if no attempt to address the issue.

10.12 We note that these issues were developing and becoming apparent during COVID and accordingly professionals may have had other priorities.

10.13 It is of note that neither zopiclone or diazepam should be taken when alcohol is being consumed as it deepens sleep and can impact on breathing, Harry was noted to have severe chronic obstructive pulmonary disease (COPD). It is unclear whether alcohol was discussed during the telephone consultation between Harry and GP on the 1 March 2019 when zopiclone was originally issued. Complacency around prescribed medication and reluctance to challenge may have played a part.

Why does it matter?

10.14 It is likely that Harry's excessive alcohol consumption was having an adverse effect on his mental health and physical well-being.

10.15 The authors consider that his drinking along with other factors increased risks related to fire.

10.16 Excessive alcohol consumption was not recognised by agencies working with Harry and subsequently no support or help was offered or given around this aspect of his care. It is probable that his alcohol consumption impacted upon his ability to evaluate fire risk and respond to fire whilst intoxicated.

10.17 Issues of mental capacity and alcohol dependence do not appear to have been considered through the assessment and care process within health and social care.

10.18 Despite the disclosure by Harry of his alcohol consumption it was not picked up or acted upon, this is despite quite a lot of evidence that he may have had an alcohol dependence and it probable this was impacting upon his physical and mental health, his day to day functioning, his weight, his falls and safety. Further-more we believe it is probable that the prescription of Zopiclone and Diazepam was having a further detrimental effect upon his wellbeing and increasing risks. There is no evidence of reviews of medication.

Systems level learning

10.19 On a systems level it is about all agencies being aware of self-neglect and the impact of alcohol and substance dependence upon risk and the appropriateness of implementation and appropriate risk assessment and escalation. The systems learning is around raising awareness of alcohol consumption, what might be excessive drinking, the risks around combining with prescription medication, escalation routes and help available to people.

10.20 We note that his motivation and willingness to engage was variable and we consider that it is probable that on occasions alcohol and prescribed medication may have impacted upon his willingness to engage as well as his mental health.

11. Findings and analysis 6: Risk assessment

11.1 Risk assessment by health and social care was inadequate and there were not attempts to complete risk assessment in a joined up and a collaborative manner.

How was this finding evident?

11.2 Harry's health and social care records shows little reference to risk. Read in isolation from other notes from the integrated chronology it would suggest he was a person with relatively straightforward needs and low levels of risk. Risks are not reviewed nor analysed or updated.

11.3 It is clear in the months leading up to Harry's death there were multiple levels of risk, in relation to several factors including housing, fire risk, self-neglect, loneliness, isolation, alcohol misuse and chronic health care needs.

11.4 Health records also demonstrate little or low levels of assessment of risk whilst there was some recognition of risk, for example the property was unkempt. There were no formal attempts to process or analyse the risk.

11.5 Health did escalate some risk to social care but there was an absence of a joined-up approach to measuring and mitigating risk and outcomes.

11.6 There were missed opportunities to recognise the many factors of risk and mitigate them.

11.7 We recognise that within social care and health there are no joined approaches or policy for assessing, measuring and mitigating risk

Why does it matter?

11.8 Had organisations working with Harry co-ordinated and agreed multi agency risk assessment it could have highlighted risks and steps needed to mitigate responsibilities around risk and informed care planning and clinical and social care intervention.

Systems level learning.

11.9 On a systems level there is a lack of joined up process across health, social care, and partner agencies for assessing, mitigating and escalating risk. This indicates a need for agreed multi-agency protocols and procedures to assist assessment of risk, escalation, and mitigation of risk.

12. Findings and analysis 7: Harry's Engagement

12.1 Harry's engagement with services was ad hoc and sporadic. He engaged well with some services and not so well with others. His non-engagement could have been approached differently.

How was this finding evident?

12.2 In terms of home care support, it is apparent that initially Harry was reluctant to engage with commissioned services. However, it appears from February 2020 that he did engage consistently with the commissioned support from Kare Plus agency.

12.3 Whilst there is some evidence to suggest that commissioned support was not entirely effective in managing Harry's needs to a safe level, to the credit of Kare Plus it appears that care staff had developed some rapport with Harry and did engage with him.

12.4 In terms of social care there are case notes that make reference to Harry not following up telephone calls and not being contactable.

12.5 Records show the allocated social worker who was initially assigned to work with Harry on a short-term basis following concerns being raised around December 2019 engaged with him well.

12.6 It appears that she had managed to gain Harry's trust. It was identified that there were a number of issues that would mean more focused intervention would be beneficial and subsequently the case was allocated to a new social worker on the 1 June 2020.

12.7 Records show that the new social worker had no face-to-face contact with Harry. We note this at odds with the self-neglect multi-agency guidance issued by the Waltham Forest SAB, (however it is also important to note that lock down restrictions had been reinstated during this time)

- *Don't walk away – walk alongside*
- *People who self-neglect can find it difficult to engage with agencies, keep persevering, take time to build a trusting relationship*
- *Work with them to help themselves*
- *Explore alternatives, fear of change may be an issue so explaining that there are alternative ways forward may encourage the person to engage*
- *Always go back – regular, encouraging engagement and gentle persistence may help with progress and risk management*

(Page 3 Self-Neglect Multi Agency Guidance November 2019)

12.8 In terms of social care intervention at this point it would be more appropriate to say that the allocated social worker did not engage well with Harry than Harry did not engage with the social worker.

12.9 In term of engagement with health, Harry actively reached out to his GP. The integrated chronology shows requests and weekly discussion.

12.10 It is apparent that Harry may have been frequently reaching out to services and trying to engage.

12.11 It is also of note that he was very engaged with the respiratory nurse and the case load manager.

Analysis

12.12 There are several factors in relation to Harry's circumstances to consider which include:

- Harry may have been feeling isolated, and he did not know how to reach out to some of the professionals working with him.
- Harry may have been reluctant to engage with some professionals out of pride, embarrassment, and possible fear that decisions will be made that are not in his interests.
- Harry had built a rapport with a practitioner from one or two agencies, it appears this engagement and input was unknown by other agencies and practitioners, this was a lost opportunity, these relationships could have been used to support wider interventions.
- The way professionals approached Harry may have felt threatening to him for example the use of language or attitudes towards him. Whilst we do not want to pass judgement on the professionals working with Harry, it is obviously important that practitioners adopt a kind, sensitive and caring approach to working with vulnerable people. Sometimes professionals fail to consider that they are going into people's homes and that this might in some instances be quite intimidating.
- Harry may have been suffering depression or anxiety.
- Practitioners may have had high workloads, especially during COVID.

12.13 An issue identified at the review panel and discussed in detail was around the language used by professionals appeared to be practitioner and outcome focussed rather than an interactive and engaging dialogue based on professional curiosity and problem solving.

12.14 Questions were posed such as

- How do we use language that cares?
- Is language used to justify actions and outcomes?

Why does this matter?

12.15 When considering the integrated chronology, a narrative emerges amongst some professionals working with Harry that he is difficult to engage and dismisses interventions. Therefore, we believe it important to consider Harry's engagement or lack of engagement, why and how this might have occurred and what factors may have been at play. Secondly, had engagement with Harry been more successful there are multiple scenarios that might have led to different outcomes.

Systems level learning

12.16 It is of note that extensive guidance and policy has been issued or made available to practitioners in the previously mentioned document Self-Neglect Multi-Agency Guidance published by Waltham Forest Safeguarding Adult Board (Nov 2019)

12.17 This document offers detailed guidance to practitioners for working with people who are difficult to engage. The guidance emphasises the importance of multi-agency work, communication, escalation, risk assessment (many of the areas of learning we have already identified). Great emphasis is given to professional curiosity and is promoted as

central to successful outcomes when working with people who are self-neglecting and non-engaging.

12.18 Evidence from this review would suggest this guidance is not embedded in practice or widely understood.

12.19 We note that interventions which involve '*professional curiosity'* and '*walking alongside'* a service user are by their nature more time consuming. We consider there may be resource issues that make it difficult to adopt this approach.

13. Are there any standout or unique features to this case and is this specific to Waltham Forest?

13.1 This chapter considers if the key issues and themes explored in this SAR are unique to Waltham Forest or reflective of wider systemic concerns related to the way people who self-neglect are supported in the United Kingdom?

13.2 **Firstly, we consider** if fire related deaths of vulnerable persons are out of the ordinary? **Secondly,** we consider if the key themes / issues in this report resonate with prior SARs relating to self-neglect?

Are fire related deaths of vulnerable adults out of the ordinary?

13.3 The research '*Focus on trends in fires and fire related fatalities'* (*Home Office Stephanie Bryant and Isabel Preston 12 October 2017)* identifies that certain groups are at high risk of fires. Whilst the report does not specifically identify 'vulnerable adults' as a group it identifies that people with a disability, older people, males 40-60, and people who smoke are at higher risk of fire death. It identifies that in 2017 drug or alcohol use was identified as a contributory factor to accidental dwelling fires in 17% of cases.

13.4 Further evidence that shows vulnerable people are at greater risk of death from fire can be seen by considering that the authors have identified 10 fire related SARS since 2019. (See Appendix 1). Furthermore, we are aware of SAR John, this was a previous fire related SAR in Waltham Forest in 2017. Sadly, many of the themes of this SAR resonate with this one (See appendix 2).

13.5 We therefore conclude that the death of vulnerable people by fire is not out of the ordinary, stand out or unique.

Do the key themes/issues in this report resonate with prior SARs?

13.6 Some of the key themes identified in this SAR relate to

I. Self-Neglect - (That Harry was severely self- neglecting)

II. Risk Assessment - (That risk assessment was inadequate and not considered across agencies and there was no common or joined up approach)

III. Safeguarding - (That Safeguarding was not adequate)

IV. Information Sharing – (That agencies did not coordinate their response across services, information was not shared or responded to appropriately and that safeguarding response were not coordinated or consistent across organisations.)

V. That there may be training needs particularly in relation to safeguarding

VI. That health concerns were not adequately responded to or coordinated

13.7 Research in England (Analysis of Safeguarding Adult Reviews: April 2017 - March 2019) was funded by the Care and Health Improvement Programme, supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

13.8 Its purpose was to identify priorities for sector-led improvement. Within the report it identifies common themes and issues identified in the 231 SARs it reviewed. These can be cross referenced against the themes identified in SAR Harry. This enables us to further consider if Harrys' circumstances are unique or unusual.

13.9 Self-Neglect - The 231 reviews in the sample investigated a range of types of abuse and neglect, the most common theme being self-neglect, this was found to be prevalent in 104 cases or 45% of the sample (See Appendix 3)

Top practice themes not meeting expected standards

Theme analysis - Comparison of prior SARs

13.10 We have found in this SAR that **safeguarding** by practitioners was not at the standard expected. The Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 identifies issues of practice not meeting expected standards in 134 of the 231 SARS it reviewed in relation to safeguarding.

13.11 We have identified in our report some learning related to **Mental Capacity**. The Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 identifies issues of practice not meeting expected standards in 138 of the 231 SARS it reviewed in relation to Mental Capacity.

Theme analysis for interagency working - Comparison of prior SARs

13.12 We have found in our report that **Case coordination** needs to be improved in relation to interagency working. The Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 identified issues related case coordination and interagency working not meeting expected standards in 168 of the 231 SARS reviewed.

13.13 We have found in our report that **information sharing** needs to be improved in relation to interagency working. The Analysis of Safeguarding Adult Reviews: April 2017 - March

2019 identified issues related to information sharing and interagency working in 162 of the 231 SARS reviewed.

13.14 We have found in our report that **safeguarding** needs to be improved in relation to interagency working. The Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 identified issues related to Safeguarding and interagency working in 115 of the 231 SARS reviewed.

13.15 We have found in our report that **procedures** may need to be reviewed, in relation to interagency working. The Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 identified issues related to procedures and interagency working in 53 of the 231 SARS reviewed

14. Conclusion

Are fire related Deaths of vulnerable adults out of the Ordinary?

15.1 No, they are not out of the ordinary. Statistically vulnerable people are more at risk of fire, there have been multiple deaths of vulnerable adults in fires, and this is reflected in numerous SAR reports.

Do the key themes / issues in this report resonate with prior SARs relating to Self-Neglect?

15.2 Yes, they do. There is a large degree of cross cutting in relation to this SAR's findings and previous SARs.

15.3 Themes and learning from SAR Harry resonate across learning from prior SARs both generally and specifically in relation to reviews for people who have died in house fires. Considering vulnerable adults are at a greater risk of dying in house fires and the cross-cutting features of this SAR the authors have not identified specific or standout features.

15.4 These conclusions are framed as per the questions originally asked by the board.

Are our partnership responses to self-neglect adequate?

15.5 On this occasion our response to self-neglect was not adequate or in line with guidance previously issued by the board and on occasion our own policies and procedures. The extent of Harrys self-neglect was such that a safeguarding response should have been considered and progressed on multiple occasions. Practitioners worked in silo and there is little evidence of multi-disciplinary working. Assessment was not in some instances detailed enough; risk assessment was virtually absent. Mental Capacity had generally been assumed; however, this is somewhat questionable and a detailed assessment around Harrys understanding of risk completed as part of a MCA assessment may have been beneficial.

15.6 Harry's housing was unsuitable. There was little co-ordinated response to this, and Harry was not placed on the housing list. Assumptions have been made about his friend David's role in caring for him and no carers assessment was offered. Interventions from professionals were ad hoc and uncoordinated. Statutory duties such as reviews were not completed as per time scales. In one instance a key professional working with Harry had no face-to-face contact during allocation over a time scale of several months.

15.7 Harry drank heavily and this was not recognised by key professionals working with him. Harry was prescribed medication that may have further impacted upon risk and compounded difficulties.

15.8 Fire risk was obviously present as concerns had been reported by a number of agencies working with Harry and there had been a previous fire at his premises. The approach of some professionals may have been hostile to Harry. Risk assessment was poor and did not have a multi-disciplinary approach.

Was practitioners' professional curiosity sufficient when presented with self-neglect?

15.9 Professional curiosity was not sufficient. Harry was severely self-neglecting. In some instances, assumptions appear to have been made around lifestyle choice and non-engagement and little attempt seems to have been made to join the dots and triangulate information across agencies. Key themes and issues had not been identified, however there is the potential that these may have been highlighted if professional curiosity was present, for example relating to Harrys alcohol consumption, housing, non-engagement with services, and his relationship with his friend David.

What were the barriers that stopped practitioners working together with Harry?

15.10 The barriers identified, include COVID (See below) working in silo, possible skills / knowledge deficit, (for example there is little evidence of awareness of our self-neglect policy), resource issues possibly relating to high caseloads. Understanding of the effects of alcohol on mental capacity and risks associated with Zopiclone and Diazepam where alcohol dependence is of concern. A key factor is that there is no recognised multi-agency process in place for assessing and escalating issues of risk.

What was the impact of COVID 19 on practice?

15.11 The impact of COVID was most likely significant. It is evident from documentation that at the start of the COVID pandemic (January 2020) when Harry's needs were increasing practitioners had to adopt new ways of working including agile / remote working which meant a greater emphasis on remote visits and telephone assessments. The COVID response meant that it was increasingly difficult for practitioners to have a lens of professional curiosity, build relationships and walk alongside service users.
Systems Level Recommendations. Learning from other SARS

15.12 It is of note that the recommendations born out of this review mirror recommendations made by other SABs for previous SARS. An example is the recommendations made by **Sutton Safeguarding Adults Board** (SSAB)**.** In June 2019, Sutton Safeguarding Adults

Board (SSAB) published a Safeguarding Adults Review (SAR) report following the deaths of two individuals (EE and GG) and the serious injury of another (HH) in separate fires within supported living accommodation. Subsequently SSAB partners agreed to actions, including:

- improving fire risk-assessment processes
- providing training on fire risk assessment and supporting those who self-neglect

15.13 Of significance is that the recommendations of the 2019 SAR were subject to further evaluation by a Fire Task and Finish Group, the purpose of the evaluation was to determine if there are any remaining barriers to recognising fire risks since the release of the EE SAR recommendations and if so, what more needs to be done to disseminate lessons.

15.14 The report published February 2022 concluded that whilst good work was being done, especially within the housing provider sector, work was still required to raise awareness of fire risk management for vulnerable people. Crucially this included understanding of fire risks in the home by carers and practitioners and how to reduce those risks.

15.15 A consideration for the Board is how might we ensure that the lessons learnt from SAR Harry translate into actions that can make a real and tangible difference to safeguarding adults who self-neglect and how do we monitor and evaluate the outcomes of any actions.

Changes Already implemented.

15.16 In making recommendations the authors note that health and the local authority have already implemented and are continuing to implement changes to Adult Safguarding processes. These include:

- Changes to ways of working within the Adult Safguarding team to enable a more hands on approach and to enable and promote collaborative working on complex safeguarding cases across the organisation.

- Improving processes on Mosaic for safeguarding to encourage a more person-centred approach which puts principles of making safeguarding personal at the core of practice

- Improving the response to organisational safeguarding concerns, including a revised system and process for addressing organisational concerns

- Improved collaborative working across organisations

15. Recommendations

15.1 Recommendations are presented below and consider the findings the recommendations relate to, the objective and how the recommendation might be achieved, forming the basis for an action plan for this SAR.

15.2 We have in making these recommendations drawn on our existing knowledge of structures and processes within the local authority to try to ensure that the recommendations are realistic and achievable. We have tried to ensure that they align with SMART goals, i.e., they are specific, measurable, attainable, relevant, and timely.

Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
i. Build greater awareness and understanding of: • Self-neglect • Excessive saving • How to balance challenging conversations with an empathetic and caring approach	F1 - Safeguarding response F3 - Awareness of fire risk F6 - Risk assessment F7 - Harry's engagement	Improved multi-disciplinary response to self-neglect and excessive saving, promoting effective engagement with vulnerable people	Develop a new joined-up (between health, social care & LFB) programme of training and awareness that includes challenging conversations, self-neglect, and excessive saving to encourage and embed good practice, promoting and embedding relevant policies into practice across the partnership. Consider covering how to present to service users in a non-threatening / caring way as well as use of language / jargon? Training should also include all resources available to support practitioners, such as the Self-Neglect Multi-Agency Guidance published by the SAB in 2019.	Numbers of professionals reporting increased awareness and understanding straight after the session and then approx. 12 weeks later

Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
ii. Build greater awareness and understanding of fire safety / risks	F3 – awareness of fire risk	Profile of the fire brigade is raised and improved knowledge and understanding by front line practitioners of fire risk	Develop a new joined-up (between health, social care & LFB) programme of training and awareness around fire safety / risk. Consider making this mandatory for all front-line health and social care practitioners, which would include details of any new process developed (see below). Ensure appropriate resources from LFB are shared including clutter scales, a short film for carers and residents' home fire safety checker for self-assessing own risk.	Numbers of professionals reporting increased awareness and understanding straight after the session and then approx. 12 weeks later Increase in numbers of views of film and hits on online home fire safety checker
iii. Improve pathways for responding to individuals at high risk and / or difficult to engage, including those for whom there are fire risks / concerns e.g. those who are confined through either ill health or disability to their homes or bed	F1 - Safeguarding response F2 - Assessment and support planning F3 - Awareness of fire risk F4 - Unsuitable housing F5 - Impact of prescribed drugs and excessive alcohol consumption F6 - Risk assessment F7 – Harry's engagement	To help ensure an effective multidisciplinary response for people who are at high risk and difficult to engage	Multi-disciplinary 'high risk' / 'complex needs' panels are developed for people in adult social care and health who support services are finding difficult to engage. This would be linked to a clearly dedicated pathway for LFB referrals/self- neglect cases and standards around risk assessment/MDT (see below) Consider whether regular, separate multi-disciplinary, review meetings of high-risk fire cases are required	Numbers of positive outcomes for individuals who are discussed at panel

Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
	F3 - Awareness of fire risk	An improved multiagency response to fire risk	A multi-agency working group (which includes LFB, health and adult social care) is set up to develop new pathways, agreed interventions and refreshed ways of working in relation to fire risk. This should consider appropriate thresholds for triggering a multi-agency response and building generic fire risk assessment into social care and health assessments as well as associated systems such as Mosaic or Rio. Also develop a multi-agency risk assessment process. Explore how fire risk and interventions can be monitored e.g. through regular monitoring meetings by health, social care, housing and LFB from a data collection point	Clear process and protocol detailing appropriate pathways are in place Audits across the partnership show that practitioners are using the pathways and considering risks relating to fire Increase in enquiries made to London Fire Brigade in relation to home fire safety

16. Appendix 1: Previous fire related SARS that have been identified by the authors

Case 1 Redbridge Mr B was 72 years old at the time of his death.	On 8.11.16, following a report of a fire in his home, he was found dead in his bedroom of a heart attack. During this attack, he had fallen into an electric fire which had caused a fire in the property. However, no smoke was found in his lungs, suggesting that he was dead before the fire started. The cause of death was determined to be heart disease
Case 2 Gloucester SJ, a 68 year woman who had been housebound since 2012 with implications for her to exit the accommodation in an emergency	On 8 June 2015 passers-by noticed smoke coming from the bungalow and unfortunately SJ was found inside having been overcome by the smoke. The source of the fire has been confirmed as the television in the lounge. An inquest undertaken on 15 November 2015 confirmed cause of death as smoke inhalation
Case 3 Hackney Mr EF, aged 89 and of African-Caribbean heritage, died in February 2019 as a result of a fire in his flat	The London Fire Brigade's investigation into the fire indicated that incense sticks were found scattered around the bedroom, propped into flammable items and therefore not used safely. The seat of the fire was on the bed and the investigation concluded that the likely cause of the fire was the use of an incense stick on the mattress, which ignited bedding and tissues – either from the stick itself or from the use of matches to light it. The door of his bedroom was closed.
Case 3 Barnsley Jack was a white British man who lived alone at an address in Barnsley. At the time of his death he received no support from local agencies.	On a date in January 2018 a 68 year old man, Jack, the subject of this Review was found dead in his bedroom when the Fire and Rescue Service attended a house fire in Barnsley

Case 4 Wandsworth WWF had been diagnosed with multiple sclerosis (MS) at the age of 55 (in 1983). She was very independent. WWF had smoked for fifty years and remained determined to continue smoking, even though it had become progressively more difficult for her to light her cigarettes safely.	On 19th July 2016 a further very serious fire occurred and WWF was taken to a local hospital, and was then transferred to Stoke Mandeville Hospital, where she sadly died on 21st July 2016.
Case 5 Lewisham At the time of his death MT was living in Lewisham in a flat that he lived in on his own.	At 11.03 the London Ambulance Service (LAS) was called. The LAS administered emergency treatment and MT was taken to University Hospital Lewisham ICU, placed on cardiac support and ventilation but he was declared dead at 16.32 on 4th March 2016. A post mortem on 7th March gave a provisional cause of death due to inhalation of fumes.
Case 6 Richmond Upon Thames Mr T was an independent minded man with full capacity who, as a result of his deteriorating condition was confined to bed. He had MS and was a smoker.	Despite interventions from a range of health and social care staff, and being aware of the risks he continued to smoke in bed. He partially accepted proposed mitigations by staff to prevent future fires. Despite these, there were accidental fires in the home on 2 previous occasions prior to his death and on one of these occasions he was hospitalized with burns.
Case 7 Tower Hamlets Mr K, a man in his sixties, died in late 2014 after suffering serious burns in a fire in his home. He had lived alone in sheltered accommodation since 2008, having previously been homeless, and misusing alcohol, for some years.	Mr. K managed reasonably well, from the summer of 2012 there was increasing evidence of him experiencing difficulties in managing his domestic affairs, and of his health deteriorating rapidly since January 2013. A range of health and social care services were in touch with him but he was a very strong character with no family, who often refused attempts to help and support him.

Case 8 Hackney Mr BC, aged 72, who was born in Guyana, died in a fire at his home on 7th November 2014. He lived as an assured tenant in a flat in sheltered housing.	Early on the morning of 7th November 2014, fire broke out in Mr BC's flat, the seat of the fire being on his bed. All emergency services attended, and ambulance personnel treated Mr BC, but he was pronounced dead at the scene. At a post-mortem on 10th November 2014 the cause of his death was identified as smoke inhalation.
Case 9 Waltham Forest John was an 83 year old man. 2012 his mobility decreased to the extent that he became housebound in his two bedroomed terraced house. He found it increasingly difficult to walk, and had difficulty getting up unaided. He needed a walking frame to move about the house. Due to this he re-located to the downstairs of the property and was sleeping on the settee.	Cause of fire was subsequently thought to have been due to a cigarette having fallen onto a pillow which then fell under the sofa and John was unable to put it out. (Emollient cream and incontinence pads)
Case 10 Lincolnshire RJ had many health and social care needs and was known to a number of different agencies. This review examines learning for agencies.	RJ had accidentally pulled over a portable liquid petroleum gas heater, starting a fire. RJ had tried to leave the room but he had poor mobility and was further compromised by his significant consumption of alcohol and anti-depressant medication. He was overcome by smoke and fumes.

17. Appendix 2 Comparison of SAR John vs SAR Roger (Cross-cutting features)

SAR John finding and /or excerpts	*Sar Harry Finding or excerpts*
Assessment and support planning in relation to adults who show signs of self-neglect, should be holistic, and build in opportunities for relationship building. Finding 3 - It can be particularly challenging for practitioners to openly address issues relating to the adult's lifestyle choices, even when these are associated with increased fire risk	Assessment and support planning should have greater consistency across specialisms, assessments and outcomes should be shared, assessment should be of an appropriate depth and to identify and consider risk.
Finding 3 - Where an adult is prone to behaviours of self-neglect and refuses measures to reduce risk, active consideration should be given to exploring their reasons for refusal as part of the assessment process. The issue of how to manage risk across agencies in response to cases of self-neglect that do not meet safeguarding criteria (or are not suited to safeguarding processes) has continued to generate difficulty for practitioners and care workers.	The process and systems for risk Assessment needs to be improved risk assessment needs to be joined up and undertaken in a collaborative manner. Non-engagement could have been approached differently, pathways for escalation developed and a joined up and cohesive approach taken.
(Not a key finding but contained within the SAR Report) *In this case was the lack of awareness amongst key professional groups about the risks associated with a combination of common factors*;	A joined up and collaborative approach to fire safety should be developed to enable opportunities to address fire safety concerns.
It can be particularly challenging for practitioners to openly address issues relating to the adult's lifestyle choices, even when these are associated with increased fire risk	Absence of a joined up and collaborative approach to fire safety resulted in missed opportunities to address concerns
Practitioners can struggle to assess mental capacity and to know when to intervene to reduce risk in cases where adults' behaviours involve self-neglect and/or substance misuse Practitioners need additional support and guidance to respond effectively to the complexities of assessing the mental capacity of an adult who shows signs of self-neglect and/or addictions.	Due to Harry alcohol consumption his capacity especially in relation to risk may have fluctuated. Given the high levels of risk intervention in the form of a detailed Mental Capacity Assessment (MCA) may have enabled a better understanding of Harry ability to understand risk.

18. Appendix 3: Analysis of SARs from April 2017 to March 2019

Types of abuse and neglect								
Type of abuse/neglect	**SARs**	**Per cent**	**Type of abuse/neglect**	**SARs**	**Per cent**	**Type of abuse/neglect**	**SARs**	**Per cent**
Self-neglect	104	45%	Domestic abuse	22	10%	Modern slavery	2	1%
Neglect/omission	85	37%	Psychological abuse	19	8%	Discriminatory abuse	2	1%
Physical abuse	45	19%	Sexual abuse	12	5%	Other	11	5%
Organisational abuse	33	14%	Sexual exploitation	5	2%	Not specified	29	13%
Financial abuse	30	13%						