Safeguarding Adults Review: Steve

Aileen Buckton
Haringey Safeguarding Adults Board
July 2023

Contents

1. Introduction

1.1. Haringey Safeguarding Adults Board (SAB) has a mandatory statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.2. Haringey SAB has discretion to commission reviews in any other circumstances where there is learning to be drawn from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. The term 'abuse and neglect' includes self-neglect.

1.3. Haringey Safeguarding Adults Board's SAR Subgroup took the decision on 16th December 2020 that the circumstances surrounding the death of Steve met the discretionary criteria for undertaking a Safeguarding Adults Review (SAR) under Section 44 of The Care Act 2014. Upon presentation of the evidence in the completed review, the SAR Subgroup agreed that the case met the mandatory SAR criteria, as the impact of Steve's alcohol misuse on his health, mental capacity and self-neglect, and the associated safeguarding implications, constituted care needs but were not known at the time of his Care Act assessment.

1.4. A number of different agencies were involved in supporting Steve and there was felt to be potential for multi-agency learning from this case. However, Steve was assessed by Adult Social Care as not having care and support needs under the Care Act 2014[2]. He certainly had housing needs and was prone to self-neglect in relation to his diabetes management. Both of these were seen to have possibly contributed to his death. There also seemed to be missed opportunities for intervention.

1.5. The purpose of this SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

[1] Sections 44(1)-(3), Care Act 2014.
[2] Care Act 2014 (legislation.gov.uk)

2. Review Process

2.1. Specific terms of reference were agreed for this discretionary review, namely:

2.1.1. How did agencies respond to evidence of Steve's difficulty in managing his diabetes?
2.1.2. Were Steve's care and support needs and a move to alternative accommodation given appropriate and timely consideration?
2.1.3. How did agencies respond to safeguarding concerns about Steve's apparent self-neglect?
2.1.4. What role might multi-agency meetings have had in coordinating support for Steve, and how might the voluntary and community sector be empowered to initiate these discussions?
2.1.5. Was consideration given to the impact of Steve's difficulty managing his diabetes and alcohol dependency on his mental capacity?
2.1.6. Were there any missed opportunities to involve Steve's family in his care planning? Did Steve's family experience any challenges in negotiating services on behalf of Steve?
2.1.7. Are there any other emerging themes to be explored through the Safeguarding Adults Review?

2.2. A SAR Panel consisting of frontline managers and staff involved in the case was established to support the Independent SAR Reviewer. Membership was drawn from:

- London Borough of Haringey Adult Social Care
- London Borough of Haringey Commissioning
- London Borough of Haringey Housing Needs (formerly part of Homes for Haringey)
- London Borough of Haringey Environmental Health
- NHS North Central London Integrated Care Board (ICB)
- Metropolitan Police Service (MPS)
- Whittington Health NHS Trust
- North Middlesex University Hospital Trust
- Public Voice Haringey

2.3. It was agreed that the review should take the form of an appreciative enquiry, with the review led by an Independent SAR Reviewer.

2.4. To understand how Steve's circumstances developed, the scope of the review covered the care and support that Steve received from January 2019 until his death in March 2020. Significant events falling outside of this scope were also considered.

2.5. The review utilised chronologies provided by agencies who had been working with Steve as well as three learning workshops with the SAR Panel to establish an integrated narrative of the sequence of events, to consider what went right and whether there were any blockages in the system, and to identify changes to address these issues.

2.6. The agencies taking part in this review engaged positively with the review process and were keen to identify learning from this case so that improvements could be made to multi-agency practice going forward.

2.7. Family members were notified of the SAR and invited to contribute through interviews or meetings with the SAR Reviewer. It took some time to establish consistent contact with the family and it was eventually agreed that Steve's brother would contribute to the review rather than Steve's son, due to his personal circumstances. This added some delay to the completion of the review but was considered a valuable part of the SAR process, for which it was necessary to defer completion of the review. Information from family members has been included in this report. Steve's family were very caring towards Steve; Steve's brother described how he supported Steve to improve his living conditions over a long period of time, including encouraging a move out of London. However, the family expressed frustration and anger that action was not taken more quickly by agencies to help Steve, particularly in finding him suitable alternative accommodation.

2.8. Completion of the review was also delayed due to the SAR Reviewer's own unexpected serious illness. Thus, the review began in November 2021 and has completed in March 2023. We are grateful to the agencies involved in the review for their continued commitment to the learning from this case and hope that this report will provide a useful tool to bring about important change.

3. Case Narrative

3.1. Steve was a White British man who lived alone in poor conditions in privately rented accommodation for which he received housing benefit. In mid-March 2020, Steve is reported to have injured his leg falling through the rotten floor in his property. Steve died in hospital on 23rd March 2020, aged 61 years, following leg amputation. The medical certificate of cause of death records Steve's death from:

1a) Necrotising fasciitis
1b) Diabetic foot ulcers
1c) Diabetes Type 2 mellitus
2 DVT on Warfarin

3.2. Steve had complex health needs, including Type 2 Diabetes, depression and deep vein thrombosis. He had suffered falls and was reported to be at risk of being re-admitted to hospital due to this.

3.3. Steve was described by those supporting him as a gentle, calm man. He very much wanted to engage with those who were supporting and caring for him. He took a pride in himself and in his appearance, despite the difficulties in his living situation. He was clearly liked by those who supported and cared for him. He was embarrassed by his personal circumstances and was therefore often reluctant to talk about them and to allow visits to his home.

3.4. Steve's brother also explained that Steve would not allow him or Steve's son into his home, even on occasions where he had brought financial assistance to Steve. His brother explained that Steve had a history of alcohol misuse and he believed that this was at the root of many of Steve's problems. Steve had been made homeless when the landlord of his previous property passed away. After some time, he found the flat that he was living in at the time agencies became involved.

3.5. Steve was referred to Haringey Reach and Connect (part of Public Voice Haringey) by the General Practice social prescriber (a commissioned service provided by Public Voice

Haringey) on 12th December 2019. Steve had a hospital admission during November 2019 and was suffering from diabetes related ulcers. He had been visited at home by a physiotherapist who raised the alarm about the appalling state of the accommodation. The physiotherapist made a referral for Steve to receive support via the GP surgery. The request was for Steve to be rehoused and given any other support required. Reach and Connect were therefore asked by the GP social prescriber to support Steve in finding alternative accommodation and in providing whatever other support might be required.

3.6. Steve had been previously admitted to hospital in 2018 with deep vein thrombosis and was receiving treatment to prevent reoccurrence. He was also asthmatic and had difficulty with his breathing. He had been treated for a number of ulcers and other diabetes related conditions over the last five years. His diabetes care is well-documented, but it is evident throughout the record from 2014 onwards, that Steve's diabetes was not well controlled, and he was always on the verge of serious and possible life-threatening complications. He was, in his own words, a heavy drinker and found himself unable to adapt to the diet recommended for him, partly because of the restrictions of his living and cooking facilities and partly from often feeling low or depressed.

3.7. Steve generally accessed community health clinics for diabetes management and wound care. His brother suggested that Steve's ability to access health care was compromised by his financial situation, that is, he often did not have money for the bus fare and had to walk long distances with an ulcerated leg. It was not until late 2019 that Steve was visited at home by a physiotherapist who raised the alarm about the appalling state of his accommodation. Health practitioners were therefore not aware of the extent to which Steve's living conditions affected his ability to self-care.

3.8. Steve lived in a very small, privately rented flat which was financed though Housing Benefit. It transpired that the landlord had not registered the property appropriately and had certainly not visited the property to inspect its condition. Steve was not aware of any paperwork relating to the tenancy of the flat and would not report any essential repairs as he was terrified of being evicted and made homeless. As he had previously been made homeless, he wanted to avoid this happening again at any cost. He was therefore both unable and unwilling to assert his rights in relation to demanding decent living conditions.

3.9. There is little doubt that Steve's living conditions did little to help him manage his complex health difficulties. His health conditions required him to deal with wound care in a clean environment and undertake self-testing and regulation of his condition. He needed adequate cooking facilities to be able to prepare and cook healthy meals. He also needed an environment that helped to lift his mood and spirits. The reality was very different. The environmental health officer described the accommodation in the following way: "The W.C. has been blocked for years, has overflowed many times, resulting in a mass of excrement on the floor, partially dried and now composted. There is no access to the shower at all. The floor is rotted and the floorboards have collapsed in the kitchenette." Steve used a bucket as a toilet and public conveniences and public washing facilities to maintain hygiene.

3.10. Steve had a number of falls over the last few years of his life. He often experienced giddiness and falls which may have been exacerbated by alcohol use. He was finally admitted to hospital on 13th March 2020, having acquired leg injuries following a fall. It appears that this was caused by a further collapse of some floorboards. Despite efforts to clean the wounds, the level of infection led to amputation and a few days later very sadly resulted in Steve's death.

3.11. In the three-month period prior to Steve's death, a number of agencies and different parts of the council made concerted attempts to help Steve. Steve's family acknowledged that agencies were trying to help him but expressed their anger and frustration that this assistance had been too slow. During this period, there were miscommunications, misunderstandings of the correct process to follow and a lack of coordination. Eventually, in March 2020, Steve was going to be given the alternative housing that he required but this could most definitely have been offered earlier and may have prevented the tragic circumstances that followed.

4. Findings

4.1. Health

4.1.1. The review looked at Steve´s medical history back to 2014. He was given regular check-ups by his GP and referred for specialist diabetic support. He was monitored closely following deep vein thrombosis diagnosis. On one occasion in 2016 he was referred to the Improving Access to Psychological Therapy (IAPT) service. At this point he had mentioned his low mood to the GP. It appears that there was no response to this referral, and this was never followed up by either Steve or his GP. This would have been an opportunity for Steve to have been able to have the space to talk about his difficulties, but which was missed.

4.1.2. Steve always wanted to appear as though he was able to help himself and make use of the referrals given to him. When he received advice in the clinic or surgery it seemed that he fully intended to take on board all the advice he was offered. Staff were reassured by this and did not follow up to see if the advice had been implemented.

4.1.3. Steve would sometimes agree to self-refer or take action for himself. For example, he agreed to refer himself to the alcohol dependency service which he did not do. This was never followed up and indeed at one point in the notes there is an assumption that Steve was attending alcohol dependency sessions. There was a tacit acceptance of Steve's alcohol dependency and a missed opportunity to try to ensure that he was given support to tackle the issue.

4.1.4. Later, during the final three months of his life, Steve agreed to contact his landlord to report the repairs required to the flat. He then found it difficult to do so. He also referred himself for sheltered housing allocation outside of London. He was successful in doing this and felt that he would no longer require help.

4.1.5. At a crucial point in his housing needs assessment, Steve said he would obtain his medical notes which he was unable to do. He was obviously very proud and wanted to remain independent and take some responsibility for himself. This sometimes masked the seriousness of his situation or caused a delay in the process.

4.1.6. Staff were right in encouraging independence and Steve's involvement in his own care. However, they should have checked in his follow up appointments that these actions had been carried through and so that additional support could have been offered. There was insufficient professional curiosity about the wider aspects of Steve's life, which if carried through might have given an insight into why it was so difficult for him to take full responsibility for improving his own health. Steve's brother noted that Steve "was trying his best to maintain his independence and integrity" however he felt that "not one of these people concerned themselves enough".

4.1.7. At the point where Steve was being given advice about how to make a healthy cheese sandwich, he was living in squalid conditions that made any hygienic food preparation virtually impossible. He did give some indication of this, but this was not really explored. During diabetes reviews in August and September 2019 at the Whittington hospital it was noted that "His diet mainly consists of fried food as he

doesn't have an oven". "Feels that cooking facilities at home are very limited as living in a single bedsit, has small fridge and hob, no oven, no toaster". Lack of understanding of Steve's living circumstances was exacerbated by the fact that nobody witnessed Steve's living conditions until the physiotherapist visit in late 2019.

4.1.8. Clinics and GP surgeries are notoriously busy and it is unrealistic to expect an exploration of other issues impacting on a patient's life but there were opportunities here to follow up on referrals, and to make referrals for practical help. When residents say they don't require additional support, as they can do it for themselves, there does need to be reassurance that appropriate action has been taken when it is quite clear that somebody is vulnerable. Repeated history of failing to complete self-referral should have led to greater curiosity and a more concerted effort to link Steve into services that might have been able to help him. It was clear that the maintenance or improvement in Steve's condition was not working and could have signalled the need for alternative support. The borough clearly has available avenues of support in these circumstances which were not explored until near the end of Steve's life.

4.1.9. There were missed opportunities to refer Steve to mental health services. Initially, he would not have reached the threshold for formal mental health intervention but there was never any real analysis of Steve's mental health state. He could well have benefitted from counselling support. This continued until the end of his life. He confided in the worker from Reach and Connect that he felt suicidal because of the delays in dealing with his housing situation.

4.1.10. A number of agencies have recognised, through the SAR process, that there is nearly always a need for mental health support when residents are facing a housing crisis. This has been recognised in the new multi-agency approach through the Multi-Agency Solutions Panel but needs to be evaluated to ensure that the links across services are working.

4.2. Housing

4.2.1. Steve's housing situation was very key to what happened in this case. When Steve's housing needs were finally assessed, in the last few weeks of his life, the response was relatively quick, and he was on the point of being offered alternative accommodation just before he passed away. However, this came far too late, and it was at this juncture that the seriousness of the housing situation had been recognised.

4.2.2. There were delays themselves in the housing needs assessment process with changes in who was undertaking the assessment, but this was primarily because the urgency of the situation had not been fully grasped. Connected Communities (part of LBH Commissioning) were asked to assist Steve with a PIP application which they did. A housing needs officer was based in their service and an assessment had been planned but the service was unaware that Reach and Connect thought that a safeguarding assessment was also underway.

4.2.3. The urgency of the situation was very clear but only to those who were supporting Steve in his referral. There were very real concerns about Steve and a recognition

that he needed to be safeguarded. Reach and Connect tried to make a safeguarding referral, as well as a referral to Environmental Health. This did not translate into immediate action to rehouse Steve in temporary accommodation as there was no overall co-ordination of the referral and the concerns raised by the voluntary sector did not trigger an overall risk assessment across council services or a safeguarding assessment.

4.2.4. The housing needs assessment function was removed from Connected Communities during the course of Steve's case, as it was not considered to be working effectively. This change should be monitored to ensure that the housing assessment process is an integrated part of the overall multi-agency working in cases where residents have significant health and care needs and are deemed to be vulnerable.

4.2.5. There are many residents who suffer from living in inadequate housing conditions across the borough. Not all can be prioritised and offered alternative emergency provision or assisted with more permanent suitable housing. However, the working through of this case made officers very aware that the overall scale of the problem could result in cases being overlooked or not escalated appropriately.

4.2.6. The housing assessment itself is of course a formal legislated process a process in its own right but the urgency of a situation or the need for temporary emergency accommodation is dependent on being very aware of other factors such as a resident's health and mental health needs, as well as a clear understanding of care and support needs and safeguarding concerns. The escalation itself of those cases that require urgent intervention are dependent on both a strong risk assessment and a co-ordination of all of the information and factors that are required to make an informed and timely assessment. Steve's brother felt that given the amount of people involved in Steve's case, it was "irresponsible and neglectful" that Steve died prematurely. He felt that Steve had "asked for help, he was ignored".

4.2.7. There has been considerable learning as a result of Steve's case and new multi-agency risk assessment processes have been put in place through the Multi-Agency Solutions Panel. These processes need to be evaluated to ensure that they operate well for voluntary sector organisations to make referrals. Voluntary sector organisations should feel as much part of the process as other council services and statutory agencies.

4.3. Environmental Health

4.3.1. The Environmental Health service was appropriately involved in this case as Steve was living in substandard accommodation in the private rented sector. The service has a responsibility to ensure that landlords fulfil their obligations so that standards of adequate accommodation are maintained across the borough. Steve's family expressed concern that there did not appear to be regular checks on multiple occupancy homes where the Council funded the rent via Housing Benefit.

4.3.2. Following the referral from Reach and Connect, the Environmental Health officer undertook a home visit and responded quickly to the urgency of the situation. A referral was made to Adult Social Care and to housing needs assessment based in Connected Communities.

4.3.3. The Environmental Health service also attempted, on more than one occasion, to co-ordinate the referral response across the council but was unfamiliar with how the different processes operated and therefore felt unable to steer the process effectively. The service now feels that they are much clearer about how to make referrals and feel that the multi-agency arrangements operating via the Multi-Agency Solutions Panel are assisting in prioritising cases and carrying out appropriate risk assessments.

4.3.4. The Environmental Health service has a crucial preventative role to play in identifying landlords that are not complying with the law. As they work through this task, they need to feel confident that they can escalate situations that they come across and they should be part of an evaluation of the Multi-Agency Solutions Panel. The Council and Safeguarding Adults Board may wish to reassure itself of the progress in tackling rogue landlords as grossly inadequate housing can lay at the base of many safeguarding concerns.

4.4. Adult Social Care and Connected Communities

4.4.1. Steve was not assessed as having care and support needs under the Care Act 2014 when he was visited by a social worker in February 2020. Steve himself felt that he could undertake his own washing and dressing for example. Technically speaking therefore there was not a continuing role for Adult Social Care in terms of providing care and support. Adult Social Care responded quickly to the referral and were clear in their analysis. Adult Social Care were not aware of Steve's history of alcohol misuse and, therefore, its impact on his mental capacity, mental health and potential self-neglect were not assessed in this context.

4.4.2. The social worker recognised the seriousness of the housing situation but felt that this was therefore the responsibility of the housing service. It was understood that a referral to housing had been made. This was agreed in discussion with the social worker's manager. There was no record of a safeguarding referral from Reach and Connect at the time of the assessment and in discussion with the social worker's manager, it was not felt that this was required at the point when this was again raised by the Reach and Connect worker. Steve was at that point confident that his housing situation was being dealt with and that he could manage.

4.4.3. There was no consideration of a Mental Health Act assessment or mention of a Mental Capacity Act assessment. Steve always presented as very much being able to make his own decisions and indeed this was right. He was reassuring to the social worker about his ability to manage. However, his mental capacity, in particular his executive mental capacity, may have fluctuated due to his diabetes and alcohol use.

4.4.4. Steve did however make decisions that were harmful to him. His reluctance to report housing repairs was based on his past experience of homelessness but impacted in a very negative way on his safety. It is quite common for residents to present as being much more able to manage than they actually are. This again requires professional curiosity and a good understanding of the wealth of more informal support that could be carefully discussed and put in place. There should have been an opportunity here to consider informal mental health support and recognise the potential safeguarding considerations. There was a real opportunity for Adult Social Care to have held the ring on the co-ordination of the case even though they would

not be offering services. This could have been the case if there was a recognition at the time of the need for a wider multi-agency response to this case.

4.4.5. Since this case, Adult Social Care have played a significant role in developing the new Multi-Agency Solutions Panel and as part of their learning have instigated changes in front line assessment working. They now ensure that they encourage follow up on other service involvement, give greater consideration to safeguarding referrals as part of the assessment process and to mental health needs and referrals.

4.4.6. Haringey have developed a front door service in Connected Communities and have developed a neighbourhood model of working across the borough which harnesses voluntary sector input and coordinated use of volunteers in the community. Reach and Connect are an example of a commissioned service that can offer so much more than statutory services are sometimes able to provide. These services however need to feel part of the overall service offer and need to be able to escalate effectively across all council departments and other statutory agencies. This lends itself to providing additional support to residents who don't necessarily have care and support needs at the point of the assessment. These arrangements are now much more embedded than at the time of Steve's death but again need to be evaluated as ways of providing more informal support for residents.

4.5. Voluntary Sector

4.5.1. The difficulties that Reach and Connect faced in supporting Steve are very familiar to voluntary sector organisations as a whole. It is difficult for them to be able to access statutory services even as a commissioned service. Pathways, referral processes and departmental boundaries are not familiar to them or necessarily explained. A neighbourhood model of working allows statutory services ways of connecting and harnessing the contribution of small organisations and residents. However, escalation pathways and referral mechanisms must be very clear and statutory agencies need to work with multi-agency co-ordination to make this effective.

4.5.2. Reach and Connect were frustrated in their efforts to speed up the referral process for Steve and, moving forward, they need to feel that they could impact upon this as equal partners in the process.

5. Recommendations

5.1. Recommendation 1: Undertake a review and evaluation of the new Multi-Agency Solutions Panel, looking at the involvement of Connected Communities, Housing, Health Services, Mental Health Services, relevant voluntary sector organisations, social prescribers and Environmental Health in the new arrangements. This should include a review of sources of referral to ensure the Panel is accessible to all and a review of the multi-agency risk assessment process to ensure that it addresses the issues raised in the review.

5.2. Recommendation 2: Haringey SAB to receive a report from Environmental Health on the effectiveness of escalating cases where private sector housing is found to be inadequate, residents require urgent intervention, and there are potential adult safeguarding risks. Environmental Health to report back on this property/private landlord in particular.

5.3. Recommendation 3: Promote and monitor the use of the available multi-agency meetings to ensure that there is communication and coordinated support across agencies for people experiencing safeguarding risk and for at people at risk of homelessness.

5.4. Recommendation 4: Ensure that mandatory multi-agency safeguarding training is provided for staff across all agencies, including the voluntary sector, on a regular basis to improve awareness and understanding of adult safeguarding and referral processes. Develop a case study based on Steve's experience to highlight the importance of identifying and responding to adult safeguarding concerns.

5.5. Recommendation 5: Ensure that mandatory multi-agency safeguarding training reinforces the importance of professional curiosity, using Steve's case as an example.

5.6. Recommendation 6: Ensure that multi-agency training on mental capacity highlights the impact of diabetes and alcohol on fluctuating mental capacity, particularly executive mental capacity.

5.7. Recommendation 7: Promote the SAB's self-neglect and hoarding strategy to reinforce understanding across all agencies, including the voluntary sector, that self-neglect falls within the circumstances that constitute abuse and neglect and should therefore be referred for consideration of the need for safeguarding action.

5.8. Recommendation 8: Review and promote safeguarding referral pathways for the voluntary sector and provide training to support this.

5.9. Recommendation 9: Ensure that the local authority has in place an effective system for providing feedback to referrers of safeguarding concerns, with particular reference to:

a) Whether the referral is being taken forward under section 42 or not;
b) If not taken forward, the reasons why, and what alternative might be necessary;
c) If taken forward, the outcome once the s.42 process is complete.

5.10. Recommendation 10: Haringey SAB to promote knowledge and understanding across the partnership, including the voluntary sector, about the roles and responsibilities of each

agency's teams, their structures, referral pathways and escalation routes so that services can be accessed more effectively.

5.11. Recommendation 11: Ensure that self-referrals to alcohol support services are routinely followed up by health care professionals to support and encourage take-up[3].

5.12. Recommendation 12: Ensure that self-referrals to IAPT support services are routinely followed up by health care professionals to support and encourage take-up[4]. Consider using a GP digital safety netting tool/template in order to capture follow up of non-responders. Raise awareness of mental ill health and how to help people with low level mental health needs access support effectively, particularly for people at risk of homelessness.

5.13. Recommendation 13: Ensure that social prescribers are able to refer to specialist clinics and GP health checks, relevant to the needs of the individual.

5.14. Recommendation 14: Provide assurance to the SAB that the housing needs assessment of vulnerable people who have significant health and care needs is working effectively.

[3] As chronic substance misuse can lead to issues with executive capacity functioning, professionals working with vulnerable people should take this into account when self-referral routes are not utilised.
[4] As footnote 3 above.