‘Robert’

Safeguarding Adults Review: Final Report

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SAFEGUARDING ADULT REVIEW – Robert

Somerset Safeguarding Adults Board

1. INTRODUCTION

1.2 Robert was found at his home dehydrated, hypothermic and confused on 4/2/19 by a General Practice (GP) Paramedic. Robert died in hospital on 6/3/19. There had been concerns about Robert's self-neglect in the two years prior to his death and Robert had been moved out of his home for six days whilst a deep clean took place. Robert returned home on 2/5/18 and then on 21/5/18 was moved to other more appropriate accommodation. Care and support was provided from 30/5/18, but following a review the care ceased on 21/6/18. There was no further Adult Social Care (ASC) input and Robert had intermittent contact with the District Council Housing Department.

2. SAFEGUARDING ADULT REVIEWS

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Somerset Safeguarding Adults Board (SAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Somerset Safeguarding Adults Board the power to commission a SAR into any other case:

'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) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

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

The SAB may also –

Arrange for there to be a review of any other 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).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3 The purpose and underpinning principles of this SAR are set out in Somerset Safeguarding Adults Board (SSAB) documents: "Safeguarding Adults Reviews – Overview" https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SARs-Overview-Document.pdf and "SSAB Learning and Improvement Policy https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SSAB-Learning-and-Improvement-Policy-16-06-2021.pdf .

2.4 All SSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.5 This case was referred to the SSAB by the Somerset County Council (SCC) Safeguarding Adults Team on 10/03/20 for their consideration of a Safeguarding Adult Review (SAR). The delay was due to it only being referred to the SSAB at the request of the Coroner in a letter following the conclusion of the inquest.

2.6 The SAR Subgroup felt that the criteria for a SAR had been met as Robert was known to be self-neglecting for at least two years prior to his death and, on review of the information requested to support the referral process, there was concern relating to the multi-agency involvement in his care and support.

2.7 A Coroner's Inquest was held into Robert's death on 23/10/19. The Coroner also recommended that a SAR be undertaken to identify learning from this case, in particular to ensure the services Robert came into contact with in the lead up to his death were providing the appropriate level of care and to identify whether they could have prevented Robert's levels of self-neglect which contributed to his death. The SAR was then delayed by the need of agencies involved in the review to focus on responding to the Covid-19 pandemic.

2.8 The Safeguarding Adults Review was led by Patrick Hopkinson, the Independent Author, an Independent Consultant in Adult Safeguarding who has had no previous involvement with this case and no connection with the agencies that worked with Robert.

2.9 Family involvement in this SAR

2.10 Robert's sister provided the Independent Author of the SAR with information about Robert and concerns about his care and treatment.

3 BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1 Robert was born in 1944 and had one older sister. When his mother and father divorced, and his father remarried, Robert and his mother moved home to a Council property. Robert's sister had married and had moved away by this time and said that Robert had been a sickly child who had received a lot of attention from his mother. Robert's sister said that Robert liked being looked after by his mother, who also liked looking after him. When Robert's mother died in 1983, Robert continued to live in the property alone and his aunt did his washing for him. Robert was unmarried and does not appear to have had a partner.

3.2 Robert was described as a quiet person by his sister. He had worked as a lorry driver, had retired in 2000, liked "anything with wheels" including armoured fighting vehicles and collected model lorries. Robert owned a car which he drove until his death.

3.3 In 2010 Robert was diagnosed with hypothyroidism, but he appears to have stopped taking his medication (thyroxine) in 2014.

3.4 On 18/1/18 Somerset County Council's Adult Social Care ASC) service[1] received a contact from a food delivery driver who was concerned about Robert and the smell from the property. The delivery driver was telephoned back for further information and he explained that cat excrement was not being cleared away and that Robert had several open wounds. This was accepted as a referral for further safeguarding enquiries under s42 of the Care Act. The ASC adult safeguarding team also contacted Robert's GP about the concerns.

3.5 On 23/1/18 the Primary Care Paramedic from the GP practice attended Robert's home and noted the "squalid" conditions, and many flies in the flat. Robert also appeared to have a piece of one of his ears missing and this was reported to Robert's GP.

3.6 In response to this, Robert's GP visited on 29/1/18 and diagnosed Robert's ear lesion as basal cell carcinoma, a slow growing and non-spreading form of skin cancer.

3.7 On 13/2/18 ASC visited Robert in his home. The report of that visit stated that Robert had care and support needs due to reduced mobility and a reduced ability to maintain the upkeep of his flat, which was described as self-neglect

[1] At the times of the events covered by the Safeguarding Adults Review Somerset had a 2-tier system of Local Government. In the area in which Robert lived housing was the responsibility of his District Council, Somerset West and Taunton Council (SWT) while Adult Social Care services were the responsibility of Somerset County Council

but “not to a degree that is challenging his welfare or life threatening”. Robert was able to get about his flat using an outdoor four-wheeled walker, and although he said he could manage the stairs to his flat, ASC concluded that Robert would make slow progress due to his reduced mobility. Robert said that he had a car and still drove it. ASC noted an unpleasant smell emanating from Robert and his flat, that he struggled to manage the cat litter, and that he would need help to manage his food and other perishable goods as these were currently attracting a significant number of flies.

3.8 On 14/2/18 ASC arranged a four-week reablement package of care to assess Robert’s needs as well as to meet his needs. The care package was due to start on 19/3/18 and was to consist of daily 30-minute morning calls to Robert. The care was arranged with Somerset Care Ltd.

3.9 On 21/2/18 a Housing Officer from the District Council Housing Department, having been alerted by the adult safeguarding team, visited Robert. The Housing Officer considered that the property was no longer suitable for Robert’s mobility needs and planned another visit on 28/2/18 to complete the paperwork to start the process of finding more suitable accommodation for him.

3.10 On 28/2/18 a Safeguarding Social Worker at Somerset County Council (SCC) asked the Housing Officer to arrange for the property to be cleaned.

3.11 For the period 28/2/18 to 22/6/18 ASC allocated an Adult Social Care Worker[2] to Robert to “offer Robert consistent support to understand Robert’s situation”, who visited him twice during this time. This resulted in the appointment of a Community Agent who was instructed to provide support in organising a deep clean of his property and supporting Robert to move home. Somerset Village and Community Agents are commissioned by Somerset County Council and employed by the Community Council for Somerset, a charity which provides “practical community-based solutions”.

3.12 On 8/3/18 the SCC Safeguarding Team closed the safeguarding enquiry, but the case remained open to the ASC Locality Team for social care assessment and care planning. This was on the basis that arrangements for a deep clean were being progressed by the District Council’s Housing Officer, a package of care was being sourced by the ASC Locality Team and Robert was on an “autobid” for extra care housing[3] properties, his upstairs flat having been deemed unsuitable for his mobility needs.

3.13 On 15/3/18 the reablement care package to be provided by Somerset Care Ltd from 19/3/18 was cancelled by the ASC Locality Team since Robert’s home had yet to be deep cleaned.

[2] Add in definition
[3] Add in definition

3.14 On 16/3/18 ASC assessed Robert's care and support needs under the Care Act 2014. Robert was unable to clean his home due to his reduced mobility and there was no clear evidence of how Robert was managing his personal care or how he was able to leave his flat due to stairs.

3.15 Unaware that the reablement care package had been cancelled, Somerset Care Ltd made its first visit to Robert on 19/3/18. The reablement carer raised concerns about Robert's living environment. The strong smell of ammonia from the soiled cat litter tray was hurting the carer's eyes and concerns about Robert's self-neglect were reported by Somerset Care Ltd to ASC on 19/3/18. Another reablement worker then visited on 20/3/18, but there was no response from Robert. Somerset Care Ltd reported this to ASC and were told that the reablement care had been cancelled. Somerset Care Ltd had no further involvement with Robert.

3.16 Robert was to be moved into extra care housing for the clean to take place. On arrival on 25/4/18, the property was not suitable leading him to be moved to a hotel the following day. He returned home on 2/5/18 after the clean had been completed, but without a care package and then on 21/5/18 Robert was moved to sheltered accommodation.

3.17 From 30/5/18 until 21/6/19 Robert received a care package of one visit per day provided by Bluebird Care, a provider of domiciliary care. The purpose of the visit was to help Robert with his personal care. Bluebird Care state that Robert never allowed staff to assist him with this, although they performed some minor tasks.

3.18 On 1/6/18 Robert had a biopsy which confirmed the nature of the lesion. On 14/6/18 the stitches were removed, but Robert did not attend three follow-up appointments at the hospital and complete excision was not achieved.

3.19 On 13/6/18 Bluebird Care reported that Robert was refusing support and that he was dressed by the time the carers arrived. This triggered a review under the Care Act by ASC which took place on 19/6/18.

3.20 The review on 19/6/18 noted that Robert was now living in a sheltered accommodation flat which was clean and uncluttered. The new flat had a wet room and Robert felt able to shower independently. The Community Agent had found a free laundry service and was supporting Robert to go to the local launderette. Some funding had been agreed by the Warm Home Grant to pay for a "micro provider" (a small-scale provider of support that does not include personal care) each week to help Robert with keeping his flat tidy. To reduce Robert's isolation various groups were arranged for him to attend over 5 days per week including a church group, Men Shed and a bike repair group. Robert reported that he had pain in his legs which had worsened in recent months. As a result the Community Agent agreed to support Robert to access his GP to review pain management and to buy a mobility scooter to go to the local shops independently. ASC notes do not indicate specifically why a mobility

scooter was needed when Robert had a car, but Somerset West and Taunton Council report that some tenants have both a car and a mobility scooter, the latter used for shorter distances.

3.21 ASC ended Bluebird Care's visits to Robert on 21/6/18 and submitted a referral to the Integrated Rehabilitation Service (IRT) of Somerset NHS Foundation Trust requesting an assessment of Robert for mobility aides to support his independence. ASC closed their contact with Robert.

3.22 From 21/6/18 Robert was supported by a Temporary Sheltered Housing Officer and Debt and Benefits Advisor, both from the District Council. The Sheltered Housing Officer visited him to help him settle in his new home, establish a support plan, risk assess his needs in relation to the property, register him with the Lifeline service, support him to complete paperwork and to sustain his tenancy. The Debt and Benefits Adviser supported and advised Robert, on an ad-hoc basis, with his benefits entitlement, on making benefit claims and on re-paying debts.

3.23 On 18/7/18 Community Agent support for Robert ended.

3.24 From July 2018 Robert began to refuse to let the Sheltered Housing Officer into his home and sometimes Robert was not in when he was visited (although not all of these visits were pre-arranged).

3.25 Between 18/7/18 and 25/9/18 the Robert was visited at home by an Adult Rehabilitation Team Occupational Therapist (twice), a Physiotherapist (three times) and Rehabilitation Assistant (once).

3.26 On 16/8/18 a physiotherapist and occupational therapist made a joint visit to Robert to assess his needs. They noted that Robert's home was in a poor condition and planned to raise it with ASC. This was delayed because Robert said that he had a support worker who helped him with his home.

3.27 On 17/8/18 the Sheltered Housing Officer visited and raised with Robert the issue of cleanliness and the fact that Robert still had no carpets. Robert said the carpets needed to be ordered.

3.28 On 13/9/18 the physiotherapist, having visited Robert again on 5/9/18 and noted a further decline in the way he was living, raised concerns with ASC about self-neglect and the deterioration in Robert's living conditions. Somerset NHS Foundation Trust's records note that the physiotherapist was told that Robert was making a lifestyle choice to live like this. ASC have no record of this contact. It appears the physiotherapist did not raise Robert's self-neglect with Somerset Foundation Trust's own safeguarding team.

3.29 Throughout the autumn of 2018 the Sheltered Housing Officer noted that he was often unable to access Robert's flat, and when he did, he witnessed a deterioration in the state of the property.

3.30 On 2/11/18 the Sheltered Housing Officer raised the cleanliness of the flat with Robert. There were still no carpets. Robert said that he would tidy up and a plan was made for the Sheltered Housing Officer to visit again a week later. However, Robert was not in when the planned visit took place.

3.31 On 24/12/18 the Sheltered Housing Officer visited and found flat to still be in a poor state. The Sheltered Housing Officer reported this to their manager and was advised to wait and assess the situation after Christmas.

3.32 During January 2019 the Sheltered Housing Officer was again unable to gain access to Robert's flat because Robert either refused entry or was not in.

3.33 On 25/1/19 the Sheltered Housing Officer received a telephone call from a neighbour who was concerned about Robert's welfare. The Sheltered Housing Officer tried to visit Robert the same day, but he was not at home and his car was not in the car park. Robert refused entry when the Sheltered Housing Officer visited on 28/1/19.

3.34 On 4/2/19 Robert's sister telephoned Robert's GP, concerned that Robert was confused and seemed physically weak. The Surgery Paramedic attended Robert and telephoned 999. The South Western Ambulance Service crew described the scene as follows. "The flat was swarming with flies, faeces in every room, Robert was sitting in his chair undressed from the waist down. Alert, pale, covered in faeces, confused, dehydrated. Severe self-neglect.". "Robert was hypothermic, unable to mobilise without help" and the "Flat (was) in an uninhabitable state, no food in the house." Robert's sister noted that when she visited the Robert, apart from milk, the only food in the house was in tins that had been put away in a cupboard. She thought that Robert may have had difficulty opening the tins.

3.35 On 4/2/19 Robert was admitted to Musgrove Park Hospital with confusion, dehydration and according to the hospital "evidence of self-neglect". He was described as critically ill and diagnosed at that time with severe renal impairment and hypothyroidism.

3.36 Whilst in A&E Robert went into cardiac arrest and was resuscitated. He was then transferred the intensive care unit where he required hemofiltration to treat his kidney injury.

3.37 On 6/2/19 ASC received a safeguarding referral from the ambulance service, regarding Robert's self-neglect. ASC liaised with the hospital team to ensure that there was social work involvement in an assessment of Robert's needs and that his property would be assessed prior to discharge.

3.38 On 26/2/19 Robert had improved and was transferred to a ward where he remained clinically stable for the next week.

3.39 On 3/3/19 Robert's condition deteriorated with respiratory distress and pneumonia and he died on 6/3/19 aged 75 years old.

4 THE EVIDENCE BASE FOR THE REVIEW

4.1 Michael Preston-Shoot (2019) argues that, "*Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice"*

4.2 The advantage of this approach is that, *"The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills*" (Preston-Shoot, 2019).

4.3 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with someone in Robert's situation: self-neglecting and with whom services found it difficult to engage.

4.4 Evidence from research

4.5 Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance. It is clear from the information provided by agencies for this SAR that certainly in the later years of his life, Robert was self-neglecting.

4.6 Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16).

4.7 Michael Preston-Shoot and Suzy Braye have undertaken extensive research into and guidance on working with people who self-neglect and this was available from December 2018 onwards. It was only available therefore in the last three months of Robert's life, however as this is about learning lessons it is appropriate to consider the guidance to help practitioners facing similar situations of self-neglect in the future. For the purposes of this SAR, it is sufficient to focus only on a summary of this guidance.

4.8 Practice with people who self-neglect is more effective where practitioners:

a) Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience

b) Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes

c) Keep constantly in view the question of the individual's mental capacity to make self-care decisions

d) Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility

e) Ensure that options for intervention are rooted in a sound understanding of legal powers and duties

f) Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks

g) Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals

In order to do this, the following approaches should be used:

a) History taking. Explore and ask questions about how and when self-neglect started.

b) Be proactive and identify and address repeated patterns of behaviour

c) Try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure

d) Ongoing assessment review of mental capacity

4.9 On a more strategic level the policy, procedural and organisational environments that foster this way of working are likely to have the following characteristics:

a) Agencies share definitions and understandings of self-neglect

b) Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems

c) Longer-term supportive, relationship-based involvement is accepted as a pattern of work

d) Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice

4.10 The extent to which these approaches and Somerset Safeguarding Adults Board's Self-Neglect Practice Guidance were applied to Robert, and the environment to support them existed, provide a useful analytical framework for this SAR.

4.11 **Self-neglect, mental capacity and freedom of choice**

4.12 Safeguarding Adults Reviews (amongst others Andrew, Staffordshire and Stoke, 2022; Harold, Brent 2022; Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998 – see Appendix 1, the Care Act 2014 – see Appendix 2, the Mental Capacity Act – see Appendix 3 and the Mental Health Act 1983.

4.13 These are further complicated by confusion in the application of the Mental Capacity Act, its statutory guidance and principles when considering questions of whether or not people are able to make decisions on a specific matter at a specific time (see for example, the post-legislative scrutiny report of the House of Lords Select Committee on the Mental Capacity Act 2005 published in 2014).

4.14 The proposed revised Code of Practice for the Mental Capacity Act will, subject to consultation, clarify the assessment process, requiring that the functional test of capacity (i.e. the ability to understand, retain and use and weigh relevant information and to communicate a decision) precedes the diagnostic assessment of the presence of an impairment in the functioning of the mind or brain.

4.15 It also proposes guidance on assessing mental capacity where there is an impairment in executive functioning and a mismatch between what a person says and what they do. The revised Code of Practice also proposes a statement that, “A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information” (section 4.39 of the proposed Code of Practice for the Mental Capacity Act).

4.16 At the intersection of the Human Rights Act, the Care Act, the Mental Capacity Act and the Mental Health Act is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it can be reduced to a question of freedom of choice versus protection. The guidance on working with people who self-neglect challenges the either/ or nature of this question by asking practitioners to consider:

4.17 Is a person who self neglects really autonomous when:

a) They do not see how things could be different
b) They do not think they’re worth anything different
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult

e) They have impairment of executive brain function

4.18 Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour
b) Their 'sense of self' is removed along with the risks
c) They have no control and no ownership
d) Their safety comes at the cost of making them miserable

4.19 **Decisional and Executive Capacity**

4.20 The extent to which a person who self neglects is able to put whatever decisions they make into effect should also be considered. Whilst the Mental Capacity Act and its Code of Practice does not, yet, explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice, especially with people who self-neglect and feign compliance or avoid contact. Executive capacity can be explored through the assessment of a person's ability to use and weigh information in order to make a decision (see for example, https://safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/11/ADASS-Eastern-Region-Self-Neglect-and-Hoarding-2020.pdf) and should be considered when there is a mismatch between what a person says and what they do. Physical conditions and illnesses can have an impact on executive functioning and executive capacity.

4.21 **Robert's physical health needs**

4.22 In 2010 Robert was diagnosed with, and prescribed medication for, an underactive thyroid (hypothyroidism). An underactive thyroid gland does not produce enough thyroid hormone, which can lead to high cholesterol and clogged arteries, potentially resulting in serious heart-related problems, such as angina and heart attack https://www.nhs.uk/conditions/underactive-thyroid-hypothyroidism/diagnosis/. Blood tests are used to measure thyroid hormone levels and, according to Robert's sister, this condition ran in Robert's family.

4.23 Common symptoms of hypothyroidism can include fatigue, slow movements and thoughts, depression, memory problems and difficulty in concentration https://www.btf-thyroid.org/hypothyroidism-leaflet.

4.24 In very rare cases, a severe underactive thyroid may lead to a life-threatening condition called myxoedema, causing confusion, hypothermia and drowsiness https://www.nhs.uk/conditions/underactive-thyroid-hypothyroidism/complications/ . The practice paramedic who found Robert in his flat on 4/2/19 described Robert as dehydrated, hypothermic and confused and Robert's death certificate cited severe hypothyroidism as an underlying cause of death.

4.25 Safeguarding concerns

4.26 Two safeguarding concerns were raised with the Somerset County Council safeguarding team about Robert in 2018 and 2019. Section 42 of the Care Act sets out the circumstances in which a safeguarding enquiry must be made (see Appendix 4). Safeguarding enquiries and interventions should also be made in such a way that they make safeguarding personal and apply the Six Principles of Adult Safeguarding: Empowerment, Prevention, Proportionality: Protection; Partnership and Accountability (Paragraph 14.13 of the Care and Support Statutory Guidance).

4.27 Impact of protected characteristics

4.28 Although there was no direct evidence of discrimination in the approaches to Robert, there is also a growing literature on the difficulties faced by men in accessing services (Baker et al 2015) and facing preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson 2011).

5 ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Robert.

5.2 Impact of Robert's physical health conditions

5.3 It is not entirely clear whether, and if so when, Robert stopped taking his medication for hypothyroidism. According to Robert's GP, Robert stopped collecting and taking medication in 2014. Robert had been advised to attend for repeat blood tests in 2014 but had not returned to the surgery for them.

5.4 Robert's sister believed that Robert had continued to take medication for hypothyroidism, with some reminders from her, up until 2016. In 2018 Robert filled in a housing form stating that he was taking hypothyroidism medication. Neither Robert's sister, who lived some distance away, nor the District Council Housing Department staff, were able to witness whether or not Robert was taking medication for hypothyroidism. Given that Robert's GP had prescribed the medication and made out repeat prescriptions, it would appear most likely that Robert had stopped taking medication for hypothyroidism in 2014, some five years before he died.

5.5 This might have been an opportunity for discussing with Robert the reasons why he was not taking medication for hypothyroidism. In addition, annual, or more frequent, blood tests are an important factor in the management of hypothyroidism and consideration should be given to closer follow up of missed appointments for people who are known to self-neglect or are unable to care for themselves.

5.6 When Robert was taken to hospital on 4/2/19 he had a cardiac arrest in the A&E department. Robert was transferred to intensive care and then to a ward where he regained consciousness. On 6/3/19 Robert died of 1a) Bronchopneumonia and 1b) Severe renal failure with Hyperkalaemia, Severe Hypothyroidism, Complete Heart- block and Self Neglect. 1a is the disease or condition which immediately caused death and 1b is the underlying cause of 1a). In light of this it appears likely that Robert's failure to take medication for hypothyroidism contributed to his death.

5.7 Meeting the health needs of people who do not adhere to treatment requirements or who self-neglect can be difficult. However, Robert's self-neglect and his mental capacity to make decisions about his care and welfare do not appear to have been explored by any professionals in contact with him.

5.8 Robert's self-neglect should have prompted a mental capacity assessment (see below), which should have considered whether hypothyroidism caused an impairment or disturbance in the functioning of his mind or brain.

5.9 Even if Robert had been assessed to have the mental capacity to make decisions about his treatment, approaches to create a "therapeutic alliance", which can increase compliance with medication, might have been used. Escalation to a multi-agency risk management forum to discuss and share concerns and consider alternative interventions may have been useful.

5.10 The symptoms of hypothyroidism can include fatigue, slow movements and thoughts, depression, memory problems and difficulty in concentration, and they may have caused an impairment or disturbance in the functioning of Robert's mind or brain. It should be noted, however that none of these symptoms were mentioned or recorded by professionals in contact with Robert during the timeframe of this review. This may have been because they were not present but might also have been because the potential significance of the symptoms was not recognised. More curiosity about a possible connection between Robert's health condition, non-adherence with treatment and his self-neglect might have prompted a more coordinated approach to assessing and meeting his needs.

5.11 It is not clear what physical health condition was causing Robert's mobility to be impaired, but the Care Act assessment confirmed that he did have mobility problems. The assessment held on 16/3/18 reported that Robert was unable to clean his home due to his reduced mobility and noted that there was no clear evidence of how Robert was managing his personal care or how he was able to leave his flat due to stairs. ASC suggested that Robert was quite slow moving about his flat, because of his reduced mobility, and he used a four-wheeled walker. The review of Robert's needs on 19/6/18 concluded that his flat was tidy and the carers reported that he was already washed and dressed when they arrived.

5.12 Consequently, ASC withdrew the daily care visits. It is not possible to determine accurately how much Robert's physical mobility contributed to the

condition in which he and his flat were found on 5/2/19. Practitioners reflected that they thought Robert had previously overstated his ability to carry out tasks (see paragraph 5.24 below). However, given that Robert appeared in June 2018 to be able to manage his own personal care, it is likely that his mental state played a not insignificant part in his relapse into self-neglect. In August 2018, only two months later, the occupational therapist considered that Robert's poor home conditions and apparent self-neglect would negatively affect his ability to benefit fully from the updated mobility aides and the independent reablement team's therapeutic support.

5.13 There can be a fine line between neglect and self-neglect and distinguishing between the two might be summarised as deciding whether a person (to coin a phrase) is, "*willing but unable, or able but unwilling".* By February 2018 it appears that Robert's mobility difficulties had made him unable, or at least reduced his ability, to undertake certain tasks. Leaving Robert in this situation would have been to neglect him and some of the difficulties he faced in self-care and domestic tasks were overcome by moving to a ground floor flat with a wet room. Despite having developed more pain in his legs at the time of the review in June 2018, Robert still appeared able to wash and dress himself and, in addition, he was noted to be more motivated to attend to these tasks. At this time, Robert appeared to be both able and willing.

5.14 Within a few months, however, it seems that Robert had become demotivated, evidenced by the condition of his flat. Consequently, Robert had remained able but had become unwilling. In other words, Robert was now self-neglecting.

5.15 It is important to note that "willingness" and "unwillingness" in this context should not be ascribed to lifestyle choice (see paragraph 5.40 below). There are many factors that may affect a person's willingness or motivation to do things, including mental and physical health conditions.

5.16 **Recognition that Robert was self-neglecting**

5.17 There was a recognition by professionals who came into contact with Robert that he was self-neglecting, as evidenced in the ASC notes of 18/1/18, for example, following an alert to signs of self-neglect by a food delivery driver. On 29/1/18 Robert's GP noted the "filthy" state of Robert's flat and that Robert's clothing was completely covered in stains, and again on 19/3/18 ASC noted that concerns about self-neglect were passed to them by Somerset Care Limited. As early as 2010 the GP had noted the "unkempt" state of Robert's flat, but it seems not severe enough to warrant an intervention.

5.18 It appears that more professional curiosity could have been applied in *seeking to understand the meaning and significance of the self-neglect, taking account of the individual's life experience.* The information provided by agencies to the SAR author suggest that they had not established, nor, with the exception of Robert's GP, sought to establish, a trigger point or life experience that may

have changed or influenced the way Robert lived. When Robert was about 10 years old, according to his GP notes, he had a psychiatry assessment and there was a suggestion that Robert was neglected in his upbringing (which Robert's sister denied when asked about this by the report writer). The other agencies, such as ASC, were not aware of this and did not explore the impact of childhood experiences on Robert.

5.19 Robert's GP tried to establish whether underlying mental health conditions or dementia affected how Robert's was living. This is evidenced, for example, by the GP's visit to Robert on 29/1/18 following the report of self-neglect to ASC by the food delivery driver on 18/1/18. The GP ascribed Robert's way of living to Diogenes (or senile squalor) Syndrome (typified by hoarding, living in squalor and becoming social isolated) and noted that there were no specific treatment options for this. The GP could find no evidence of mental health conditions or of dementia and felt that Robert's way of living was "intrinsic to his personality**".** It does not appear that the GP considered whether any other physical health problems, such as underactive thyroid, were influencing Robert's way of living.

5.20 In response to the food delivery driver's report on 18/1/18, which was accepted as a safeguarding concern for further enquiries, a safeguarding social worker from ASC visited Robert on 13/2/18. Robert said that he received help from a local church (which the safeguarding social worker confirmed) and a neighbour. Robert agreed to have a home fire safety check and for an assessment of his care needs. It does not appear that the reasons for Robert's self-neglect or his background were explored.

5.21 The adult safeguarding team's request on 28/2/18 to arrange, and the housing department's decision to pay, for Robert's flat to be cleaned appears to have been prompted by the need to make the environment healthy and hygienic enough for carers to enter and provide care and support to Robert. A housing officer was also asked to support Robert to find a new ground flat because of his mobility needs.

5.22 Despite this, Robert was moved to a hotel on 26/4/18 to allow for the deep clean and then returned home on 2/5/18 but without a care package in place and does not appear to have received a completed assessment of his care needs after Somerset Care Limited was told by ASC to withdraw. The deep clean might have been an opportunity to disrupt the pattern of Robert's self-neglect and for this to have been a possibility an understanding of why Robert self-neglected was required. Skilled work with Robert at this time might have assisted with this. Instead, Robert's newly cleaned flat was determined to be no longer suitable for him due to his mobility needs and he moved again to a ground floor flat 1.5 miles away on 21/5/18. Here, Robert was provided with support to help with his morning routine, the arrangement of activities to reduce his social isolation and the suggestion of help from a cleaner to keep his flat clean.

5.23 Whilst there was an element of *working patiently at the pace of the individual, who was not unduly pressured,* this does not seem have occurred *within the context of knowing when to make the most of moments of motivation to secure changes.* After the clean Robert's pattern of self-neglect soon returned. This is evidenced by a note in the District Council Housing Department's records that on 9/5/18 ASC and the Community Agent visited Robert and found that the flat was once again in a poor condition, only one week after Robert had returned home on 2/5/18. Once Robert had moved to his new supported accommodation it soon deteriorated to a state similar to, and perhaps worse than, his original flat, as did his own hygiene and self-care. This is evidenced by the visit by the physiotherapist and occupational therapist on 16/8/18, which was less than three months after Robert's move to supported accommodation.

5.24 **Understanding Robert's mental capacity in the context of self-neglect**

5.25 In the view of the District Council Housing Department, once Robert had moved into his new supported accommodation, he presented himself as capable of managing all key aspects of his life and acknowledged that he had previously self-neglected. The District Council Housing Department Council also reflected that Robert might have presented himself as more able than he was. Robert might have had *decisional* capacity to decide to care more for himself but not the *executive* capacity to do so.

5.26 On 29/01/18 during a home visit Robert's GP asked questions to establish the extent to which Robert was orientated to time and place. Whilst this is helpful, for example, in screening for dementia as possible cause of Robert's self-neglect it would not be a test of whether Robert had the mental capacity to look after himself.

5.27 There does not appear to have been consideration of how Robert's other physical health needs (hypothyroidism) may have affected his capacity to make decisions and care for himself. Despite Robert's diagnosis of hypothyroidism, and awareness that he was not adhering to treatment, no symptoms were reported by the professionals in contact with him. This may have been because no symptoms were present but may have been because symptoms were not recognised and were subsumed within the understanding that Robert was self-neglecting.

5.28 Hypothyroidism could have been considered to be potential cause of an impairment or disturbance in the functioning of Robert's mind or brain (the generally understood 2-stage mental capacity assessment current at the time of this review is set out in Appendix 3) and decisions Robert made about, for example, looking after himself or to refuse access should have been tested to ensure that they were capacitous by the professionals in contact with him on each occasion.

5.29 Even if Robert appeared to be able to understand, retain and use or weigh information relevant to decisions and to be able to communicate his decisions,

it does not mean that decisions to neglect himself should have been left unchallenged.

5.30 When professionals recognised that Robert was self-neglecting, his mental capacity to make decisions about self-care, for example, should have been assessed. No formal mental capacity assessment, however, was completed by any of the agencies. Whilst Robert's capacity may have been considered intermittently, it was assumed rather than tested. Consequently, more could have been done to have *kept constantly in view the question of the individual's mental capacity to make self-care decisions*.

5.31 **Legal literacy in the context of self-neglect**

5.32 The lack of attention to mental capacity and lack of assessment also suggests that *options for intervention were not rooted in a sound understanding of legal powers and duties*. The SSAB Self-Neglect Practice Guidance includes legal interventions and mental capacity assessment but there does not appear to have been consideration that if Robert lacked the mental capacity to make decisions about his safety, then decisions could be made in his best interests. All public sector bodies, whether they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights. These include Article 2 to protect life and Article 8 to protect the right to respect for private and family life (autonomy of decision making). Practitioners must balance the need to protect life with the need to protect autonomy and the duty to protect life may override the duty to protect autonomy. This can be challenging but attention should be given to developing an understanding of a person's previous choices, decisions and way of life and with compassion for them rather than as an abstract exercise.

5.33 There were some interventions *to communicate about risks and options with honesty and openness.* For example, on 5/9/18 the physiotherapist noted Robert's soiled clothing and bedding and the presence of cat faeces on the floor. The physiotherapist discussed the health and slip hazards posed with Robert and raised this with him again on 13/9/18. It is likely that these overt risks were indicators of rather deeper and more concerning risks arising from Robert's inability to protect himself and presented an opportunity to share awareness of, and concerns about, risks between agencies.

5.34 There were opportunities for some of the other practitioners involved with Robert to communicate with Robert about risks, but the extent to which these were taken cannot be determined from the information provided to the SAR author. For example, there is no evidence that there was a conversation with Robert about the risks of not taking medication for hypothyroidism. Robert was advised to attend for blood tests, but did not do so. When Robert was no longer supplied with medication from 2014 onwards this could have been an opportunity to try some other intervention or follow up. It is also not clear that the risks to Robert of open wounds (his ear, for example) and living in unhygienic conditions were explained in way that he understood.

5.35 There appeared to be some *flexible thinking about how community resources could contribute to interventions,* but less so with *family members*. For example, ASC and the Community Agent sought to get help from the local church to deep clean Robert's flat (although the church had to decline as a deep clean was too great a task for its volunteers), and also suggested a regular cleaner through the church to help Robert keep his flat clean on an on-going basis. They identified a free short-term laundry service for Robert. They also suggested various activities for Robert to improve his social connections, including a Men Shed. According to practitioners, the Men Shed was reported to have a positive impact on Robert as he had been given the task of sorting out all the donated tools each week, which made him feel very useful and needed. However, it seems that this was not followed up longer-term and it is unclear whether Robert continued to engage with such activities.

5.36 There was less consideration of involving Robert's family. Robert's sister had a cataract operation in the first few months of Robert's move to his new sheltered housing accommodation. She lived some distance from Robert and driving to him was difficult. She therefore maintained contact with Robert by telephone. The agencies involved with Robert had little contact with his sister, who instigated contact with them. For example, Robert's sister called Robert's GP expressing her concerns about him on 4/2/19. Robert's sister does not recall any of the agencies contacting her, although the notes from the District Council suggest that the Housing Department did update her about plans for getting Robert's flat cleaned. It seems therefore that *little attempt was made by agencies to engage and work with Robert's sister to explore new strategies for supporting Robert.*

5.37 The "Think Family" approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016). This approach recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs.

5.38 The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family.
- Working jointly with family members as well as with different agencies to meet needs.
- Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

5.39 Such an approach may have led to greater consideration of how Robert's sister might have been engaged as a partner in meeting Robert's needs and how she could have been supported to do so. It might also have prompted faster escalation of concerns about Robert's ability to meet his own needs, particularly after the Community Agent support had ended.

5.40 **Self-neglect and life-style choice**

5.41 According to Somerset NHS Foundation Trust on 13/9/18 a physiotherapist raised concerns with ASC about a deterioration in Robert's living conditions and was told that this was Robert's lifestyle choice. ASC have no record of being contacted by the physiotherapist, nor of such a conversation, and questioned whether "appropriate channels" were used for communication. There appears to also to have been a missed opportunity for these concerns to have been raised with Somerset NHS Foundation Trust's own safeguarding team.

5.42 The concept of lifestyle choice is a potentially dangerous one in self-neglect and exploration of the reasons for self-neglect is required. To ascribe self-neglect or poor living conditions to lifestyle choice may be misleading.

5.43 If ASC had been contacted by the physiotherapist, it should have reopened their contact with Robert (having closed it in June 2018), and this would have been an opportunity for multi-agency working to consider the pattern of re-occurring self-neglect and to explore new interventions in the hope of breaking this pattern.

5.44 There was no record that the physiotherapist discussed Robert's self-neglect with the Somerset Foundation Trust's own Safeguarding Team to consider how the risk of harm could be reduced.

5.45 **Multi-agency working with Robert**

5.46 There were clear examples of agencies working together to support Robert. ASC and the Community Agent, Robert's GP and the District Council Housing Department liaised and worked together. For example, following the first safeguarding concern, ASC contacted the GP suggesting he visit Robert, ASC worked with the Community Agent to provide and source other forms of support for Robert and ASC and the District Council Housing Department liaised over a deep clean of the property. It should be noted however that from the safeguarding concern being raised on 18/1/18 it was not until 30/5/18, some four and a half months later, that Robert received the reablement package of care.

5.47 From 21/5/18 Robert was supported by a Temporary Sheltered Housing Officer and Debt and Benefits Advisor, both from the District Council. The Sheltered Housing Officer visited Robert weekly to help him settle in his new home, establish a support plan, risk assess his needs in relation to the property, register him with the Lifeline service, support him to complete paperwork and to sustain his tenancy. The Debt and Benefits Adviser supported and advised Robert, on an ad-hoc basis, with his benefits entitlement, on making benefit claims and on re-paying debts. The Sheltered Housing Officer met with Robert and the Community Agent on 4/6/18 and 11/6/18 to undertake his support planning and risk assessment. These highlighted the difficulties Robert had in maintaining his previous accommodation and in looking after himself.

5.48 Despite this, there were a number of missed opportunities to escalate concerns and draw in other agencies to consider alternative interventions. On 3/7/18, for example, the Debt and Benefits Adviser visited Robert to help him complete benefits claims. The Advisor raised a concern with the District Council Housing Department about Robert's living conditions and that the Community Agent and carer support had ended. This was not responded to and not escalated further.

5.49 On 16/8/18 a physiotherapist and occupational therapist visited Robert together to assess his mobility, the provision of therapeutic support to improve mobility and the use of aides and adaptations to facilitate Robert's independence. They concluded that Robert's poor home environment and apparent self-neglect in his new flat would negatively affect his ability to benefit fully from the updated mobility aides and the teams' therapeutic support. They planned to raise the poor condition of Robert's home with ASC but did not pursue this further at the time since Robert told them that was receiving help from a support worker. There is a discrepancy between Somerset NHS Foundation Trust and ASC about whether or not this was later raised with ASC, but the fact that Robert's property was deteriorating again was evident also to the Sheltered Housing Officer, who noted it on 17/8/18, the day after the physiotherapist and occupational therapist visited.

5.50 From July 2018 onwards, Robert had refused the Sheltered Housing Officer entry into his flat, and on other occasions Robert was not there when the Sheltered Housing Officer visited. In December Robert let the Sheltered Housing Officer in to help him with a financial issue and the cleanliness and tidiness of the flat appeared improved. It soon deteriorated again but from July through until December 2018 the Sheltered Housing Officer did not escalate concerns until 24/12/18 and was then advised by a manager to review the situation in January 2019. In January the Sheltered Housing Officer again experienced difficulty accessing Robert's flat but did not escalate the matter. Robert may have been avoiding the Sheltered Housing Officer and this could have raised concerns about Robert's health and welfare.

5.51 Whilst one agency might have discussed Robert with another agency, at no time did all the agencies come together for a multi-agency, multi-disciplinary meeting to generate and explore ideas of how best to support Robert, considering his self-neglect and his disengagement with services. A forum to which practitioners could bring cases that were difficult and may need some extra impetus and coordination to manage them would be helpful. The SSAB Self-Neglect Practice Guidance includes a flow-chart which recommends using a multi-agency case conference to consider all aspects of risks and potential resolutions https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SSAB-Self-Neglect-Practice-Guidance-Appendix-3-Agreed-24-09-2019.pdf . Alternatively, practitioners could have considered using Somerset's One Teams structure to develop multi-agency approaches to working with Robert. Since Robert's death the SSAB has published guidance to promote a joint approach to the assessment and management of risk to adults with care and support needs across organisations where the person

has complex needs, but where a safeguarding referral is not required or where it has been determined that a statutory or non-statutory safeguarding enquiry under the Care Act (2014) is not required https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/What-to-do-if-it's-not-Safeguarding-Guidance-v1.01.pdf .

5.52 In summary, there were examples of good practice multi-agency working, but it was not sustained and after services closed contact with Robert (for example, ASC and the Community Agent), there was little or no follow up. This left the District Council Housing Department as the only main long-term contact with Robert, and they did not escalate or report their concerns to ASC when Robert had begun to self-neglect again. Consequently, there was some work to *proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals,* but it required a long-term view and Robert's case was closed too soon without sufficient safeguards in place.

5.53 The relationship between ASC (part of the County Council) and Housing (part of the District Council) may not be entirely conducive to effective partnership working. The structure of local government in Somerset is changing and from 1/4/23 Somerset will become a unitary authority, replacing the County Council and the four District Councils. The preparation for this is an opportunity to develop excellent channels of communication, a shared understanding of statutory powers and duties and review the county wide self-neglect policy and procedure.

5.54 **Handling of safeguarding enquiries**

5.55 Three safeguarding concerns were raised about Robert. The first safeguarding concern was received on 18/1/18 when the food delivery driver contacted ASC with concern about Robert's self-neglect. ASC telephoned Robert's GP, found that Robert had not been seen recently by his GP and left a message asking for the GP to visit Robert in light of the concerns. A safeguarding social worker was allocated on 7/2/18 to complete the enquiry. The social worker was "unavailable" and so first tried to contact Robert on 12/2/18, over three weeks after receipt of the safeguarding concern. As there was no response to the telephone call, the social worker visited Robert on 13/2/18. The following day the social worker contacted the Environmental Health and Housing Departments of the District Council regarding Robert's home environment. ASC would assess Robert's needs and agreed a package of care to start in four weeks' time. ASC requested a home fire safety check and contacted Robert's GP for an update following the GP's visit on 18/1/18. On 28/2/18 the Safeguarding Social Worker advised the Housing Officer that Robert's flat would need a clean before carers could support Robert in his home. Somerset Care Ltd visited Robert on 19/3/18 to start the reablement package of care, not knowing that ASC had cancelled it, and on that same day raised their concerns to ASC about Robert's self-neglect (the second safeguarding concern).

5.56 The *empowerment* principle of safeguarding includes establishing what an adult at risk of abuse or neglect, including self-neglect, wants any safeguarding actions to achieve. The safeguarding social worker visited Robert on 13/2/18 and talked with Robert about his current circumstances and the outcomes he wished to achieve. These included getting out and about and seeing his family and his support network. Robert identified the local church as an important contact for him.

5.57 With regard to the *prevention* and *protection* principles of safeguarding, while it is clear the safeguarding social worker began the process for obtaining care for Robert and prompting others' actions, this was not done with sufficient urgency to ensure *protection*. There were 26 days between the first safeguarding concern being received (18/1/18) and the safeguarding social worker's visit to Robert's flat (13/2/18).

5.58 The safeguarding social worker asked the Housing Officer on 28/2/18 to arrange a deep clean so that carers could provide care to Robert in his home. If the safeguarding team had visited sooner after receiving the safeguarding concern on 18/1/18 or had requested the deep clean when they visited on 13/2/18 rather than on 28/2/18, it may have resulted in the clean taking place sooner and Robert's care needs might have been met sooner. A reablement package of care for Robert was requested on 15/02/18 and an ASC practitioner was allocated to Robert on 28/2/18. Somerset Care Limited visited Robert on 19/3/18 and received no response from Robert on 20/3/18 and were notified by ASC that the reablement care they were commissioned to provide had been cancelled. This was pending a deep clean of Robert's property and to enable this, Robert moved to a hotel on 26/4/18 and returned home on 2/5/18 and moved again on 21/5/18 to sheltered accommodation.

5.59 No care and support was provided to Robert, except on 19/3/18, until 30/5/18, over four months after the first safeguarding concern had been received on 18/1/18. Whilst potential carers were being protected from unhygienic conditions during this period, Robert was not.

5.60 The safeguarding team acted in *partnership* with other agencies to bring in services and activities, and to help safeguard Robert by for example requesting a home fire safety visit.

5.61 The third safeguarding concern was made by the Ambulance Service to Somerset County Council Safeguarding Team on 6/2/19. This concern was not "accepted" as an enquiry under Section 42 of the Care Act. Instead, contact was made with the hospital to ensure there would be social work input to an assessment of Robert's needs and an assessment of his flat prior to his return home to ensure his safe discharge. Unfortunately, Robert died in hospital.

5.62 In summary, the safeguarding team acted in the most part in accordance with the six principles of Making Safeguarding Personal. Some delays meant that

measures designed to *prevent* and *protect* from harm and neglect were not taken until 26 days after the first safeguarding concern was raised.

5.63 **Feigned Compliance**

5.64 Robert may have been behaving in a way that was intended to convince professionals and his own sister that he was working with them whilst taking few actions. This has been referred to as “Disguised Compliance” but perhaps a more accurate term is “Feigned Compliance” or even avoidance. Examples include Robert not correcting his sister when she assumed that he still had supplies of his hypothyroidism medication and was taking it (with prompting from her), giving the impression that he was motivated to improve his own self-care when he first moved into his sheltered accommodation, and from July 2018 onwards avoiding the Sheltered Housing Officer on numerous occasions and not letting him into the property.

5.65 **Effect of various accommodation moves**

5.66 On 26/4/18 Robert was moved out of his Council flat for a deep clean to take place. He was accommodated at a hotel. On 2/5/18 Robert returned home, knowing that he would be moved again, this time to sheltered accommodation**.** This was because his existing flat was no longer suitable for his needs, particularly in relation to his deteriorating mobility. On 21/5/18 the District Council Housing Department moved Robert to sheltered accommodation, which was a ground floor, one bedroom flat with a wet room.

5.67 It seems that most of Robert’s possessions had been packed in a garage while the deep clean took place. Some of his possessions may have been destroyed due to their poor condition. Robert’s sister wondered where they had gone. This suggests there may have been a need for greater communication about his possessions.

5.68 Robert had lived in his original flat for 50 years, initially with his mother, and knew people in the area. Despite wanting to stay in the locality, his new flat was in a different area, some 1.5 miles away, in an area that he was not used to and was not familiar with. The District Council Housing Department had noted that Robert wanted to stay in the area he knew, and involved Robert’s sister and a friend in discussions around the move. However, although the distance between the two flats may seem small, it appears to have been significant for Robert. As part of this Review, Robert’s sister reflected she used to call Robert every week when she did, he would often recount what and who he had seen out of his window as it overlooked an area with quite a bit of activity. After he had moved to his new flat, he had very little to say to her as he only had trees and a hedge to look at from the new property.

5.69 The District Council Housing Department stated that when it has to rehouse someone as a matter of urgency they can only be rehoused within vacant properties and that if there is no accommodation available within the desired area, an alternative as near as possible to the desired area will be offered.

5.70 ASC and the Community Agent made links for social activities for Robert to reduce his social isolation in his new accommodation. These activities (for example, the Men Shed) did appear to be appropriate to Robert's interests, and his sister has agreed with this, but there was no follow-up to check whether Robert was still attending and whether there were any barriers to his participation.

5.71 Despite the Community Agent's help given to Robert over this period, Robert's sister felt that the various moves were detrimental to Robert. She observed that once Robert had moved to the new flat, he did not bother to unpack everything. He had no carpets laid or curtains.

5.72 **Good Practice**

5.73 On receipt of the safeguarding concern by ASC in 2018 there was a multi-agency response involving social care, health, housing, and environmental health.

5.74 SCC and the Community Agent used the involvement of a combination of agencies and community resources in a hybrid package of support designed to meet Robert's care, domestic cleaning and social support needs.

5.75 Reablement care is usually only provided on discharge from hospital. ASC commissioned reablement care for Robert to support the assessment of his needs even though he had not been recently discharged from hospital.

5.76 The District Council Housing Department also readily agreed to pay for the deep clean for Robert's flat.

5.77 The South Western Ambulance Service staff acted appropriately in identifying and reporting self-neglect to ASC when they were called to Robert's flat on 4/2/19.

6. FINDINGS

6.1 The cause and impact of Robert's self-neglect was not understood

6.2 Despite the evidence available that Robert was self-neglecting, and the use of the term "self-neglecting" to describe his situation, approaches set out in practice guidance for effective work with people who self-neglect were only partially used. There was a focus on the components of Robert's self-neglect, which include poor hygiene and cleanliness and living in a poor environment, at the expense of exploring its causes and its consequences. More professional curiosity could have been applied in *seeking to understand the meaning and significance of Robert's self-neglect* (See Recommendations 2 and 3)

6.3 Some steps were taken to ascertain whether Robert had underlying mental health conditions or dementia which might have influenced the way he was living. Potential physical health factors in Robert's self-neglect such as hypothyroidism, however, do not appear to have been explored fully or shared beyond the GP. The potential consequences of physical health factors were not therefore linked conceptually in the minds of the practitioners as both a possible cause and a consequence of self-neglect. In hindsight the coordinated response was not as broad and insightful as it could have been**.** It is likely that Robert's failure to take or, if it was a deliberate decision, to stop taking his medication for hypothyroidism contributed to his death. (See Recommendations 2 and 4).

6.4 Apart from asking Robert to attend for blood tests, Robert's cessation of medication for his hypothyroidism did not prompt follow up, nor did the missed appointments for the blood tests themselves prompt further investigation or enquiry. Robert's disengagement with the assessment and treatment of his health condition may have been an early indicator that something was amiss. (See recommendation 9).

6.5 Mental Capacity was not formally assessed

6.6 The question of *Robert's mental capacity to make self-care decisions was not kept constantly in view* and *options for intervention were not rooted in a sound understanding of legal powers and duties*. (See Recommendations 1 and 3)

6.7 Robert's mental capacity was assumed and never formally assessed. There was a lack of professional challenge to the assumption of capacity despite Robert's self-neglect. This should have prompted a mental capacity assessment, which considered Robert's executive capacity, but did not.

6.8 Communication of risks of self-neglect

6.9 Although there were some interventions *to communicate* with Robert *about the risks* to him of self-neglecting, there is no evidence that for example the risks of not taking hypothyroidism medication and the risks to open wounds when living in unhygienic conditions were explored with Robert. (See Recommendation 2)

6.10 Engagement of community resources and family

6.11 There was *flexible thinking about how community resources could contribute to interventions,* but less so with *family members*. Little attempt was made by agencies to engage and work with Robert's sister to explore new strategies for supporting Robert to find out about him. The Think Family approach may have led to greater consideration of how Robert's sister might have been engaged as a partner in meeting Robert's needs and how she could have been supported to do so. This might also have prompted faster escalation of concerns about Robert's ability to meet his own needs, particularly after the Community Agent support had ended. (See Recommendation 2)

6.12 Insufficient safeguards were put in place following case closure

6.13 There were some examples of good practice in working to meet Robert's complex needs, but it was not sustained and when the support from carers, and the involvement of ASC and the Community Agent, ended there was no follow up and insufficient safeguards were put in place to identify, report on and intervene in preventing Robert from self-neglecting again. (See Recommendation 4)

6.14 There was inter-agency coordination, but opportunities for escalation and joint working were not always taken

6.15 There were several missed opportunities to escalate concerns and work together to consider alternative interventions.

6.16 At no time did all the agencies come together for a multi-agency, multi-disciplinary meeting to generate and explore ideas for how best to support Robert. They could have convened a multi-agency case conference or used Somerset's One Teams structure. Since Robert's death neighbourhood multi-disciplinary teams have been developed in Somerset, although the District Council Housing Department has not been included. SSAB has also published guidance to promote a joint approach to the assessment and management of risk to adults with care and support needs across organisations where the person has complex needs. (See Recommendations 3, 4 and 5)

6.17 It appears the relationship between ASC and the District Council Housing Department was not entirely conducive to effective partnership working. (See Recommendation 6)

6.18 There appears to have been insufficient attention to bringing together information about Robert to form a cohesive picture of his needs and his ability to care for himself. For example, in 2014, Robert appears to have stopped taking medication to treat hypothyroidism despite the risks to him of doing so. In 2018 one of Robert's ears was found to be cancerous to the point that it had been described as having part of it missing, yet Robert had sought no help for this, nor did he attend follow up appointments following the biopsy to have the cancer removed. Robert was self-neglecting, which his GP attributed to his personality, and was unable to care for himself or for his surroundings or clean up after his cat. These pieces of information should have been considered as part of a pattern and used to prompt at least further assessment of Robert's mental health needs, physical health needs and his mental capacity but do not appear to have done so.

6.19 Handling of safeguarding concerns

6.20 The safeguarding team acted in the most part in accordance with the six principles of Making Safeguarding Personal. Some delays meant that

measures designed to *prevent* and *protect* from harm and neglect were not taken until 26 days after the safeguarding concern was raised (see Recommendation 7).

6.21 Changes in accommodation and location

6.22 It seems that most of Robert's possessions had been packed in a garage while the deep clean took place. Some of his possessions may have been destroyed due to their poor condition. Robert's sister wondered where they had gone. This suggests there may have been a need for greater communication about his possessions. See Recommendation 8)

6.23 Feigned compliance

6.24 Robert may have been behaving in a way that was intended to convince professionals and his own sister that he was working with them. Professionals need to be alert to disguised compliance, or more accurately feigned compliance and avoidance, and employ professional curiosity to check that agreed actions have been taken. (See Recommendation 2)

6.25 Protected Characteristics

6.26 Although there was no direct evidence of discrimination in the approaches to Robert, there is a growing literature on the difficulties encountered by men in facing preconceived notions about their lifestyle choices. (See Recommendation 2)

7. RECOMMENDATIONS

7.1 The following recommendations are made and it is recommended that the Somerset Safeguarding Adults Board create and monitor a multi-agency action plan to implement them.

7.2 **Recommendation 1.** Somerset County Council Adult Social Care and Somerset Clinical Commissioning Group (for GPs) should agree a multi-agency action plan aimed at improving the understanding of the practical application of the Mental Capacity Act (to include but not limited to: that self-neglect should trigger a mental capacity assessment, that mental capacity requires assessment rather that assertion, that physical and mental health conditions may mean there is an impairment or disturbance in the functioning of the mind or brain, that mental capacity is decision and time-specific, yet should be seen as a video rather than a snapshot, that the Mental Capacity Act does not give the right to make unwise decisions). An audit tool should be used across the partnership to demonstrate that improvements have been made.

7.3 **Recommendation 2.** Somerset County Council Adult Social Care, the District Council Housing Department and the Somerset Clinical Commissioning Group (for GPs) should agree a multi-agency action plan to increase understanding

and recognition of self-neglect (including ways of working with people who self-neglect as outlined in this SAR, for example that refusal of treatment can be self-neglect, that self-neglect can be reported as a safeguarding concern, that it should not be regarded as a lifestyle choice, that people who self-neglect can disguise or feign compliance) and that there is a need to involve people's families.

7.4 **Recommendation 3**. Somerset Safeguarding Adults Board should update its self-neglect practice guidance to ensure it covers the most up to date practice research including understanding childhood and other life experiences and involving families. An audit tool should be used across the partnership to demonstrate that improvements have been made. In updating the guidance, the Board should agree methods to raise multi-agency awareness of, and processes for, using legislation (Care Act, Mental Capacity Act, Human Rights Act, Mental Health Act, environmental health acts etc) to intervene to support people who self-neglect and the circumstances and risks which exceed the capability of a single agency, team or individual to manage them on their own and when there is a need to involve other agencies or teams.

7.5 **Recommendation 4.** The Somerset Safeguarding Adults Board should lead an analysis of the extent to which the policy, procedural and organisational environment in Somerset fosters effective ways of working with people who self-neglect and ask:

- Do agencies share definitions and understandings of self-neglect?
- Is inter-agency coordination and shared risk-management facilitated by clear referral routes, communication and decision-making systems?
- Is longer-term supportive, relationship-based involvement accepted as a pattern of work
- Does training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice?
- When services withdraw is there sufficient risk management planning to identify and act upon any self-neglect relapse?

This is something that SWT and Somerset County Councils are currently working on.

7.6 **Recommendation 5.** Somerset County Council Adult Social Care should invite Housing and other relevant partner agencies to Neighbourhood Multi-disciplinary team meetings so that difficult cases can be shared and ideas for intervention generated and explored with the benefit of a broader skill-set and experience base.

7.7 **Recommendation 6**. Somerset County Council and District Councils should ensure that now, and in the future, with the creation of a unitary authority in Somerset from 1/4/23, that there are open channels of communication between partner agencies, clear pathways and referral points for raising

concerns including safeguarding concerns, and a shared understanding of statutory powers and duties and the self-neglect policy and procedure.

7.8 **Recommendation 7**. The Somerset County Council Adult Social Care Safeguarding Team should ensure that safeguarding enquiries are made in a timely manner and are not delayed by the lack of “availability” of a staff member and have a process for allocation on the basis of risk.

7.9 **Recommendation 8.** When supporting an individual’s rehousing or move to temporary accommodation, the District Council Housing Department and Somerset County Council Adult Social Care should ensure there is communication with the individual’s family to avoid misunderstandings about the whereabouts of possessions.

7.10 **Recommendation 9.** GP practices should give more consideration to follow-up when patients disengage with the assessment and treatment of their medical health conditions (including disengagement with prescribed medication).

APPENDIX 1: HUMAN RIGHTS ACT

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 2: WELLBEING

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

2. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or

– Communicate their decision (by talking, using sign language or any other means)

Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 4: S42 CARE ACT 2014

Section 42 of the Care Act 2014 sets out the circumstances in which an adult safeguarding enquiry must be made as follows:

The local authority must make enquiries (or cause enquiries to be made) where it reasonably suspects that an adult:

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect,
- and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

If the criteria under s42 are not met then a non-statutory enquiry can still be made.