Safeguarding Adults Review

Case C 2024

"Trevor"

1. Background

The subject of this review is referred to as Trevor.

Trevor was an elderly male of White British origin. He lived alone but had some contact with his children and neighbours.

Trevor appeared to have difficulty in caring for himself. He appeared unkempt and his address was in a state of disrepair. At the time of his death (and on previous occasions of agency contact), he was found to be living without electricity, heating and with minimal food. His family had taken steps to support him, but it appeared he was self-neglecting and would refuse offers of help and engagement from services.

In the immediate period prior to his death, Trevor was found to be living in unkempt and unsanitary conditions with no utilities. He appears to have had issues with alcohol and was suffering issues with his mobility, and fire safety concerns were raised due to his smoking.

Trevor was found deceased at his home address in December 2023. HM Coroner concluded his death as natural causes.

2. Referral for Safeguarding Adults Review (SAR)

In December 2023, Leicestershire Police notified HM Coroner of the recent passing of Trevor, and a coronial investigation was commenced. This was concluded in January 2024.

The SAR referral was discussed at the Leicestershire & Rutland Safeguarding Adults Board Case Review Group (CRG). It was agreed that the case met the criteria for a SAR under Section 44. (4) of the Care Act 2014 because:

- It involved an adult in the area with needs for care and support.
- The local authority were not involved.
- There was reasonable cause for concern about how the Safeguarding Adults Board (SAB), members of it or other persons with relevant functions worked together to safeguard the adult.
- The adult had died.
- The Safeguarding Adults Board (SAB) suspected that the death resulted from neglect.

3. Agencies identified as having contact with Trevor.

- East Midlands Ambulance Service (EMAS)
- GP
- Leicestershire County Council Adult Social Care (ASC)
- Leicestershire Fire and Rescue Service (LFRS)
- Leicestershire Partnership NHS Trust (LPT): Phlebotomy service, Single Point of Access (SPA), Community Therapy, Safeguarding
- Leicestershire Police

4. Methodology

The decision of the CRG was to complete a SAR, using a scoping and learning approach, looking at the individual case but in the more general context of self-neglect[1], as there was going to be wider system learning with regards to self-neglect given that work was already planned to update the local process for self-neglect cases. This was seen as proportionate because it was identified that there was minimal contact between Trevor and agencies. A chronology of events and contact was requested from agencies, covering a period of December 2020 to December 2023 inclusive (initial enquiries revealing this period covered when Trevor had agency contact). Agencies outlined:

- Their involvement with Trevor
- Information outside of the scoping period deemed relevant/significant.
- Analysis of their involvement
- Identification of single agency learning points
- Analysis of multi-agency working
- Identification of multi-agency learning points.

The single agency responses were collated into a combined summary report, and the findings were discussed and analysed at a single Case Review Group meeting.

The following themes and key lines of enquiry were considered:

- Understanding of the self-neglect pathway, including when a Care Act assessment is required.
- Consideration of mental capacity to make decisions about care and support, particularly in self-neglect cases, including:
    - When to complete a mental capacity assessment regarding a person's ability to make care and support decisions for people deemed to have care and support needs as per the Care Act 2024.
    - Who should complete mental capacity assessments for relevant decisions to do with a person's care and health needs, etc?

[1] The Second National SAR Analysis, published in June 2024, looked at Safeguarding Adults Reviews completed between 2019-23 and found that self-neglect appeared in SARs more frequently than any other form of abuse and neglect.

    - Timely use of best interests' meetings where the person is deemed to lack mental capacity to make the specific decision required for themselves and multi-agency meetings to ensure agencies are current with action and developments.
- Accurate recording of rationale for decisions and evidenced-based practice.
- Understanding of the roles and remits of all agencies involved and the need for appropriate and timely referrals to agencies best placed to take positive action.
- Information sharing between agencies, including the provision of accurate details of contact for named workers.

Within the meeting, single and multi-agency learning was identified and considered in terms of repeated themes from previous local reviews and audits and national learning.

Due to the features identified, it was agreed that Trevor's story would be utilised as a learning support tool / case study to help embed the new local Leicester, Leicestershire & Rutland (LLR) Self-Neglect (including Hoarding) Guidance. It demonstrates key practice points, such as risk escalation, and key points for multi-agency engagement and opportunities to intervene positively. Trevor's story provides a real-life situation for practitioners to explore decision making options in a self-neglect environment and this would be beneficial for practitioners across agencies and the sub-region.

5. Engagement with Family

Several attempts were made to contact Trevor's son (records named him as the Next of Kin), via telephone and email, to inform him of the commencement of the SAR and to ask for his input. Trevor's son responded after several attempts and stated that the family did not wish to engage, and they had found Trevor's passing traumatic. He stated they did have some points to raise but did not respond further with these.

6. Engagement with Practitioners

It was recognised that Trevor did not have long-term contact with any practitioners. Therefore, it would be difficult to hold a Practitioner Reflective Learning Workshop. As referenced above, it was decided that, in order to share Trevor's story and the related learning with practitioners, it would be utilised as a learning support tool / case study linked to the LLR SAB Self-Neglect Guidance.

7. Chronology of events and agency involvement

7.1. Agency/Department Name – Leicestershire County Council Adult Social Care

Leicestershire Adult Social Care's involvement with Trevor started on May 2022 with a referral from East Midlands Ambulance Service (EMAS), stating that Trevor was living at home with no electricity, no heating, and minimal food; that he was self-neglecting, he looked unkempt, and the house was dirty; and that he had refused an offer of support from social services, declined hospital admission, and had 'full capacity' to make these decisions.

In June 2022, Trevor's daughter-in-law was contacted and advised that she was not aware of any health condition that Trevor had, that EMAS was called out because he was hit by a car, and he declined being taken to the hospital. Regarding the concerns raised by EMAS, she advised that the family had sorted out the electricity, that the family provides food for him, that he appears unkempt at times, but this was not all the time. She also said that his ex-wife and daughter visited regularly and sometimes helped with clearing the property, but Trevor did not like help. She added that Trevor had a lot of family support, and she was unsure of whether he would accept support from Adult Social Care. She took Adult Social Care's Customer Service Centre (CSC) contact details to make contact in the future if there were any further concerns and provided Trevor's contact details.

Later in June 2022, Adult Social Care made a phone call to Trevor. He confirmed that his electricity was sorted out and that '*he felt embarrassed by the whole situation*.' His care needs were discussed during this telephone conversation, and he declined any care and medical support. He was given Adult Social Care's contact details to use if he changed his mind and needed support. The assigned social worker was of the view that Trevor did not appear to have any eligible needs at the time. As a result, Adult Social Care's involvement was ended at this stage.

In May 2023, Adult Social Care received a telephone call from Trevor's concerned neighbour, advising that they had picked him up from the floor the day before. The neighbour advised that he had '*not eaten for 3 weeks drinking whiskey*'. They wanted to call an ambulance, but Trevor refused. The neighbour further stated they were concerned that Trevor might die, that he had left a frying pan on previously and a neighbour visited just in time to turn off the gas before the frying pan could be set alight.

Adult Social Care spoke to Trevor on the phone to discuss his support needs, but it is recorded he "*repeatedly told me he does not want any help. I asked I if we could come out for a chat and complete an assessment, he declined he said he doesn't like change. I advised we would not do anything he did not want us to do, but he still declined*." The staff analysis was that "*Trevor has declined assessment and said he is independent with his personal care and shopping. He is currently making himself some mac and cheese a neighbour bought for him. He would prefer we did not speak to his family.*"

Deciding that Trevor's immediate needs were health related, and noting his decision to decline any input, Adult Social Care contacted his neighbour on the same day. They sought assurance from the neighbour regarding whether Trevor had any

injuries from the fall and requested that he should not be moved if he has a fall in the future but to call the ambulance. The neighbour was disappointed that Adult Social Care were not able to become involved at that time.

A case note entry (May 2023) explaining why Adult Social Care could not get involved at the time states: "*There is no reason to question Trevor's capacity to make a decision regarding care and support needs or medical treatment. Trevor explained why his mobility was poor, but said he was feeling better today and was having something to eat. Trevor said he goes out to the shop (the fall was outside yesterday) to get a few bits of food at a time. Trevor has children who have visited him recently and neighbours appear to have sight of him as well. Trevor has declined any referrals to the GP. We have stressed the importance of the neighbours calling 999 if they see Trevor has fallen, rather than picking him up. I can see in case notes that similar concerns were raised in 2022, and family were visiting to provide food, which still appears to be the case as neighbours have said his son visits fortnightly. Trevor has said that he does not want an assessment from ASC, and we have to respect his wishes.*" Involvement was ended (end of May 2023) following the above rationale.

In August 2023, an online referral was received concerning Trevor, stating that he was "*living in squalor"*. The referrer advised that he was independent with all his activities of daily living but had noted that "*the gardens are overgrown, the occupant has mice in the house, the carpets are dirty, and no housework is able to be done*."

Trevor was contacted on the same day. He confirmed that he was aware of the referral, that it was made by the gas man who had been out to check his gas. A discussion was had about his care needs and support offered, but he declined the support and also declined signposting. The conclusion by staff was that "*Based on the information received, I am of the view the contact can be closed to ASC as Trevor does not appear to have any care/support needs and he has declined any domestic support."* The referral was closed (end of August 2023) with the following comment "*Please let referrer know we have spoken to Trevor, and he has declined support with domestic tasks/clearing property. *ASC have no reason to believe Trevor lacks capacity to make this decision Post info re cleaning services/ASC number to Trevor …. Email sent to referrer and closed.*"

In November 2023, Adult Social Care received a referral from EMAS stating that they have had a discussion with Trevor's son about his current living standards (very cluttered lounge, empty bottles of alcohol and fizzy drinks left on the floor, etc) and his hygiene and felt that Trevor would benefit from having carers or cleaners to support him with his hygiene and regular food supplies.

Trevor was contacted on the same day to discuss the referral. Trevor stated that he was embarrassed about his home. He agreed to a Single Point of Access (SPA) referral for his mobility and also agreed to have an Adult Social Care assessment but requested that this should take place in a few weeks to give him time to clear out some of the bottles prior to a home visit.

Trevor was contacted to request for his consent to complete a referral to Safe Spaces following the concerns raised about him "*struggling to manage his home*" environment. He agreed but requested that this should be in a couple of weeks as he

currently had “*too much on*.” The referral to Safe Spaces was completed on the same day (late November 2023).

In late November 2023, First Contact Plus (Safe Space referral) contacted Trevor. He disclosed that he was feeling unwell, that he had no gas/electricity because he was unable to walk to the shop to top it up and had not been able to move from the sofa for three days. Adult Social Care contacted Trevor who confirmed that he was not feeling too well, that he had no strength in his legs and was unable to see because it was pitch black in his house. He further confirmed that he had no gas/electricity and was unable to walk to the shop to top up the gas/electricity. He added that his daughter-in-law was unable to get the top up for him as she lived a long drive away. He also said he had not contacted his GP for being unwell and declined for Adult Social Care to contact his GP. He stated he did not need anything other than help with his gas/electricity top up.

Adult Social Care received a phone call from a staff member of the health team who had gone out to see their patient (a neighbour of Trevor’s) who had concerns about Trevor. The patient related that they saw Trevor’s door open the week before and found him lying flat on his back. Trevor did not have electricity, the room smelt unsanitary and there were cigarette burns on carpets and alcohol everywhere.

In late November 2023, Adult Social Care received another concern for welfare referral for Trevor. He was contacted and advised that he now had electricity and that he had had a welfare check the day before from two Police Officers. He also stated that he did not want any support, that the Police Offices that visited helped him to clear up around the house, that he had smoked his whole life and if he cannot have his cigarettes and drink, then he was ready to “*top himself.”* He added that he was currently unable to go out to get food, but all he needed more than food was cigarettes and whiskey. A visit to deliver a food parcel was arranged for the next day, and a call to the duty GP was made to share concerns of suicidal ideation and possible alcohol withdrawal.

On the same day Adult Social Care contacted Trevor’s named surgery (on records) to share the concerns of suicidal ideation and possible alcohol withdrawal but were informed that he was not their patient and had never been. The named surgery advised that he was not a registered patient at their surgery. Adult Social Care decided to call 111, who were able to provide correct details.

Again, in late November 2023, Adult Social Care received a Public Protection Notice (PPN) from the Police. A welfare check visit was completed, and concerns were raised with the GP Surgery. An email update from the GP after their home visit stated that the GP visited (within 24 hours of the PPN), that all his vital signs and observations were normal, that he was mobilising around his house but went upstairs on his hands and knees. The GP added that Trevor did not need any alcohol withdrawal treatment as he had not had any alcohol for a couple of weeks, and that he was fed up but did not express any suicidal ideation or plans. The GP further stated that Trevor wanted help with getting his electricity and gas back and help with buying food rather than any medical help; that they suggested blood tests just to check for any vitamin deficiencies with his alcohol intake and poor diet, which he appeared to accept, and they were going to arrange for a District Nurse visit. The

GP's view was that Trevor's immediate needs appeared to be "*almost entirely social/welfare*."

In early December 2023, a referral to Leicestershire Fire and Rescue Service (LFRS) was made due to fire concerns following a welfare check home visit. The Community Safety Team stated that they had visited Trevor on that day and unfortunately a lot of the support offered was refused. They advised that they had concerns as his gas fire had been capped off due to a carbon monoxide leak, that there were burn marks and ash on the carpet, but Trevor refused the offer of a fire alarm and carbon monoxide alarm. It was added that he also refused the offer of an ash tray and a fire-resistant blanket. The Community Safety Team staff member also advised that, due to the fact that he was currently not smoking or drinking and was living in the front part of the property, the risks identified were lowered as he was able to get out of the property in the case of an emergency. The Community Safety Team staff member further stated that, whilst he was at the property, Trevor kept trying to get him to buy him alcohol and cigarettes, that he was malnourished and bordering on self-neglect, but advised that he did not "*want people coming round and visiting."* The Community Safety Team staff member reported that there were no doubts about Trevor's capacity as he was "*cohesive […] able to hold a conversation and answer questions."*

A Vulnerable Adult Risk Management (VARM) meeting was considered by Adult Social Care (mid December 2023) following a case progression supervision meeting. Trevor passed away before this could be progressed.

Analysis of single agency involvement

Adult Social Care were at the beginning of a restructure (April 2022) when the first referral was received (May 2022). At this point, the UK was still in the process of emerging from the disruption of Covid lockdowns.

Adult Social Care workers responded to referrals promptly and made timely personal visits and contact with Trevor. A comprehensive referral was made to his GP, but this was delayed due to a lack of accurate recording on systems.

The engagement with Trevor (June 2022) could be viewed as a missed opportunity to signpost to appropriate services to address his needs, as it was determined that he did not have care and support needs.

From the records reviewed and information supplied to this review, it is Adult Social Care's view that a see and solve home visit should have been completed earlier than it took place (November 2023). Completing a care and support assessment in May 2023, when further concerns were raised about Trevor's welfare, would have determined earlier on whether he had care needs arising from a physical or mental impairment. With the implementation of the 3Cs[2] ways of working, the situation

[2] Three Conversations model developed by Partners for Change.

- Conversation 1: How can I connect you to things that will help you get on with your life – based on your assets and strengths, and those of your family and neighbourhood? What do you want to do? What can I connect you to?
- Conversation 2 (Applicable to people who are at risk): What needs to change to make you safe? How do I help to make that happen? What offers do I have at my disposal – including

would have been approached in a more holistic way to build support in the here and now.

Single agency learning point 1: A see and solve home visit should have been completed earlier than it took place (November 2023).

Single agency learning point 2: Completing a care and support assessment in May 2023, when further concerns were raised about Trevor's welfare, would have determined earlier on whether he had care needs as described by the Act, needs arising from a physical or mental impairment.

Actions completed:

- Continuous Professional Development days (7th, 11th, 14th and 21st March 2024) focused on learning from SARs and emphasis was placed on seeing the person; considering mental capacity to make decisions about care and support; and clearly recording why there are no doubts, and if there are doubts, a mental capacity assessment should be completed about the person's capacity to make decisions for themselves regarding their care and support needs.

- Emphasis also placed on evidenced-based practice, especially with mental capacity decisions – if the person is telling you something (talking the talk) and doing something else (not walking the walk), then consideration should be given as to whether this is denial about their circumstances, an unwise decision, or a lack of mental capacity regarding the specific situation under discussion.

7.2. Agency/Department Name – GP Practice – (via Leicester, Leicestershire & Rutland Integrated Care Board [LLR ICB])

From his registration date at the practice in 1997 to 2023, the GP Practice had not met Trevor. There are no consultations in his records prior to that time, and he was taking no prescribed medication.

In late May 2022, the Practice received a safeguarding referral from EMAS with concerns about his living conditions and possible self-neglect following their involvement previously (EMAS had made a referral in April 2022 after Trevor was involved in a road traffic collision – he declined all treatment and walked home) and assessment of his home conditions and alcohol use. A Vulnerable Adult alert was added to records, and he was discussed in a practice meeting. He was, at that time, recorded as having refused support from Social Care.

In November 2023, the GP Practice received a Safeguarding Adult Referral from the Police. The report was discussed at the practice meeting that day and a visit was

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small amounts of money and my knowledge of the community – to support you? How can I pull them together in an 'emergency plan' and stay with you to make sure it works?

- Conversation 3: What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning?

planned later that week. The practice had no next of kin details or a telephone number for Trevor.

In late November 2023, the GP Practice received a report from 111 that Adult Social Care had called to say that Trevor was having suicidal thoughts and was withdrawing from alcohol. The wrong GP details were on file; 111 technician was able to supply correct details to Adult Social Care.

A professional discussion with Adult Social Care was held regarding their involvement to date, outlining concerns that he was not able to support himself, and for his mental health. Trevor had refused their help, but details of next of kin and contact for Trevor were shared. A request was made to share any details of engagement with the practice to assist Adult Social Care's ongoing support.

At the end of November 2023, a home visit by the GP took place. The house was very cluttered. Trevor was frustrated that his electricity and gas had been switched off, and that his mobility had decreased, so struggled to get out. He expressed no suicidal thoughts; he was just fed up with his situation. He was fully alert and orientated and had had no alcohol or cigarettes for a week. He described no physical symptoms other than being less mobile. His physical examination was normal. He declined any help with low mood anxiety and did not want any medical input. He did accept having blood tests to check for any underlying illness/deficiencies from his diet.

The GP shared details of their visit with Adult Social Care and suggested that Trevor needed help with his utilities, and having food delivered. He had accepted the idea of this help when the GP saw him. The GP telephoned Trevor's daughter-in-law. Trevor had told her that his electricity was back on, and the GP confirmed that this was not the case. The GP also referred Trevor to the Practice's Social Prescriber with his consent, for further support. The Social Prescriber texted Trevor to arrange a telephone call, but sadly Trevor passed away before this date.

Analysis of single agency involvement

It is the GP Practice's standard practice to discuss any safeguarding referrals from other agencies at practice meetings to facilitate any appropriate assessments and support, and to flag the patient's notes as 'vulnerable adult' where appropriate.

The home visit assessment was based on information provided by Adult Social Care that raised concerns primarily about Trevor's mental health and possible suicidal ideation. Notice was taken of his living conditions and social circumstances in a non-judgemental way. Capacity to make decisions was assessed and onward referrals discussed and actioned with Trevor's consent.

Appropriate assessments and onward referrals were completed, including discussing with the family/next of kin.

Single agency learning point 1: Discussion of cases concerning vulnerable people in Practice meetings added as an agenda item, due to rise in complex need caseload.

Action completed:

- The practice has introduced a Multi-Disciplinary Team agenda to practice meetings to share ideas to manage complex cases.

7.3. Agency/Department Name – Leicestershire Partnership NHS Trust (LPT)

Trevor was known to:

- LLR Phlebotomy Service, December 2023 to February 2024
- LLR Single Point of Access (SPA), November to December 2023
- LLR Community Therapy, November 2023 to February 2024
- LLR Safeguarding Service, December 2023

In November 2023, the LLR SPA received a referral from East Midlands Ambulance Service (EMAS). The referral described self-neglect, including living standards and hygiene, noting it was very cluttered in the lounge and there were empty bottles of alcohol on the floor. Saliva and urine were being left in bowls in the lounge and there was no fresh food in the house. Risk factors identified included hoarding, being a smoker and cluttered furniture. This information was shared with the GP, Adult Care Concern and Leicestershire Fire and Rescue Service.

A referral was received from Adult Social Care in late November 2023 in relation to a mobility and walking aid assessment. Trevor was accepted into the team, but they were unable to contact him as details of contact methods were not up to date. The therapy plan was to contact the original referrer and for Trevor to be placed on the waiting list. However, the Therapy team were unable to contact the original contact. A letter was sent to Trevor with contact details of the Therapy Team. An incorrect home address number was recorded on the form.

A referral was accepted into SPA from the GP Practice (December 2023). Concerns listed included self-neglect and excess alcohol use. Trevor consented to blood tests. Again, his home address number was recorded incorrectly, so the case was discharged from SPA. A referral was rejected by Phlebotomy because of incorrect and/or inconsistent address records.

In mid-December 2023, Trevor was seen for a blood test, but staff were unable to obtain bloods from him. The LPT Safeguarding Team were contacted, who advised to contact the GP urgently to see if an Adult Social Care referral had been completed concerning self-neglect. Trevor's son was contacted who stated he would visit (although he did not drive).

Given there is little information on the records on SystmOne, there were concerns noted by the Phlebotomist and they sought advice from the Safeguarding Team in LPT.

Analysis of single agency involvement

The decision to seek advice from the GP and to see if a referral for self-neglect was in action can be viewed as accurate and proactive. However, there is no evidenced

follow up from the Phlebotomy Service and it is unclear why further attempts were not undertaken by the practitioner.

The safeguarding response was viewed as adequate given the information available and it is not clear if the Phlebotomy practitioner would be trained in managing a patient displaying multiple risk factors with physical health issues (in the view of the LPT submission).

Self-Neglect and Capacity are a concern across Leicester, Leicestershire and Rutland and it is unclear if a formal capacity assessment was considered at that time given the multiple concerns identified.

Single agency learning point 1: An Electronic Incident Reporting Form (EIRF) was not completed relating to the escalation to LPT Safeguarding and ASC safeguarding and neglect.

The safeguarding policy states that an EIRF (incident notification) must be completed with every safeguarding referral. This learning was shared with the team and the policy was reinforced. The process for all referrals is also included in the monthly safeguarding team briefing sent to all LPT staff.

7.4. Agency/Department Name – Leicestershire Fire and Rescue Service (LFRS)

A Home Safety Check was conducted in December 2023, following referrals from Leicestershire Police, EMAS and Adult Social Care.

The following were refused by Trevor:

- Smoke alarms and Carbon Monoxide alarms.
- Fire retardant blanket and ashtray.

However, advice was given on smoking and plug in heater. The Community Educator undertook a case discussion with the Adult Social Care re-enablement worker and concerns were shared regarding the refusal to have any further fire safety equipment in the home. It was apparent that Adult Social Care were also experiencing the same problem. It was agreed that the case would remain open and, if Adult Social Care were successful in engaging with Trevor, a follow up visit could be conducted.

Analysis of single agency involvement

The case was escalated due to the number of referrals received from 3 different partner agencies. The Home Safety Check visit was conducted within the service time limit. Due to monitoring of referrals, certain protective characteristics are logged when a Home Safety Check is being conducted but this does not impact on a Home Safety Check being conducted. This service is offered to all residents of Leicester, Leicestershire and Rutland but is triaged according to their vulnerability.

There are no single agency learning points.

7.5. Agency/Department Name – East Midlands Ambulance Service (EMAS)

EMAS attended Trevor's home address on three occasions.

In May 2022 Trevor's daughter-in-law called 999 concerned for his welfare. Trevor was in the house, with the front door open, no electric, heating, minimal food. He declined all offers of help, so the crew contacted his daughter-in-law to inform her of their concerns. A safeguarding referral for self-neglect was shared following this attendance with his GP and Adult Social Care.

EMAS attended in relation to a welfare concern in November 2023. Trevor's son had not heard from his father for the last 4 weeks and had been unable to contact him. On arrival, Trevor answered the door, alert, orientated, but with visible signs of self-neglect. The lounge was hoarded with alcohol bottles, cigarette butts, and soft drink bottles. He had a bucket for urination, various bowls for saliva to be spat into and poor overall cleanliness. Trevor had not washed for over one month and had no fresh food in the house.

His son was contacted by the crew, but Trevor declined any help and was worried about passing the burden on to his son. His mobile phone was put on charge and his son advised he would contact later. A safeguarding referral for self-neglect was shared following this attendance with the GP, Fire Service and Adult Social Care.

EMAS attended (December 2023) following a report of cardiac arrest. Sadly, he was deceased on crew arrival.

Analysis of single agency involvement

EMAS responded appropriately on all three occasions. On the two occasions while Trevor was alive, staff appropriately raised two safeguarding referrals in relation to self-neglect.

There are no single agency learning points.

7.6. Agency/Department Name – Leicestershire Police

Leicestershire Police have two recorded occurrences relating to contact with Trevor.

In November 2023, Leicestershire Police received a call asking for a welfare check to be conducted at Trevor's home address, following concerns raised by a neighbour. A THRIVE[3] assessment was completed by the police call handler and resources deployed. They reported seeing Trevor at the address, but "*he was suffering from long term effects of carbon monoxide poisoning*" received some months ago. His house was "*uncared for*" with "*rubbish and cigarette butts all over the floor*."

The attending officers determined that Trevor required assistance with his finances, cleanliness of the address, personal care and help with obtaining food, as he appeared unable to leave the address. Although he was not currently intoxicated, concern was raised that he had been drinking considerable volumes of alcohol due

[3] Threat, Harm, Risk, Investigation, Vulnerability, Engagement.

to the presence of numerous whisky bottles, increasing his vulnerability. Other than a small fan heater, there was no heating, as a result of a previous carbon monoxide leak. He had limited mobility, being unable to freely move about his address.

Officers cleared a large amount of cigarette butts which were strewn over the living room carpet and completed a detailed Public Protection Notice (PPN) which was submitted to the Adult Safeguarding Hub (ASH), the Leicestershire Police Team that receives, processes, and disseminates adult PPNs.

The ASH assessed that the circumstances amounted to a Tier 3 referral. Tier 3 is assigned to those cases where the ASH considers that the statutory threshold (Care Act 2014) has been met; if agreed by the Local Authority they must act to safeguard the subject. Notifications were made to Trevor's doctor, Adult Social Care, and the Fire Service to report the health concerns and fire risk, respectively.

Leicestershire Police received a call from a neighbour (in December 2023) who believed Trevor to have died. Officers entered and unfortunately found Trevor deceased at the address.

Analysis of single agency involvement

Leicestershire Police deployed resources to conduct a visit and verify welfare after completing a THRIVE assessment. This was expected practice, given the information known at the time.

Staff conducting the visit correctly established that the circumstances amounted to Trevor being an Adult at Risk. An adult is "at risk" if, because of their situation and/or circumstances, they are unable to take care of or protect themselves or others from harm, abuse, or exploitation. The officers conducted some initial actions at the property before compiling a detailed PPN to facilitate appropriate information sharing with those agencies most able to meet Trevor's needs. This was expected practice. However, given the circumstances, there may have been a further opportunity to expedite the process by the attending officers making direct contact with the ASH.

The ASH assessed that the circumstances amounted to a Tier 3 referral and shared information with those agencies best suited to address the extant risks. This was expected practice, although there may have been a further opportunity to expedite the process by making direct contact with relevant partners.

Single agency learning point 1: Where officers have identified ongoing adult safeguarding risks requiring prompt information sharing with relevant agencies, opportunities may exist to communicate directly with the ASH to expedite such matters and for the ASH to consider the merits of direct contact with Adult Social Care.

Single agency learning point 2: The ASH making direct contact with Adult Social Care.

Actions completed:

- This learning point is refreshed / revisited by existing professional development / protecting the vulnerable training programmes within

Leicestershire Police. ASH feedback relating to this particular scenario has already been provided. No further organisational action is required.

- ASH manager has reviewed the case and a planned training programme for staff is in place regarding PPN assessment. This case is to be used for learning for all staff going forward. The ASH provide training to new officer and PCSO cohorts, together with the police call management centre and Detectives, around the PPN process. However, this case highlighted a lack of information around the course of action that frontline officers should take in circumstances where immediate safeguarding is necessary. ASH training now includes information that officers should contact the ASH by phone to share information and advice that a PPN is to be submitted if they have immediate concerns for the welfare of a vulnerable adult. The ASH will then make a call to Social Care to ensure that safeguarding is implemented as quickly as possible. Once received, the PPN will be assessed and sent to Social Care as a Tier 4 PPN, which partners are aware requires immediate attention. Officers are also advised to contact Social Care directly if the incident is out of hours.

8. Good practice identified.

There was evidence of good practice across agency reports including:

Leicestershire Fire and Rescue Service: Due to the number of referrals from different agencies, this case was escalated, and a home safety check was conducted before the required timescale that the Fire Service have internally.

Leicestershire Police: Attending officers completed and submitted a detailed PPN at the point of attendance ensuring that information could be exchanged with the most appropriate agencies to address extant risks.

East Midlands Ambulance Service: On attendance, whilst Trevor was alive, crews submitted detailed safeguarding referrals in relation to self-neglect issues.

GP Practice: Appropriate assessment and onward referrals were completed, notably discussing with the family/next of kin.

Leicestershire Partnership NHS Trust: There was recognition that the patient was self-neglecting, and the practitioner contacted the Safeguarding team for advice and support. Contact was made with the GP/Adult Social Care to share those concerns of him self-neglecting.

Leicestershire Adult Social Care: there were prompt responses when referrals came through; appropriate referrals to Single Point of Access, GP, Leicestershire Fire and Rescue Service and Trevor's family. They spoke to Trevor at all times to keep him informed, discussed decisions with Safe Spaces, etc. Leicestershire Adult Social Care determined that Trevor had mental capacity to make decisions for his care and support needs. All other agencies confirmed this.

9. Thematic Analysis

Between May 2022 and December 2023, Trevor was the subject of several referrals and a concern for welfare check, from agencies but also neighbours and a tradesperson. There were numerous contacts, including Trevor receiving home visits, from different agencies. All agencies identified Trevor as someone who was self-neglecting, with concerns including his living conditions, hygiene, and access to food, and provided offers of support. There was a pattern of some of these offers being accepted, whilst other offers were declined by Trevor, with agencies referencing how they had observed Trevor's wishes. Trevor's mental capacity appears to have been assessed, but there is little evidence that this was completed formally, revised, or reassessed at any point, despite the worsening of his living conditions and multi-agency concerns.

Towards the end of his life, there were increased concerns for his welfare that led to different processes and support being considered, including the use of the VARM and a referral to a Social Prescriber. Trevor died before these could be implemented.

In their publication, "Working with people who self-neglect," Research in Practice identifies a list of factors that mean self-neglect is challenging for practitioners. Several of these were present with Trevor, including "the possibility that adult social care intervention is not welcomed by the individual, making engagement difficult;" "the challenges of assessing mental capacity" and "ethical dilemmas between respecting autonomy and fulfilling a duty of care."[4]

Considering thematic analysis against the key lines of enquiry:

- Understanding of the self-neglect pathway, including when a Care Act assessment is required.

  Earlier completion of a care and support assessment would have determined earlier on whether Trevor had care needs as described by the Care Act, arising from a physical or mental impairment.

- Consideration of mental capacity to make decisions about care and support, particularly in self-neglect cases

  Agencies made reference to Trevor having "full capacity" and "having no reason to question his capacity;" however, it is not always clear if formal mental capacity assessments were undertaken. Also, with Adult Social Care, sometimes these views were based on telephone conversations. Trevor's chronic use of alcohol, and the carbon monoxide poisoning could have impacted on his mental state. It is extremely important that if there is any doubt or concerns, practitioners must consider a person's capacity. The Second National SAR Analysis Report, which notes that absence of attention to mental capacity appeared in 58% of SARs considered, highlights that "Determining whether an individual has mental capacity to make decisions is a central element of practice; the outcome of capacity assessment plays a pivotal role in determining the future direction of

[4] "Working with people who self-neglect", Suzy Braye and Michael Preston-Shoot, Research in Practice, December 2020, page 4.

intervention."[5] Mental Capacity Assessments should be undertaken by all professionals and not just confined to Adult Social Care.

- Accurate recording of rationale for decisions and evidenced-based practice.

  When considering Trevor's mental capacity to make decisions about care and support, it should have been clearly recorded why there were no doubts – this did not always occur. It is also unclear from the records why the Phlebotomist was not able to get blood from Trevor and why further attempts were not made.

- Understanding of the roles and remits of all agencies involved and the need for appropriate and timely referrals to agencies best placed to take positive action.

  In May 2023, Adult Social Care recorded that Trevor's "immediate needs were health related". Trevor refused an ambulance, and the GP Practice recorded that between 1997 (when he was registered) and 2023 they had not met him. In November 2023, Adult Social Care requested that the GP visit Trevor and get back to them following the visit to enable ongoing support from Adult Social Care. During the visit, a physical examination was undertaken by the GP. Adult Social Care recorded that the GP's view was that Trevor's immediate needs appeared to be "almost entirely social/welfare." There were different views about medical needs and social care needs and where they intersected. Numerous referrals were made and received by different agencies regarding Trevor. In some instances, they were, arguably, misdirected. In other instances, referrals were not followed up.

- Information sharing between agencies, including the provision of accurate details of contact for named workers.

  There are several examples of issues with information sharing and recording. Adult Social Care had the wrong GP Practice recorded on their system. They contacted two different surgeries before having to contact 111 to get the correct registration information. The GP struggled to get back in contact with the Adult Social Care worker. Phlebotomy refused a referral because the wrong address was recorded on the blood form.

10. Multi-Agency Learning and Systems Findings

As indicated in section 8 of this report, single agency learning has been identified. It should be noted that agencies have also instigated single agency actions to address any needs prior to this report. It is documented with clear detail that these actions are in place and do not require further monitoring.

The following multi-agency learning points have been identified:

- Assessments specific to self-neglect

[5] "Second national analysis of safeguarding adult reviews: Final Report: Stage 2 analysis", Local Government Association (LGA) / Association of Directors of Adult Social Services (ADASS) / Partners in Care and Health, June 2024, pages 30 and 57.

Assessments completed appeared generic and did not identify specific risks, delaying effective solutions and resource allocation.

- Mental capacity assessments
  There were issues around who completes these and when. There is a need to revisit assessments as circumstances and information change, so they reflect the current situation.

- Understanding of the roles and remits of all agencies involved
  There needs to be further work on clarifying roles and remits of agencies involved in such cases. Analysis suggests that Adult Social Care received a multitude of referrals but were not best placed to progress these.

- Information sharing and record keeping.
  There needs to be accurate recording keeping within agencies of named support workers, where applicable, and direct contact, as opposed to reliance on generic contact numbers for urgent assessments. On a number of occasions, agencies struggled with incorrect information and unobtainable contacts.

  There needs to be accurate recording of next of kin details and support network contacts – there was a lack of these details in submissions and/or means of current contact for them.

  There needs to be accurate record keeping of actions taken, by whom and why. It appears unclear what was happening from a multi-agency point of view and a lack of sharing of these on a multi-agency basis.

- Professional curiosity
  There needs to be an improvement regarding clear, concise recording of actions and rationale supporting a reassessment of needs and consideration of what else could be tried in the face of repeated non-engagement, but persistent risk factors.

11. Work already in progress and/or completed.

Self-neglect was a priority in the Leicester, Leicestershire & Rutland Safeguarding Adults Boards (LLR SABs) Business Plan 2023-25. A multi-agency self-neglect audit was completed in Quarter 1/2 of 2024/25, and the learning was fed into the group that produced the new LLR Self-Neglect Guidance, as was learning from a previous Leicestershire & Rutland SAB SAR. From 1st December 2024, in Leicester, Leicestershire & Rutland, the Vulnerable Adults Risk Management process was replaced by the Responding to Self-Neglect (including Hoarding) Guidance. It was relaunched during National Safeguarding Adults Week 2024 (18th-22nd November), with three online briefings for practitioners. Other new resources were published around this guidance: a PowerPoint, an introductory briefing video on the LLR SABs YouTube Channel, a 7-Minute Briefing on Self-Neglect, a 7-Minute Briefing on Hoarding and a Self-Neglect animation. The new guidance has more information about risk levels and different types of services available.

Mental Capacity was also a priority in the Leicester, Leicestershire & Rutland Safeguarding Adults Boards (LLR SABs) Business Plan 2023-25. Part of the rationale for this priority was that local SARs and audits over the last few years had identified MCA learning around Best Interests, advocacy, recording of decisions and that assessments have been carried out, complexity of co-existing conditions, fluctuating capacity and lack of understanding of the process by frontline workers and whose responsibility it is to carry out assessments. The LLR SAB Learning & Development Subgroup commissioned Mental Capacity Act (MCA) Training which covered the following areas: Mental Capacity Act awareness; Mental Capacity Act in practice; Advanced Mental Capacity Act training; Self-Neglect and the Mental Capacity Act. They commissioned 24 sessions, with a mixture of online and in-person sessions over a 12-month period commencing from March 2024. The learning from local SARs informed the multi-agency training being provided. Edge Training, the commissioned provider of the training, agreed to weave in local learning from SARs across LLR and local procedures to personalise their standard course materials. Due to the high volume of interest in the 2024/25 MCA sessions, the Safeguarding Adults Boards commissioned some further events for staff working across LLR for 2025.

The LLR SAB Learning & Development Subgroup also produced a series of documents entitled "Mental Capacity Act and safeguarding adults: what good looks like". They were adapted from documents produced by Durham SAB. They were published in November 2024 on the Multi-Agency Policies and Procedures (MAPP), alongside existing MCA "How To" guides. There are six documents which focus on different elements of the MCA: "About Capacity, the Act and the Court of Protection"; "Assessment Form and Expected Standards"; "Best Interest Decision Making Process"; "Capacity Assessments"; "Next of Kin, Living Wills, Attorneys, Deputies and Office of the Public Guardian"; and "Preferred communication and all practicable steps". Additionally, a multi-agency mental capacity audit was completed in Quarter 3/4 of 2023/24. The learning from this and reviews informed the content of a Special Issue of Safeguarding Matters on MCA, published in November 2024.

The Leicester and Leicestershire & Rutland Safeguarding Children Partnerships and Safeguarding Adults Boards jointly produce Building Confidence in Practice Resources, which aim to focus on often complex issues that arise for practitioners when they are working with people whether they are children or adults. There is a resource on Professional Curiosity for Practitioners, published in March 2022, and one on Professional Curiosity for Supervisors and Managers, published in January 2024. In July 2024, a new chapter was added to the LLR SAB Multi-Agency Policies and Procedures (MAPP) on Professional Curiosity.

12. Multi-Agency Recommendations

1. Develop understanding of the self-neglect pathway, including when a Care Act assessment is required.
2. Improvement regarding clear, concise recording of actions and rationale supporting a reassessment of needs and consideration of what else could be tried in the face of repeated non-engagement, where persistent risk factors are present.
3. Information sharing between agencies- ensure the provision of accurate details of contact for named workers.