HARINGEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

MARTIN

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1. Introduction

1.1 The subject of this review, Martin (not his real name), was a white working class man. He died on 13.3.25. He was 55 years old. The cause of death was recorded as:

- 1a Acute heart failure
- 1b Ischaemic heart disease
- 2 Type 2 diabetes mellitus, chronic kidney disease, left above knee amputation, learning disability

1.2 Following a referral from Whittington Health Safeguarding Adults Team, the SAR subgroup of the Haringey Safeguarding Adults Board decided on 11th June 2025 that the circumstances surrounding Martin's death met the mandatory criteria for undertaking a Safeguarding Adults Review (SAR) under Section 44 of The Care Act 2014: that Martin had care and support needs, that it was known or suspected that his death was the result of abuse or neglect (in his case self-neglect), and that there was reasonable cause for concern about how agencies had worked together to safeguard him. The purpose of a SAR is to consider the work of all the agencies and individuals involved in the case and to explore what they might have done differently, working together or individually, to prevent harm or death. "This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again."[1]. It has a multi-agency focus at its core.

1.3 John Goldup was commissioned to undertake the review. He was Director of Adult Social Services in LB Tower Hamlets from 2000 to 2009, and National Director of Social Care and Deputy Chief Inspector in Ofsted from 2009 to 2013. Since 2013 he has chaired both Safeguarding Adults Boards and Safeguarding Children's Partnerships in two local authorities, and undertaken a range of independent consultancy work. He was the author of the "Victoria" SAR[2] for Haringey Safeguarding Adults Board, published in October 2024. Martin's story was seen at the outset as having a number of similarities to Victoria's.

1.4 A SAR Panel was established to oversee the review and to support the independent reviewer. Membership was drawn from:

- LB Haringey Adult Social Care
- LB Haringey Commissioning
- Haringey Learning Disabilities Partnership
- North Central London Integrated Care Board
- London Ambulance Service
- Whittington Health Safeguarding Team
- Royal Free Hospital

The Panel met for the first time for the first time on 8th October 2025.

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, para.14.168

[2] https://haringey.gov.uk/sites/default/files/2024-11/victoria_sar_report.pdf

1.5 Terms of reference were agreed for the review. It was agreed that the review should focus on the period from January 2023 to Martin's death in March 2025. A number of key lines of enquiry were identified:

- What learning can be identified in how agencies identified and responded to Martin's self-neglect?
- What learning can be identified in how agencies worked together to ensure Martin's health and social care were appropriately managed?
- What learning can be identified from the assessment of Martin's capacity to make decisions about his care and treatment at key points?
- What learning can be identified in how the safeguarding concerns raised with the local authority were responded to?
- What learning can be identified about the delivery of the local authority's responsibilities under the Care Act in this case?
- What learning can be identified about the relationship between the HLDP and adult mental health services?
- Are there any other emerging themes to be explored through the Safeguarding Adults Review?

1.6 The reviewer analysed in detail the chronologies produced by partner agencies, identifying detailed questions to be explored with individual agencies, both in writing and through discussion with nominated representatives. He examined relevant policy and practice documents and a range of case records. He met with a number of practitioners who worked with Martin, and with managers in relevant agencies. He also facilitated a workshop with managers from all the agencies involved, to explore the challenges of working with such complex and high-risk cases, the obstacles to meeting those challenges, and potential solutions and recommendations for improvement.

2. Martin's story

2.1 It may be helpful at the outset to present an outline chronology of Martin's story. It focuses on the period within the scope of this review – from January 2023 to his death – but includes some key facts that have been established about his history and earlier life.

1969 to 2002	Martin was born in 1969. His father left the family when he was three months old, and he was brought up by his mother and his grandparents. It was a very close family, and he is described as devastated when his grandfather died in 1983. He was identified as having a mild learning disability in childhood. He left school at the age of 14. His grandmother died in 1995. His mother died in 2002 at the age of 59.
2002 to 2008	Martin lived in a supported living property provided by HAIL (Haringey Association for Independent Living, which later merged with Vibrance). He had a number of serious medical conditions, including type 2 diabetes, chronic kidney disease, essential hypertension, hyperkalaemia, and repeated leg abscesses. He was morbidly obese. A mental health

	assessment in 2005 found that he met the criteria for compulsory detention. However, he was admitted for a period as a voluntary patient to "an assessment and treatment learning disability facility". He was diagnosed as having an emotionally unstable personality disorder.
2008	Martin moved to an independent flat. He continued to receive support from HAIL.
2008 to 2022	In 2018 Martin was assessed under the Mental Health Act 1983 following a magistrate's warrant made under S135 of the Act. S135(1) allows the removal to a place of safety for assessment of a person who is suffering from a mental disorder, who lives alone, and who is unable to care for themselves. He was not found to be detainable. He had previously had a number of appointments with community mental health services, mainly with the Personality Disorder Team. He did not engage, and his case was closed to mental health services in 2013. Safeguarding concerns including self-neglect, refusal of medication, and refusal of urgent hospital treatment were raised by HAIL / Vibrance in 2011, 2017, 2020 and 2022. The last two were closed after screening on the day they were received as there was no indication that Martin lacked capacity to make decisions about his care and treatment.
2022	Martin had a series of appointments with a psychologist within the Haringey Learning Disability Partnership. The sessions ended in August 2022.
October to December 2022	An abscess developed on Martin's ankle. He would not take antibiotics and it got worse. The Community Learning Disability Nurse, who visited Martin regularly, District Nurses and Vibrance support workers all tried to persuade him to accept treatment but he declined. By the end of the year he was refusing to allow anyone to look at the wound or change the dressing, although he said it was hurting him a lot.
January to March 2023	Martin continued to decline treatment or admission to hospital for his infected abscess. He began to refuse all support from Vibrance, who raised a safeguarding concern about self-neglect on 18th January. Martin's Community Learning Disability Nurse was tasked with making safeguarding enquiries. On a number of occasions the GP, the CLDN, and the London Ambulance Service judged that Martin had capacity to make decisions about his care and treatment. The safeguarding concern was closed on 17th March. The closure decision recorded: "He has capacity to understand the risks of not accepting the recommended treatment. It appears that he is choosing to make unwise decisions."

March 2023	The Tissue Viability Nurse visited Martin on 24th March and raised a safeguarding concern about the very poor conditions in which Martin was living, the extreme lack of hygiene, and the risks to his health from his refusal of nursing or medical intervention. An ambulance was called. Martin said he would go to hospital when his CLDN returned from leave after the weekend. Martin agreed to go to hospital on 27th March and was taken to North Middlesex University Hospital. He was transferred to the Royal Free where his left leg was amputated above the knee. He was discovered to have large pressure sores on his back which had not previously been seen by anybody caring for or supporting him. Following their attendance on 27th March to take Martin to hospital, the London Ambulance Service raised a safeguarding concern detailing many of the same issues that had been raised by the Tissue Viability Nurse. The CLDN also raised a safeguarding concern in relation to the pressure sores which had been discovered on his admission to hospital. S42 enquiries were undertaken by a social worker within HLDP. It is not clear from the case records what the outcome of the S42 enquiry was.
April 2023.	At the request of the CLDN, a "significant event" meeting took place with the GP following the amputation of Martin's leg. The CLDN felt that this "was a significant event which could have been prevented". Various communication difficulties in the lead up to Martin's admission were acknowledged. However, the GP noted that any delays were "extremely unlikely to have changed the outcome of {Martin} requiring an amputation as he required hospital admission much earlier and had declined."
April to December 2023	Martin remained in hospital for the remainder of the year, first for rehabilitation and then as a result of difficulties in identifying a discharge destination and plan. He spent time in four different hospitals, and was returned twice to the Royal Free for brief periods when he required specialist assessment or treatment. His left eye was removed on 31st July as a result of a severe infection. In April Martin's case was allocated to a new CLDN. A social worker was allocated to work with him in June. However, when she first met him in hospital in July, he was extremely abusive towards her, and she left the room. Although she remained the allocated social worker until June 2024, she subsequently felt unable to have direct contact with him.

	Planning and arranging Martin's discharge was very difficult, in part because he was unwilling to accept any of the options available. Discharge plans were not agreed until over the Christmas period.
4th January 2024	Martin moved to new accommodation in a supported living development provided by Vibrance. He initially believed that this was a temporary arrangement until he could return to his previous flat. This was not the plan. The previous accommodation was described as "uninhabitable" and could not meet his mobility needs. A personal care package was commissioned from a domiciliary care agency - two carers, four times a day.
January to May 2024	In February Martin registered with a new GP practice as he had moved out of the catchment area of his original practice. However he was not happy with the new practice, and was warned by them about his abusive behaviour. He re-registered with the original practice. Martin again developed an open wound on his toe. The care provider and Vibrance raised further safeguarding concerns, and Martin's social worker undertook a S42 enquiry. The social worker completed a referral for legal advice from Haringey Legal Services about a possible application to the Court of Protection for an order about arrangements for Martin's accommodation and welfare, but Legal Services can find no record of the referral being received. The safeguarding concern was closed on 15th April. The closure decision recorded that Martin was now accepting support from carers, had agreed a referral to District Nursing for wound management, and had agreed to engage with the HLDP psychology service. A Care Act review on 9th April concluded that "Care package is in place to meet personal care needs, administer medication and carry out activities of daily living which reduces the risk of self-neglect". Martin's case was transferred to the review system for a further review in twelve months' time. Further safeguarding concerns were raised in April and May. After District Nurses attempted five unsuccessful visits, he was discharged from the District Nursing Service in May. Martin engaged with eleven psychology sessions between mid-March and the end of May. He declined to attend the final two planned sessions. By mid- May his health appeared to be deteriorating very quickly and he was in extreme pain. An ambulance attended but he refused transfer to hospital and would not engage in any discussion or assessment. A mental capacity assessment

	undertaken by Martin's GP concluded that he understood the risks and had capacity to make these decisions, however unwise they might be.
June to December 2024	In June a new social worker was allocated to Martin, following the reallocation of social workers working with people with learning disabilities from HLDP to Haringey's locality social care teams. She first visited him on 26th June and he was calm and engaged. Unsuccessful attempts were made to engage him with the Multi-Agency Care and Coordination Team. Through the combined efforts of Vibrance staff and the CLDN, Martin did attend two day care hospital appointments for some necessary tests. Further S42 enquiries by his new social worker were initiated in June. The safeguarding concerns were closed on 22nd October. The rationale recorded in the case notes appears, however, to have been copied and pasted from the record of the previous S42 enquiry closure on 15th April. Concerns about Martin's refusal of medical care continued to escalate. The CLDN and Martin's social worker made joint visits to try and convince him to accept treatment, and recorded a detailed discussion with him of how he wanted agencies to respond to any deterioration in his condition. At the end of November his GP was concerned that the infection in his foot was spreading to his leg, that he was showing signs of confusion, and these were indications of possible sepsis. Ambulances attended on three separate occasions over four days between 27th and 30th November but Martin refused all intervention. The ambulance staff made a further safeguarding referral to the local authority. It stated that as Martin would not engage with the ambulance crew, they were unable to complete an in-depth capacity assessment and it was unclear if he understood the risks associated with not allowing medical intervention. By the beginning of December blood tests were showing potentially fatal levels of potassium in his blood, which could lead to cardiac arrest. Martin said he did not care, and he did not believe the results. A Whittington Health multi-disciplinary team teleconference on 10th December asked for an urgent mental capacity assessment to be carried out by the CLDN and GP to assess whether Martin had the capacity to decide whether or not to accept urgent medical treatment due to his high potassium levels. If it was assessed that he did have capacity, he should be referred for palliative care. The assessment was carried out on 11th December, and was recorded by the GP. It was agreed that Martin had the mental capacity to make this decision. "It would be a deprivation of

	liberty to arrange an acute admission to hospital against his wishes based on this assessment."
January to March 2025	Major refurbishment works required Martin and the other residents in the supported living accommodation to move into temporary accommodation for six to twelve months. Martin's care package continued to be delivered in the new temporary accommodation, and support from Vibrance continued. Concerns continued to be raised about his physical health and refusal of treatment. Ambulances were called on two occasions in January and February because of his worsening chest pain and breathlessness. On each occasion he declined assistance. On one occasion the ambulance crew were told that he had not taken his potassium medication for a week as it had run out. There were ongoing problems with an attempted referral to physiotherapy and the supply of a new wheelchair. Martin's health had deteriorated very badly by the beginning of March. He had become unable to move sideways on the bed to allow the carers to undertake his personal care. He was suffering from pressure sores, which he consistently refused to allow District Nurses to attend to in spite of several visits. He was described as extremely weak. He had not eaten or drunk since 1st March. He was described as "screaming with pain" when he moved his leg. On 7th March it became apparent that the electricity and the water supply in the temporary accommodation had broken down. The other residents agreed to move to other alternative accommodation but Martin insisted on staying in the property alone. An ambulance attended following a report of chest pain and beathing difficulty and offered to take him to hospital where his pain could be managed, but he refused. On 11th March District Nurses reported that on visiting Martin they had found that his bariatric bed was at floor level. It could not be raised as there was no electricity. His hybrid mattress could not be turned on. They tried to persuade Martin that he needed to move but he would not talk to them. On 13th March Martin's social worker and the CLDN made a joint visit to see him. The Tissue Viability Nurse, who had known Martin in 2023, also attended. Two carers were present, as was a manager from Vibrance who had known Martin for over 20 years. Martin's leg was extremely swollen with the ankle area affected by large abscesses. He was in excruciating pain. A formal mental capacity assessment was completed and it was concluded that Martin did not at this time have capacity to make a decision about conveyance to hospital. An ambulance was called. However, shortly after the capacity assessment was completed Martin went into cardiac arrest.

	When the ambulance arrived, Martin was unconscious. The paramedics undertook Cardiopulmonary Resuscitation (CPR). Further assistance was requested and a second ambulance arrived. Following their assessment and treatment CPR was stopped and Verification of the Fact of Death was recorded at 2.14 p.m.

What follows is a more detailed account of Martin's story. The reviewer stresses however that the review does not attempt a comprehensive account of every episode of agency involvement, or of the communication and interaction between agencies.

2.2 Martin's father, who worked as a milkman, left the family when Martin was three months old. He did not see him for the first time until he was 16 years old. His mother and grandparents brought him up. Martin described his childhood family as very close and loving. He called his grandfather "dad". He said that his grandfather was a sergeant in the army, which was something Martin was proud of. He said that he felt guilty that he was not present when his grandfather died, because he was in school, and that he "hadn't been the same since". According to Martin, his grandfather died in 1983, when he was 14, and his grandmother in 1995. In late 2022 he told a Community Learning Disability Nurse that that "his world ended after his dad died and he has not enjoyed anything since. He said that cutting himself off from the world is his way of showing his dad he still misses him." His school attendance was poor and he described being bullied at school. He left school at the age of 14. He also said at some point that when he was younger "an uncle" used to get him drunk and take him to visit massage parlours. His mother died at the age of 59 in 2002, and he described the impact of this as something he had never got over.

2.3 It is recorded that he had two younger half-siblings, a brother and a sister, but it appears that he had no contact with them or knowledge of them for many years. He did make a number of references during the period focused on by this review to a brother, niece and nephew who lived in Leicestershire. However, he said they were not biological relatives, but he regarded them as his family. On a number of occasions in 2023 and 2024 he spoke about how important they were to him, and how much he had enjoyed a visit from his "niece". He said he often sent them gifts because he appreciated their care for him. During a protracted period in 2023 when he was awaiting discharge from hospital, he said that if he could not return to his previous flat in Haringey he wanted to go to live in Leicestershire "to be near my family". Carers from the domiciliary care agency who worked with Martin in the last fifteen months of his life recalled being present at a birthday party he put on for his niece in late 2024. However, by January 2025 he told his Community Learning Disability Nurse that he did not want any more contact with his family, that they did not care about him and only contacted him when they wanted money. The review has identified only one occasion when any agency working with Martin had any contact with this family. A doctor at the Royal Free Hospital phoned Martin's brother P at his request to update him about his condition, after

Martin had had a leg amputated and was refusing antibiotics. P said he had told Martin off and had told him to do everything the doctor asked.

2.4 According to the GP records, Martin was identified as having a mild learning disability in 1979, when he was 9 years old. He lived with his mother until she died. When she died, he moved into supported living accommodation. On site support, funded by Haringey, was provided by HAIL (Haringey Association for Independent Living), a registered charity, which in 2019 formally merged with Vibrance. Vibrance was a registered charity, founded in 1989, providing a range of services to adults with a disability across London and the South of England. (Since the events covered in this review, their services have been transferred to another organisation.) In 2008 Martin was offered the opportunity to move into an independent tenancy. HAIL staff did not feel this would be right for him, but he decided to accept. HAIL continued to provide off-site support.

2.5 The move to independent living took place in the months following the arrest and charging of those later convicted of causing or allowing the death of Peter Connelly (Baby P). Martin had been friends with the family, and was interviewed by the police as part of their investigation. There was never any suggestion that he was in any way complicit. However, a Vibrance manager who spoke with the reviewer and who had known Martin for over 20 years said that the episode, and the discovery of what his friends had done to a small baby, had a "dreadful impact" on him, and that he felt guilty for the rest of his life that he had "failed" Baby P. She felt strongly that services had failed Martin at this time, allowing him to move to independent living for the first time in his life immediately following this traumatic experience with no psychological or therapeutic support.

2.6 Martin had a number of serious and longstanding health conditions. These included type 2 diabetes mellitus, chronic kidney disease, essential hypertension, and hyperkalaemia. He had repeated leg abscesses. He was morbidly obese, weighing 145 kilos in February 2023 with a body mass index of 57.4. Records suggest a very longstanding pattern of aggressive and abusive behaviour, self-neglect, fluctuation between acceptance and refusal of support, and non-compliance with medication and medical treatment. The reviewer saw many examples of emails sent by Martin over the years, particularly to social workers but also sometimes to support staff with whom he had a long term and generally positive relationship, which were exceptionally abusive, verbally threatening, and full of repeated obscenities. However, those who knew him best who spoke to the reviewer also described a very different side to Martin. Vibrance staff described a man who could also be "the nicest person you could meet", very able practically, and with a thirst for knowledge. He managed multiple bank accounts, credit agreements and debts, "keeping all the balls in the air". They felt he had autistic traits, although he had never had an autism diagnosis. Community Learning Disability Nurses, who worked very closely with him, said he was "a pleasure to work with", had a great sense of humour, and could be very giving. He was also described as highly manipulative. It was very important to him to feel that he was in control of what happened to him, and he reacted very adversely if he felt he was not being listened to, if he was pressured to do things he did not want to do, or if people were disrespectful to him.

2.7 In 2005, in his mid-thirties, he was diagnosed with an emotionally unstable personality disorder. This appears to have been the outcome of a mental health assessment in August 2005. He was taken to hospital by a police officer under S136 of the Mental Health Act 1983, which gives a constable the power to remove a person to a place of safety for assessment if he appears to be suffering from mental disorder and to be in immediate need of care or control. He had been inflicting superficial wounds on his arms and saying he wanted to end his life. The assessment concluded that he met the criteria for compulsory admission to hospital. However he agreed to admission as a voluntary patient to what the record describes as "an assessment and treatment learning disability" unit. It is not clear how long he remained a patient there. Over the years he frequently made references to wanting to die, although the review saw no indication that he had ever actively attempted suicide. However, often in the same conversation, he would talk about wanting to get better and to plan for his future.

2.8 He had a number of subsequent appointments with community mental health services, mainly with the Personality Disorder Team. He did not engage with these services. He did not keep appointments. It appears that for at least some of this time he was not leaving his flat at all. His case was closed to mental health services in 2013.

2.9 Safeguarding concerns about self-neglect and refusal of medication were raised by HAIL / Vibrance in 2011 and 2017. Further concerns were raised in November 2020 and August 2022. On the first occasion paramedics had recommended urgent admission to hospital as there was a risk of sepsis from two very swollen and infected ankles. Martin declined transfer to hospital. The concerns raised in 2022 related to his non-compliance with his diabetes medication. Both safeguarding concerns were closed on the day they were raised as there was no indication that Martin lacked capacity.

2.10 In 2018 Martin was subject to an assessment under the Mental Health Act 1983 following the issue of a magistrate's warrant under Section 135(1) of the Act. This allows a magistrate to issue a warrant for removal to a place of safety for a person believed to be suffering from mental disorder who is living alone and unable to care for him/herself. The application for the warrant included statements that:

- He was suffering from delusions that the ashes of a dead relative he was keeping in his flat would be brought back to life
- The flat was heavily cluttered with "boxes of stuff", he was sleeping on a mattress which was heavily stained and the flat smelt of urine
- He was not allowing anybody into his flat and was refusing medical tests and treatment for his diabetes
- He was seen to be at risk of deliberate self-harm

2.11 He was not found to be detainable. The care plan recorded as an outcome of this assessment was for an urgent medical assessment to be carried out by the GP, a referral to be made to the Learning Disability Team to request urgent social work input to address "social / housing problems", and a referral to be made to the Consultant Psychiatrist in the Learning Disability Team "to request a mental state assessment, to rule out any underlying mental health problems e.g. low level

depressive symptoms that he may be amenable to accepting treatment for." The review has not been able to establish whether these actions were carried out and responded to.

2.12 The primary responsibility for seeking to address Martin's health and social care needs for most of this period rested with the Haringey Learning Disability Partnership (HLDP). This service included Community Learning Disability Nurses (CLDNs), a Consultant Psychiatrist, psychological therapies, speech and language therapy and, until April 2024, social workers. Haringey adult social care service have reported that Martin was reluctant to engage with social workers as he did not trust them. He often demonstrated extreme hostility. Social workers who worked with him reported instances of verbal and racial abuse and did not see him on their own. There were for example difficulties with completing annual social care reviews because Martin kept cancelling appointments. However, reviews were completed in April 2021 and August 2022. In April 2021 it was noted that he had not left his flat for six years. The review in 2022 highlighted Martin's wish to move. The flat in which he was living was described as uninhabitable. Major repairs were required but these could not be carried out until Martin had been able, with support, to clear the extreme clutter in the flat, at which point he would be able to seek a home swap. Martin was in hospital for most of 2023. The next review took place in April 2024.

2.13 In 2022 Martin had a series of two-weekly sessions with a psychologist in HLDP. These sessions are described as focused on "exploring what it means to have a learning disability, his mental health difficulties, and how these impact on his anxiety when trying to communicate with new people, keeping up with his medication and trying to eat more healthily. He was also working on how to allow other people into his life and wanting to build relationships with people who are trying to support him in his life." The sessions ended in August 2022. He had also had some engagement with psychology services in 2019.

2.14 In October 2022 an abscess developed on Martin's ankle. He did not agree to take the required antibiotics, and the abscess gradually got worse. Attempts were made to involve the District Nursing (DN) service. However contact proved difficult, as the service was not able to plan contacts in advance. Generally, Martin would only accept visits if he knew about them in advance and had been arranged through someone that he trusted. As a result, when DNs tried to visit, he would turn them away. As an interim measure, the CLDN and his Vibrance support worker were undertaking aseptic dressing changes. On 30.12.22, Martin would not allow the support worker to look at his wound or change his dressing, despite complaining it was hurting him a lot.

2.15 Throughout the first three months of 2023, repeated attempts were made at various times by his CLDN, his support worker from Vibrance, District Nurses and his GP to persuade Martin to accept urgent treatment for his infected abscess and admission to hospital. He consistently refused. He did accept referrals to the Tissue Viability Nurse and the District Nursing Service. However there were delays in accessing both services. Although the GP record indicates that the GP made both referrals on 13th February, the referral to the DN service was not received.

The reasons for it getting "lost in the system" are not known. The TVN was not initially able to accept the referral as Martin was not being seen by District Nurses. The CLDN contacted the GP practice on 7th February to request a re-referral to District Nursing, which the GP made on 8th March. District Nurses began visiting on 16th March, although the first couple of home visits were unsuccessful as they were unannounced and Martin would not open the door if he did not know and agree to who was coming. Some subsequent DN visits were more successful, when they were prearranged with the CLDN as a person Martin trusted. However, this was not always the case, and the CLDN felt there were continuing difficulties in arranging "reasonable adjustments" with the DN service to facilitate Martin's engagement with them. The duty to make reasonable adjustments is defined in S20 of the Equality Act 2010 as the requirement "where a provision, criterion or practice .. puts a disabled person at a substantial disadvantage .., to take such steps as it is reasonable to have to take to avoid the disadvantage."

2.16 There appear to have been some other difficulties in liaison with the GP practice. The GP and the CLDN had made a joint visit on 10th March. Three weeks later the CLDN contacted the practice to chase a number of actions that had been agreed following that visit, including the prescription of antibiotics, pain killers, and aseptic dressing packs. The CLDN recorded that "due to delay in requested dressings being delivered he had purchased his own dressings which may not be appropriate to meet his wound." On 15th March the CLDN wrote to the GP practice requesting an urgent meeting to discuss her concerns about Martin's care and how best to support him at home. She stressed that he needed "reasonable adjustments" in order to access health services and urgent care.

2.17 From the beginning of January Martin had been refusing all support from Vibrance. They managed to visit him on three occasions, but he would not engage with them. They raised a safeguarding concern about Martin's self-neglect with Haringey Adult Safeguarding Team on 18th January. The referral stated that Martin was in extreme pain and experiencing regular sickness. "He does not want to seek medical attention and understands the risks." Enquiries under S42 of the Care Act 2014 were initiated. S42 places a duty on the local authority to make or cause to be made enquiries if they have reasonable cause to suspect that an adult with care and support needs appears to be suffering or at risk of abuse or neglect, and is unable, due to their care and support needs, to protect themselves. The purpose of a S42 enquiry is to enable a decision to be made whether any action should be taken to safeguard the adult, and if so, what and by whom. The enquiry was assigned to Martin's CLDN "as this concern is regarding self-neglect of pressure sores". The CLDN wrote to social work managers outlining the details of Martin's case and saying "Further advice in regard to his social care and long-term support would be great." There does not appear to have been a response to this, other than the allocation of the S42 enquiry to the CLDN. In a number of visits over the next two months Martin was judged by both the GP and the CLDN to have the mental capacity to choose whether or not to accept treatment and admission to hospital. On 17th March, by which time all health professionals judged the need for hospital admission to be extremely urgent, the CLDN recorded: "Patient again encouraged to go to hospital however refused. The patient demonstrated

understanding of risks and needed treatment, retaining information given to him by GP and DN team. Assessed to have mental capacity and agreed to contact emergency services if health deteriorated." The local authority closed the safeguarding concern on17th March, noting that "He has capacity to understand the risks of not accepting the recommended treatment. It appears that he is choosing to make unwise decisions." The record also stated that a safeguarding plan was in place to reduce the risks. The elements of the safeguarding plan were:

- Martin had consented to medication and treatment in the home
- He had also consented to investigations in hospital in the future. However he wanted his wound to heal first.
- He had agreed to contact 999 if there was any further deterioration in his health
- He would like to have support from Vibrance once he is ready. However, he wanted first to focus on his health needs.

2.18 Some time in the week beginning 20th March, Martin agreed that he would go into hospital on Monday 27th when his regular CLDN returned from leave. After a number of difficulties in making contact, the Tissue Viability Nurse visited Martin for the first time on 24th March. She raised a safeguarding concern on the same day. She listed the reasons for the concern as:

- Cluttered house
- EXTREMELY POOR HYGIENE CONDITION: patient urinates and defecates on plastic bags
- Unkempt
- No food in the house
- Patient currently 'bedbound' – not moving at all from the floor
- Neglect/self-neglect
- Extremely dirty and malodorous house
- Patient sleeps on the floor on very dirty surface
- Patient refuses medical/nursing intervention
- Patient refuses hospital admission
- Large, infected wounds to left lower limb. High risk of developing sepsis and death
- Fire risk identified

However, the adult safeguarding team do not appear to have a record of receiving this referral.

2.19 During this week, the TVN, the District Nurse, and the ambulance service all tried to persuade Martin to go to hospital immediately, without success. Ambulance staff were called by the TVN on 24th March in the hope that they would be able to persuade Martin to go to hospital. They assessed that he had the capacity to be able to refuse. They did however raise a safeguarding concern.

2.20 Martin was admitted voluntarily to the hospital of his choice, North Middlesex, on 27th March. He was transferred the next day to the Royal Free. The medical assessment was that life-saving amputation was required immediately. His left leg was amputated above the knee, with Martin's consent, that night.

2.21 At the beginning of April the CLDN wrote to the GP surgery requesting a meeting to discuss Martin's amputation as "a significant event which could have been prevented", from which a lot of learning could be derived. The meeting took place on 19th April. Issues discussed included:

- Issues with communication between the CLDN service, GP and District Nursing team, resulting in delay in intervention and difficulties arranging reasonable adjustments for treatment of deteriorating left leg ulcer in the home.
- Referral to District Nursing was lost resulting in delayed specialist input.
- Delayed requested actions and response from GP practice, such as prescription for antibiotics, aseptic packs, and painkillers, resulting in patient buying their own dressing.
- Emails to GP were not always picked up due to the volume received and reception capacity in the practice. Telephone calls would be more reliable but CLDNs reported long waiting times for an answer. The practice provided the CLDN with a bypass number for contacting the duty GP. It was also agreed that HLDP would be given bypass numbers for all GP practices in Haringey, and telephone contact details for the District Nursing Co-ordinators.

The GP notes state that any delays were "extremely unlikely to have changed the outcome of {Martin} requiring an amputation as he required hospital admission much earlier and had declined."

2.22 Following their attendance on 27th March to take Martin to hospital, the London Ambulance Service raised another safeguarding concern. It covered very similar issues to those raised by the TVN on 24th March, but in more graphic detail. A further safeguarding concern was received from the CLDN on 28th March, triggered by the discovery of pressure sores on Martin's back when he was admitted to hospital which nobody had previously been aware of. From the case records seen, it appears that the safeguarding concerns were not screened until the end of May. It was determined that the concerns met the threshold for a S42 enquiry. The enquiry was allocated on 23rd June to a social worker in HLDP, who visited Martin in hospital on 10th July. It is not clear from the records seen what the outcome of the S42 enquiry was. The chronology of involvement from adult social care submitted to this review states: "Closed on LAS {the local authority's case recording system} when migration took place from Mosaic to Liquid Logic. Outcome states referral to Mental Health but no further info found." There is no record of any referral received by mental health services.

2.23 Martin remained in hospital until the end of 2023, initially for rehabilitation and then as a consequence of difficulties in identifying and agreeing a discharge destination. His previous address was not suitable for his mobility requirements as an amputee, and was again described as "uninhabitable". During this period he was transferred first to St Pancras Hospital, and then to Finchley Memorial Hospital, for rehabilitation. He also had two further short episodes of acute care at the Royal Free. One was for the removal of his left eye following a severe eye infection and necrosis – a condition in which cells in living tissue are injured and die uncontrollably. During this admission acute kidney disease and chronic liver

disease were also diagnosed. The other, in late November, was for suspected hyperkalaemia, a potentially life-threatening condition in which blood potassium levels are abnormally high. Further blood tests showed normal potassium levels, and he was transferred back to Finchley Memorial after three days.

2.24 Initially Martin appeared to respond well to his experience at the Royal Free and the amputation. When his CLDN visited him, he spoke on more than one occasion about his positive experience in hospital and his guilt about not having agreed to go to hospital earlier. He engaged with Occupational Therapy and with physiotherapy. However, after a couple of months this engagement declined and he began to frequently refuse to take the medication prescribed. He found the repeated transfers from one hospital to another extremely frustrating and upsetting, and did not believe they were necessary. According to the chronology submitted by the Royal Free, on the day he was transferred to St Pancras the Royal Free Liaison Psychiatry service made a referral to the HLDP Consultant Psychiatrist for follow up after Martin was eventually discharged home. It does not appear that there is a record of this referral being received. Martin initially refused transfer back to the Royal Free for treatment for his inflamed eye. When asked what he would do if his eye burst, or if he became drowsier, his response was "it won't happen". On this occasion he was judged by medical staff to lack capacity to make a decision about transfer, and eventually, after an ambulance had attended twice, agreed to be taken to the Royal Free. His left eye had to be removed on 31st July, following a severe infection. On his return to St Pancras, he was described as "hopeless and flat". He declined prescribed medication for his kidney injury. He said this was because "he didn't want to be bothered any more" rather than because he was deliberately wanting to make himself ill and die. On other occasions however he did say he did not mind if he died, or that he wanted to put himself into a coma and die. On occasion he would talk about wanting to die and looking to the future in the same conversation. On one occasion he talked about wanting to engage with rehabilitation but "I want to but putting words into action is too overwhelming and difficult." While in the Royal Free for treatment for his eye and his kidney injury, he was again referred to the Liaison Psychiatry service for assessment in relation to his depressive symptoms. However he was transferred back to St Pancras a few days later.

2.25 Both Vibrance and the CLDN maintained regular contact with Martin while he was in hospital. Martin's case was reallocated in April 2023 to a different CLDN, who, while he said he did not remember, had previously worked with him while the first CLDN was on leave. The CLDN requested the urgent allocation of a social worker to co-ordinate discharge planning, to support with mental capacity assessments when needed, and to organise care on his discharge. Martin was allocated a social worker on 23rd June, with her first task being to undertake the S42 enquiry relating to concerns raised by the ambulance service and the CLDN in March. The social worker visited Martin in hospital with the CLDN on 10th July. However, Martin would not engage with her. He said he hated social workers and became extremely abusive, using repeated obscenities. The social worker left the room. On 15th December, in response to a request to discuss a matter related to his discharge with Martin, she responded that she was unable to work directly with

him “due to a previous incident” and that the matter would have to be followed up by the CLDN. She did however meet Martin again once, on 21st December, to view a potential property for his discharge.

2.26 In July 2023 Martin’s social worker initiated the process of seeking appropriate accommodation for Martin to be discharged to. Over several months there were a number of different plans or contingency plans considered, including supported living, step down accommodation, or nursing home care. At various points Martin said he wanted to move out of Haringey, and at others that all he wanted to do was to return to his previous flat. In October his social worker made a referral to Haringey’s Legal Services for advice about a potential application to the Court of Protection for an order settling Martin’s discharge destination. However Legal Services do not have a record of this referral, and the social worker did not follow it up. A mental capacity assessment carried out in October 2023 by the two CLDNs who had worked with him throughout the period covered by this review concluded that he had capacity to make decisions about his placement and support after his hospital discharge. Martin‘s “abusive behaviours” were described as “escalating”, and at one point he physically attacked a member of hospital staff. As late as mid-December a return to his previous flat had re-emerged as the plan, although no assessment had taken place either of its condition or of its suitability for his mobility needs, requiring a bariatric wheelchair as well as a bariatric bed. When undertaken, it was clear that this was not a viable option. He finally agreed to move to a studio flat within a supported living unit managed by Vibrance. There were a number of last minute issues to be sorted out over the Christmas period about equipment and the delivery of equipment, which it fell to the CLDN and Vibrance to resolve. Martin finally moved into the studio flat on 4th January 2024. He was under the impression that this was a temporary move pending a return to his old flat. There were clearly a number of communication problems at this point. The CLDN was not informed in advance of the discharge date, and was also under the impression that this was a temporary move. Martin’s social worker seemed to be under the impression that Vibrance were commissioned to provide him with three hours a day of support, whereas in fact it was three hours a week. As late as mid-November Vibrance seem, from an email seen by the review, to have been unaware that Martin had an allocated social worker.

2.27 A personal care package from a private domiciliary care agency had been commissioned before his move to support Martin in his new accommodation. This consisted of two carers visiting four times a day, for an hour at a time. Tasks were to include assistance with medication, strip washing, dressing, toileting, continence management, meal preparation and light household duties. Martin’s acceptance of and cooperation with the care provided fluctuated considerably. On occasions he would tell them to go away, refuse all medication, and be angry and abusive. On others he would be described as in a good mood, cooperative, and appreciative. Personal care staff who worked with Martin told the reviewer that he could switch from one kind of behaviour to the other in a single interaction, with no apparent trigger. There were ongoing issues with the supply and delivery of equipment. Martin developed an open wound on his toe which he was refusing

to allow anybody to treat. By the end of February the concerns of both the domiciliary care provider and Vibrance staff had escalated significantly. Both agencies raised safeguarding concerns, and S42 enquiries were allocated to Martin's social worker to complete. The social worker completed a referral to Haringey Legal Services asking for advice on whether an application should be made to the Court of Protection for an order concerning decisions about Martin's accommodation and welfare. However, the Legal Department can find no record of receiving this referral, and it does not appear to have been followed up. A care review on 9th April noted that "Care package is in place to meet personal care needs, administer medication and carry out activities of daily living which reduces the risk of self-neglect". Martin's case was transferred into the review system for a further review after twelve months. The safeguarding enquiry was formally closed on 15th April. The safeguarding risk assessment was that his self-neglect was "short term", and that the risk of it continuing or escalating was medium. The recorded rationale was that Martin was now accepting support from his carers, he had agreed to a referral to District Nursing for wound management, and had agreed to engage with the psychology service within HLDP. "There are still some concerns about his engagement with carers and district nurses however this will be followed up by case management and liaising with the MDT."

2.28 Martin's new address was outside the catchment area of his GP practice. In February he registered with a new practice. However, he was not happy with the practice, and was warned by them about his abusive behaviour. He decided to return to his original practice, who accepted him as a returning patient. However, as he was well out of their catchment area, it was difficult for his GP to maintain face to face contact with him.

2.29 Further safeguarding concerns were raised by the domiciliary provider and by Vibrance in April and May, reporting further refusal of medication, reliance on a diet of fizzy drinks and crisps with potential serious implications for his diabetes, and refusing to allow his foot wound to be dressed. After five unsuccessful attempts to gain access or consent to dress the wound between 18th April and 4th May, Martin was discharged from the District Nursing service. Martin did however engage with the HLDP psychologist. Between 11th March and 30th May he attended 11 out of 13 planned sessions. He declined to attend the last two. He used the sessions to talk about the things that made him feel angry or depressed, but was not willing to consider approaches which might involve practising small changes in behaviour or thinking styles. In his last session he told the psychologist that he had no active plan to harm himself but he had made the decision to stop taking medication or accepting any help for his physical health.

2.30 In mid-May Vibrance reported that Martin's health appeared to be deteriorating very quickly and that he was in extreme pain. Support staff called an ambulance but he did not consent to be taken to hospital. He was abusive to the ambulance staff and would not engage in any conversation or assessment. In the light of this intensifying concern and at the request of Martin's CLDN, the GP who knew Martin best undertook an assessment under the Mental Capacity Act 2005 of his decision- making capacity in relation to accepting or refusing medical treatment.

He concluded that Martin had capacity to make that decision, however unwise health professionals believed it to be.

2.31 At the beginning of June a new social worker from one of Haringey's locality social work teams was allocated to work with Martin. Since April, social workers for people with learning disabilities had been reallocated to locality teams and were no longer based in HLDP. In response to the concerns raised by Vibrance, further S42 enquiries were initiated.

2.32 On 13th June, Vibrance staff again called an ambulance as Martin had been reporting chest and kidney pians. On this occasion he allowed them to make an assessment, but again declined transfer to hospital. Following a referral from the CLDN, a Community Matron, a Nursing Associate and a pharmacist from the Multi-Agency Care and Coordination Team (MACCT) visited Martin on 14th June but he would not engage with them. Martin's new social worker met him with his CLDN on 26th June. Despite his previous antagonism towards social workers, he was calm and engaged. There were continuing issues about the size of his bed and the suitability of his wheelchair, and the social worker agreed to arrange a joint follow up visit with an Occupational Therapist. On 22nd July MACCT members met with the social worker, the CLDN, the psychologist, Vibrance and domiciliary care staff. The MACCT members said that they believed that Martin was at high risk of physical deterioration, and it was agreed that all involved needed to continue to encourage him to accept blood and glucose monitoring and wound care. There was a detailed discussion of the best ways to try and work with him – for example, always prepare him in advance for appointments, do not place too many demands on him, go at his speed, repeat back what he has told you, do not contradict him. Through the joint efforts of the CLDN and Vibrance staff, Martin did attend two day care hospital appointments through the Same Day Emergency Service (SDEC) – one at North Middlesex in August and one at the Whittington in December. These did allow some necessary tests, including blood and glucose tests, to be undertaken. SDEC is described as a service that provides urgent assessments and treatments by appointment for people who would otherwise be admitted to hospital.

2.33 The outstanding S42 enquiry was formally closed on 22nd October. The rationale recorded in the case notes appears, however, to have been copied and pasted from the record of the previous S42 enquiry closure on 15th April. Concerns about Martin's continuing refusal of medical care continued to escalate. On 27th November his GP expressed a concern that his foot infection was getting worse and was spreading to his leg, that he was showing signs of confusion, and these were indications of possible sepsis. An ambulance was called by staff on three separate occasions over four days at the end of November. On each occasion Martin refused transfer to hospital. On 27th November the ambulance crew made a safeguarding referral to the local authority, although it did not reach Haringey until 4th December. It was passed to the locality team on 5th December, but does not appear to have been registered there until 17th December. The referral stated:

> M has a wound/ulcer on the top of his right foot that has reportedly been growing in size over the last 2 weeks. M has type 2 diabetes and this affect

his body's ability to heal without external management. The warden staff on site have been speaking with M's GP to inform them of the growing wound. His GP arranged a rapid response team and district nurses to visit the patient within his home to assess and treat the wounds however each time he has become verbally aggressive with these Health Care Professionals and the consultations have been finished before treatment could occur. Over the last 3 days the warden staff have noticed that the patient has been getting forgetful and are concerned that the infection may be getting worse. A similar cascade of events occurred in March 2023 where the infection became so severe that he required amputation of his left leg. During this instance, M repeatedly refused help until he became incapacitated and the Ambulance Service was able to treat him under the Mental Capacity Act. Today the ambulance service attempted to speak with M to devise a plan of treatment that he would be comfortable with however he immediately was verbally aggressive behaviour towards the crew and declined to engage with them. M has a learning disability and the crew used language appropriate for M and made attempts to reason with M and respect his wishes. The crew attempted to speak through warden staff as he had a good rapport with her however he continued to decline against medical advice. At present the patient doesn't visually appear acutely unwell with signs of sepsis however M refused to allow the ambulance crew to complete assessments or treatment to his wound. R appears to be self-neglecting his physical health by not allowing any health professionals to treat his wound. As M wouldn't engage with the ambulance crew, they were unable to complete an in-depth capacity assessment and it is unclear if M currently understands the risks associated with not allowing medical intervention.

Vibrance also raised a safeguarding concern on 28th November. Martin had a sore on his right food which seemed infected. His foot and leg were swollen, and he complained of a severe pain. It was noticed he was confused at times and he struggled to follow conversations.

2.34 Martin's social worker visited him with the CLDN on 8th and 29th November. On the second visit they carried out a joint assessment of his capacity to make decisions about taking his prescribed medication. They concluded that he did have capacity. They also had and recorded a detailed discussion with Martin on how he wanted his health needs met:

If M needs medical treatment/attention, the following should happen
1. Assess if M understands what is happening and why he needs medical attention.
2. If M appears to be unwell and its early stages, M would like to be seen by community services first (e.g. GP, District nurse, Rapid response). Always let M know who is coming, when, why and what clinical procedures they'll need to do.
3. Health professionals need to give M time to process the information being present to respond.
4. If M needs to be seen by multiple professionals, its important that they don't all come at once. M likes to do one process at a time.

5. M does not mind cooperating with clinical procedures such as blood test, blood pressure, BMs. M likes to have someone who is experienced at taking bloods as he does not like multiple tries. He also likes professionals who have experience with working with people who have LD.
6. M states if community service advise that he goes into hospital (on assessment) due to his health deteriorating or needs more medical support/assessment, he agrees to go to hospital.
7. If SDEC (ambulatory care unit) can be referred instead, R would prefer this, but M understands that this may not always be available depending on his health presentation at the time.
8. If M is becoming more ill, assess his capacity and his consciousness. M states, if he is speaking and it does not make sense after 10 minutes, he needs emergency medical attention.
9. M has requested for staff/carers to call emergency services if he appears to be very unwell.
10. M has asked, if ambulance service come to collect him, he'd like them to have the right equipment, e.g. bariatric stretcher/bed, large cuffs for blood pressure etc.
11. M would like female practitioners, if possible, he understands that this may not always be available
12. M would like people that knows him very well to help explain things to him.
13. If there are any changes to M's medication, please explain to him why this change has happened, the name of the medication and the benefits.
14. M does not want his family to be called unless he is in a critical condition in which he cannot make a decision.
These are Ms wishes. Please remind him of this when he is unwell.

2.35 There was extreme concern about his hyperkalaemia. By the beginning of December blood tests were showing potentially fatal levels of potassium in his blood, which could lead to cardiac arrest. Martin said he did not care, and he did not believe the results. A Whittington Health multi-disciplinary team teleconference on 10th December asked for an urgent mental capacity assessment to be carried out by the CLDN and GP to assess whether Martin had the capacity to decide whether or not to accept urgent medical treatment due to his high potassium levels. If it was assessed that he did have capacity, he should be referred for palliative care.

2.36 The assessment was carried out on 11th December, and was recorded in some detail by the GP. A senior manager from Vibrance who knew Martin well was also present. All agreed that Martin had the mental capacity to make this decision. "It would be a deprivation of liberty to arrange an acute admission to hospital against his wishes based on this assessment." Martin did however agree to the SDEC appointment at the Whittington which he attended on 13th December.

2.37 Following this assessment, the GP emailed the CLDN to say "it would be great if you had access to any LD consultants in Haringey (I know there was not one previously) to help and assess M's mental health needs". When the Consultant Psychiatrist within HLDP (a long-established post) was copied into the email, she asked the CLDN to make an internal referral as she had no previous knowledge of

Martin and whether he had a mental illness, and she was unclear what the GP was asking for. She did question why Psychiatry had not been previously involved. The CLDN advised that a discussion would be helpful before any referral was made, as Martin would resist going through any diagnostic process.

2.38 Martin had been advised at the end of November that he and all the other residents would need to move to temporary accommodation at the beginning of January, as major refurbishment work which would take six to twelve months was required at their existing accommodation. He was extremely resistant to this. The move took place on 10th January, preceded by a great deal of confusion on the part of the agency responsible for arranging the transfer of Martin's bariatric bed, wheelchair and other equipment which was only resolved at the last minute. In the days leading up to the transfer, the care agency recorded that Martin was in a lot of pain, had difficulty in moving his body, and was refusing his medication. They raised another safeguarding concern on 27th December.

2.39 Martin's care package continued to be delivered in the new temporary accommodation, and support from Vibrance continued. Concerns continued to be raised about his physical health and refusal of treatment. Ambulances were called on two occasions in January and February because of his worsening chest pain and breathlessness. On each occasion he declined assistance. On one occasion the ambulance crew were told that he had not taken his potassium medication for a week as it had run out. Martin had agreed to a referral to physiotherapy. The referral from the GP was rejected because of incomplete information but the GP was not informed of this. When told he would have to submit a new referral (without knowing why the first one had been rejected) he refused to engage in any more "back and forth bureaucracy". It appears that several referrals for physiotherapy had been made over the previous year without success. It appears that a physiotherapy referral was never successfully progressed. There were also ongoing difficulties with his wheelchair which he had never been able to use comfortably and which was now broken. A new wheelchair had been built specifically for him, but it could not be delivered to the temporary address as it was not his long-term home. Martin was therefore wholly bedbound.

2.40 On 10th February the domiciliary care agency raised a safeguarding concern about Martin's insistence on taking his own medication, which was not felt to be safe. The Safeguarding Adults Team emailed back:

> "This is to inform you that the query presented is not for the safeguarding team, as refusal to take medication should be discussed with Martin's GP in order to explore other options of how this can be managed. This case also needs to be discussed with the locality team that manages the case for a review to be conducted given the concern raised"

2.41 It appears from the records seen that Martin's health had deteriorated very badly by the beginning of March. He had become unable to move sideways on the bed to allow the carers to undertake his personal care. He was suffering from pressure sores, which he consistently refused to allow District Nurse to attend to in spite of several visits. He was described as extremely weak. He had not eaten or drunk since 1st March. He was described as "screaming with pain" when he moved his

leg. On 7th March it became apparent that the electricity and the water supply in the temporary accommodation had broken down. The other residents agreed to move to alternative accommodation but Martin insisted on staying in the property alone. This was a Friday, and all involved considered him to be at high risk over the weekend. An ambulance attended following a report of chest pain and beathing difficulty and offered to take him to hospital where his pain could be managed, but he refused. His social worker liaised with Vibrance and the care agency to ensure that the personal care visits would remain in place four times a day, that Vibrance would visit twice in between visits, and that sufficient supplies of bottled water were available. Vibrance provided the care agency with a range of emergency contact numbers.

2.42 Following the weekend, Martin continued to refuse personal care, medication, pressure sore care, food or drink. On Tuesday 11th March District Nurses reported that on visiting Martin they had found that his bariatric bed was at floor level. It could not be raised as there was no electricity. His hybrid mattress could not be turned on. They tried to persuade Martin that he needed to move but he would not talk to them.

2.43 On 13th March Martin's social worker and the CLDN made a joint visit to see him. The Tissue Viability Nurse, who had known Martin in 2023, also attended. Two carers were present, as was the manager from Vibrance who had known Martin for over 20 years. Martin's leg was extremely swollen with the ankle area affected by large abscesses. He was in excruciating pain. A formal mental capacity assessment was completed and it was concluded that Martin did not have capacity to make a decision about conveyance to hospital. An ambulance was called. However, shortly after the capacity assessment was completed Martin went into cardiac arrest. When the ambulance arrived, Martin was unconscious. The paramedics undertook Cardiopulmonary Resuscitation (CPR). Further assistance was requested and a second ambulance arrived. Following their assessment and treatment CPR was stopped and Verification of the Fact of Death was recorded. It was 2.14 p.m.

3. Key lines of enquiry, thematic analysis and learning

3.1 The review identifies a number of areas for learning from Martin's story. However, it is essential to recognise that by January 2023 Martin's way of engaging with the world, with professionals, and with his own health, had been firmly established over more than twenty years. It is probably not realistic to suggest that by January 2023 any practice, however exemplary, would have fundamentally changed the trajectory of his story.

3.2 It is also important to stress that the review has identified dedicated and committed practice on the part of many of those who sought to help Martin. The two Community Learning Disability Nurses who worked closely and intensively with Martin throughout the period covered by this review worked tirelessly to find ways of engaging with him and of advocating for his needs. The CLDN's insistence on following up with the GP practice her concerns about the events leading up to the amputation of Martin's leg, which she believed could have been avoided, through the "significant event" meeting which took place in April 2023, was

commendable. The Vibrance staff and managers who supported Martin over many years were similarly committed both to meeting his needs as well as possible, in spite of his frequent refusal to engage, and to advocating for him. The day after Martin's death, the Director of Operations at Vibrance wrote to the domiciliary care agency to thank the two carers who had mainly worked with Martin for their professionalism and compassion, being very caring even when Martin was being very challenging. The social worker who was allocated to work with Martin in June 2024 succeeded in engaging with him, in spite of the longstanding and engrained hostility to social workers which had defeated previous efforts. The close work that she and the CLDN completed with Martin in November 2024 to record Martin's wishes about how he wanted health care professionals to work with him struck the reviewer as an excellent example of person-centred practice. In the last months of Martin's life, the co-ordination of care between the CLDN, the social worker and Martin's GP practice, with one GP in particular providing a consistent link, was much improved. Some professionals clearly recognised the importance of trauma-informed practice in working with Martin.

What learning can be identified in how agencies identified and responded to Martin's self-neglect?

3.3. Many research studies suggest a strong link between self-neglect and childhood or adult trauma.[3] The potential significance of trauma in understanding Martin's behaviour was recognised. In April 2024 a multi-disciplinary team meeting (the review has not identified the details of who was involved) emphasised the importance of working in a trauma-informed way with Martin. The HLDP psychologist and Vibrance jointly organised a workshop on trauma-informed practice in September 2024.

3.4 Martin described his childhood as close and loving, although his experiences at school appear to have been very difficult. He referred several times to his devastation when he lost members of his family, particularly his grandfather and his mother. He said he had never got over these losses. Christmas was always a very difficult time for him, as it coincided with the anniversary of family deaths. He said he hated hospitals because family members had died in hospital, and he adamantly refused to go the Whittington Hospital because his mother had died there. He did engage with psychological therapy and shared some information about his history. However, he was determined to remain in control of what he shared. He was not willing to consider ways or potential techniques of modifying his behaviour.

3.5 Both the Community Learning Disability Nurses who worked with Martin between 2013 and 2025 had very clear ideas of how to work with Martin. These were documented jointly with Martin's social worker in November 2024. The nurses made efforts to share their expertise with other agencies, linked with their emphasis on the essential "reasonable adjustments" needed to have a chance of successfully engaging with Martin. However, it was not always possible, due to

[3] See, for example, An overview of self-neglect, Iriss, 2022, https://www.iriss.org.uk/sites/default/files/2022-08/esss_outline_an_overview_of_self-neglect_2022.pdf

operational, organisational or resource constraints, for other agencies to take these requirements on. For example, the District Nursing service was not consistently able to plan and inform Martin of their visits in advance. However, there were several examples of other professionals approaching Martin in ways that were sensitive to his particular mode of engaging. Vibrance staff spoke of how he needed time to absorb information and to feel he had control over what he did and did not do, and how, given that time, he would often eventually comply with advice. The Consultant Physician who saw him in SDEC (Same Day Emergency Care) at North Middlesex University Hospital in August 2024 was able to allow him 20 minutes to express, in a very abusive way, his hatred of all hospitals before being able to persuade him to accept blood and a range of other tests. The GP who was closely involved with Martin's care in the last few months of his life was equally patient, in spite of the pressures of a busy GP practice.

3.5 The response to adult safeguarding concerns focused exclusively on self-neglect in terms of health. While his neglect of his health needs was certainly potentially overwhelming, a more holistic response was needed. Safeguarding concerns raised described in graphic detail the exceptionally cluttered, dirty, unhygienic, and unsafe condition of Martin's home environment. These did not seem to be addressed in any of the safeguarding enquiries or reports seen. The S42 enquiry in January 2023 was allocated to the Community Learning Disability Nurse "as this concern is regarding self-neglect of pressure sores". This was too limited a view.

3.6 On two occasions Martin's social worker at the time made a referral to Legal Services seeking advice on a possible referral to the Court of Protection. Unfortunately, Legal Services have no record of receiving either referral. There was no follow up by the social worker to chase a response. These were potentially missed opportunities to consider a response to Martin's extreme self-neglect in a different framework. It is unfortunate that the Safeguarding Adults Board's recently revised Self Neglect and Hoarding Procedure[4] does not draw attention to the potential role of the Court of Protection in some circumstances.

Recommendation 1: in disseminating the learning from this review, the Safeguarding Adults Board should ensure that the potential role of the Court of Protection in responding to complex and high-risk cases of self-neglect is highlighted.

3.7 Until the allocation of a new social worker in June 2024, social care do not seem to have fully appreciated the seriousness and potential consequences of Martin's self-neglect. The conclusion of the safeguarding enquiry in April 2024 was strikingly and surprisingly optimistic. The risk assessment was that his self-neglect was "short term", and that the risk of it continuing or escalating was medium. The evidence recorded for this assessment was that "Risk of self-neglect is low due to varying levels of engagement with professionals". Martin was now accepting support from his carers, he had agreed to a referral to District Nursing for wound management, and had agreed to engage with the psychology

[4] https://haringey.gov.uk/sites/default/files/2024-11/haringey_multi-agency_self_neglect_and_hoarding_procedure.pdf

service within HLDP. Given Martin's history, these were flimsy grounds to rely on for assurance about Martin's future welfare. "There are still some concerns about his engagement with carers and district nurses however this will be followed up by case management and liaising with the MDT." It is not clear who was going to carry out the case management, as a care review a few days earlier had concluded that Martin's case should be returned to the review system for a further review in a year's time. The review had concluded that as a care package was in place to meet personal care needs, administer medication and carry out activities of daily living, the risk of self-neglect was reduced. This again seems to have been as assessment at odds with what was known of Martin's history.

3.8 The review concludes that the seriousness of the concerns about the risks to which Martin was exposing himself should have been escalated to more senior levels in the organisations concerned. The CLDN did seek to escalate her concerns about Martin's care to the Integrated Care Board in March 2023. The review has not seen a response. However, in general the Community Learning Disability Nurses seem to have accepted that the risk should be contained at their level, together with their immediate supervisor. This led to the nurses involved with Martin's care, who demonstrated an exceptional commitment to helping him, even or especially when he would not accept that help, carrying the bulk of the risk of Martin's care without adequate multi-agency support. To support front line staff working with such high risk cases, managers in all agencies need to create cultures in which staff are enabled and encouraged to escalate their concerns without feeling that this is in any way a reflection on their own professional competence or commitment.

3.9 The District Nursing Service maintains a "Patients of Concern" list. Martin was on that list until January 2025, when he moved temporarily to an address covered by another District Nursing team. The service has acknowledged that there was not a robust handover, and Martin was not placed on the Patient of Concern list in the new area. However, the review understands that placement on the Patient of Concern list is the first step in an escalation process. If the patient at risk continues to refuse care, they should be visited by a Team Manager or Deputy Team Manager who will seek to engage them. If refusal continues, the case should be escalated to the Lead District Nurse, who will convene a multi-agency panel to consider a way forward. In Martin's case such a panel would have included the safeguarding adults team, the GP, the Lead Nurse, and the learning disability team. Although Martin was on the list as a patient of concern, none of these things happened.

3.10 Front line practitioners were struggling with enormously challenging and life-threatening risks of self-neglect. Over the period covered by this review, multiple safeguarding concerns were raised, S42 enquiries were undertaken and closed, but nothing changed. Not only was the risk not reduced; it continued to escalate. While safeguarding is indeed everybody's business, it is the local authority which is the lead statutory agency under the Care Act with responsibility for safeguarding adults. The review has already noted that for much of the period covered, local authority adult social care services did not seem to fully appreciate

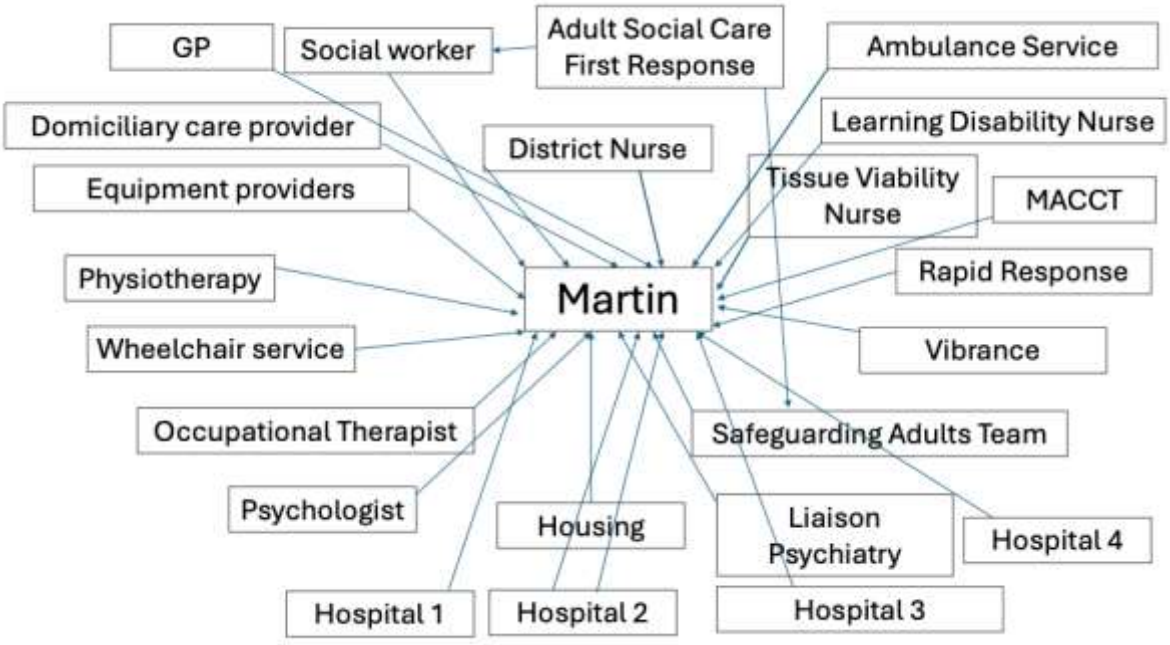
the seriousness and potential consequences of Martin's self-neglect. Nevertheless, this is a case that should have been brought to attention at the most senior levels in the organisation. The review understands that there is a monthly "Cases of Concern" meeting in Haringey, which brings together the Chief Executive, the Director of Children's Services, the Director of Adult Social Services, and the Head of Legal Services. Martin's case was never considered at such a meeting. However, there is no formal documented "Need to Know" procedure, such as exists in many local authorities, which sets out criteria for cases and issues that must be brought to the attention of the Director of Adult Social Services. This review recommends that such a procedure be developed.

Recommendation 2: all agencies represented on the Safeguarding Adults Board should review and if necessary strengthen escalation pathways available to front line practitioners and managers carrying high levels of risk, and support and encourage staff to make appropriate use of them.

Recommendation 3: Haringey adult social care should develop a "Need to Know" procedure setting out criteria for cases and issues which must be brought to the attention of the Director of Adult Social Services.

<u>What learning can be identified in how agencies worked together to ensure Martin's health and social care were appropriately managed?</u>

3.11 In considering the effectiveness of multi-agency working, it may be useful to visualise the number of agencies involved over the 27 months focused on by this review. It is an image which could be reproduced for many, many individuals with care and support needs on the caseloads of health and social care agencies.



Co-ordinating Martin's care effectively would always have been a huge challenge just due to the sheer number of agencies involved. And at the centre of this web

was a man who hated being pressured about what he should do by lots of different people, who insisted on great control about who he would see and on what terms, and who reacted very adversely if he felt he was not being listened to.

3.12 On one level, the answer to the question posed in this key line of enquiry must be that, given the outcome, Martin's health and social care were clearly not appropriately managed. However, it must immediately be emphasised that this was primarily due to Martin not allowing his needs to be appropriately managed.

3.13 The review identifies a number of instances where poor communication, the inflexibility of some agency systems, or inefficiencies led to fragmentation in joint working:

- It was not possible for the District Nursing service to consistently accommodate Martin's need for advance planning of and consent to visits
- There were early communication difficulties with the GP practice, around issues such as the issuing of prescriptions and the supply of dressing packs
- On a number of occasions issues seemed to bounce to and fro between agencies, with delayed or no resolution. The involvement of District Nursing and the Tissue Viability Nurse were delayed for over a month in early 2023 because referrals got lost in the system. There were never resolved issues about Martin getting a wheelchair which he was able to use. The specialist provider charged with executing the removal of Martin's equipment and possessions in January 2025 confused the collection and delivery addresses and would not accept a change without a new order. On 9th January they informed the Occupational Therapist who was dealing with the issue that the move, originally booked for 7th January and rescheduled as a result of the confusion to 10th January, could not now go ahead. This was not resolved, through escalation to senior management, until 8pm on the evening before the scheduled move. (The company has now gone into liquidation.) A GP referral for physiotherapy in early 2025 was rejected because of incomplete information, but the GP was not informed. Martin had expressed keenness for physiotherapy to gain some mobility. The referral had not been successfully progressed by the time of his death.

3.14 It may perhaps be said that some of these sorts of confusions or inflexibilities are inevitable in human systems. However, it is not hard to imagine the impact they had on Martin, who hated being out of control or feeling that he was not being listened to, and was prone to believe that agencies did not value him or take any care in delivering on their promises.

3.15 in many ways front line practitioners did their best to co-ordinate their work and share information. However, apart from discussion in a couple of MDT meetings under the auspices of the Whittington Hospital / Haringey Multi-Agency Care and Coordination Team, there do not appear to have been any occasions when all the agencies involved, including the care and support providers who had raised multiple safeguarding concerns, came together to discuss Martin's rapidly deteriorating condition. As risk increased, the case was never escalated to multi-agency discussion at a senior level to ensure maximum co-ordination, effective multi-agency working, and the sharing of risk.

3.16 Martin's case was never referred to the Haringey Multi-Agency Solutions Panel, which was created "to ensure that professionals working with people experiencing complex needs/high levels of risk are able to access multi-agency creative, problem-solving support." The Panel brings together members with "the appropriate authority to agree actions for and on behalf of [their] organisation or service" from around 15 Haringey agencies across social care, primary and secondary health care, housing, the emergency services, and the voluntary sector. On the face of it Martin's case would have scored the maximum risk rating on the Risk Assessment Decision Matrix contained in the Panel's Terms of Reference[5] in terms of both likelihood and consequence of harm. If it had been so scored, the MASP Terms of Reference suggest it should have led to "an emergency multi-agency strategy meeting to agree immediate actions and make a referral to the Multi-Agency Solutions Panel." At the multi-agency workshop held as part of this review, there was broad agreement that Martin's case should have been referred to the Panel. However, this does not appear to have been considered in any agency. The first recommendation of the Safeguarding Adult Review about Eleanor[6] published by the Safeguarding Adults Board in December 2024 was "Wider awareness raising of the MASP is needed". Analysis of Martin's story re-emphasises the point.

Recommendation 4: In disseminating the learning from this review, the Safeguarding Adults Board should ensure that the role of multi-agency meetings including all partners, including care providers, in responding to high-risk cases of self-neglect is emphasised; and that in particular the potential role of the Multi-Agency Solutions Panel in such cases is highlighted.

<u>What learning can be identified from the assessment of Martin's capacity to make decisions about his care and treatment at key points?</u>

3.17 Throughout the period focused on by this review there are numerous references in the records seen to Martin having capacity to make decisions about his care and treatment, or being "deemed" to have capacity. Apart from those assessments carried out by the London Ambulance Service, the review has seen formal records of five mental capacity assessments:

- 7th March 2023 – assessment completed by CLDN
- 23rd October 2023 – completed by two CLDNs
- 29th October 2024 – completed by CLDN and social worker
- 11th December 2024 – completed by GP
- 13th March 2025 – completed by Tissue Viability Nurse

Each of these assessments, apart from that carried out on the day of his death, concluded that Martin had the capacity to make the decision under consideration – whether that was to consent to or refuse care, treatment, and support, to make decisions about where he should live after he was discharged from hospital, to decide not to take his medication, or to accept or refuse admission to hospital.

[5] https://haringey.gov.uk/sites/default/files/2024-11/terms_of_reference_high_risk_panel.pdf
[6] https://haringey.gov.uk/sites/default/files/2025-03/eleanor-sar-report-2025.pdf

3.18 All these assessments are fully recorded and explicitly address the criteria set out in the Mental Capacity Act: the ability to understand the information relevant to the decision, to retain the information, to weigh or use the information, and to communicate the decision. The conclusions are carefully considered and evidenced. They strongly embed the principle of the individual's right to make unwise decisions. The review does not criticise them or seek to second guess them.

3.19 The London Ambulance Service also carried out a number of mental capacity assessments, when Martin was strongly advised to allow himself to be taken to hospital but he declined. On each occasion the ambulance crew either decided that Martin had the capacity to make that decision, or recorded that a full assessment was not possible as Martin would not engage with them. LAS judgements about capacity are made in a particular context: staff involved will probably have no prior knowledge of the patient, no access to the history, and are operating in an emergency situation under pressure of time for assessment, action, and recording. They may have no opportunity to discuss their assessment with others who know the patient. While the recording of their capacity assessments is inevitably briefer than the other assessments reviewed, the sample recording seen by the reviewer concisely but clearly evidenced Martin's capacity for understanding, retaining and using information, and communicating his decision.

3.20 On occasions the ambulance crew recorded that they were unable to carry out a capacity assessment because Martin would not engage with them. In such circumstances the default position appears to have been to assume capacity. This is consistent with Section 1(2) of the Mental Capacity Act – "A person must be assumed to have capacity unless it is established that he lacks capacity." It might be noted, however, that Section 5 of the Act provides that if:

- someone (for example, a health professional), having taken reasonable steps to establish if an individual lacks capacity, reasonably believes that the individual lacks capacity to agree to an act of care or treatment which it will be in their best interests to carry out (for example, removal to hospital), then
- they do not incur any liability for carrying out that act, unless they do so negligently

3.21 It should also be borne in mind that removing Martin to hospital, in particular without his consent, would have been a major operation. When he was admitted to North Middlesex in March 2023, the assistance of the London Fire Brigade was required to get him out of his flat. In 2024, it would have required at least a bariatric stretcher, a carrying board, a four person crew, and close co-ordination with the hospital to prepare them to receive him.

3.22 The London Ambulance representative on the Review Panel suggested that it would have been helpful if a Universal Care Plan[7] had been drawn up with and for Martin. With access to a UCP, ambulance staff would have been able to access information, not only about his health history, but also about his wishes and

[7] ucp.onelondon.online

preferences, giving them much fuller information to inform their interaction with him. However, no healthcare professional ever created a UCP for Martin. Contributors to the Safeguarding Adult review on Victoria also felt strongly that greater use of the UCP would make a huge impact on highlighting complex patients, sharing information between partners and working proactively to support vulnerable people. This review endorses the recommendation from that earlier review that the Integrated Care Board should promote the wider roll out of the Universal Care Plan across the local healthcare system, and seek to accelerate its take up.

Recommendation 5: The Integrated Care Board should continue to promote the wider roll out of the Universal Care Plan across the local healthcare system, and seek to accelerate its take up.

3.23 The mental capacity assessment on 13th March 2025 concluded that he did not have capacity to make the decision to refuse admission to hospital. He could give no reason for this decision except "I don't want to go", and when asked what he thought would happen if his leg was not treated, having been told that the possible consequences were infection, sepsis and death, replied "I don't know". The initial referral for a Safeguarding Adults Review suggested that the outcome of this assessment potentially called into question the validity of the earlier assessments. This review does not support that suggestion. The responses given by Martin on this last occasion were qualitatively different from his response to earlier assessments. All mental capacity assessments are time and decision specific.

<u>What learning can be identified in how the safeguarding concerns raised with the local authority were responded to?</u>

3.24 At least 14 safeguarding concerns were raised with Haringey's Adult Safeguarding Team between January 2023 and Martin's death in March 2025. They were raised variously by a Community Learning Disabilities Nurse, Vibrance, the Tissue Viability Nurse, the London Ambulance Service, a District Nurse, and the domiciliary care provider.

3.25 The review has identified four occasions on which S42 enquiries were initiated, in January 2023, June 2023, March 2024, and June 2024, often covering a number of concerns raised from different sources. This was an appropriate response. However, this review has already suggested that the focus of most of the enquiries was too exclusively on self-neglect in relation to health, when a more holistic approach would have also considered the risks to which Martin's exceptionally unhygienic, dirty, cluttered and unsafe living conditions exposed him. The S42 enquiry opened in January 2023 was allocated to the CLDN "as this concern is regarding self-neglect of pressure sores". This may also have reflected a policy that if the individual concerned has an allocated worker, the S42 enquiries should be undertaken by that worker. This may not always be appropriate. In this instance, it is questionable whether the person who was already deeply engaged with addressing the concerns which were the subject of the enquiries was best placed to undertake a fresh and independent assessment of the actions in place or which needed to be in place to safeguard the individual. Enquiries should be

allocated to the most appropriate person to undertake them, who will often but not always be the allocated worker.

Recommendation 6: In allocating S42 enquiries, there should be an explicit consideration of who is the most appropriate person to undertake the enquiry, who may or may not be an existing allocated worker.

3.26. The first of the S42 enquiries was closed in March 2023 on the basis that while Martin may have been making unwise decisions, he had the capacity and the right to make those decisions. The record also stated that a safeguarding plan was in place to reduce the risks. The elements of the safeguarding plan were:

- Martin had consented to medication and treatment in the home
- He had also consented to investigations in hospital in the future. However he wanted his wound to heal first.
- He had agreed to contact 999 if there was any further deterioration in his health
- He would like to have support from Vibrance once he is ready. However, he wanted first to focus on his health needs.

All elements of the safeguarding plan depended on assurances from Martin about what he would do or what he would accept in the future. His history, however, did not support great confidence that he would safeguard himself by following through on those assurances.

3.27 The record of the outcome of the S42 enquiry opened in June 2023 was lost when data was transferred in the replacement of the local authority's social care information system with a new one. There is a suggestion that one outcome was to be a referral to mental health services, but no referral was received. The S42 enquiry opened in March 2024 was closed a month later. The rationale was that Martin was now accepting support from his carers, he had agreed to a referral to District Nursing for wound management, and he had agreed to engage with the psychology service within HLDP. Although he did participate in but not complete a number of psychology sessions, in other respects the safeguarding plan did again depend on Martin's assurances about his future intentions. The enquiry opened in June 2024 was closed in October 2024, but the record of the rationale for the closure appears to have been cut and pasted from the closure decision in April.

3.28 Haringey Safeguarding Adults Board has adopted the Pan-London Safeguarding Adults Policy and Procedure[8]. These procedures define two key roles in the management of safeguarding concerns and safeguarding enquiries:

- Safeguarding Adults Manager (SAM): A Safeguarding Adults Manager is the local authority member of staff who manages, makes decisions, provides guidance and has oversight of adult safeguarding concerns that are referred to the local authority, or through the mental health trust where those agreements are in place.

[8] https://haringey.gov.uk/sites/default/files/2024-10/multi-agency-adult-safeguarding-policy-and-procedures-final-.pdf

- Enquiry Officer: An Enquiry Officer is responsible for undertaking actions under statutory adult safeguarding procedures.

In all the S42 enquiries undertaken in the period focused on by this review, it is clear in the records seen who was the Enquiry Officer - the person charged with carrying out the enquiries. However, the review has seen no explicit reference in any of the enquiry records to the role or identity of the SAM – responsible among other things for guiding and directing the Enquiry Officer, and making decisions on closure of the enquiry. Senior management within the adult safeguarding service in Haringey told the reviewer that the nature and responsibility of the SAM role is not always fully understood in Haringey. This is particularly important when the Enquiry Officer is being undertaken by a professional outside of adult social care, as was the case in January 2023.

Recommendation 7: Haringey Adult Social Care should take steps, in training and management oversight, to ensure that the role and responsibility of the Safeguarding Adults Manager is fully understood in all relevant teams and services.

3.29 The reality is that nothing changed as a result of the four separate enquiries undertaken under S42 of the Care Act 2014. The risks were not removed or reduced. Where a rationale is recorded for the closure decisions, it might fairly be said to tend towards a bias toward optimism. What appears to be lacking is any proactive recognition on the part of the adult safeguarding system that although action under S42 had been completed, continuing efforts were needed to find ways to mitigate the high level of ongoing risk. This might have meant, for example, escalating to multi-agency strategy discussion, or referral to the Multi-Agency Solutions Panel. However, this would have required a recognition of the seriousness of the risk to which Martin was exposing himself, which appears to have been lacking on the part of the local authority for much of 2024.

Recommendation 8: When authorising the closure of a S42 enquiry, the Safeguarding Adults Manager must be proactively satisfied that all possible action is being taken to mitigate outstanding risks.

3.30 The reviewer is pleased to note that Haringey Safeguarding Adults Board has reviewed and revised its Self-Neglect and Hoarding Protocol[9] in response to the recommendations of the Safeguarding Adults Review on Victoria. It is disappointing, however, that the flowchart on page 16 of the document continues to state without qualification at the first stage of the safeguarding pathway: "If the adult has mental capacity to make an informed decision, and there is no danger to public health, then that person has the right to make their own choices". To cite the Victoria report:

> "A danger to public health should not be the only basis for responding to self-neglect as a safeguarding concern. The level of risk to which a person is exposing themselves must also be a consideration. This is not in any way to suggest that the use of the S42 safeguarding framework is or should be a way of imposing choices on people that they do not wish to make; but it

[9] https://haringey.gov.uk/sites/default/files/2024-11/haringey_multi-agency_self_neglect_and_hoarding_procedure.pdf

> does suggest persistent multi-agency effort should be made to explore every possible creative and often incremental way in which people might be encouraged to make different choices or to mitigate the harmful impact of some of the choices they are making. This would be an appropriate safeguarding response."

As the SAR on Eleanor[10] published by the Safeguarding Adults Board in December 2024 makes clear, "it is the 'ability to protect themselves' rather than the capacity to make decisions that is the basis for safeguarding legal duties under S42'".

The revised document also repeats the confusion of the previous version when it states on page 19:

> "If an agency is satisfied that the adult has the mental capacity to make an informed decision on the issues raised, then that person has the right to make their own choices. But this should not be seen as an "all or nothing" strategy. It is in these circumstances staff needs to follow the procedures in this document."

It remains unclear what procedures are being referred to.

<u>What learning can be identified about the delivery of the local authority's responsibilities under the Care Act in this case?</u>

3.31 The chronology submitted by Adult Social Care to this review noted that, as a result of Martin's hostility to social workers, "most of his support was provided by Learning Disability health staff prior to January 2023." This remained the case until the latter part of 2024. After a new social worker was allocated to work with Martin in June 2024, there was more active social care involvement.

3.32 Up until this point there was a lack of social care oversight. At the beginning of February 2023 Martin's CLDN wrote to social workers to say, "Further advice in regard to his social care and long-term support would be great." There does not appear to have been a response to this. In mid-April there was a discussion between the CLDN and the social work team in which the CLDN highlighted the need for a social worker to support with discharge planning and a review of his care needs. A social worker was allocated to work with Martin at the end of June. However, on her first meeting with him in hospital, he was so aggressive and abusive towards her that she had to leave the room and felt unable to have further direct contact with him. This made effective discharge and care planning significantly more difficult.

3.33 It was right that Martin's social worker was not expected to tolerate Martin's abusive behaviour. However, in the reviewer's view, adult social care management should have taken steps to consider how in these circumstances active social work involvement could be continued. The situation appears to have been accepted without any attempt at management intervention. The view stated in an email sent in November was simply, "we don't have capacity at the moment to reallocate and the same issues would arise with a different social worker."

[10] https://haringey.gov.uk/sites/default/files/2025-03/eleanor-sar-report-2025.pdf

3.34 In the two years before Martin's admission to hospital in 2023, the local authority complied with the expectations set out in the Care and Support Statutory Guidance[11] relating to an annual review of care and support. Reviews took place in April 2021 and August 2022. For most of 2023 Martin was in hospital. As required by the guidance, a review took place in April 2024, a few weeks after the implementation of a new care package following his discharge from hospital. However, as already noted, this review took little account of the escalating concerns that were already being raised by both Vibrance and the domiciliary care provider, concluding optimistically that "Care package is in place to meet personal care needs, administer medication and carry out activities of daily living which reduces the risk of self-neglect".

3.35 As already noted, there was more active engagement and joint working from mid-2024 onwards, when a new social worker was allocated from a locality team. Up to that point, the responsibilities of the local authority for the oversight and co-ordination of Martin's care and support were effectively delegated to the Community Learning Disability Nurse. There should have been more active social care support and oversight.

<u>What learning can be identified about the relationship between the HLDP and adult mental health services?</u>

3.36 This was identified as a key line of enquiry as it clearly arose in the Victoria SAR and the initial information collated on Martin's experiences suggested that there may have been similar issues in his story. The HLDP includes a Consultant Psychiatrist. The Victoria SAR found that there was a need to review the arrangements for the provision of mental health services for service users under the care of HLDP, to improve their access to specialist mental health services such as the Personality Disorder Team. This was not however an issue in Martin's case. As previously noted, he was subject on two occasions to assessment under the Mental Health Act. He had been offered a number of appointments with the Personality Disorder Team, but failed to keep them. It has however been suggested to the review that for at least some of this time Martin felt unable to leave his flat, which would have meant it was impossible for him to attend office appointments. This raises the question of what reasonable adjustments might have been needed or were made to help facilitate his engagement.

3.37 Martin's GP practice made a referral to adult mental health services in August 2024. It was referred back to the GP on the basis that "There would be no role for us since the patient is open to the LD team" and had a named nurse there. This seems slightly confusing, as the CLDN was not a psychiatric nurse, and Martin was not known to the Consultant Psychiatrist in HLDP. Furthermore, the GP was clearly not aware of the psychiatrist role in HLDP, as he wrote to the CLDN in December 2024 to say "it would be great if you had access to any LD consultants in Haringey (I know there was not one previously) to help and assess M's mental

[11] https://assets.publishing.service.gov.uk/media/5a7dcf2aed915d2ac884dafa/Care-Act-Guidance.pdf

health needs". More dialogue between adult mental health services, the GP, and the HLDP psychiatrist would have been helpful.

4. Conclusions

4.1 This review has emphasised that Martin's way of dealing with his own life and with other people was deeply entrenched over many years by 2023. It is unlikely that by this time any different practice would have fundamentally changed the outcome of his story, even if it might have affected the timing of that outcome. The reviewer recognises that Martin's death was deeply distressing to those who had worked closely with him, some of whom had consistently "gone the extra mile" to trying to help him.

4.2 The review does note what appears on the face of it to have been a lack of urgency in the response to the final crisis. It was clear on Friday 7th March 2025 that his situation was untenable. There was no heating, no electricity, no water in his accommodation, which all other residents had left. He was sleeping on the floor on a pressure mattress that could not be inflated. He was screaming with pain when he moved his leg. He was refusing personal care, medication, pressure sore care, food or drink. An ambulance attended but he refused to go with them to hospital. Martin's social worker and CLDN had already arranged a joint visit for the following Thursday, 13th March, and the CLDN was on leave on the Monday and Tuesday, 10th and 11th. The review cannot judge if, for example, it had been possible to bring that visit forward to the Monday, and the assessment that Martin did not have the capacity to make his own decision about transfer to hospital had been made on that day rather than three days later, his death could have been avoided.

4.3 Even if the eventual outcome could not have been avoided, this review suggests that there are some very significant areas of learning from Martin's story:

- Over the 27-month period focused on by this review, Martin was the subject of multiple safeguarding concerns. S42 enquiries were undertaken and closed, but nothing changed. Not only was the risk not reduced; it continued to escalate. Multiple mental capacity assessments were carried out, and Martin was consistently assessed as having the capacity to make his own decisions, in spite of the hugely harmful and sometimes potentially fatal consequences of those decisions. Healthcare professionals recognised the severity of the risk. It should have been escalated to multi-agency consideration at a senior level, and in particular should have been taken to the Multi-Agency Solutions Panel. A lack of effective risk escalation and use of multi-agency meetings have been consistent themes of Safeguarding Adults Reviews in Haringey since at least 2019 – not just the reviews of the cases of Victoria and Eleanor, but also Steve[12] and Miss Taylor[13].
- Until the allocation of a new social worker in June 2024, adult social care did not sufficiently appreciate the seriousness of Martin's self-neglect and the risks of harm to which he was exposing himself. The focus on his healthcare

[12] https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_steve_2023.pdf
[13] https://haringey.gov.uk/sites/default/files/2024-10/sar_report_ms_taylor_2019_pdf_549kb.pdf

needs, while they were indeed overwhelming, was too exclusive. Responsibility for meeting his care and support needs was almost entirely delegated to health professionals, who did not always receive the social care support that they asked for. There should have been more active social care oversight and support.

- The adult safeguarding system was not sufficiently proactive in identifying outstanding risks at the closure of S42 enquiries and ensuring that continuing action was taken to mitigate them.

4.4 Specific recommendations arising from this review are collated in the next section

5. Recommendations

Recommendation 1: in disseminating the learning from this review, the Safeguarding Adults Board should ensure that the potential role of the Court of Protection in responding to complex and high-risk cases of self-neglect is highlighted.

Recommendation 2: All agencies represented on the Safeguarding Adults Board should review and if necessary strengthen escalation pathways available to front line practitioners and managers carrying high levels of risk, and support and encourage staff to make appropriate use of them.

Recommendation 3: Haringey adult social care should develop a "Need to Know" procedure setting out criteria for cases and issues which must be brought to the attention of the Director of Adult Social Services.

Recommendation 4: In disseminating the learning from this review, the Safeguarding Adults Board should ensure that the role of multi-agency meetings including all partners, including care providers, in responding to high-risk cases of self-neglect is emphasised; and that in particular the potential role of the Multi-Agency Solutions Panel in such cases is highlighted.

Recommendation 5: The Integrated Care Board should continue to promote the wider roll out of the Universal Care Plan across the local healthcare system, and seek to accelerate its take up.

Recommendation 6: In allocating S42 enquiries, there should be an explicit consideration of who is the most appropriate person to undertake the enquiry, who may or may not be an existing allocated worker.

Recommendation 7: Haringey Adult Social Care should take steps, in training and management oversight, to ensure that the role and responsibility of the Safeguarding Adults Manager is fully understood in all relevant teams and services.

Recommendation 8: When authorising the closure of a S42 enquiry, the Safeguarding Adults Manager must be proactively satisfied that all possible action is being taken to mitigate outstanding risks.