SOUTH TYNESIDE SAFEGUARDING ADULTS BOARD

Adult C: The response of partner agencies to self-neglect

Safeguarding Adults Review Executive Summary

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Contents	Page no:
Understanding this report	2
Glossary	2-4
Introduction	5
Terms of Reference	6-7
Synopsis	8-18
Engagement with the family of Adult C	19-20
Analysis	21-32
Findings	33-38
Recommendations	39-42
References	43
Appendix A – Process by which SAR conducted	44-45
Appendix B – SAR Panel members	46

Understanding this report

It is standard practice not to disclose the name of the person or persons about whom a Safeguarding Adults Review (SAR) has been written. In this case the person who is the subject of this SAR will be referred to as Adult C throughout the report.

Adult C received services and support from a number of agencies. The key agencies which provided services and support to Adult C are listed below. Abbreviations are used for some of these agencies throughout the report and these abbreviations are listed alongside the agency name.

- Allied Healthcare
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- North East Ambulance NHS Foundation Trust (NEAS)
- Northumbria Police
- South Tyneside Clinical Commissioning Group
- South Tyneside Council (STC)
- South Tyneside Homes (STH)
- South Tyneside NHS Foundation Trust
- Tyne and Wear Fire and Rescue Service (TWFRS)

Many professionals employed by the above agencies came into contact with Adult C. Professionals are referred to by their job title throughout the report. Sometimes abbreviations are used for job titles such as CPN for Community Psychiatric Nurse. Abbreviations are only introduced after the full job title has been used for the first time. Where more than one person with the same job title came into contact with Adult C, the professionals are also given a number. e.g. CPN 1, CPN 2 etc.

Additionally, a glossary has been provided to define some of the specialist terms used in the report.

Glossary

Adult Duty Team (ADT) The "front door" through which referrals for service from STC Adult Social Care are received and assessed.

Best Interests: If a person has been assessed as lacking mental capacity, then any action taken, or any decision made for, or on behalf, of that person, must be made in his or her best interests. In deciding what is in a person's best interests, the factors to take into account include the individual's past and present wishes and feelings, including beliefs and values likely to have a bearing on the decision.

Care Programme Approach: This is a national system which sets out how "secondary mental health services" should help people with mental illnesses and complex needs.

Depot antipsychotic medication

A special preparation of medication that is used for some types of mental distress or illness, known as psychotic illnesses and which is given by injection. The medication is slowly released into the body over a number of weeks. The injection is usually given into the buttock, because the injection is quite thick, it therefore needs to be given into a large muscle, so that there is less (or no) pain and swelling. Depot medication potentially benefitted Adult C because he only had to have the medicine once a month rather than pills taken daily and as a result he was less likely to forget to take his medicine and become ill as a result.

FACE Risk Profile: ("Functional Analysis of Care Environments") The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.

Home Assessment and Reablement Team (HART) The HART team work with people who have had a recent stroke or who are receiving a care package for the first time. This service can assist a person for up to three months and assess how much service is required, or any potential for reablement, before a service is then commissioned from the private sector for the longer term.

Mental Capacity Act: The Act is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 or over.

Mental Health Act: The 1983 Act (which was substantially amended in 2007) allows people with a mental disorder to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people.

Mini-Mental State Examination (MMSE) is a 30-point questionnaire that is used extensively in clinical and research settings to measure cognitive impairment.

Occupational therapy (OT) is the use of assessment and treatment to develop, recover, or maintain the daily living and work skills of people with a physical, mental, or cognitive disorder.

Reablement: This is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

Safeguarding Adults Review: when someone with care and support needs dies as a result of neglect or abuse and there is concern that the local authority or its partners could have done more to protect them.

Self-Neglect: The statutory guidance which supports the Care Act 2014 defines self-neglect as covering "a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding".

Introduction

1.1 Adult C died on 24th July 2014 in the ground floor flat in South Shields in which he had lived alone for 20 years. At the time of his death he was 82 years of age. His cause of death was an acute myocardial infarction (heart attack) which is believed to have taken place around 7 days prior to his death.

1.2 As a young man he had been diagnosed with schizophrenia and had been detained under the Mental Health Act for a period in the 1960s. He received ongoing treatment and care from this time. Around 1980 he was prescribed depot medication which largely continued until his death.

1.3 Adult C was known to many agencies which, despite substantial contact with him, were unable to prevent him from seriously neglecting himself. He lived in considerable squalor despite periodic "deep cleans" of his flat. However, it should be noted that this Safeguarding Adults Review covers just the final seven years of Adult C's life. Although he experienced mental health issues throughout his adult life, he lived an independent life and held down a job until he retired.

1.4 On 10th November 2014 the South Tyneside Safeguarding Adults Board (ST SAB) decided to commission a Serious Case Review in respect of Adult C.

1.5 The Care Act 2014 came into force on 1st April 2015. The Act provides a statutory basis for Safeguarding Adults Boards and states that one of the three core duties of a Safeguarding Adults Board is to conduct Safeguarding Adults Reviews when the criteria for doing so are met. (1) Although the decision to commission this review took place prior to the introduction of the Care Act 2014, it was decided to refer to the review as a Safeguarding Adults Review. (SAR)

1.6 ST SAB established a Panel to oversee the SAR which carried out an initial assessment of the information held by the agencies which had had contact with Adult C, before agreeing the terms of reference for the SAR and requesting each of the agencies involved to submit detailed chronologies of their involvement with Adult C. These were completed by 1st May 2015.

1.7 On 24th April 2015 ST SAB commissioned David Mellor to fulfil the role of independent author of the SAR Overview Report. He had no previous connection with South Tyneside. He is a retired chief police officer and has been the independent author of several Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.8 ST SAB received and approved the SAR Overview Report and decided to publish this Executive Summary of the Overview Report.

2.0 Terms of Reference

2.1 The SAR Panel consisted of senior managers from the agencies which had contact with Adult C together with the independent author of the SAR overview report. The SAR Panel was chaired by the Business Manager of ST SAB. Following careful consideration of the chronologies of agency involvement with Adult C and consultation with the family of Adult C and their solicitor, the SAR Panel decided on the following terms of reference for this SAR:

Function of the Safeguarding Adults Review

- To establish the lessons learned from the case about the way in which multi agencies operated and worked together to provide care, support and safety for the adult at risk
- To identify how the lessons will be acted upon and what is expected to change as a result – identify opportunities for immediate learning
- To improve interagency working to better safeguard adults at risk of self-neglect and or abuse
- To review the effectiveness of management decision making, thresholds, risk management procedures, safeguarding adults procedures
- To establish what worked well within all agencies
- To monitor the progress of any recommendations from the review

Timescale for the review

All agencies will examine records as far back as 1st January 2008, or from the point that they became involved if this is later. If there is vital information prior to this date that informs the Safeguarding Adults Review, the single agency author can consider the value of including it in the report.

Areas of Focus

- To consider how agencies worked together to ensure the health and social care needs of Adult C were met.
- To what extent did agencies recognise, respect and value Adult C to realise his full potential, removing any discrimination. e.g. specific to his needs, ensuring equal access to opportunities, and valuing his place in society.
- To establish what multi agency arrangements were in place to manage the risks identified.
- To establish what threshold tools and guidance were in place and to what extent escalation occurred when risks appeared to increase?

- To consider what opportunities for multi- agency communication were afforded to allow sharing of information that would lead to necessary responses.
- To establish how concerns in relation to Adult C neglecting himself and his home were identified and managed.
- To consider the effectiveness of Care Programme Approach (CPA) in coordinating the Care and treatment of Adult C.
- To critically evaluate the application of the Safeguarding Adults Framework specifically in relation to concerns of financial abuse.
- To establish how the Mental Capacity Act 2005 and Mental Health Act 1983 were used to ensure Adult C's needs were met and to promote his mental health and wellbeing.
- To review what involvement was considered by professionals with Adult C's family.

3.0 Synopsis

2007

3.1 During September 2007 Northumberland, Tyne and Wear NHS Foundation Trust (NTW) – which specialises in mental health and disability - conducted an assessment of Adult C. At this time he was living alone in his ground floor flat in South Shields where he had lived since 1994. In the assessment, Adult C's mental health was described as stable. He was said to be "fit and healthy- no problems" and that he "keeps himself to himself and rings his niece in North Wales twice a week."

3.2 The NTW assessment described Adult C's home environment as "very sparse and unkempt". Reference was also made to Adult C previously refusing a "home care package" on several occasions. The assessment alluded to a discussion with NTW Consultant 1 who was considering reducing Adult C's depot medication if his mental health remained stable. It was decided to revisit this issue in six months. Meantime NTW Community Psychiatric Nurse (CPN) 1 would continue to visit Adult C at his home address to administer depot medication.

3.3 Depot medication is a special preparation of intra-muscular medication that is used for some types of psychotic illnesses and which is given by injection. The medication is slowly released into the body over a number of weeks. The injection is usually given into the buttock, which was the case with Adult C, because the injection is quite thick, and so it needs to be given into a large muscle, so that there is less (or no) pain and swelling. Depot medication potentially benefitted Adult C because he only had to have the medicine once a month rather than taking pills daily and as a result he was less likely to relapse through forgetting to take his medication. By this time he had been receiving depot medication for approaching thirty years and was keen to stop it.

2008

3.4 During 2008 Adult C's depot medication was reduced gradually until it was stopped altogether in September of that year. After the final depot injection was administered to Adult C, it was planned that NTW Consultant 1 would review the situation in three months. This review took place in December of that year, at which point Adult C's mental health was considered to have remained stable, the risk of relapse was felt to be small and Adult C was considered to present no greater risk than any other elderly man in his situation. Adult C was thus discharged from the care of the NTW Older People's Community Mental Health Team (OPCMHT) and a letter was sent to his GP (GP1), advising him to refer Adult C back if there was any deterioration in his mental health. The letter also advised GP1 that Adult C would benefit from a care package to assist with shopping and housework but noted that he had refused this type of support on the basis that he was able to cope.

3.5 During 2008 CPN1 expressed concern that Adult C was becoming socially isolated but he told CPN1 that he did not see isolation as a problem as he has been a loner all of his life.

2009

3.6 No agency appeared to be in contact with Adult C again until an evening in early June 2009 when the police received a telephone call from one of his neighbours reporting concerns about him. The neighbour said that Adult C's house was "very dirty", his clothing "filthy" and he had no food in his home. As a result, neighbours had been offering him food. The neighbour added that Adult C had been regularly throwing rubbish into the garden, praying on a mat in the street, screaming during the night and earlier that day had been seen playing cricket in the street with an imaginary bat.

3.7 The police attended and spoke to Adult C who said he was fit and well and coping fine. The police made contact with South Tyneside Council (STC) Emergency Duty Team. (EDT)

3.8 The following day GP1 made a home visit to Adult C following contact from STC Adult Social Care and noted that Adult C's clothes were "not very clean", his home and furniture "dirty", his kitchen also looked "dirty" and his cooker looked "very old and unclean". GP1 also noted evidence of memory impairment on the part of Adult C. GP1 appeared to conclude that NTW OPCMHT had not visited him on a three monthly basis and reviewed him as intended. GP1 appeared to have been mistaken on this point as Adult C had been discharged from NTW OPCMHT in December 2008.

3.9 GP 1 subsequently communicated to STC Adult Social Care that Adult C's home was not "liveable" and that he needed to be relocated without delay. GP 1 also recommended that the "Mental Health Team" visit Adult C to assess him.

3.10 In September 2009 an STC Adult Social Care manager and a housing officer visited to establish if Adult C met the criteria for respite care as South Tyneside Homes (STH) "Decent Homes" (Government initiative to bring all Council homes up to a defined decent standard) were planning to undertake a full renovation of his flat. (Apparently "Decent Homes" had declined to undertake this work six years earlier as the property had been assessed as a health hazard by environmental health at that time.) They made some progress in encouraging Adult C to move into respite to enable the renovation of his flat to take place.

3.11 A referral in respect of a fire risk was made in October 2009. Tyne and Wear Fire and Rescue Service (TWFRS) has no evidence of any referral although they subsequently carried out a home safety check later in the month.

3.12 Also in October 2009 an Approved Social Worker, NTW Consultant 2 and Doctor 1 completed a Mental Health Act assessment of Adult C and concluded that there was insufficient justification to detain him under the Mental Health Act. The behaviours earlier described by neighbours suggested a possible relapse of his symptoms of schizophrenia. He was not considered to be at risk of harming himself or others and they concluded he could continue to be managed in the community. He was referred back to NTW OPCMHT so that his mental state and level of functioning could be further assessed in order to determine how best to manage his condition.

3.13 Later in October 2009 TWFRS categorised Adult C as "very high risk" on the grounds of age, open plan flat, a smoker, poor housekeeping with no smoke detection. (The risk factors considered did not include Adult C's mental health.) Two smoke detectors were fitted in his flat.

3.14 The same month NTW CPN1 visited Adult C and reiterated her concern that he had become isolated. Adult C said he had lost his niece's contact details. She also noted Adult C's clothing to be extremely dirty, his feet were black and toe nails curled over. His home environment was noted to be very dirty and the appliances old and rusted. The floor in the sitting room was very sticky, the bath was dirty but appeared to have been used recently. She gained the impression that Adult C had experienced a late relapse of schizophrenia. His memory appeared intact, scoring 22/30 on the Mini Mental State Examination (MMSE), a score which suggested mild cognitive impairment. She recorded him to have capacity.

3.15 NTW Consultant 1 subsequently decided to restart depot medication although Adult C was reported to be "adamant" that he saw no need for it to be recommenced.

2010

3.16 In February 2010 the police responded to a 999 from Adult C's home. It appeared that he may have dialled the number accidentally whilst unplugging the phone. The oven grill and all rings were noted to be switched on – in order to heat the house according to Adult C. A Vulnerable Adult referral form was completed by police.

3.17 In April 2010 Adult C agreed to go into Chichester Court Care Home in South Shields for 3 weeks in order for his flat to be renovated. (Previously referred to in Paragraph 3.10) Whilst there he declined the offer of home carers to help prepare meals when he returned to his flat. His stay at Chichester Court extended until mid-June 2010 to facilitate deep clean, redecoration, electrical repairs and installation of a cooker and washing machine. The renovation was jointly funded by STH and STC.

2011

3.18 In February 2011 NTW Consultant 1 reviewed Adult C and considered him to be mentally stable but expressed concern about Adult C's self-care and the condition of his flat. NTW made a referral to STC Adult Social Care but they (STC) closed Adult C's file after staff made many unsuccessful attempts to contact him via his telephone which Adult C was known to unplug when not in use.

3.19 On a visit to Adult C to administer depot medication later the same month, NTW CPN 8 noted that he looked dishevelled and unshaven but noted that this was his usual presentation and reflected a "lifestyle choice" by Adult C which was "well documented".

3.20 In June 2011 NTW CPN 8 was told by a neighbour that there had been a fire in Adult C's flat at 5am the previous morning which had set off the smoke alarm. When the neighbour had tried to gain access to Adult C's flat he wouldn't let him in. The neighbour expressed concern as they lived above Adult C's flat and had a young child. The neighbour also described what NTW CPN 8 took to be a general deterioration in Adult C's mental health, mentioning that he was hiding things in the garden and coming out of his flat half naked.

3.21 It is unclear how serious the fire in Adult C's flat had been, or indeed if there had actually been a fire. NTW CPN 8 stated that she saw no fire damage and Adult C denied there had been a fire. TWFRS had no record of being called out to such a fire. NTW CPN 8 also carried out a Mental Health Assessment and a MMSE and concluded that Adult C was not dementing and had full capacity.

3.22 She also requested a home visit from Adult C's GP and arranged for further monitoring, assessment and follow up by her service and STC adult social care. The response of STC Adult Social Care Social Work Assistant 1 was that they had carried out two assessments during the previous year and there had been no changes in Adult C, who had continued to decline support from social services, and so they were unwilling to make a further visit to assess Adult C.

3.23 NTW Consultant 1 proposed a case conference to bring the relevant assessments of Adult C to the table but his did not happen.

2012

3.24 In January 2012 CPN 8 carried out a home visit to Adult C and used the FACE risk assessment tool to assess the risks of severe self-neglect, domestic risk and isolation as "1" (low apparent risk) although "susceptibility to infection" had emerged as a current risk due to Adult C's poor home environment. (The FACE risk profile consists of a numeric rating for risks ranging from 0 (no apparent risk) to 4 (serious and imminent risk)).

3.25 In April 2012 NTW CPN 9 used the FACE risk profile to assess Adult C's risk of severe self-neglect as "2" (significant) which required a contingency risk management plan, but no plan was drawn up. During this visit Adult C agreed to consider getting someone in to help him clean up. This does not appear to have been followed up nor was Adult C's agreement to have someone tidy up his flat when visited by NTW Community Support Worker (SUP) 1 and South Tyneside Homes Housing Officer 1 the following month.

3.26 In August 2012, STH Housing Officer 2 made a safeguarding alert in respect of financial abuse following an anonymous allegation from a neighbour. The alleged abuser was Neighbour 2, who STH staff did not visit alone because of risks associated with violence and drug addiction. Mental Health, Social Care and Supported Housing gathered information before concluding that there was insufficient evidence to indicate that money was being taken. It appears that Adult C was involved in the decision-making about this safeguarding alert which STC felt precluded the need to contact his niece in North wales at that time.

3.27 Following a joint visit to Adult C by NTW CPN 9 and SUP 1 the same month, he agreed to a further deep clean of his flat. His fridge was noted to be in a dirty state and fears were expressed that Adult C was putting himself at risk of food poisoning.

3.28 In November 2012 NTW CPN 9 was approached by a neighbour as she left Adult C's home, who alleged that others who were taking advantage of him. Later the same month a safeguarding referral was completed in respect of Adult C and sent to STC Adult Social Care. No further details of this safeguarding referral have been found.

2013

3.29 In January 2013 the police received a call from a neighbour to say that three males posing as gas men had knocked on Adult C's door and when he answered, one had rushed past him into the flat. The police attended to investigate. Adult C had £300 in cash in his flat which had not been stolen. The police made a referral to STC Adult Social Care in view of Adult C's "mental health, living conditions and possible inability to care for himself".

3.30 The incident prompted a joint visit by NTW CPN 9 and SUP 2. They asked Adult C if it was time for him to accept help with housework and shopping which he declined although he said he would think about it. Later in January 2013 a STC Adult Social Care Senior Practitioner appeared to take the view that this "bogus caller" offence was an isolated incident and concluded that there were no safeguarding issues. She tried and failed to contact Adult C via his unplugged telephone.

3.31 Later in January 2013 North East Ambulance Service (NEAS) attended an incident at Adult C's flat in which it had been reported that two men had knocked on his door and whilst one of them covered his mouth and pushed him inside the flat, the other entered the flat and "robbed him". The police attended to investigate the matter and also installed a panic alarm in Adult C's flat. However, the police subsequently concluded that the second illegal entry into Adult C's flat did not happen and that Adult C reported the matter having become confused.

3.32 However this second alleged incident prompted a visit by STC Social Worker 1 and on this occasion Adult C agreed to open a bank account having declined to do so previously and also acknowledged that "it would be nice to have some help". There is no evidence that this latter comment was followed up. (Adult C's family say they are unaware of any bank account. It is presumed that the reference to bank account relates to the post office account into which Adult C's pension was paid weekly)

3.33 The deep clean first discussed in August 2012 (Paragraph 3.27) had still not taken place by the following April 2013. That month NTW CPN 10 contacted STC Adult Social Care about the renovations and was advised that they would begin shortly as STC had made a referral to The Soldiers, Sailors, Airmen and Families Association (SSAFA), a charity which supports members of the armed forces and their families, which had agreed to fund the work. STC Adult Social Care added that, with Adult C's agreement, services would be put in to teach C how to take care of himself and improve the quality of his life.

3.34 In June 2013 South Tyneside Homes visited Adult C and formed the view that he had "seriously deteriorated." He was seen to be wearing a pair of trousers tied with a rope and a coat although he was wearing nothing underneath the coat. The flat was described as filthy with the floors full of mud, mould throughout and the walls and fixtures were also described as filthy. When the state of the flat was raised with him, Adult C said that it was spotless and that he cleaned it every day. The South Tyneside Homes worker completed a "concern matters" referral.

3.35 Following on from the "concern matters" referral, in July 2013, South Tyneside Homes conducted a joint visit to Adult C with STC Social Worker 1 and found the property to be in a "terrible" condition. Adult C was wearing a female's jumper back to front and inside out. The fridge could not be closed and all food inside was rotten. Adult C had been making cups of tea in his oven and also frying sausages in a frying pan in the oven. This was considered to be a "huge fire risk". It was also recognised that Adult C needed to be encouraged to refrain from pouring thick "flash" cleaning fluid on the floor which only made matters worse as the dirt stuck to it. Whilst they were there two neighbours approached them and expressed concerns about Adult C. They described how he kept leaving the house as though he had somewhere to go,

then forgetting and returning home. He was stated to knock on his neighbour's door through the night asking them to change his TV channel. When the workers returned to Adult C, he came to the door naked saying he needed a bath. STC Social Worker 1 stated that Adult C needs would not be met by providing domestic support and that he needed to be "reassessed". (There is no record of any referral to TW FRS in respect of the "huge fire risk".)

3.36 By August 2013 the deep clean of Adult C's flat had still not begun as a result, apparently, of STC Social Worker 1's "overwhelming case load". However, STC Social Worker 1 planned to persuade Adult C to accept respite care whilst his flat was cleaned and to activate the STC Home Assessment and Reablement Team (HART) to assist Adult C with food preparation for 6-8 weeks following his return to the flat. STC Social Worker 1 was also hoping to fund home care cleaning for a period after Adult C returned. Additionally, he said he would arrange a financial assessment for Adult C as he could be eligible for Attendance Allowance which could cover the cost of home carers. (The outcome of the financial assessment was that, because of the relatively low income he received, he would not to be charged for any home support STC commissioned.)

3.37 A joint visit to Adult C by NTW CPN 12 and STC Social Worker 1 the following day found that when his fridge door was opened, flies flew out. The FACE risk profile generated a score of "3" (serious risk) for severe self-neglect. This should have triggered the drawing up and implementing of a risk management plan. It is not clear whether this happened or not.

3.38 Later in August 2013 GP 2 made a home visit to Adult C at the request of an NTW CPN as a result of concerns about his weight loss. (7 stones 12 pounds at that time) GP 2 concluded that Adult C was a threat to himself and that he had no insight into his self-neglect or did have insight, but would not engage.

3.39 In September 2013 NTW Consultant 3 assessed Adult C's mental capacity, concluding that he lacked capacity for his psychiatric treatment, physical health and social situation as he was unable to comprehend, retain or weigh and use information. The plan in place for Adult C's mental health care and treatment would have been updated to reflect his lack of capacity for his psychiatric treatment but no "best interest" decision was recorded, nor was there timely communication of the assessments to other agencies who would have been responsible for the necessary "best interest" decisions.

3.40 In late September 2013 HART services reported that there was evidence that there had been a fire in Adult C's kitchen. Apparently it smelled of smoke and the door was blackened. HART services state they made a referral to TWFRS which that service has no record of receiving.

3.41 The long awaited deep clean of Adult C's flat took place at the beginning of October 2013 but when he returned home later that month, the flat remained undecorated, the cooker had not been replaced as planned and more could have been done to bring it up to a liveable standard according to NTW SUP 1. However, HART Carers began visiting him at mealtimes which Adult C expressed gratitude for.

3.42 At the beginning of November 2013 a Lead Professionals Review meeting was held in respect of Adult C but only NTW CPN 9 and an NTW team manager attended. The plan envisaged the regular monitoring of Adult C's mood, medication for benefits and side effects, assessment of risks and liaison with family members.

3.43 That same month NTW CPN 9 made a home visit to Adult C and found his door wide open. She found him in a neighbouring block of flats trying to contact Neighbour 3. CPN 9 spoke to Neighbour 3 and Neighbour 1 who expressed concerns for Adult C. Neighbour 1 said she shopped for Adult C, made mention of him keeping an envelope containing £700 in the flat and added that there were a few people in the area who were taking advantage of him financially. CPN 9 used the FACE risk profile to assess his risk of abuse/ exploitation by others as "3" or "serious risk". A risk management plan should have been drawn up and implemented but this does not appear to have been done, nor was a safeguarding alert made in respect of possible financial abuse.

3.44 NTW CPN 9 noted that Adult C's living conditions had improved since the deep clean but considered the current situation less than ideal and deteriorating, including a continued risk of infection due to poor hygiene.

3.45 In late November 2013 NTW Consultant 3, NTW CPN 9 and STC Social Worker 1 jointly visited Adult C. Neighbour 3 again raised concerns about Adult C's management of money, his apparent lack of insight into his confused state and constant requests for help with his TV. Adult C's home was noted to be more hygienic but evidence of deterioration was apparent. Residential care was discussed but Adult C was adamant he wanted to stay in his own home and NTW Consultant 3 felt that Adult C had capacity to make this decision. STC Social Worker 1 agreed to request an increase in the care package referred to in the following paragraph. Adult C's niece strongly feels that her uncle needed residential care by this stage and feels that stronger efforts should have been made to persuade him to accept this option.

3.46 In December 2013 STC Social Worker 1 sought approval for a care package for Adult C consisting of carers calling 3 times daily, 7 days per week for meal preparation, personal care and dressing, with an additional half hour per day Monday to Friday for domestic assistance (cleaning the flat) and an additional two hours on Wednesday for shopping and assistance with laundry if necessary. STC Social Worker 1 said he intended to contact the Tenancy Support team to request support for finances and bills. There is no evidence that this happened.

2014

3.47 A care package was provided by Allied Healthcare from February 2014. However Adult C began refusing Allied Healthcare carers access and one of the company's carers logged a concern that he was living in squalid conditions and that carers were unable to gain regular access to his flat. This concern was escalated to STC Adult Social Care.

3.48 Concerns about Adult C continued to escalate and in March 2014 an Allied Healthcare carer expressed concerns that Adult C had no food in his cupboards or fridge. The carer had apparently shopped for food for Adult C on several occasions but recently Adult C had not let him shop for him, saying he had no money for food. The carer said he had been unable to raise these concerns with STC Social Worker 1 as he was on sick leave.

3.49 In April 2014 an Allied Healthcare Field Care Supervisor expressed "grave concerns" about the upkeep of Adult C's flat, lack of food and money. The Field Care Supervisor passed an electricity bill for £460 and a phone bill to STC Social Worker 1 and expressed concerns that Adult C was being financially abused on the grounds that he did not have money for food and that money appeared to have gone missing from his flat. (Adult C's family say they can't understand how a single person living in a small one bedroom flat could generate such a large electricity bill and wonder why effective action wasn't taken to intercede on Adult C's behalf.)

3.50 In June 2014 the Allied Healthcare Field Care Supervisor again logged concerns about severe lack of food, unkempt appearance, run down living conditions and possible financial abuse of Adult C with STC Social Worker 1. The same month Adult C told the Allied Healthcare Field Care Supervisor that a neighbour had taken his microwave back to the shop to be fixed and had later informed him that it was not possible to fix it. The Field Care Supervisor established that the microwave was not broken, was only two months old and was under guarantee.

3.51 Also in June 2014 Allied Healthcare Field Care Supervisor and STC Social Worker 1 made a joint visit to Adult C after which STC Social Worker 1 agreed to a financial assessment of Adult C and another deep clean of his flat. Adult C declined the help of carers to collect his pension and do his shopping, preferring to leave these tasks with his neighbours.

3.52 Later the same month NTW Consultant 4 visited Adult C and decided to prescribe Olanzapine to be taken orally following representations from Adult C that he no longer wished to receive the monthly depot injections as he said they left him with a sore back, adversely affecting his mobility. His carers were to be asked to prompt Adult C to take his medication and CPN's would monitor the situation. NTW

Consultant 4 also wrote to STC Adult Social Care to request a reassessment of Adult C's care package.

July 2014

3.53 On 4th July 2014 the Allied Healthcare Field Care Supervisor noted that Adult C was living off bread and coffee so the Field Care Supervisor began taking meals from his own home for Adult C. STC Social Worker 1 advised Allied Healthcare that a "review meeting" in respect of Adult C was scheduled for the following week but there is no record of such a meeting taking place.

3.54 On 17th July 2014 NTW CPN 17 visited Adult C at home. He had not yet started on his new medication because it was yet to be prescribed by his GP. (CPN 17 later contacted the GP and a prescription was issued the following day.) NTW CPN 17 felt that a safe would be necessary to store the medication in Adult C's flat. A neighbour advised NTW CPN 17 that Neighbour 1 was suspected of financially abusing Adult C on the grounds that she never used to have money but now she had money and Adult C never had any.

3.55 The following day NTW CPN 17 discussed the potential financial abuse of Adult C with STC Social Work Assistant 2, who said she was aware of the allegations about Neighbour 1 and was planning to investigate further. When it became clear that Social Work Assistant 2 had not made a safeguarding alert in respect of the matter, CPN 17 said she would make an alert if Social Worker Assistant 2 did not do so.

3.56 At 11.55am on 21st July 2014 police and NEAS were called by an Allied Healthcare carer who was unable to gain access to Adult C's flat and saw him lying on his bed, apparently unresponsive. When NEAS arrived, Adult C came to the door and said he had been sleeping. The NEAS crew completed a safeguarding adult referral form on the basis that Adult C lived in squalor, his flat posed a significant risk to him, he had mental health problems and did not appear to be eating or drinking properly. It is assumed that NEAS obtained this information from the Allied Healthcare carer.

3.57 The following day GP 2 made a home visit to Adult C after calling the previous afternoon and not receiving a reply. Adult C refused hospital admission but GP 2 did not think C could retain information to make this decision. GP 2 decided to obtain bloods in order to ascertain how pressing the grounds for admission to hospital were.

3.58 The bloods were obtained by a district nursing assistant who visited Adult C the next day - 23rd July 2014. The same day STC Social Work Assistant 2 met with her manager and explained that in her opinion Adult C lacked capacity around his living conditions and health. The STC Social Work Assistant 2 was advised to make a

mental health assessment referral as soon as possible. This mental health assessment referral led to a telephone conversation between NTW CPN 17 and an Approved Mental Health Practitioner later the same day. During the discussion reference was made to the bloods requested by GP 1 which he intended to review on 24th July (the next day) with a view to using the Mental Health Act or the Mental Capacity Act for admission to hospital.

3.59 NTW CPNs 17 and 18 visited Adult C later on 23rd July 2014. They found it difficult to assess Adult C's capacity as he would not engage in conversation. He did not seem to understand the possible consequences of not seeking medical treatment. Hospital admission was discussed with him but he kept repeating "I'm alright, I'm alright". And when the conversation turned to his lack of money and food he became irritable and asked CPNs 17 and 18 to leave.

3.60 The same day NTW CPN 17 phoned GP 1 to advise him of the visit. GP 1 confirmed he was awaiting the blood results which would arrive the following day. NTW Consultant 4 was made aware of the situation.

3.61 At 11.16am on 24th July 2014 an Allied Healthcare carer made an emergency telephone call to police and NEAS stating she was unable to access Adult C's flat and had observed him to be lying face down on his bed. Despite banging on the window and door, the carer said Adult C remained unresponsive. The police forced entry to the flat and found Adult C to be dead.

4.0 Engagement with the family of Adult C

4.1 At the time of his death Adult C was in contact only with his niece who lives in North Wales. It is understood that Adult C maintained contact with his niece by phoning her weekly although this ceased around two months prior to his death. His niece was unable to phone Adult C because he appeared to keep his phone unplugged when not in use.

4.2 Adult C's niece has contributed to this review. She described the strong relationship Adult C had with her mother (Adult C's sister) until her death in 1988. Adult C's sister had moved away from the North East many years previously and Adult C would travel to see her and her family and stay in their home in Middlesex. He would sometimes arrive unannounced having hitched lifts in order to get there. Other visits appear to have been planned, as Adult C would bring prescriptions for his depot injections. Adult C's niece said that her mother would often "kit him out" in new clothes. Apparently Adult C had been quite particular about his appearance at one time but he became unkempt. His niece described how he would damage his clothes with his cigarettes or by spilling coffee on them because his hands shook.

4.3 Adult C's niece said that after her mother died in 1988, she assumed responsibility for keeping in touch with her uncle. Once or twice a year, he would catch the train to her home in North Wales and stay with her and her family. His niece would "clean him up" by washing all of his clothes which were often grubby or stained.

4.4 This continued until 2007 when he made his final visit. His niece said that he seemed unable to take care of himself that year. For the first time she was unable to persuade him to take his hat or clothes off in order to clean them.

4.5 Adult C's niece became seriously ill in 2008 so it was not possible for Adult C to stay with her that year. He never visited her again after that despite the fact that she invited him again in 2009 after her health had recovered. She doesn't know why he never returned to North Wales.

4.6 Thereafter she maintained weekly telephone contact with her uncle. As stated in Paragraph 4.1, he always rang her from his flat. She says he always told her that everything was fine. This arrangement altered in the latter months of his life when Adult C began to ring her from Neighbour 1's phone. Adult C explained that his own phone had been cut off. (Adult C appears to have had difficulty in paying a phone bill to Virgin in the final months of his life and on 9th May 2014 told CPN 15 that he had not got the money to pay his phone bill and was happy for Virgin to cut him off as he was able to use his neighbour's phone) His niece says that she heard nothing from him after May 2014 – two months prior to his death.

4.7 After she was advised of her uncle's death, Adult C's niece travelled to South Shields to sort out his affairs with her husband and son. She said that she had been warned by Adult C's social worker to "prepare herself for a shock" when she visited her uncle's flat. She said that they were appalled at the state of it and her husband and son later returned to take photographs and a video recording which she subsequently shared with the SAR Panel. They say that as well as being extremely dirty throughout, there was an overpowering smell of cigarette smoke. They saw "thousands" of marks where cigarettes had been stubbed out on the walls.

5.0 Analysis

5.1 In this section of the report the "Areas of Focus" from the SAR Terms of Reference are used to analyse the effectiveness or otherwise of agency involvement with Adult C.

To consider how agencies worked together to ensure the health and social care needs of Adult C were met.

5.2 There is much evidence of sound partnership working to try and ensure Adult C's health and social care needs were met. NTW was the single agency which was most engaged with Adult C for the period covered by the SAR. NTW worked effectively with Adult C's GPs throughout this period. However, when the decision was taken by NTW to reduce, and then cease, Adult C's medication in 2008, Adult C was discharged from the care of the NTW OPCMT to his GP. From the date of his discharge from NTW OPCMT on 11th December 2008 until the police received a call from a neighbour to express concerns about Adult C on 8th June 2009, no agency was in contact with Adult C. By this time, it appears that Adult C's mental health had deteriorated. At this point Adult C's GP appeared to have had inaccurate expectations of NTW continuing to monitor Adult C, when in fact Adult C had been discharged from the care of NTW OPCMT and the GP had been advised of this by letter. Given that NTW had properly discharged Adult C and given that his GP would only proactively contact Adult C for an annual recall, does the poor outcome for Adult C suggest that there should be any service "in between" NTW and the GP or that in such circumstances GP services should be more proactive in monitoring the mental health of service users such as Adult C?

5.3 NTW and STC did not work together well on a consistent basis. There were periods when STC were extremely engaged with Adult C and during those periods there is ample evidence of STC and NTW collaborating quite effectively. However, there were occasions on which NTW was obliged to challenge STC on issues such as the delayed deep clean of Adult C's flat which finally commenced in October 2013 after being first considered in August 2012, although STC state that the first involvement they had in arranging this deep clean was when they approached SSAFA to fund it in February 2013.

5.4 If NTW, STC and Adult C's GP can be seen as the "core" partners in working together to support Adult C over the period covered by this SAR, Allied Healthcare became a core partner after they were commissioned to provide domiciliary care to Adult C for the last six months of his life. Their involvement in Adult C's life was not successful. It is clear that they found Adult C a very challenging and an increasingly vulnerable service user to support. They appear to have raised numerous concerns with STC with little impact, or effective managerial intervention on the part of Allied Healthcare. However, evidence of Allied Healthcare and STC working effectively

together is not abundant. Nor is there a great deal of evidence of STC, as commissioners of the service provided by Allied Healthcare, monitoring the provision of that service with adequate rigour.

5.5 The SAR Panel take the view that Allied Healthcare failed to deliver the services they were commissioned to provide. The independent author concurs with this view but considers that Adult C's entrenched behaviours, the previous lack of success of any agency in improving Adult C's living conditions and the previous rapid deterioration in his living conditions following successive deep cleans were mitigating factors.

5.6 South Tyneside Homes as landlord provided Adult C with much individual attention and did some effective joint working with South Tyneside Council on occasions but appear to have been somewhat peripheral and not as proactive as they might have been in engaging with the core partners or in escalating concerns.

5.7 The police could have played a more significant role if they had been informed of the safeguarding alerts about financial abuse of Adult C or been engaged in the mounting concerns of financial abuse which emerged as Adult C became increasingly vulnerable in the final months of his life.

5.8 The fire risk posed by Adult C's habits periodically came to the fore over the period of the SAR. Concerns don't always appear to have been communicated with, or recorded by Tyne and Wear FRS, and when they were, it is unclear whether sufficient information was shared to fully inform the risk assessments carried out by Tyne and Wear FRS.

5.9 The standard methods of working together were by letter, telephone or email. There were some very effective joint visits but multi-agency meetings, at which accumulating concerns could be shared, were extremely rare. It is unclear why this was the case. There were occasions when practitioners appeared to be on the verge of actually calling a meeting only for it to fail to materialise. Given the challenges involved in working effectively with people who self-neglect, the absence of evidence based options for addressing self-neglect at that time and the isolation, powerlessness and frustration that practitioners working in this area can feel, it seems odd that convening a multi-agency meeting did not become a sufficiently attractive option. When one considers the investment of time and resources various agencies committed to supporting Adult C over a prolonged period, the absence of multi-agency meetings becomes even more inexplicable.

5.10 The lack of any multi-agency meetings to share information, review risks, consider options etc. may also have limited the opportunity for practitioners to challenge one another.

5.11 On reading this report, Adult C's family expressed surprise at the amount of involvement various agencies had in his life. They said they had previously thought that Adult C had been "forgotten about" and "fallen under the radar". However, they felt that agencies could have worked together better. They felt that too many interventions were "non-productive".

To what extent did agencies recognise, respect and value Adult C to realise his full potential, removing any discrimination. e.g. specific to his needs, ensuring equal access to opportunities, and valuing his place in society.

5.12 Adult C was of white British ethnic origin.

5.13 Practitioners from all agencies respected Adult C's views, wishes, feelings and beliefs. One of the principles of the Care Act 2014 is that "considering the person's views and wishes is critical to a person-centred system. Local authorities should not ignore or downplay the importance of a person's own opinions in relation to their life and their care". (Although the Care Act 2014 came into force after the death of Adult C, considering the person's views and wishes has been an important principle in adult social care for some time.)

5.14 Adult C described himself as a loner and appeared to wish to be left to live his life in the way he wanted to live it. In so far as it was possible to respect this wish, practitioners did so. Practitioners needed to take into account the impact of his behaviour on others and there is much evidence of them listening to the concerns expressed by neighbours about the fire risk he posed for example.

5.15 When practitioners intervened in his life more assertively, such as those occasions when it was decided to arrange a deep clean of his flat, every effort was made to encourage him into suitable respite accommodation to enable the necessary work to be done.

5.16 At times, practitioners demonstrated a high degree of empathy for Adult C. An example was when NTW decided to reduce, then cease, his depot medication. He had been enduring this injection in his buttock every month for over three and half decades. NTW were sensitive to the impact of these injections as he became older and frailer and made every effort to see if he could manage without them.

5.17 NTW point out that people with a mental illness often experience stigma. Although there is no direct evidence that Adult C's mental illness affected the way in which he was viewed by any agency which had contact with him, it is possible that what was perceived to be his "odd behaviour" might have been seen as a barrier to effective engagement with him.

5.18 An issue for practitioners involved in this case to reflect upon is whether sufficient attention was paid to Adult C's right to dignity. The Care Act 2014 – which as previously stated did not come into force until after Adult C's death - places a duty on Local Authorities to promote wellbeing. Wellbeing is defined broadly by the act but includes "personal dignity" and "suitability of living accommodation". "Dignity in care" has been a prominent issue in safeguarding adults for many years. The description of Adult C's daily life in his final years is distressing to read at times and calls into question whether personal dignity received sufficient emphasis. (See paragraph 6.3)

5.19 Adult C's family raised concerns about Adult C's dignity and asked why it was not possible to obtain some additional clothing for their uncle when he was seen to be wearing a pair of trousers tied with a rope and a coat with no shirt or vest underneath it. (Paragraph 3.34)

To establish what multi agency arrangements were in place to manage the risks identified.

To establish what threshold tools and guidance were in place and to what extent escalation occurred when risks appeared to increase?

5.20 As both of these terms of reference relate to risk, they will be considered together.

5.21 Partner agencies became aware of the risks Adult C posed to himself and others primarily through their contact with Adult C and as a result of contact with his neighbours who frequently expressed concerns about Adult C to visiting practitioners.

5.22 Partners used a variety of methods to assess risks in respect of Adult C. The most frequently used risk assessment tool used was the FACE risk profile employed by NTW. This tool includes 43 risk factors grouped under five headings , "clinical symptoms indicative of risk", "behaviour indicative of risk", "treatment related indicators", "forensic history", and "personal circumstances indicative of risk". Several of the 43 factors were, or became relevant to Adult C such as "severe self-neglect" and "isolation". The factors are assessed against a five point numeric scale of 0 – 4 with 0 denoting "no apparent risk", 1 denoting "low apparent risk", 2 denoting "significant risk", 3 denoting "serious risk" and 4 denoting "serious imminent risk".

5.23 A score of 1 or "low apparent risk" triggers no specific action as it is assumed that required precautions are covered by standard care plans. However as the scores escalate, specific plans are required. A score of 2 or "significant risk" requires a contingency risk management plan whilst a score of 3 or "serious risk" requires a risk

management plan to be drawn up and implemented. Adult C was never assessed at 4 or "serious and imminent risk" but the response triggered by a score of 4 is the highest priority being given to risk prevention.

5.24 There is clear evidence that NTW staff regularly utilised the FACE risk profile on a planned basis and in response to changes in presentation or following incidents in accordance with Trust policy. Where justified, practitioners adjusted the level of assessed risk and the NTW IMR author states that when actions were required to be undertaken as a result of the risk assessment these were documented and implemented.

5.25 However it is not always clear from the evidence whether the relevant plan triggered by an increase in risk was implemented. For example the risk of "severe self-neglect was raised to 2 ("significant") in April 2012 and then 3 ("serious") but it is unclear whether the contingency risk management plan required for a score of 2 or the risk management plan required for a score of 3 were drawn up and implemented. NTW contend that the lack of engagement of partner agencies in multi-agency risk assessment hampered the effective utilisation of the FACE risk profile.

5.26 Additionally the FACE risk profile was not helpful in assessing the fire risk Adult C appeared to pose to others. The only reference to fire in the FACE profile is the risk factor "fire-setting" which seems to require intent which was never present in Adult C's case. There is a factor entitled "reckless or unsafe behaviour" which might have encompassed the risk of fire, but this factor does not appear to have been considered. NTW contend that the fire risk posed by Adult C was assessed under risk to self and others. If this is the case, then it is not explicit in the records shared with this review.

5.27 The risk of fire was separately assessed by Tyne and Wear FRS. In October 2009 they categorised Adult C as "very high risk" on the grounds of age, open plan flat, a smoker, poor housekeeping with no smoke detection. However, there is no mention that Adult C's mental health was considered as a factor, or whether the FRS were aware of his mental health needs.

5.28 In February 2010 Tyne and Wear FRS concluded that Adult C was then medium risk following a Home Safety Check, two smoke detectors having been fitted since their previous risk assessment. (However unsafe practices such as using his cooker for heating were not mentioned.)

5.29 The FRS risk assessments did not always appear to be consistent with each other and did not appear to take account of all relevant factors. However, a challenge to all of the risk assessments carried out in respect of Adult C is that they were carried out by individual agencies in accordance with their individual policies.

Were the risk assessments sufficiently informed by the information held and the expertise available within partner agencies?

5.30 The STC IMR author acknowledges that Social Workers engaged in risk management of Adult C at times but that "there was little in the way of formal tools to manage the risks". And where risk management tools were used, they were not always employed effectively. For example, when STC Social Worker 1 looked to close Adult C's case in September 2012, he completed a risk management plan. It is clearly good practice to consider risk at the point of case closure. The risk management plan includes twelve potential areas of risk including "self-neglect", which inexplicably was not identified as a risk and the case was closed. The risk management plan was not signed off by a manager which it should have been.

5.31 There was good evidence of escalation of concerns within NTW with consultants engaged at key points in decision making. This is in contrast to STC where the extensive chronology of their involvement with Adult C contains just two occasions when his case was escalated to managerial level.

5.32 Allied Healthcare carers had much contact with Adult C during his final months and frequently raised concerns about Adult C with STC as commissioners of the domiciliary care service they were providing to him. They did not appear to have any policy or process in place to escalate their concerns as opposed to repeatedly logging them.

To consider what opportunities for multi-agency communication were afforded to allow sharing of information that would lead to necessary responses.

5.33 Information sharing between agencies could have been improved. As previously stated there was an absence of agencies meeting to share information together and agencies which could have contributed more substantially remained on the periphery such as South Tyneside Homes, Tyne and Wear FRS and the police.

5.34 Internal agency communication could also have been improved. Times without number, practitioners attempted to contact Adult C by phone despite the fact that it was well known and documented that he unplugged his telephone when not in use.

5.35 Recording of information appears to have been problematic at times. As a result of this SAR, STC has made several single-agency recommendations to improve recording of information. Also referrals were apparently made by one agency which were either not received or recorded – and therefore not actioned – by the receiving agency on occasions.

To establish how concerns in relation to Adult C neglecting himself and his home were identified and managed.

5.36 The statutory guidance which supports the Care Act 2014 defines self-neglect as covering "a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding". (2) The statutory guidance includes it as one of ten forms of abuse or neglect which could give rise to a safeguarding concern. (3)

5.37 During the period of time covered by this SAR, self-neglect became an increasingly prominent issue for practitioners. However, whilst self-neglect was clearly referenced in the risk assessment tools used by NTW and STC to assess the risks to Adult C, there appears to have been an absence of specific policy, pathways or indeed training in respect of self-neglect.

5.38 It is clear that practitioners found Adult C's case very challenging to deal with. However, the frequent description of his self-neglect as a "lifestyle choice" betrayed an attitude of mind which was not conducive to searching for potential solutions.

5.39 The solution which practitioners turned to regularly was organising a deep clean of Adult C's flat. This was a solution which was only successful in the short term. Unless Adult C would agree to receiving support, then the gains achieved from successive deep cleans were quickly squandered. Practitioners recognised this and made persistent efforts to persuade Adult C to accept help. Practitioners also recognised the opportunities which "crises", such as the one, or possibly two, break-ins to Adult C's flat presented to try and influence him to accept more help.

5.40 When Adult C finally accepted help, the domiciliary care package commissioned by STC did not achieve the desired improvement in the quality of Adult C's life. The STC IMR is critical of the service provided, stating "it is difficult to comprehend how despite providing 13.5 hours of care per week including 1 hour weekly for cleaning that the property could have been in such disarray". This criticism is echoed by the family of Adult C.

5.41 As the chronologies completed for this review reveal, there was no shortage of agency involvement in Adult C's life. So what might have helped practitioners to more successfully address Adult C's self-neglect? This question is addressed from Paragraph 6.18 onwards.

To consider the effectiveness of Care Programme Approach in coordinating the Care and treatment of Adult C.

5.42 The Care Programme Approach (CPA) is a national system which sets out how "secondary mental health services" should help people with mental illnesses and complex needs.

5.43 Adult C received "secondary mental health services" for most of the period covered by this review from the NTW Older Peoples Community Mental Health Team (OPCMT) but his case was not managed under CPA arrangements.

5.44 In 2007 Adult C was managed under "Standard Care Co-ordination" as his presenting mental health was stable and effectively managed with the provision of monthly depot medication.

5.45 The author of the NTW IMR discussed care co-ordination management with the NTW NHS Trust Care Co-ordination Lead and reviewed the decision referred to in Paragraph 5.44 in line with the Care Co-ordination Policy and associated Practice Guidance note for Older People. The Lead advised that in 2007 there was a change in Department of Health Policy resulting in the removal of the term "Standard Care Co-ordination".

5.46 The criteria for "enhanced need" which would justify CPA in Older Peoples Services requires:

- evidence of severe mental disorder with a high degree of clinical complexity,
- significant risk to self or others requiring immediate assessment and treatment,
- mental health needs having significant impact on activities of daily living,
- current or potential risks including self-neglect,
- multiple service provision.

5.47 The judgement of the NTW IMR author is that Adult C did not meet these criteria on the grounds that his case did not involve a high degree of clinical complexity, his mental health did not significantly impact on Adult C's activities of daily living and Adult C did not pose significant risks to himself or others. The NTW IMR author recognised that Adult C presented with increasing self-neglect but this was not thought to be due to Adult C's mental health condition and would have been insufficient on its own to increase care co-ordination to "enhanced need". However the NTW IMR author acknowledges that it would be reasonable to say that it is not clear why C lived the way that he did.

5.48 However it was deemed necessary to provide Adult C with a support worker for the purpose of increasing the monitoring of his mental health and wellbeing, to encourage him to accept help from other services, and to assist in improving rapport with professionals. The NTW IMR author concludes that this did not increase the need to provide Adult C with enhanced care co-ordination.

5.49 Adult C was also allocated a named nurse who undertook the role of lead professional and was responsible for liaising with other agencies as needed in relation to Adult C's social and physical health care needs.

5.50 The Department of Health guidance on CPA (4) emphasises the importance of continuing to review the care needs of people receiving secondary mental health services. Clearly NTW reviewed the needs of Adult C on a regular basis and adjusted the services he received in order to better meet his needs on several occasions during the review period. Whilst respecting the view of the NTW IMR author, there appears to be a case for Adult C edging closer to meeting the "enhanced need" criteria as his self-neglect became more and more pronounced. The independent author is not a clinician but asks if one could not exclude the possibility that Adult C's mental health condition was a factor in his self-neglect, should his increasingly severe self-neglect not have led to a review of whether his case should have been managed under CPA arrangements?

To critically evaluate the application of the Safeguarding Adults Framework specifically in relation to concerns of financial abuse.

5.51 The South Tyneside Safeguarding Adults Framework: Multi-Agency Procedures was published in 2009. (5) The framework stresses the importance of making safeguarding alerts immediately should anyone suspect abuse or neglect. The framework also advises that alerts can also be made without an incident taking place, if there are concerns that a person is at risk and action is necessary to prevent harm. Failure to make an alert is regarded as a failure in a person's duty of care to the adult concerned.

5.52 A safeguarding alert was made in respect of financial abuse in August 2012 but the police were not notified. The Safeguarding Adults Framework states that where there are suspicions that a crime may have taken place, the police should be contacted immediately. This didn't happen on this occasion.

5.53 A safeguarding referral was made by STC in November 2012. It has not been possible to ascertain what this refers to - which suggests that recording of safeguarding referrals may not be as effective as it should be.

5.54 In January 2013 a STC Adult Social Care senior practitioner appeared to take the view that the "bogus caller" break-in to Adult C's flat was an isolated incident and concluded that there were no safeguarding issues. This is a conclusion which it is difficult to comprehend.

5.55 The second alleged break-in at Adult C's flat later in January 2013 (Paragraph 3.31) was not recorded as a crime by the police after interviewing Adult C. There was no independent evidence to support Adult C's account and they concluded that Adult C had reported the second break-in after becoming confused. The police do not appear to have consulted partner agencies before deciding not to record the crime. Given Adult C's mental health needs, the confusion he exhibited and his vulnerability, it might have been prudent to err on the side of caution and record the

second alleged break-in as a crime. Not recording it meant that safeguarding issues were not further considered. And as we have seen it enabled agencies to take the view that the earlier break-in was an isolated incident when it is possible that it wasn't.

5.56 The synopsis makes clear that concerns about potential financial abuse of Adult C began to accumulate in the last year of his life at a time when it was known that he kept large amounts of cash in his flat. (When Adult C went into respite care in October 2013, STC took £1078.62 from his flat into safe keeping. By the end of that month the cash in Adult C's flat had shrunk to £240, although he had had some bills to pay in the interim.) None of the concerns about financial abuse appear to have generated safeguarding alerts and as late as 14th July 2014 (10 days before Adult C's death) there appears to have been conflict or confusion over who should make a referral in respect of suspected financial abuse. None of the accumulating concerns about financial abuse were shared with the police.

5.57 Adult C's family question how secure Adult C's flat was. They say that when they visited the flat after his death there was no safety chain on the front door which was secured by what they regarded as an insubstantial single lock.

To establish how the Mental Capacity Act 2005 and Mental Health Act 1983 were used to ensure Adult C's needs were met and to promote his Mental Health and Wellbeing.

5.58 In relation to the use of the Mental Health Act, the clinical opinion was that Adult C did not require assessment or admission under the Act during the time frame reviewed. This was because his mental health remained predominantly stable and effectively managed through the treatment plan in place.

5.59 There are numerous references to Adult C having mental capacity to make decisions about his care. However, with the exception of NTW Consultant 3's assessment in September 2013 the rationale as to how the decision was reached was not recorded.

5.60 In general practitioners appeared to assume that Adult C had capacity (as the Mental Capacity Act requires them to do) to make decisions although it was apparent to practitioners that Adult C did not appear to appreciate or recognise the concerns raised by staff in relation to his self–care, home environment or his mental health.

5.61 The capacity assessments completed would have been better supported with written evidence, with specific focus on Adult C's ability to weigh up the risks of decisions he was making to support his very clear wishes and desires.

5.62 However when Adult C's mental capacity was more formally recorded by NTW Consultant 3 (in September 2013) there is no evident Best Interest Decision made or recorded, or timely communication of the assessments to other agencies who would have been responsible for the necessary Best Interest Decisions in respect of Adult C's lack of capacity in respect of physical care and home environment. These decisions should have been shared with Adult C's GP and STC social worker on the day of completion to allow for necessary Best Interest Decision Making.

5.63 Almost three months later (in November 2013) NTW Consultant 3 felt that Adult C had got the capacity at this time to decline residential care which demonstrates that mental capacity assessments are specific to the date on which they are completed and that mental capacity can fluctuate.

5.64 Attempts to assess whether Adult C had capacity to decide whether to be admitted to hospital following the concerns expressed about his health 3 days before he died (21st July 2014) could have been handled more confidently. If ambulance service staff have any doubts about whether a patient lacks capacity to consent to treatment, they should complete a written assessment. On completion of this assessment, if the patient is deemed to lack capacity then the ambulance crew can make a decision on what is the least restrictive option and best interests for the patient. On this occasion the NEAS Paramedic did not complete the assessment on the basis that the carer present advised that this was Adult C's "normal state", that he "could be difficult to talk to" and was "very wary of people he did not know".

5.65 Adult C's GP also appeared to be unsure how best to proceed at this point, given Adult C's refusal to be admitted to hospital. The GP did not feel Adult C could appropriately process the information provided to him and his replies to questions was in one word answers only which did not give the impression he understood fully what he was being asked. However instead of carrying out an assessment of Adult C's mental capacity, the GP requested blood tests to be taken to try and determine which condition might be responsible for his apparent lack of capacity.

To review what involvement was considered by professionals with Adult C's family.

5.66 There is no record that any agency involved in the care and support of Adult C made contact with his family at any time during the period covered by this SAR. There is no indication that Adult C's family initiated any contact with any of the agencies providing care and support to Adult C. Adult C's niece states that she tried to contact his GP after receiving a telephone call from Neighbour 1 which caused her concern. However, either the incorrect spelling of Adult C's GP's name was provided or she wrote the name down incorrectly. As a result she was unable to locate Adult C's GP and made no contact with him. As stated in Paragraph 4.1 above Adult C maintained contact with his niece in North Wales by telephoning her weekly from his

flat. She was unable to phone her uncle because of his habit of unplugging his phone when it was not in use.

5.67 Adult C's niece found an A4 size piece of paper in her Uncle's flat following his death, on which her telephone number was written. She confirmed that she was never contacted by any of the organisations involved in caring for and supporting Adult C and says she simply can't understand why this was the case. However, Adult C's family accept that they may have allowed concerns about Adult C to have gone to the "back of their minds" and now feel that they should have made contact with his social worker.

5.68 Not all agencies had recorded details of Adult C's next of kin, but where they had recorded the contact details of Adult C's niece, the approach of practitioners was only to contact her if Adult C consented to this course of action. A STC Social Worker who had worked with Adult C states that Adult C had shared his niece's contact details with him but Adult C was a private person and when he asked if he (the Social Worker) could discuss Adult C's situation with the niece he was advised by Adult C he was not to do this. The Social Worker said it was not appropriate to go against Adult C's wishes.

5.69 The Lead Professionals Review meeting held in November 2013 (Paragraph 3.42) generated a plan in respect of Adult C which included an action for CPN's to liaise with the family. It is assumed that this action was not implemented because to do so would not be in accordance with Adult C's wishes. (Adult C's family can't understand why they were not contacted if this was a specific action in the plan.)

5.70 There could have been opportunities to contact Adult C's family at times when he was particularly vulnerable such as the one or possibly two occasions on which men forced their way into his flat intending to steal.

5.71 Additionally as Adult C became increasingly frail and vulnerable, efforts might have been made to try and obtain his consent to contact them. Adult C proved himself to be very resistant to efforts to persuade him to consider doing things he was not minded to do, but there are examples in this review of occasions on which he did eventually change his stance. It is conceivable that he might have been persuaded to agree to his relative being contacted, but it is accepted that this was probably not an issue it was appropriate for practitioners to make a high priority, given that fact that his relatives lived some distance away and did not visit him.

6.0 Findings

6.1 The developing body of research into self-neglect provides a useful framework for deepening understanding of the case of Adult C and may provide valuable pointers to action which could improve practice.

6.2 Researchers Suzy Braye, David Orr and Michael Preston-Shoot (6) have produced the following reports over recent years which have greatly contributed to our understanding of self-neglect:

- "Self-neglect and adult safeguarding: findings from research". (2011)
- "A scoping study of workforce development for self-neglect work". (2013)
- "Self-neglect policy and practice: building an evidence base for adult social care". (2014)
- "Learning lessons about self-neglect? An analysis of serious case reviews". (2015)

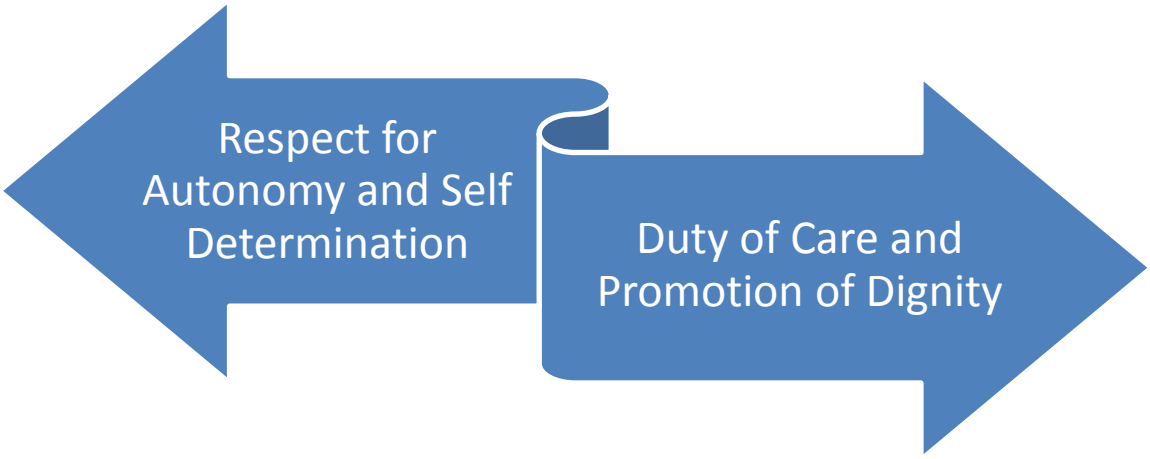
6.3 The research highlights a number of challenges presented by self-neglect, many of which were present in this case. The challenges highlighted include:

- Competing Moral Imperatives
- Physical, Mental and Social factors including personal history
- Complex interplay of inability and unwillingness
- Integrated, parallel or missing inter-agency communication
- Nobody 's or somebody else's business
- Mental Capacity
- Workflow patterns
- Little evidence of effective interventions

I will address how each of these challenges revealed themselves in Adult C's case:

The challenges of self-neglect:

Competing moral imperatives:



6.4 Looking at the competing moral imperatives of "respect for autonomy and self-determination" and "duty of care and promotion of dignity" as a continuum, it could be quite revealing to place the approach adopted by agencies in South Tyneside to providing care and support to Adult C at an appropriate place on the above continuum. This is not an easy task given the large volume of single and multi-agency interactions with Adult C, but on the whole the South Tyneside approach appears to be located closer to the "respect for autonomy and self-determination" end of the continuum.

6.5 If it is accepted that the approach adopted in respect of Adult C is closer to "respect for autonomy and self-determination" than "duty of care and promotion of dignity", is that an appropriate place on the continuum to occupy and if a shift towards "duty of care and promotion of dignity" was desired, what steps would be needed to accomplish this?

6.6 In Adult C's case these steps might have included adopting a more assertive approach including confident use of the Mental Capacity Act, multi-agency panels at which information about risks was shared and outcomes for Adult C discussed, investing in building a relationship where Adult C might have been prepared to disclose what had happened in his life which had led to the circumstances in which he now found himself, more consistent engagement by South Tyneside Council in which premature case closure was avoided and more dogged persistence generally.

Physical, mental and social factors plus personal history

6.7 It is not known to what extent Adult C's "personal history" was explored but NTW have confirmed that in their records he is known to have served in the Merchant Navy as a young man which may offer some explanation for his tendency to put things away in drawers – and even the oven - including persistently unplugging the telephone, storing it away and only getting it out when it was necessary to plug it in to use it. This may have been the accepted way of life on board ship.

6.8 Additionally Adult C has never married. It is not known whether he has had relationships with women. His family think it unlikely and Adult C described himself as a "loner". Living with another person invariably involves a degree of compromise which can lead to quite significant adjustments in lifestyle. If Adult C has rarely had to adjust his lifestyle to accommodate the needs and preferences of another, this may offer a partial explanation of why he was so resistant to changing his habits.

6.9 Investing in building a relationship with self-neglecting service users like Adult C may reveal something of their personal history which may in turn yield insights into how they might be motivated to change their habits.

Complex interplay of inability and unwillingness

6.10 The research suggests that either inability or unwillingness can be features of self-neglect cases and that both can often be present. Inability and unwillingness are interlinked, and can be indistinguishable where unwillingness arises from the care and support needs of the individual.

6.11 In Adult C's case he consistently articulated his unwillingness to accept help. He also appeared to lack the ability to keep himself and his home clean. His attempts at cleaning were largely ineffective although he appeared to believe otherwise. For example, when South Tyneside Homes visited him in his flat in June 2013 they found the property to be filthy with the floors full of mud and mould throughout. In addition, the walls and fixtures were described as filthy. Adult C responded by stating that the property was spotless and that he cleaned it every day.

Integrated, parallel or absent inter agency communication

6.12 There was an abundance of inter agency communication in Adult C's case. Such communication was sometimes absent when referrals appear to have been omitted, safeguarding alerts not made or mental capacity assessments not passed on to relevant partner agencies. However, the amount of inter agency communication achieved less than it should have done because it was not integrated which would have been much easier to achieve if partner agencies had convened and attended meetings and shared information, particularly information about risk.

Nobody's or somebody else's business

6.13 There were indications of a "nobody's business" when some agencies disengaged with Adult C for periods but primarily there is a sense that Adult C was "somebody else's business". NTW staff appeared to feel that their partners all too often regarded Adult C as primarily NTW's business. Although there is good evidence of joint working at times, perhaps what is lacking in this case is sufficient evidence that Adult C's self-neglect was "everybody's business".

Mental capacity

6.14 As previously stated, when situations arose in which use of the Mental Capacity Act was justified, the outcome of an assessment was not shared and on other occasions practitioners appeared to lack confidence.

Workflow patterns

6.15 The self-neglect research suggests that the Adult Social Care "care management models" are based on a time limited journey through a series of stages, which does not allow for the kind of work which will secure engagement of the service user. There is some evidence of this in Adult C's case particularly when Adult Social Care disengaged. However, the more or less continuous involvement of NTW allowed the opportunity to secure engagement on the part of Adult C. There is an abundance of evidence of positive engagement with NTW CPN's and Community Support Workers, although their primary objective appeared to be helping Adult C maintain stable mental health.

Little evidence of effective interventions

6.16 There is not a large repository of evidence of the types of interventions which appear to be effective in addressing self-neglect. In Adult C's case the most significant interventions were periodic deep cleans of his flat which were successful only in the short term. However, the lack of success of this intervention did not appear to deter agencies from choosing the option again, which probably reinforces the paucity of self-neglect interventions with a track record of effectiveness.

Learning from previous self-neglect Serious Case Reviews:

6.17 The research identifies six broad areas of learning from an analysis of SCR of cases involving self-neglect. These are:

- Unclear interface with safeguarding
- Lack of co-ordination between agencies
- Poor understanding of legal rules
- Capacity assessments insufficient
- Failures of support and challenge

- Guidance missing or incomplete

6.18 In Adult C's case each of these broad areas of learning appear to be present in that the interface with safeguarding in respect of the growing evidence of financial abuse was weak; co-ordination between agencies was undermined by a lack of multi-agency meetings; understanding of the Mental Capacity Act was stronger in some quarters than others: Capacity assessments sometimes went unrecorded and a key assessment was not shared; challenge was generally lacking with virtually no escalation to managerial level in one core agency; and there was an absence of a self-neglect policy framework.

6.19 The self-neglect research has identified a number of approaches which appear to have led to positive outcomes as articulated through interviews with service users, practitioners and managers.

Service users' views on what helps achieve positive outcomes:

- Respectful, timely engagement
- Intervention delivered through relationship: connection, emotional literacy and trust
- Support relevant to the service user's own perception of needs

Practitioners' views on what helps achieve positive outcomes:

- Self-neglect work feels lonely, helpless, frustrating and risky
- Collaborative work is essential
- Effective practice involves understanding of motivational approaches, mental capacity and legal rules; Qualities of persistence, (Adult C's niece recounts that when he visited her in Wales she would have a fresh set of clothes waiting for him and when he refused to remove his soiled clothing for her to wash, she simply persisted until he eventually agreed) patience, resilience, modesty of expectation, respectful curiosity, respect and honesty; Finding the latitude for agreement , however tiny and starting there (In Adult C's case partner agencies were sometimes very quick to identify and act upon opportunities to make progress but on other occasions, opportunities were missed or responded to with insufficient urgency. However Adult C not infrequently changed his mind after initially indicating he would be open to greater support) ; balance of hands-off and hands-on approaches, knowing which when; Finding value in small achievements, recognising what is being given up

Managers' views on what helps achieve positive outcomes:

- The importance of strategic infrastructure such as shared strategic ownership, referral pathways and data to inform strategic policy development

- Turning strategic commitment into operational reality through workforce development, guidance, training, supervision; New approaches to workflow: organisational learning and service improvement mechanisms

7.0 Recommendations

Self-Neglect Policy Framework and Training

7.1 During the period covered by this Safeguarding Adults Review, there appeared to be an absence of a self-neglect policy framework to guide practitioners.

Recommendation 1:

South Tyneside Safeguarding Adults Board should seek assurance that all partner agencies and all providers of local services to adults with care and support needs have a framework in place, and training to support that framework, which addresses self-neglect.

Recommendation 2:

South Tyneside Safeguarding Adults Board should explore the possibility of the design of a pathway for self-neglect cases which enables decisions over funding for support to be expedited very quickly where an opportunity presents itself to intervene positively in the person's life.

Speedy investment here could save much greater resources further along the line.

Recommendation 3:

South Tyneside Safeguarding Adults Board should ensure that the experiences of partner agencies in attempting to provide care and treatment to Adult C is used as a case study to inform single and multi-agency training on self-neglect.

Financial Abuse

7.2 Concerns that Adult C was being financially abused escalated in the final year of his life. The response of practitioners to these concerns was generally weak and not in accordance with the Safeguarding Adults Framework.

Recommendation 4:

South Tyneside Safeguarding Adults Board should obtain assurance that partner agencies take all necessary steps to ensure that their staff are made aware of their responsibilities in respect of financial abuse within the South Tyneside Safeguarding Adults Framework.

Dignity

7.3 It may be helpful for the South Tyneside Safeguarding Adults Board to reflect on the "respect for autonomy and self-determination" and "duty of care and promotion of dignity" continuum referred to in Paragraph 6.3 and consider how they might obtain assurance that a greater emphasis on duty of care and dignity was becoming a feature of professional practice in addressing self-neglect. Paragraph 6.6 suggests ways in which dignity in care could have been a more prominent feature of Adult C's case such as adopting a more assertive approach including confident use of the Mental Capacity Act, multi-agency panels at which information about risks was shared and outcomes for Adult C discussed, investing in building a relationship where Adult C might have been prepared to disclose what had happened in his life which had led to the circumstances in which he now found himself, more consistent engagement by South Tyneside Council in which premature case closure was avoided and more dogged persistence was demonstrated generally. The Board could gain assurance by receiving case studies of self-neglect cases chosen at random. Adult C's family strongly feel that the life he was leading in his final years was not a dignified way to live.

Recommendation 5:

South Tyneside Safeguarding Adults Board should seek assurance that "duty of care and promotion of dignity" considerations become more prominent in professional practice in addressing self-neglect.

Multi-Agency Working

7.4 Multi-agency working was not a strong feature of this case. (Paragraph 5.9) The absence of a Care Programme Approach in this case does not explain this adequately. There were several occasions when there may have been considerable benefit in agencies involved in Adult C's life meeting to share information and ensure their plans complemented each other. Such meetings would also have allowed greater opportunity for challenge than was evident in this case.

Recommendation 6:

That multi-agency working should be an integral part of the approach to Self-Neglect in South Tyneside. South Tyneside Safeguarding Adults Board should seek assurance that this is the norm rather than the exception.

Mental Capacity Act

7.5 The case strongly suggests that practitioners across a number of agencies did not use the Mental Capacity Act well. Often Mental Capacity assessments went unrecorded. On occasions the outcomes of Mental Capacity assessments were not communicated to agencies which needed to carry out prompt Best Interests assessments. In some cases practitioners appeared to lack confidence in their use of the Act.

Recommendation 7:

South Tyneside Safeguarding Adults Board should seek assurance that all partner agencies working with adults with care and support needs (and young people of 16 and over) provide their staff with the training and support necessary to enable them to confidently make appropriate use of the Mental Capacity Act. The Safeguarding Adults Board should also seek assurance that those partner agencies actively monitor the use of the Mental Capacity Act by their staff.

Risk Assessment

7.6 The approach to assessing and mitigating risks in Adult C's case was entirely single agency in focus. This may be linked to the absence of multi-agency working in this case. Had partner agencies met to discuss adult C, then it is possible that risk assessments might have been shared.

7.7 One area in which the narrow single agency approach to risk assessment was a particular problem was in assessing fire risk. Fire risk and self-neglect is a concern, particularly when hoarding is also a feature of the self-neglect – which it was not in Adult C's case. However, risk assessments of Adult C's mental health appeared to pay insufficient attention to the risk of him inadvertently causing a fire whilst the FRS's home safety checks appeared to take insufficient account of Adult C's mental health.

Recommendation 8:

South Tyneside Safeguarding Adults Board should seek assurance that the risk assessments carried out by individual agencies are sufficiently holistic in design and application or, at the very least, they are sufficiently informed by partner risk assessments.

Domiciliary Care

7.8 The care package commissioned by South Tyneside Council was ineffective in supporting Adult C. This was always going to be a very challenging assignment for the provider, Allied Healthcare. Adult C had resisted a package of care for years. His behaviours were entrenched. He lacked insight into his circumstances. South Tyneside Council may wish to consider commissioning arrangements for care packages for service users who are self-neglecting and consider an enhanced specification which includes approaches to self-neglect which are beginning to emerge from research.

Recommendation 9:

South Tyneside Council should seek assurance that where support is commissioned for adults who neglect themselves, that support is sufficient to meet their needs. Additionally, South Tyneside Council should seek assurance that domiciliary care providers have undertaken training in relation to self-neglect, that their staff have the knowledge and skills necessary to work with individuals who neglect themselves and that they have appropriate mechanisms in place to escalate any concerns which arise.

Escalation process to raise professional concerns

7.9 During the course of this SAR, it became apparent that no formal arrangements currently exist for escalating the concerns of partner agencies where there is a professional disagreement or conflict between partner agencies in respect of any safeguarding adults issues. There are many ways to resolve such conflicts informally or through formal processes such as contract monitoring. However the SAR Panel felt that the lack of a formal mechanism for resolving occasional professional disagreement in adult safeguarding cases was a gap which ought to be filled.

Recommendation 10:

South Tyneside Safeguarding Adults Board should consider developing a formal process to resolve professional disagreements which arise in safeguarding adults cases.

References

(1) Care and Support Statutory Guidance Department of Health (2014) Para 14.107 – duty and Paras 14.133 and 134 re SAR criteria retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

(2) Ibid

(3) Ibid

(4) Refocussing the Care Programme Approach: Policy and Positive Practice Guidance; March 2008, Department of Health retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

(5) South Tyneside Safeguarding Adults Framework: Multi-Agency Procedures (2009) retrieved from http://www.southtyneside.gov.uk/CHttpHandler.ashx?id=18203&p=0

(6) Braye, S., Orr, D. and Preston-Shoot, M. Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care. London: Social Care Institute for Excellence. http://www.scie.org.uk/publications/reports/report69.asp

(7) SAR Executive Summary A South Tyneside Adults Safeguarding Board retrieved from http://www.southtyneside.gov.uk/CHttpHandler.ashx?id=27360&p=0

(8) Ibid

(9) Ibid

Appendix A – Process by which the SAR was conducted

South Tyneside Safeguarding Adults Board (ST SAB) decided to commission a Serious Case Review on 10th November 2014.

The Care Act 2014 came into force on 1st April 2015. The Act provides a statutory basis for Safeguarding Adults Boards and states that one of the three core duties of a Safeguarding Adults Boards is to conduct Safeguarding Adults Reviews when the criteria for doing so are met. Although the decision to commission this review took place prior to the introduction of the Care Act 2014, it was decided to refer to it as a Safeguarding Adults Review. (SAR)

ST SAB established a Panel to oversee the SAR which carried out an initial assessment of the information held by the agencies which had had contact with Adult C before drafting terms of reference for the SAR and requesting each of the agencies involved to submit detailed chronologies of their involvement with Adult C.

Chronologies were commissioned from the following agencies:

- Allied Healthcare
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- North East Ambulance NHS Foundation Trust (NEAS)
- Northumbria Police
- South Tyneside Clinical Commissioning Group (CCG)
- South Tyneside Council (STC)
- South Tyneside Homes (STH)
- South Tyneside NHS Foundation Trust
- Tyne and Wear Fire and Rescue Service TWFRS)

Chronologies were submitted on 1st May 2015 and these were used by the SAR Panel to finalise the terms of reference. At this point the family of Adult C was consulted on the terms of reference.

The above agencies then submitted individual management reports (IMR) by 17th July 2015. These IMRs analysed the involvement of the agency with Adult C and identified learning and prepared single agency action plans to address any areas for development.

The SAR Panel held a meeting with the authors of all the agency IMRs at which the authors were challenged on their findings and the terms of reference questions were further explored.

The independent author then prepared the SAR overview report and the SAR Panel commented on each draft prepared. Additionally the independent author shared a late draft of the SCR overview report with the family of Adult C, whose comments

were incorporated into the final draft of the report which was presented to the ST SAB on 20th November 2015.

Appendix B – SAR Panel members

Role	Organisation
Safeguarding Adults Board Business Manager (Chair)	Safeguarding Adults Board
Service Manager for Older People & Physical Disabilities	South Tyneside Council, Adult Social Care
Housing Plus Service Manager	South Tyneside Homes
Head of Safeguarding	South Tyneside Clinical Commissioning Group
Named Professional for Safeguarding Vulnerable Groups (Adult)	North East Ambulance Service
Lead Safeguarding Nurse	South Tyneside NHS Foundation Trust
District Manager for South Tyneside	Tyne and Wear Fire and Rescue Service
Head of Safeguarding and Public Protection	Northumbria Tyne and Wear NHS Foundation Trust
Care Delivery Director	Allied Healthcare
Detective Chief Inspector	Northumbria Police
Branch Manager	Allied Healthcare
David Mellor	Independent Author