1. Introduction

This summary report was presented to the Redbridge Safeguarding Adults Board on 26th June 2018. The Board agreed all the recommendations.

This Safeguarding Adults Review was commissioned by the then Chair of the Redbridge Safeguarding Adults Board (SAB) in December 2016. Dr Paul Kingston, Professor of Ageing and Mental Health at the University of Chester, Chair of the Wigan Children and Adults Safeguarding Board, Chair of the Royal British Legion Safeguarding Forum, Home Office Expert Advisor on the Disclosure and Barring Scheme (adult protection), and Chair of the NHS Safeguarding Adults National Network was commissioned to produce an independent report on the case.

Following receipt of Dr Kingston's draft report, agencies involved in the case were then given an opportunity to identify what they believed to be any factual inaccuracies in the report. Having considered these, Dr Kingston submitted his final report in May 2018.

A SAR Panel, with representatives from the Safeguarding and Adult Protection Team, the integrated Health and Social Services (HASS) service, the hospital social work service, BHRUT, the London Fire Brigade, and LBR Housing Service, met on 15th June 2018 to consider Dr Kingston's report. Dr Kingston was in attendance. This report summarises the discussions of the Panel, the areas of learning that the Panel identified arising from this review, and the Panel's recommendations to the Safeguarding Adults Board.

2. A brief outline of the facts of the case

2.1 Mr B was 72 years old at the time of his death. He lived alone. On 1st September 2016, following a report from a neighbour who heard him calling for help, he was found in his bath, in which he had been stuck for three days, by the police and the London Fire Brigade. He was taken to King George Hospital by the London Ambulance Service and was admitted to hospital. He was discharged from hospital on 22.9.16. On 8.11.16, following a report of a fire in his home, he was found dead in his bedroom of a heart attack. During this attack, he had fallen into an electric fire which had caused a fire in the property. However, no smoke was found in his lungs, suggesting that he was dead before the fire started. The cause of death was determined to be heart disease

2.2 From December 2009 onwards, Mr B had a number of hospital admissions or attendances, for a variety of reasons including leg ulcers, congestive cardiac failure, atrial fibrillation, and kidney injury. On one admission in April 2015, his home was described as 'unkempt'. A later admission in July 2016 was triggered by a fall in public after self-reported consumption of six beers. On this occasion he was again described in the hospital record as 'unkempt'. No safeguarding referrals or other referrals to social care were made on any of these occasions, and he was not known to social care services before his admission on 1.9.16.

2.3 The London Ambulance Service completed a welfare concern form on arriving at hospital with Mr B on 1.9.16, and the ward made a safeguarding referral to the hospital social work team on 2.9.16. The reasons for the safeguarding referral were recorded as:

"Patient admitted to hospital presenting complaint of being found in the bath after three days, patient was very unkempt, known to have type 2 diabetes, lives alone and no carers, patient has leaking bilateral leg ulcers, bruises all over body and swollen scrotum"

The police, who had attended when Mr B was found in the bath, submitted a 'Notification of Pre-Assessment Checklist' on 2.9.16 via the adults.alert mailbox. The report stated:

'This is one of the worst condition premises I have ever seen, it is clearly a breeding ground for all manner of disease and bacteria and is not in a habitable state. The carpets were all rotten; wall paper peeling from the walls, there was a strong smell of faeces and urine. A newspaper on the mat near the front door was yellow in colour and was dated October 5th 2007! In my opinion subject clearly needs some intervention from Social Services with his living conditions as they are very bad and not a fit environment for somebody to live in'.

2.4 The management decision of the hospital social work team was that no further action should be taken under safeguarding procedures, but that the concerns raised should be addressed through care management. The reason for the decision was recorded on the Safeguarding Concerns Form as:

"Prior to admission Mr B was not in receipt of services to prompt with medication and to assist with personal care. He will be assessed for services before discharged to minimise the risks highlighted in this referral."

This decision was endorsed by the Safeguarding and Adult Protection Team.

2.5 Between 2.9.16 and 14.9.16 Mr B was seen on numerous occasions by hospital Occupational Therapy and physiotherapy staff for observation and assessment. A hospital social worker visited Mr B on the ward to begin an assessment of his needs for care and support. The assessment was not completed at that point, pending the conclusions of the OT and physiotherapy assessments. On 20.9.16 the team received a completed OT Discharge report. The social worker went to see Mr B to undertake a care management assessment on 23.9.16. However, she discovered that Mr B had been discharged from hospital the previous day. The hospital social work team had not received advance notice of his discharge, as required by the BHRUT Discharge Policy. The Trust acknowledges that this was an oversight. The social worker tried to contact Mr B by telephone, without success. She was eventually able to leave the contact details of the Seven Kings Cluster with the partner of a friend of Mr B's, to pass on to Mr B so he could contact them should he require assistance from social services in the future. The hospital social work team referred Mr B by email to Seven Kings on 29.9.16.

2.6 District Nurses from Seven Kings visited Mr B at home on numerous occasions between 24.9.16 and 6.11.16. From the first visit, the District Nurses were recording that Mr B was in need of social care assistance. An urgent referral was made to social services on 30.9.16, and again on 28.10.16. On 24.10.16 and 28.10.16, the duty social worker requested that a social worker be allocated. The case was not allocated, and social services had no contact with Mr B between his discharge from hospital and his death

3. Analysis and conclusions

3.1 The Panel agreed that there were two significant aspects of this case on which discussion should be focused: firstly, the decision made by the management of the hospital social work team, on receipt of the safeguarding referral from the ward, that no further action should be taken under safeguarding procedures, but that Mr B's needs for care and support should be considered through care management; and secondly, the lack of action by social services within Seven Kings on the referral from the hospital team, in spite of the increasingly urgent requests from the District Nursing service for social care involvement.

The decision on the safeguarding referral on 2.9.16

3.2 The Panel did not reach a consensus on the question of whether this was an appropriate decision in the circumstances, or whether a safeguarding enquiry should have been pursued. It was strongly argued that it was right to recognise that Mr B was making a lifestyle choice, which he had the right and the capacity to make; furthermore, that it was clear that he was unwilling to accept services, and there was no likelihood that a decision to pursue the issues as self-neglect under the safeguarding procedures would have led to any change in that position.

3.3 Conversely, the independent reviewer in particular felt that the level of risk to which Mr B was exposing himself; the history of previous presentations in which he had been described as "unkempt" and consuming excessive amounts of alcohol; and the description of his home environment contained in the police report, should have led to further safeguarding enquiries. Dr Kingston also pointed out that in his reading it was not the case that Mr B had consistently and absolutely declined all offers of help. The LAS welfare report on 1.9.16 stated that 'patient said he would like someone to come round and assess his care needs and put something in place'. At the point at which the decision was made not to take any action under safeguarding procedures, the hospital social work team had had no contact with Mr B and therefore no discussion with him of what help he might be prepared to accept. In subsequent contacts he did say, for example, that he would need one call a day to support him with getting out of the bath, and that he might need assistance once a month for bulk shopping and a life line in the event of an emergency. The outcome of his hospital admission was that he was subsequently discharged to a home environment which no professional involved in his care or discharge planning had actually seen and that had been described by the police in the terms described in paragraph 2.3 above.

3.4 Although the Panel could not reach a consensus on the appropriateness of this specific decision, all recognised that an alternative decision, to pursue through safeguarding procedures, would not have conferred on social services any additional powers to override Mr B's choices, and would not have guaranteed any change in the circumstances to which he was discharged. It was suggested, however, that if it had been defined as an adult safeguarding issues, it would have focused more urgent attention while Mr B was still in hospital on working with him to persuade him to recognise the risks to which he was exposing himself and to accept some support to mitigate those risks, and that it would have secured a more urgent response on discharge from the Seven Kings duty service.

3.4 Whatever the different views on the appropriateness of the decision on the safeguarding referral, all Panel members agreed that what the case highlighted, and the most important learning to come out of this review, was the extreme complexity

of decision making on self-neglect within the adult safeguarding framework, and the need for the most effective possible support and guidance in making such decisions. Everybody recognised that the first principle was that adults have the right to make their own decisions about how they live their lives, so long as they have the mental capacity to do so, however unwise those decisions appear to professionals or others. However, everybody also recognised that there is a line above which the consequences of those decisions, for the individual and / or for others, are so severe or so detrimental to health and wellbeing, that, even though the individual has capacity to make them, the self-neglect involved should be regarded as an adult safeguarding issue within the terms of the Care Act. Where to draw that line is an extremely difficult decision for professionals to make, and one in which, as in this case, there will not often be a clear cut 'right or wrong' answer.

The response of the Seven Kings duty system

3.5 The Panel accepted the findings of the independent review that the service provided by the Seven Kings duty system at this time, as evidenced in this case, was inadequate, unsafe, unfocused and lacking in sound practice, supervision and management. Indeed this conclusion was drawn verbatim from the adult social services Individual Management review of the case, completed by the then interim Team Manager in June 2017. The failings were described as including but not restricted to:

- No clear duty lead/manager;
- No evidence of a duty communication process;
- Delayed decisions due to pressure of work;
- Uncoordinated communication between staff and managers;
- Limited evidence of overall management;
- Inadequate cover for the duty rota;
- Managers and staff not reading case notes on Care First;
- A system using urgent/non urgent allocation, with limited evidence on Care First of urgent activity.

3.6 The Panel was therefore very pleased to receive a very detailed report, with appendices, from the current permanent Team Manager at Seven Kings, in post since January 2018, describing the current duty arrangements in the cluster, and describing the improvements made against each of the bullet points above. After considerable discussion, the Panel felt assured that, while the accepted failings in the autumn of 2016 are deeply regrettable, the system and the arrangements now in place have satisfactorily addressed those failings. The Panel was also aware, however, that there are a variety of duty systems operating in the different clusters, and felt reassurance should be sought that the arrangements in all clusters are as robust as those in Seven Kings appear to be. The case of Mr B had highlighted significant issues at the time about communication and responsiveness between different elements of the service, the District Nursing service and the social care duty service. The Panel were pleased to learn, for example, that there are now twice weekly meetings between service leads in the cluster, to ensure that any issues are shared and resolved promptly, and that joint visits between social care and health professionals are now established as common practice.

Other issues

3.7 The Panel noted that the form in use at the time by the London Ambulance Service to report a safeguarding or welfare concern was potentially confusing in that it invited a yes or no answer to the question whether the subject of the referral, as a result of care and support needs, 'is unable to protect themselves' from the risk or experience of abuse or neglect – i.e. if the subject is not able, the answer is yes. Although it was recognised that this formulation is taken directly from the Care Act, it would have been be much clearer if the question was rephrased to ask if the subject was able to protect themselves, rather than unable to protect themselves. However, the LAS, who were not able to be at the Panel, have subsequently reported that this form is no longer in use and that safeguarding and welfare referrals are now completed via Datix. The referral form does not have yes / no questions. It is a typed referral and no longer hand written. This change was implemented in January 2017.

3.8 It is clear that the fire in Mr B's property was not the cause of his death. However, there were points during the course of events where a more robust response to fire risk would have been appropriate. Although the London Fire Brigade did fit smoke alarms to the property after the incident of 1.9.16, they did not raise a safeguarding concern, which in the words of the LFB IMR 'did not entirely comply with LFB policy standards'. Although on two occasions District Nursing staff alerted Mr B about the dangers of using his electric fire, they did not make a referral to the fire service. Representatives of the LFB at the Panel were extremely keen to emphasise that they welcomed and wanted referrals on any individuals that health or social care services identified as potentially at any level of fire risk, and that the great majority of fire deaths were of individuals who were vulnerable as a result of mobility, frailty, mental health, self-neglect, and other care and support issues.

3.9 The Panel acknowledged that process aspects of this this and the other Safeguarding Adult Review recently completed highlighted a need to review and update the Board's Safeguarding Adults Review Protocol, adopted in 2016.

3.10 Finally, the Panel felt it was important to reiterate that Mr B died of natural causes, a heart attack, and that no alternative actions on the part of any of the agencies involved in this review would have prevented his death.

4. Recommendations

The Safeguarding Adults Board are recommended to:

4.1 Express its appreciation to Dr Paul Kingston for his work on this review

4.2 Acknowledge the complexity of decision making on self-neglect within the adult safeguarding framework, and the need for the most effective possible support and guidance in making such decisions.

4.3 Ensure that this is fully considered and reflected in the review of the Board's Self Neglect and hoarding Protocol which is programmed in the Board's Action Plan 2018/19.

4.4 Ask the HASS Management Team to assure itself of the robustness of social care duty systems throughout the service and to report the outcomes of such an assurance programme to a future meeting of the Board

4.5 Work with the London Fire Brigade to promote to all agencies and providers the importance of referring to the LFB any vulnerable individual who they identify as potentially at any level of fire risk.

4.6 Develop for consideration at its meeting in October 2018 a multi-agency escalation and dispute resolution protocol, for use by any professional who disagrees with any decision, action, or inaction on the part of a responsible agency in relation to the safeguarding of an individual vulnerable adult.

4.7 Develop for consideration at its meeting in October 2018 a revised version of the Safeguarding Adults Review Protocol.