



## **Gloucestershire Safeguarding Adults Board**

### **Practice and Learning Review into the death of AT.**

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#### **ACKNOWLEDGEMENTS**

With thanks to Herefordshire Safeguarding Adults Board, whose Procedure for Multi Agency Practice and Learning Review has been utilised to undertake this review.

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## **INTRODUCTION**

On 11<sup>th</sup> May 2015 the Gloucestershire Safeguarding Adults Review (SAR) sub group received a referral under section 44 of the Care Act 2014 from the 2gether NHS Foundation Trust regarding Mr AT, a 50 year-old man who had been found dead at his home. He had been dead for a number of days and had been known to services. The sub group concluded that the case represented an opportunity for multi agency learning. It was agreed that a Practice and Learning Review should be the methodology employed to undertake the review. This is the first review of its kind to be undertaken in Gloucestershire and was facilitated by Sarah Jasper (GCC Safeguarding Adults) and Alison Feher (2gether Trust). Although both agencies had had involvement with the case, neither of the facilitators had direct involvement with AT.

## **PROCESS**

Chronologies were obtained from the following agencies:

2gether NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Broomfield Care

Adult Social Care, Gloucestershire County Council (ASC, GCC)

Saintbridge GP Surgery

Gloucestershire Care Services (GCS)

South West Ambulance Trust (SWAST)

Gloucester City Homes (GCH)

The chronologies covered the scoping period from 02/01/2014 to 19/05/2015. A Review meeting was held on 29<sup>th</sup> April 2016. With the exceptions of SWAST and GCH, representatives from all the above agencies attended. There is no record of any family contacts so it was not possible to involve any family members in this review. The merged chronology was examined and learning points were identified.

Because the majority of the chronology covers the period prior to the introduction of the Care Act, the language used to describe the safeguarding incident reflects the process at that time.

## **BACKGROUND**

AT was a white British man who lived alone in a Housing Association property first floor flat. He was single and was aged 50 when he died. He had a diagnosis of bi-polar affective disorder and received support from the 2gether Trust Recovery Team. He had a Body Mass Index of 45 (also recorded as 51 in the social care record), which put him in the category of morbidly obese, and lymphoedema, which caused ulceration to his legs. His mobility was

compromised but he was able to leave his property independently. He had a history of intermittent engagement with services, refusing to let carers in on occasions and failing to attend health appointments. No concerns about his mental capacity to make decisions were noted.

He was last seen by a professional on 02/04/15, when his care co-ordinator from 2gether Trust made an unannounced visit to him. She made a further visit on 11/05 and gained access via the keysafe as AT did not answer the door. She found AT propped against the wall by the toilet. Emergency Services were called and AT was pronounced dead. The post mortem revealed that AT had died from Bi-lateral Pulmonary Emboli (blockages in the pulmonary artery) and Morbid Obesity related Lymphoedema.

### **The scoping period**

In January 2014, AT received visits from Occupational Therapists (OTs) from GCC and 2gether Trust. Difficulties around his bed mobility were noted and it was suggested that he needed a bariatric bed. This would necessitate a move to a ground floor property. In the interim, a Dream Master bed was provided.

On 17/02/14 AT was admitted to GRH with cellulitis. He was discharged a week later with care of GP and Community Nursing Team. It was recorded that he was in receipt of a care package consisting of 2 calls per day.

ASC received a call on 28/02/14 from the 2gether Trust OT to advise that the care package had been cancelled. A Social Worker from GCC visited AT, who stated that he was unable to access the community and was sleeping in a chair. Reablement made one visit but could not gain access on the second call as AT had taken the keysafe off the wall. The worker made a further call to the property, at which AT told her he did not want them to visit. A review was arranged however AT declined the appointment, saying he did not want a visit for a few weeks. The GCC OT sent a letter to AT on 28/03/14 advising him his case was being closed as he did not want a review.

On 10/03/14, AT was again admitted to GRH (Acute Care Unit) with bilateral cellulitis. He was admitted and discharged on the same day to the Community IV Team. He was re-admitted the following day with a possible allergic reaction to the first dose of IV medication. AT was discharged on 12/03/14 with oral antibiotics and advice to contact his GP if any further adverse reactions occurred.

From 28/03/14 until August 2014 domiciliary carers from Broomfield Care were seeing AT regularly to assist with household tasks and care of his legs. No difficulties were recorded until 04/08/14, when AT appeared stressed and angry. Carer was concerned about AT not having access to his medication and she contacted the District Nurses and her manager. She impressed on AT the importance of going to collect his medication. No further domiciliary care records are available for AT, however Broomfield Care state that they continued to visit

AT intermittently until February 2015, when they ceased the care package due to AT's behaviour towards carers.

On 19/08/14 AT sent text messages to the domiciliary care manager expressing that he did not want carers to visit for the next two weeks. He was upset by the death of Robin Williams and the anniversary of Elvis Presley's death. She shared these texts with his care co-ordinator, who made several unsuccessful attempts to see AT, including arranging to collect him for a joint medical appointment on 25/09/14. AT was not available and a professionals meeting went ahead, at which it was agreed that the GP would assess AT and initiate appropriate treatment.

AT proved difficult to engage with throughout October 2014, his care co-ordinator managing to see him once (on 01/10/14), when she visited with a physiotherapist, and a comprehensive plan was agreed to support AT with various issues (housing, debt management, orthotics referral).

On 23/10/14 the care co-ordinator received a fax from AT's GP, which advised that AT's brother had recently died and AT had no knowledge of this until after the funeral. GP requested urgent support for AT from 2gether Trust. The GP advised that he would make a referral to ASC for funding (it is not clear for what). He also advised that AT's leg dressings should be changed daily, however the District Nurses would not make home visits to AT as he was ambulant and therefore considered able to access the surgery independently.

On 20/11/14 AT told his care co-ordinator that his GP wanted him to have his legs dressed daily but that he could not afford the taxi fares to get him to the surgery as this would cost over £70 per week.

The erratic engagement from AT continued throughout November, with carers reporting to his care co-ordinator on 09/12/14 that AT was unpredictable regarding what support he would accept from them. Carers remarked that AT's legs were in a poor state.

On 10/12/14, AT made numerous calls to his care co-ordinator and left a message at 1 am. Noting that this is an early warning sign of relapse, she visited him that afternoon. She then arranged a further visit with colleagues from 2gether on 16/12, however AT would not answer the door when they arrived. Another worker from 2gether visited on 24/12 and noted that AT was taking his medication erratically. Carers were contacted to ask them to prompt medication.

On 08/01/15 his care co-ordinator saw AT to carry out a Care Programme Approach (CPA) meeting. This had been intended to include a joint medical review but the care co-ordinator was unaware of a change of GP appointment (a phone consultation had been carried out the day before). Those present at the CPA appeared to be his care co-ordinator and AT himself. Decrease in hygiene in the flat was noted, and that AT was experiencing ongoing grief at the death of his brother and his cat had died the previous week.

A social care review took place with AT on 12/01/15 with his care co-ordinator and domiciliary carers, where his Individual Budget and care package was reduced. He did not answer the door when his care co-ordinator visited a week later.

On 22/1/15 AT had a joint consultation with GP and District Nurses. The GP noted the issues re the care of his legs because AT was not strictly housebound so expected to attend surgery, however he was not mobile enough to walk to the surgery and frequently did not have enough money for a taxi. A referral was made to the Lymphoedema nurse, who was not able to see him until 01/04/15.

On 28/01/15 AT visited the surgery. Concerns about his legs were noted and antibiotics prescribed. On the same day a GP referral was received by Adult Social Care, requesting an urgent Multi Disciplinary assessment. A phone call was made to AT on 05/02 and he agreed to an OT visit on 11/02/15. The OT visited and AT mentioned financial abuse. A safeguarding alert was raised. This met the threshold for investigation and was sent to the GCC Adult Social Care referral centre. Gloucester City Homes was contacted, along with the 2gether Trust and Broomfield as part of the screening process. One of the recommendations from the screening worker was to consider arranging a multi agency meeting to include Housing, carers and 2gether Trust to consider the wider issues regarding AT's health and social care.

During February 2015 there was a further deterioration in AT's engagement and on 04/02, 05/02, 13/02, AT did not attend 3 appointments with the GP surgery. Phone messages had been left to remind him to attend.

On 09/02/15 the care agency emailed the care co-ordinator to advise that they were withdrawing the care package due to AT's increasingly erratic behaviour, cancelling of visits and verbally abusive behaviour towards carers.

A GCC worker tried to visit AT on 16/02/15 in response to safeguarding alert. She was not able to gain access, so the Police were contacted and welfare check requested. This was carried out and AT was reported to be safe and well. A joint visit with GCC OT was made on 17/02, where AT confirmed that the financial abuse was historical. Contact was made with Broomfield and the care co-ordinator, who also confirmed the historical nature of the financial abuse. Safeguarding alert was then closed.

In March 2015 it is noted that AT did not attend outpatient appointments at the hospital. AT did not attend a meeting with his care co-ordinator and GP on 12/03 despite the care co-ordinator's attempts to contact. An assessment of AT's mental health was planned for 13/03 but access could not be gained. AT did however text his care co-ordinator to say he had been too unwell to attend the GP appointment on 12/03.

On 01/04/15 AT's care co-ordinator and her manager visited unannounced and had a doorstep conversation with AT. It was mentioned that his legs were cyanosed, not previously noted. AT reported that he wasn't washing as he was frightened of falling forward on the shower seat. His care co-ordinator agreed to contact Broomfield to see if

visits could be re-instated for leg care and to contact GCC regarding the outcome of the assessments and safeguarding investigation in February.

On 07/04/15 the District Nurse and Lymphoedema Nurse had a 'no access' visit to AT. The District Nurse made a call to the care co-ordinator where it was noted that because he was mobile he was not for the District Nurse caseload. A Housing report was sent to Gloucester City Homes regarding a move to a ground floor property so a bariatric bed could be provided.

The GP contacted the recovery team by fax on 08/04/15 to express his concerns about AT's lack of engagement and to enquire about the outcome of the meeting in mid March.

On 14/04/15 the care co-ordinator phoned GCC to ask for the pending assessment of care needs to be carried out.

On 21/04/15 the GP phoned AT and left a message asking him to make contact. A further attempt was made on 26/04. A compliment slip sent 29/04 with request to contact GP.

There was no further contact between AT and agencies until 11/05, when his care co-ordinator visited AT and found him deceased.

## Analysis

The review of the chronology has identified a number of missed opportunities which may have changed the outcome for AT. These in turn represent learning opportunities for the agencies involved. Two themes have emerged prominently from this review:

- i. AT's history of intermittent engagement with services: does AT's case offer potential learning for working with individuals deemed to have capacity who regularly disengage from the support offered?
- ii. Communication between services: AT had significant contact with health services (acute, community and mental health), social care and domiciliary carers during the scoping period. Could information have been shared more effectively? AT's health was deteriorating from early 2015: how was this communicated between agencies?

### i. **History of intermittent engagement**

AT's willingness to receive support from his domiciliary carers reduced towards the end of 2014, and the care package was cancelled in February 2015. This was about the time that AT failed to attend three appointments with his GP surgery. During February the only agencies that gained access to AT were the police and GCC.

A recurring issue throughout the chronology is AT's failure to attend GP and other health appointments. His difficulty in attending these appointments was noted, with financial problems and reduced mobility offered as reasons. District Nurses did visit him at home

at times, however if he was seen out in the community, the home visits ceased and AT was expected to attend the surgery to see the Practice Nurses.

Apart from AT's physical health problems, his recurrent non-engagement indicates self-neglecting behaviour. Self-neglect is described as covering "a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings" in the Care Act 2014 (which came into force a month before AT's death). Since AT's death, best practice guidance on working with people who self-neglect has been issued by the Gloucestershire Safeguarding Adults Board. This recommends a creative, multi-agency approach to working with people who self-neglect.

It is noted that a safeguarding alert was not raised due to concerns about AT's self-neglect. Although self-neglect was not officially included as an issue potentially requiring a safeguarding response until the introduction of the Care Act in April 2015, Gloucester Safeguarding Adults Board had included it in the multi-agency policy and procedures from 2011.

AT's capacity is referred to in the chronology on two occasions in relation to his capacity regarding his finances. It is also mentioned by his care co-ordinator in relation to a planned joint appointment for 12/03/15: "if client does not attend, capacity to be discussed between professionals". The Mental Capacity Act 2005 is clear that capacity should be presumed and that people with capacity have the right to make unwise decisions. In these circumstances, it would be good practice to record that the person is believed to have capacity if they make an unwise decision that places them at risk of harm. Where the risks are severe, further attempts at engaging the person should be made regardless of the person's capacity.

While AT may have been considered to have the mental capacity to make decisions about his care needs, it is possible that his executive capacity was impaired (i.e. his ability to follow through on decisions) because of factors associated with his physical and mental health.

## ii. **Communication between services**

While there was a lot of contact between agencies, this appears to have been fragmented at times, with the main communication being between health agencies. Although a CPA was carried out in January 2015, the only people present were his care co-ordinator and AT. The CPA is underpinned by a systems approach intended to address the range of service users' needs, with risk management and contingency planning integral to the process (DoH, 2008). Had all the professionals involved in AT's care been present at this review it may have led to a more holistic plan to address his health and social care needs and the housing issues identified.



Because AT's care category was "working age mental health", he received support primarily from the 2gether Trust. However, because he also had social care needs, he also received assessments from GCC social workers and OTs. This led to some confusion about the safeguarding alert, as it was sent by the safeguarding team to GCC, who accepted it and allocated a social worker. If this had been sent to his care co-ordinator in 2gether Trust, this may have ensured continuity. The way services are organised for people of working age with mental health issues means that, where they also have social care needs, services are provided to them by both agencies, focusing on the presenting issue as relevant. While it is beyond the scope of this review to make recommendations about the provision of services at this level, the potential for fragmentation that this arrangement represents is a point for consideration.

It was also noted that changing medical IT systems meant that not all relevant health agencies had access to System One (the healthcare recording system). This situation is improving as the IT system develops.

Although AT lived in a flat provided by GCH and the need for a move was discussed with AT early in 2014, there is little evidence that GCH were involved in any ongoing discussions about this. Their chronology (not included in the merged version) reports that in August 2014 AT said he did not want to move from his flat. GCH was contacted by the safeguarding screening team in February 2014 to ask if they were aware of any financial abuse/harassment issues with AT, but there does not appear to have been contact with Housing other than the housing report, which was sent in February 2015.

The safeguarding alert appears to have diverted attention from the main concern, which was AT's deteriorating health and lack of engagement with health care for his legs. The recommendation by the safeguarding team to hold a multi-agency meeting to consider the wider issues related to AT's health and social care was not followed up and the safeguarding strategy dealt only with the presenting issues of financial abuse. A multi-agency meeting may have led to recognition of the increasing risk to AT's health as he retreated from offers of support.

The GP agreed to make a referral to GCC for an assessment in October 2014. There is no record of this on GCC system. A referral for an urgent multi-disciplinary assessment was received by GCC from the GP on 28/01/15. This was placed on the pending list and had not been actioned at the time of AT's death in May. The workload pressure means that requests for assessments often have to be placed on the pending list, however had the risks to AT been recognised, this assessment may have been prioritised.

Risk assessment: District Nurses had a policy of visiting in twos but Broomfield care was not aware of this arrangement.

## Good Practice

AT's care co-ordinator made repeated attempts to maintain engagement with AT, turning up unannounced because of her knowledge that AT was likely to be out when visits were pre-arranged. She was also persistent in raising her concerns with the GP and with following up with Adult Social Care to check on the progress of the referral for a re-assessment of his care needs in early 2015.

The domiciliary carers had clearly built a good rapport with AT and raised concerns with his care co-ordinator appropriately.

The GP made several attempts during early 2015 to engage AT in appointments to review the care of his legs.

## Conclusions

The circumstances of AT's case reflect a number of issues which have been identified as causing difficulties for professionals working with people who self-neglect. It is acknowledged that since his death in May 2015, more resources are available which offer best practice guidance to professionals. However, it is also possible that the agencies involved with AT did not recognise his failure to engage with health care as self-neglect, as it is often equated with hoarding behaviours. It is possible that a more proactive approach to his refusal to engage, in line with best practice guidance on self-neglect, may have changed the outcome for AT.

While there was clearly concern from 2gether Trust about the state of AT's physical health during February and March 2015, it seems that the level of concern was not understood by the GP surgery. At this point a multi-agency meeting may have helped to identify the risks that AT was facing and arrived at a plan which attempted to re-engage AT with the support that was available to him. The fragmented nature of the communication between the agencies involved led to missed opportunities to understand the whole picture as the concerns accumulated in early 2015.

## Recommendations:

- **Consideration to be given by Gloucestershire Care Services to District Nurses making reasonable adjustments to standard practice of not making home visits in cases where an individual is deemed to be capable of attending the surgery but does not present for treatment, and this leaves the person at high risk of serious harm.**
- **Where a person with capacity is making an unwise decision which places them at risk of harm, this should be documented on the person's record. Where there are doubts about the person's executive capacity, consideration should be given to carrying out a capacity assessment and making reasonable adjustments which accommodate this.**

- The CPA to include all relevant agencies involved in supporting the individual to assess the person's needs in a holistic way.
- Safeguarding screening recommendations to be followed by the person leading the section 42 enquiry. If recommendations are not followed, the reasons for this should be documented in the safeguarding paperwork.
- Self-neglect guidance to be reviewed by the Policy and Procedure sub group of the GSAB to ensure that neglecting to care for one's physical health is emphasised as a feature of self-neglect.

### References:

Department of Health (2008) *Refocusing the Care Programme Approach. Policy and Practice Guidance.*

Gloucestershire Safeguarding Adults Board (2015) *Adult Self-Neglect Best Practice Guidance.*  
Available at:

<http://www.gloucestershire.gov.uk/safeguardingadults/CHttpHandler.ashx?id=64344&p=0>