South Tyneside
Safeguarding Adults Board

Adult D:
The response of partner agencies to severe self-neglect

Safeguarding Adults Review
Executive Summary

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Date agreed by South Tyneside Safeguarding Adults Board: 8th May 2017

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

- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- North East Ambulance NHS Foundation Trust (NEAS)
- Northumbria Police
- Pin Point Care
- South Tyneside Clinical Commissioning Group (CCG)
- South Tyneside Council (STC)
- South Tyneside NHS Foundation Trust (STFT)
- Tyne and Wear Fire and Rescue Service (TWFRS)

Several professionals employed by the above agencies came into contact with Adult D. Professionals are referred to by their job title throughout the report. Sometimes abbreviations are used for job titles such as GP for General Practitioner. Abbreviations are only introduced after the full job title has been used for the first time.

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

Glossary

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.

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.

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.

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 D died in2015 in South Tyneside District Hospital after being admitted four days earlier. At the time of his death he was in his late fifties He died following multiple organ failure as a result of severe sepsis and pneumonia.

1.2 He had had a professional career and was an active member within his local community. However, after his career ended prematurely, mental and physical health issues together with alcohol dependency appeared to contribute to a steep decline in his care of himself and his home environment.

1.3 Adult D had intermittent contact with a range of agencies over a number of years but from 2013 agency contact with him intensified in an effort to prevent him from seriously neglecting himself. Despite these efforts he lived in considerable squalor in his privately owned flat.

1.4 In August 2016 the South Tyneside Safeguarding Adults Board (ST SAB) decided to commission a Safeguarding Adults Review (SAR) in respect of Adult D. The statutory guidance which accompanies the Care Act 2014 states that SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.5 ST SAB delegated responsibility for overseeing the completion of the SAR to their SAR Sub group and commissioned David Mellor to fulfil the role of independent author of the SAR Overview Report. He has no connection with services in South Tyneside other than conducting a previous SAR. 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. The process by which this SAR was conducted is set out in Appendix A.

1.6 No inquest has been held in respect of Adult D. His death had not been referred to the Coroner prior to contact from the Safeguarding Adults Board to advise that this SAR had been initiated. It is understood that the Coroner has requested a copy of this report to determine whether there are any issues the Coroner needs to investigate.

Terms of Reference

2.1 This review was overseen by the SAR Sub Group of the South Tyneside Safeguarding Adults Board which consists of senior managers from a wide range of partner agencies. Following careful consideration of the chronologies of agency involvement with Adult D, the SAR Sub Group decided on the following terms of reference:

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 consider the potential relevance of other recent local reviews and the extent to which any failings identified may already have been addressed by multi-agencies as a result of those. Identify any further action that is still needed to demonstrate changes have been embedded into practice

- To develop succinct and focussed recommendations as to how practice should be improved and what is expected to change as a result, identifying opportunities for immediate learning wherever possible

- 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 appropriately involve any identified family members and/or carers throughout the case review.

Timescales for the review

The review focussed on the period from 1 April 2014 to 21 October 2015. If there was vital information prior to this date that informs the SAR, agencies were requested to consider the value of including this.

Areas of focus

- To consider how agencies worked together to ensure the health and social care needs of Adult D were met.
- To consider the extent to which agencies recognised, respected and valued Adult D 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 the extent to which escalation occurred when risks appeared to increase
- To establish whether capacity was properly considered within the framework of the Mental Capacity Act.
- 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 D neglecting himself and his home were identified and managed.
- To consider the potential relevance of the Care Programme Approach in coordinating the Care and treatment of Adult D.
- To critically evaluate the application of the Safeguarding Adults Framework specifically in relation to concerns of financial abuse.

Synopsis

4.1 Adult D had periodic contact with social care, mental health and environmental health services prior to 2013 and made regular unplanned visits to his GP. Concerns arose over his vulnerability and living conditions from time to time.

4.2 In June 2013 Adult D's General Practitioner (GP) referred him to STC environmental health. The latter service noted that he had first come to their attention a number of

years previously. He and his father were said to be "unable to look after themselves". Apparently Adult D's mother "tidied up" after them and when she died, father and son employed a cleaner. After Adult D's father died the family home at Address 1 deteriorated, was sold and Adult D moved to his then home at Address 2.

4.3 The GP referral said that Adult D had mental health and mobility issues, did not answer the phone but left his door open. Human dirt covered the walls of his flat and clothes were lying around which appeared to be wet through urination. Environmental health visited and noticed that Adult D's legs were dark red in colour and that his coat was smeared with faeces. At this time, he presented as somewhat meek and slightly confused. He agreed to be seen by STC adult social care although it appears he subsequently declined an assessment and his case may have been closed.

4.4 The following month a neighbour of Adult D contacted STC to express concerns about the behaviour of Adult D and a person the neighbour described as his carer. They were said to urinate in the rear yard of the premises which the neighbour described as a health hazard with "flies all over". The neighbour described Adult D's clothes as very stained, dirty and smelling of faeces.

4.5 STC adult mental health and environmental health jointly visited Adult D. It was established that his toilet was blocked and so he was disposing of his urine and faeces in the rear yard. Adult D accepted assistance in unblocking his toilet but otherwise declined any further intervention including having his flat cleaned. Adult D was described as articulate and having holistic insight into his situation. Also present was his informal carer who Adult D said helped him by shopping and running various errands for which Adult D paid him £20 weekly. When spoken to alone he denied that he was under any form of duress from his carer.

4.6 There was little further contact with Adult D until April 2014 when a district nurse had a discussion with Adult D's GP after a home visit to obtain blood samples for diabetes review had found faeces "over everything". One nurse had apparently vomited at the stench. This led the GP to contact STC environmental health and STC adult mental health. Home visits were undertaken and the consensus of practitioners at this time was that Adult D's physical health gave cause for concern – diabetes, swollen and discoloured legs, facial sores – but that there were "no concerns" about his mental capacity. His self neglect was described as "severe". At that time there was no hot running water in his home, he couldn't access his bath, he had no shower and the floor was covered in excrement. There appeared to be no food in the house although takeaway menus were seen. He declined to pay for the repair of his boiler. The conditions in his home made a full medical review difficult to carry out. Adult D appeared to agree to a deep clean of his home although his GP noted that there had been a number of deep cleans before.

4.7 To enable the deep clean to take place, Adult D agreed to go into respite in a residential care home which began in early June 2014. During that time STC environmental health arranged for his flat to be thoroughly cleaned and sanitised with the cost treated as a charge on his property. His boiler was also later replaced (August 2014) and a five year maintenance agreement put in place. It was hoped that the period of respite would also allow for physical and mental health assessments and attention to ulcers on his left leg.

4.8 Whilst in respite a district nurse attended to a wound on Adult D's lower left ankle which was described as a diabetic leg ulcer. His diet controlled diabetes was noted as was osteoporosis. Adult D said he had not been washed for two years.

4.9 Adult D returned home in early July 2014 having agreed to accept the support of STC home and reablement team (HART) to prompt him to maintain the cleanliness of his home. Handover was arranged to the STFT community district nursing service, which would continue the treatment begun in respite by visiting Adult D at home.

4.10 When the community district nurse carried out her first home visit to Adult D on five days after his return from respite, she found the house unkempt with urine on the floor and human excrement "all over the flat". She was unable to change his dressings as he had apparently lost the fresh dressings with which he had been provided. During the visit the district nurse suffered numerous insect bites to her head and body. The boiler was still broken resulting in no heating or hot water.

4.11 The district nurse raised a safeguarding alert on the grounds of severe self neglect. However, self neglect was not formally defined as an adult safeguarding matter until the later implementation of the Care Act 2014. As a result, it was decided to oversee Adult D's case by invoking the risk management meeting (RMM) process.

4.12 The first RMM took place on 16th July 2014 when it was decided that a joint adult mental health team (AMHT) and environmental health home visit would take place, HART would continue to engage with Adult D and provide an update at the next meeting and a private domiciliary care provider experienced at managing risk would be approached to provide a package of home care.

4.13 On the same date Adult D was assessed by a community psychiatric nurse (CPN) from NTW – which specialises in mental health and disability. Adult D's social worker was present for the assessment which took place on NTW premises. The CPN found Adult D to be very communicative and possessing good insight. There was no evidence of alcohol use but there were signs of slight self neglect. Adult D referred to his recent period in respite which he said he had found "stressful" and "overwhelming". No symptoms of an earlier bi-polar diagnosis were apparent. Adult D struck the CPN as very independent. Aware that Adult D had accepted a home care package, the CPN concluded that he had no identified mental health needs.

4.14 HART withdrew provision from Adult D on 17th July 2014 following concerns over verbal abuse from Adult D's informal carer whilst both he and Adult D appeared to be under the influence of alcohol. HART decided that two male staff working together were required because of the behaviour of Adult D's informal carer, which they lacked the capacity to provide.

4.15 The district nurse service questioned whether their duty to care for Adult D required them to administer care at his home. On health and safety advice, it was decided that district nurses would wear protective clothing on future home visits to Adult D. After carrying out a lone worker risk assessment, it was also decided that because of potential aggression from Adult D's informal carer, district nurses would not visit him alone. A district nurse sister visited Adult D who agreed to attend a clinic at Cleadon Park for future treatment of his leg ulcer. An appointment was made for 25th July 2014 which Adult D did not attend. This prompted a further home visit from the district nurse sister who arranged another clinic appointment for 5th August 2014 at Flagg Court Health Centre which Adult D said was more accessible by public transport than Cleadon Park.

4.16 STC adult mental health team obtained approval for a home care package which Adult D agreed to contribute financially to. The provider was Pin Point Care who were contracted to provide two visits per week, each of one hours duration, during which Adult D would be prompted to attend to personal hygiene and domestic tasks. Adult D was assessed as requiring 7-8 hours of support weekly but was reluctant to accept this level of support. The Pin Point Care support would be provided by two staff working together because of identified risk factors. This package appears to have begun on 30th July 2014.

4.17 On 5th August 2014 Adult D attended Flagg Court clinic and saw a district nurse who noted exudate on his dressing, cleaned his wound and re-applied bandages. There is no evidence from records that any subsequent Flagg Court appointment was made for Adult D nor is he believed to have attended any further district nurse appointments at Flagg Court or elsewhere.

4.18 On 19th August 2014 a second RMM was held. The disengagement of HART did not appear to be discussed. The district nurse service did not attend but the RMM was made aware of the arrangements for Adult D to attend Flagg Court clinic. The recently commissioned providers of Adult D's home care package did not attend. Information had been obtained from the NTW Community Treatment Team which had had contact with Adult D's informal carer which indicated that he had gambling debts and had borrowed £4,000 from a friend around 10 months earlier in order to settle these debts. It was not known if the "friend" was Adult D, but there was concern that Adult D may be being financially abused by his informal carer. It was decided that his social worker would contact the police public protection unit in respect of this matter. A further home

visit was to take place on 26th August 2014 and TWFRS were to be requested to carry out a fire safety check.

4.19 On 20th August 2014 STC adult mental health team sent an email to the police to express concern that Adult D may be being financially abused by his informal carer. In the email it was suggested that Adult D had incurred credit card debts of approximately £4,500 and that his informal carer had gambling debts which had led him to borrow £4,000 from a friend. It was suspected that the friend from whom he had borrowed the money may be Adult D. The police reviewed the information provided and decided that no further action was necessary as Adult D had capacity, freely paid his informal carer for errands and if he had loaned £4,000 to his informal carer then there was no indication of criminality. STC adult mental health team also completed a safeguarding referral in respect of the same concern of potential financial abuse the following day. As was policy at the time, the adult mental health team manager decided to take no further action through safeguarding as Adult D was said to be happy with his relationship with his informal carer which he wished to maintain. It was decided not to convene a safeguarding strategy meeting.

4.20 On 21st August 2014 Adult D had a telephone consultation with a GP from his surgery regarding medication for lower back pain. Adult D said he wasn't mobile and couldn't attend health clinics. It was agreed that he would attend the surgery for assessment the following week but he did not do so.

4.21 On 29th August 2014, the TWFRS fire safety check took place. Adult D was assessed as at "very high risk" from fire on the grounds that he was aged 40-64, lived alone, consumed alcohol, had restricted mobility, his informal carer was a smoker and there was evidence of hoarding. Two smoke detectors were fitted and advice given over potential fire risks.

4.22 On 2nd September 2014 Adult D's social worker visited him in company with an assistant occupational therapist (OT). Adult D said he had difficulty in getting in and out of his bath. However, the OT was unable to assess Adult D as there was no lighting in the bathroom and the floor boards were described as "wet and slimy".

4.23 On 5th September 2014 the scheduled RMM in respect of Adult D was cancelled owing to staff sickness. No further meeting was held until 28th January 2015.

4.24 The OT returned later in September with environmental health who resolved the lighting problem in the bathroom. The OT arranged for the delivery of a swivel bather which would allow Adult D to transfer his legs over the side of the bath. This was to be delivered the following day. The OT intended to review Adult D in three weeks to check whether he also required a grab rail. During this visit, it was noted that "there is still a lot of cleaning up to be done within the bathroom". Adult D said he would mop the floor and clean the toilet. A mop bucket with dirty water in it was seen in the bathroom.

4.25 On 1st October 2014 STC adult mental health team contacted Pin Point Care who expressed "no major concerns" about Adult D.

4.26 During November 2014, the OT made unsuccessful attempts to telephone Adult D to check how he was getting on with the swivel bather. She then wrote to him asking him to contact her if he was struggling to use the bather. The letter stated that if she heard nothing from Adult D within two weeks, she would assume that he was managing to use the equipment and close his case to OT. She subsequently requested case closure on 8th December 2014.

4.27 On 11th December 2014 STC adult mental health team contacted Adult D by telephone and he disclosed that he had received no care from Pin Point for three weeks. STC adult mental health team twice contacted Pin Point for an explanation but received no substantive response. A planned home visit by Adult D's social worker scheduled for 19th December 2014 did not take place due to staff sickness.

4.28 On 6th January 2015 Pin Point were requested to attend their a RMM for Adult D scheduled for 21st January 2015.

4.29 A planned home visit by his social worker was rescheduled to 15th January at Adult D's request but this was also cancelled due to the social worker's other work commitments. The 21st January RMM was cancelled as no representative from Pin Point Care was said to be available and sickness prevented the attendance of any representative from environmental health.

4.30 Three further home visits were cancelled in January 2015 because the social worker was required to cover "office duty", Adult D declined a visit as a result of tiredness and on the third occasion Adult D sounded intoxicated when his social worker rang him prior to the visit and so she decided to cancel.

4.31 The RMM went ahead on 28th January. The package of care provided by Pin Point Care was discussed. It was noted that the care package had been reduced 12 weeks ago and ceased altogether 8 weeks ago without STC being advised by the provider who had not attended the RMM. Adult D was said to be "coping well at the last home visit with no evidence of self neglect, deterioration in his mental health or social functioning". It is not known when the home visit referred to took place. It was confirmed that the new boiler had been fitted and that Adult D now had hot water and heating. However, only Adult D's social worker and her senior practitioner attended the RMM. The district nurse service was to be invited to the next meeting.

4.32 Following the RMM a letter was sent to Pin Point Care to which no reply was received.

4.33 On 2nd February 2015 Adult D was referred to the district nurse service by his GP for blood tests to be carried out for his annual diabetes and general health check. Adult D cancelled the appointment for his bloods to be taken and his annual diabetes and general health check did not take place.

4.34 A home visit by his social worker was declined by Adult D on 5th February 2015. Over the telephone Adult D said that he had plans for that day and that his informal carer was visiting him. He went on to say that he was managing to bathe two or three times weekly and using the swivel bather. He added that he was visiting local shops at least twice a week. His social worker expressed concern that it had been some months since she had seen him. Adult D acknowledged that she "had a job to do" and requested that the visit be rearranged for the following day. He is said to have sounded highly intoxicated. When his social worker visited the next day she received no answer to the door.

4.35 Adult D's social worker suspected that the information Adult D had provided over the telephone the previous day may have been intended to give her false reassurance and decided to telephone his GP and the district nursing service to check if there had been recent contact. She established that Adult D had not been seen by a district nurse since August 2014 and that he had recently cancelled an appointment for routine blood tests which were required for diabetes and general health checks.

4.36 On 9th February 2015 Adult D's AMH social worker was able to make a home visit to Adult D who was not intoxicated and his mobility appeared to have improved slightly. However, his home environment was still concerning in that there appeared to be faeces up the wall, there were flies around and rubbish did not appear to have been put out. There was food in the fridge and Adult D was eating when they arrived. Adult D said his informal carer visited twice daily and that he paid him £30 weekly. The informal carer's mother usually did Adult D's washing but she was unwell at this time so a backlog had built up. Adult D was provided with contact details of the community laundry service. Adult D was noted to have low levels of motivation around his self care. He was not engaging with his GP and declined a further home care package. He was also reluctant to accept support to help him get out of the house and engage in activities such as visiting the library. It was said that there were no concerns about Adult's D's mental capacity.

4.37 On 12th February 2015 a further RMM for Adult D took place at which his social worker reported back on the home visit three days earlier. The meeting was only attended by staff from STC adult mental health team. It was noted that Adult D had had no involvement with the district nurse service since August 2014. Actions from the meeting included the social worker visiting Adult D weekly and taking a support time recovery worker with her on the next visit in order to try and engage Adult D in activities in the community. It was also decided to contact Home Care Living– a well-regarded local provider - regarding a care package, to consider what Adult D's personal

financial contribution to any package would be and to contact STC safeguarding in respect of Pin Point Care. (STC safeguarding later advised that Pin Point Care was not a local authority commissioned service.)

4.38 During a home visit on 20th March 2015, Adult D declined support to engage in social activities away from his home and declined a further home care package. He did however request support to obtain a concessionary bus pass. The same day his social worker asked environmental health to arrange costings for cleaning Adult D's home subject to access being agreed with him.

4.39 The RMM scheduled for 26th March 2015 was cancelled because the chair was unavailable. There was considered to be no imminent risk to Adult D.

4.40 Adult D's annual mental health review was scheduled for 30th March 2015 but it did not take place.

4.41 On 17th April 2015 Pin Point Care contacted STC to request payment for Adult D's care package which they stated had been outstanding since August 2014. STC responded by referring to previous unsuccessful attempts to obtain information from Pin Point Care relating to the care they provided to Adult D.

4.42 On 18th April 2015 South Tyneside Homes visited Adult D's property in error but reported concerns about his home conditions to STC.

4.43 On 20th April 2015 Adult D's social worker made a home visit in company with environmental health. She noticed that though sober and wearing unsoiled clothing, he appeared quite fatigued, had a cough, had lost weight and his personal care had deteriorated. Once again Adult D declined the support of a social work assistant to engage in activities away from his home and declined a home care package, even if fully funded by STC. He reiterated his request for support to obtain a bus pass and his social worker said she would ask his GP to write a letter of support for this. Adult D appeared to agree to a further deep clean of his home.

4.44 On 24th April 2015 Adult D's GP, AMH social worker and an approved social worker (ASW) visited him at home. His home conditions were described as "disgusting", having significantly deteriorated. He declined an initial memory assessment. The practitioners were in agreement that Adult D "just about" had capacity but whether he understood the effects of his choices on himself was considered to be less clear. He was advised about his alcohol intake and the impact of his diet on his diabetes. Adult D expressed frustration with people turning up at his property and emphatically declined respite to facilitate a further deep clean of his home.

4.45 On 29th April 2015 a RMM in respect of Adult D was advised that he had declined all support. It was decided that contact with Adult D would be maintained by fortnightly

phone calls and monthly home visits, Adult D's capacity would be formally assessed and STC safeguarding would be contacted in respect of self neglect. It was also decided to contact the Care Quality Commission (CQC) in respect of Pin Point Care. The next RMM was to be held in 5-6 weeks although it did not take place until 24th September 2015.

4.46 Environmental health were to visit Adult D's property on 1st May 2015 in respect of the proposed deep clean but there is no record of this taking place. Telephone contact was made with Adult D by his social worker on 20th May 2015 when he described himself to be "fine".

4.47 Following a period of long term sickness, Adult D's social worker phoned him on 13th August when Adult D said he was "fine" although he acknowledged a decline in his mobility.

4.48 On 19th August 2015 Adult D declined a home visit at which it had been intended to complete the mental capacity assessment decided upon at the 29th April 2015 RMM.

4.49 On 18th September 2015 STC adult mental health team contacted Adult D's GP surgery which advised that Adult D had not been seen since 12th May 2015 when he attended for diabetic screening. It has been subsequently discovered that Adult D did not attend but that the surgery mistakenly believed that he had attended and erroneously advised STC to that effect.

4.50 On 22nd September 2015 Adult D declined a home visit from his social worker, saying that he becomes anxious and stressed when professionals visited.

4.51 On 24th September 2015 a RMM was held for Adult D at which his resistance to professional help was discussed. Concern was expressed about his physical health and whether he was being financially exploited by his informal carer given the poor state of his living conditions. There appeared to be no actions arising from this RMM and the date for the next meeting was set for 23rd October 2015.

4.52 On 10th October 2015 STC adult mental health wrote to Adult D to arrange a home visit for 23rd October 2015 at which he was to be introduced to a new social worker as the social worker who had previously managed his case was moving to another role.

4.53 During the afternoon of 15th October 2015, Adult D was brought into A&E by his informal carer. He presented with ulcers to both legs which he said had become worse. He appeared very unkempt. His ulcers were cleaned and fresh dressings applied. "Social" admission was considered but Adult D stated that he wished to return home. A referral was made to the district nurse service for alternate daily wound care and his GP was to be updated. STC Out of Hours service (OOHS) was notified.

4.54 The following day (Friday 16th October 2015) another social worker visited Adult D who was unable to stand as a result of his declining mobility. The social worker considered his home to be "uninhabitable". She discussed the case with STC safeguarding who advised that the case should continue to be managed under RMM arrangements. The AMH social worker recorded that she disagreed with this decision. The social worker made contact with Adult D's GP and requested he visit Adult D in an effort to persuade him to be admitted to hospital. The GP visited Adult D following which he agreed to be admitted to hospital. His GP noted that Adult D was able to stand with effort, was scratching lesions on his body and his living conditions were very poor with faeces "everywhere".

4.55 At 4.55pm the same day Adult D's GP booked an urgent ambulance transfer to A&E for Adult D in relation to leg ulcers. North East Ambulance Service (NEAS) were unable to attend Adult D's address to convey him to hospital until 3.24am the following morning. During this period NEAS contacted Adult D on several occasions to apologise for the delay and check if his condition had worsened. The priority of the job was upgraded at 12.53am. The ambulance crew which attended D's home reported that he was in a "very poor state of self neglect" and that his living conditions were "deplorable".

4.56 Adult D was admitted to South Tyneside hospital where he was noted to have worsening leg ulcers which had become infected and that he was confused at times.

4.57 On 20th October 2015 concerns were expressed in respect of his capacity on the grounds that he was unable to perceive risk to himself posed by his home environment. He was diagnosed with pulmonary odema (fluid accumulation in the lungs). His condition was subsequently described as "critical" and he was transferred to the intensive care unit.

4.58 The following day (21st October 2015) Adult D further deteriorated. He was diagnosed with sepsis syndrome and he died following multiple organ failure as a result of severe sepsis and pneumonia.

Contact with Adult D's family and friends

5.1 The wife of Adult D's deceased cousin agreed to contribute to the SAR. She had known Adult D all his life. He was an only child. His mother died when he was in his teens. Adult D's cousin's wife said that Adult D's mother was a "lovely" woman but not very house proud, adding that this probably influenced Adult D in the way he lived his life. As a boy he was very bright and when he grew up he had a professional career

5.2 Adult D's cousin's wife never visited him in the property in which he lived for the last years of his life although at one time she had been a regular visitor to his family home as she helped to care for Adult D and his father after Adult D's mother died. She

said she kept the place clean and cooked and washed for them. After Adult D's father died, he would not accept help from anyone. She said he wouldn't let people into his home because he felt ashamed. She added that whenever she saw Adult D in the street, he would turn and walk the other way.

5.3 She said she was never aware of Adult D being in a relationship with a woman. She just couldn't imagine it because he kept himself to himself so much. He did have good friends and mentioned a man who was a particularly good friend who had died a few years ago.

5.4 Adult D's cousin's wife said that his informal carer claimed to be his next of kin and tried to make a claim on his estate when Adult D died. In the event the bulk of Adult D's estate was required to cover debts he had accumulated.

5.5 She had no comment to make about the services Adult D received in the final years of his life because she had no knowledge of them. The contents of this report were later shared with her and she had no further comments she wished to make in response.

5.6 Adult D's informal carer declined to contribute to the review.

5.7 A friend of Adult D who is also from the same professional career contributed to this review. He said he hadn't seen anything of Adult D for a number of years. He had had telephone contact with him 2 or 3 years before he died but had never visited him at his property.

5.8 The friend described Adult D as a clever man educated at degree level and an active member within his local community.

5.9 He said Adult D had been heavily involved with the church but had cut himself off from that. When Adult D died, this friend attempted to inform his other friends of the funeral arrangements but said he had great difficulty in finding anyone Adult D had stayed in touch with from his earlier life.

5.10 He was unable to offer any explanation as to why Adult D behaved as he did. He said there was a degree of eccentricity about Adult D. He said he knew Adult D's home was "in a state". He had always lived like that to his knowledge and that "that was his way". However, he referred to the circumstances in which Adult D's career within his profession came to an end. This happened before the friend knew Adult D. However, Adult D had told him that he had been implicated in the unsatisfactory conduct of his senior colleague and restrictions were placed on Adult D's future practice. This made it difficult for him to continue working. Adult D's friend said that he felt very unfairly treated by the decision to place restrictions upon him.

5.11 Whilst working within his profession he had been the advisor for the licensed victualler's association and his friend believed that regularly visiting clients in public houses had been a factor in the problems with alcohol he developed.

Analysis

6.1 The conversations with practitioners involved in Adult D's case brought out what an extremely difficult case this was. By the time agencies began to work together in a co-ordinated way to support Adult D, his extreme self neglect had become deeply entrenched. He had become almost completely isolated from family, friends and bodies with which he had been enthusiastically involved. His motivation to care for himself appeared to have largely disappeared. When his boiler broke down it was not repaired and he lost access to hot water and heating, light bulbs were not replaced so he could not safely get around his home in the dark and when his toilet became blocked he began to defecate in his bath and wash basin before repeatedly defecating in his lounge arm chair. Adult D's home conditions were unsanitary and presented a health hazard to himself, anyone visiting him and probably his neighbours as well. Engaging with Adult D in these circumstances required considerable determination and resolve on the part of practitioners.

6.2 Although he lacked motivation for self care he appeared to prize his independence greatly and deployed his intelligence and erudition to advocate for his privacy thus enabling him to successfully keep professionals at "arms length". In the final year of his life he began to turn away services more emphatically.

6.3 A further challenge for practitioners was the frequent presence of Adult D's informal carer who could adopt a hostile approach to practitioners and sometimes appeared to be under the influence of alcohol, as did Adult D.

Areas of focus of this SAR:

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

6.4 There were some very good examples of joint working between Adult D's social worker, who was widely praised for her persistence, his GP and environmental health. During the periods when these partners were fully engaged and working collaboratively, marked progress could be observed.

6.5 Adult D's GP had cared for him for four years and had developed an understanding of his needs. He had valuable insights to share with this review which once again emphasised the key role that GP's can play in safeguarding. However, the complete absence of the GP from the multi-agency Risk Management Meeting (RMM) regime introduced to oversee Adult D's case is an all too common feature of both the

safeguarding children and adults agendas. The GP advised that the staff at his surgery are empowered to "hound" him for reports for safeguarding children meetings. This does not appear to be the case with the safeguarding adults agenda however.

6.6 Environmental health appears to have much to contribute to the self neglect agenda but understanding of what they do may not be particularly widespread. Adult D's case was referred to them by his GP which they said was a very unusual referral route. Environmental health appears to have quite a persistent approach and seem particularly effective in encouraging service users to work with them on a voluntary basis through explicit reference to the strong powers of enforcement they possess – should they be required.

To consider the extent to which agencies recognised, respected and valued Adult D 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.

6.7 Agencies respected Adult D's autonomy in decision making even though the choices he made exposed himself to harm. STC adult mental health team, Adult D's GP and environmental health invested in building relationships with Adult D which for a time held out the promise of substantial progress, particularly when Adult D agreed to enter respite whilst his home was deep cleaned and also agreed to accept services into his home on his return home. Although the plan agencies put in place to help Adult D improve his self-care and maintain his improved home environment ultimately failed, practitioners made a determined effort to fulfil a duty of care to Adult D and promote his dignity. However, once the plan failed, practitioners appeared discouraged and lacking in resourcefulness.

6.8 Although several practitioners had substantial contact with Adult D, no-one appeared to gain any insight into why he behaved as he did. Indeed, this did not appear to be an issue which was explored to any significant extent. His AMH social worker arranged for Adult D's ability to care for himself to be assessed whilst he was in respite. The conclusion of this assessment was that he was capable of caring for himself subject to some assistance with washing and bathing which was arranged via Occupational Therapy. The RMM appeared to take the view that having established that Adult D was largely capable of caring for himself, then the squalor in which he lived once his living conditions deteriorated following his return to his deep cleaned home, was a personal choice on his part.

6.9 Olsen at al (2007) engaged in "spontaneous conversation" with people who were self-neglecting and found that 75% of respondents related one or more traumatic life experiences such as physical or sexual abuse as a child, problems with mental illness or alcoholism, lifelong struggles with sexual orientation etc. This compared with fewer than 25% of controls who spoke of such experience. (1) The researchers concluded

that these traumatic and potentially life changing histories appeared to be "associated with, and could possibly lie on the causal pathway to development of" self-neglect. (2)

6.10 Contact with Adult D's family and friend for this review suggest possible factors in Adult D's behaviour. The trauma of losing his mother at the age of 15 may have been a factor. The premature ending of his career, his feelings that he had been unfairly treated and the resultant loss of income and social standing has the appearance of an event which may have adversely affected his motivation to care for himself. There is also a reference to the impact of the suicide of a very close friend. If, as researchers suggest, traumatic events may "lie on the causal pathway", gaining insight into why a person self neglects *may* help to suggest strategies for addressing the problem. Certainly, when South Tyneside Safeguarding Adult Board brought together a large gathering of practitioners to consider an earlier SAR on self-neglect, a key message on which there was wide agreement was that professionals supporting people who self-neglect need to invest time in understanding their "lived experience".

6.11 However, it must be acknowledged that efforts to explore *why* Adult D neglected himself could have been frustrated by the articulate defences he put in place and by the state of his home which was not a place where practitioners could readily sit down and attempt to engage him. Additionally, the presence of his informal carer was often a barrier.

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

6.12 The RMM process appeared to have the potential to be an effective way of managing the complexity of Adult D's case. There was good attendance from relevant agencies and regular meetings at the outset. However, attendance gradually dwindled to Adult D's social worker and her senior practitioner. Diminishing partner engagement left STC adult mental health team to carry the risks associated with this case alone.

6.13 There was also considerable drift in the RMM process. Twice there were gaps of around five months between meetings (August 2014 to January 2015 and April 2015 to August 2015). Additionally, the RMM process appeared open ended once it had begun. It was unclear under what circumstances the process would conclude.

6.14 Nor was the RMM process very effective at the management of risk. The risks affecting Adult D were assessed by his social worker via the FACE risk profile ("Functional Analysis of Care Environments") which was completed in May and June 2014 when the "risk related to physical condition" was scored 2 ("significant risk") and "risk of severe self neglect" was scored 4 ("serious and imminent risk"). (The FACE risk profile consists of a numeric rating for risks ranging from 0 (no apparent risk) to 4 (serious and imminent risk)).

6.15 This level of assessed risk necessitated the implementation of a risk management plan for Adult D which was completed on 29th May 2014 – just prior to his period in respite - and the plan set out risks and identified a series of potential actions to reduce or mitigate those risks. It would appear no further FACE risk profiles were completed until shortly before Adult D's death in October 2015. Nor does the risk management plan appear to have been updated after May 2014. Once the plan put in place to support Adult D upon his return from respite to his deep cleaned home in July 2014 began to fail, and he began to increasingly turn away support, one would have expected the risk management plan to be updated but this didn't happen and the fact that it did not happen did not appear to be an issue of concern to the RMM.

6.16 And when the February 2015 RMM was advised of the fact that Adult D had not engaged with the district nurse service for six months from August 2014 to February 2015 this generated no action apart from unsuccessful attempts to invite district nurses to future RMMs. Given the fact that Adult D's leg ulcers had been assessed as being of high risk of infection from his home environment by the district nurse service in July 2014, one would have expected a prompt re-referral to the district nurse service, the completion of a fresh FACE risk profile and the updating of Adult D's risk management plan. None of these things happened.

6.17 It is not known whether the district nurse service shared its July 2014 assessment of the risk of infection of Adult D's leg ulcer with his GP, STC or any other agency. If not, this suggests that risks assessment continues to be primarily a single agency as opposed to a multi-agency activity. This was a key finding of the previous SAR conducted by South Tyneside Safeguarding Adults Board in respect of self-neglect.

6.18 And placing Adult D's case within RMM arrangements may have provided false assurance to senior management that the risks associated with the case would be managed more effectively than was actually the case.

6.19 This review has been advised that Adult D's case would not necessarily have been discussed in supervision with his social worker although it is understood that a new style of supervision which focusses on an audit of cases had been introduced more recently. It is unclear how effectively Adult D's case was managed when his social worker was on extended sick leave for two periods.

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

6.20 Gaining Adult D's agreement to enter respite whilst his flat was deep cleaned in June 2014 was a significant breakthrough by his social worker. Environmental health also played their part in managing to persuade Adult D to agree to the cost of the deep clean being treated as a charge on his house. The period in respite allowed a number of

assessments to be completed and contact with the district nursing service to assess his leg ulcer and begin a programme of treatment.

6.21 Additionally, support was organised to try and prevent Adult D's living conditions deteriorating when his period of respite came to an end. This included HART services, a home care package and Occupational Therapy.

6.22 Unfortunately, conditions in Adult D's home appeared to deteriorate rapidly following his return from respite after the deep clean. HART withdrew within days. The presence and behaviour of Adult D's informal carer appeared to be a factor in HART's decision.

6.23 The home care package was provided by Pin Point Care. Two members of staff from Pin Point Care contributed to this review. Neither had been employed by Pin Point Care at the time and had any knowledge of Adult D's case although they were able to locate some records of visits, invoices and other correspondence. They advised that Pin Point Care was currently undergoing considerable change after a very critical CQC inspection report. They suggested that the company may have previously taken on contracts without necessarily having the capacity to deliver them.

6.24 The decision to commission Pin Point Care, which at that time was a new provider and an unknown quantity, to provide a home care package to a service user whose self-neglect had been so entrenched was somewhat perplexing. Adult D's social worker advised the review that the STC adult mental health team considered a well regarded local provider (Homecare Living) with a track record of managing higher risk. However, that provider lacked the capacity to take on Adult D and so STC turned to Pin Point Care which subsequently reduced and then ceased the service provided to Adult D and failed to notify STC as commissioner of the service. Pin Point Care effectively abandoned Adult D which was a very serious failure.

6.25 It is suggested that there is a relative shortage of providers which have the confidence and capability to manage higher risk cases such as that of Adult D. Indeed, the well regarded service provided by Homecare Living referred to above is no longer operating.

6.26 A great deal of hope was invested in the plan to deep clean Adult D's flat and put in place a package of support. Valuable work had been done to overcome his resistance to support but when the promising post respite plan began to fail, practitioners appeared to run out of ideas and seemed frustrated and somewhat powerless at their inability to achieve enduring change. This is consistent with self neglect research in which practitioners have expressed the view that self neglect work feels "lonely, helpless, frustrating and risky". (3) Conversations with practitioners involved in Adult D's case featured comments such as "definitely a "banging head against wall" case" and "maybe there was a level of nihilism – nothing is going to work".

6.27 It is apparent that practitioners involved in cases such as this require support, encouragement and signposting to guidance and emerging good practice

6.28 The district nurse who visited Adult D following his period in respite (four days after his return home) described the difficulty in changing his dressing whilst he was sitting in his armchair on which he had defecated. She also described experiencing insect bites whilst in Adult D's home. Given the state of Adult D's flat, she questioned whether the deep clean had actually taken place. (Environmental Health confirmed that the deep clean had in fact taken place and provided photographic evidence of this.)

6.29 The district nurse made a safeguarding alert. In response it was decided that the case would be managed under RMM arrangements as self neglect was not at that time defined as an adult safeguarding issue.

6.30 The district nurses who contributed to this review described the arrangements by which they transferred Adult D's case from community to clinic services. The district nursing sister, who managed the district nurse who had attended Adult D's home following respite, recognised the risks involved in transferring this case to clinic services, particularly the risk that Adult D would not attend clinic and may therefore not access the care he required for his leg ulcer. When he failed to attend his first clinic appointment (Cleadon Park clinic), she arranged a clinic appointment in a location which was more accessible by public transport (Flagg Court clinic). Adult D attended this rearranged appointment on 5th August 2014. The district nursing sister checked that he had attended and asked this clinic to advise her should there be any problems with his future attendance.

6.31 In the event Adult D did not attend clinic again and did not seek out medical attention for his leg ulcers until he presented at A&E shortly before his death 14 months later. The district nursing sister recognised the risk of Adult D not accessing the clinic service and made arrangements for him to attend a more accessible clinic after he failed to attend his first clinic appointment. This was good practice, although the sister acknowledged that she had not recorded much of what she did in respect of Adult D. However, relying upon the Flagg Court clinic - with which she and her staff did not appear to have a routine organisational link - to inform her of future non-attendance by Adult D on the basis of an informal unrecorded conversation with a member of the clinic staff, whose name was unrecorded, appears to have left too much to chance.

6.32 At that time the district nurse service did not have a system in place to enable a patient to be visible to staff in other parts of their service. So the fact that Adult D had disengaged from the service was not visible to the community district nurse team. The review has been advised that this problem has now been addressed by the introduction of EMIS which is an electronic clinical system which allows community health care practitioners to view and contribute to a patient's health care record. This system was

introduced into South Tyneside community settings from April 2015 with access extended to clinics during 2016.

6.33 As previously stated, the fact that Adult D was not accessing district nursing care for his leg ulcers was brought to the attention of the RMM which responded by resolving to invite the district nurse service to the next RMM. It is not known whether or not they were invited but they did not attend and the risks associated with Adult D's disengagement from their service went unaddressed.

6.34 The systems employed by Adult D's GP surgery to ensure the health checks he required appeared less than effective, particularly during the final year of Adult D's life when he began to turn away, and disengage from services more frequently. For example, when he told a GP that he wasn't mobile and couldn't attend clinics on 21st August 2014 he was nonetheless advised to attend surgery and his subsequent failure to attend was not followed up. There was again no follow up when Adult D cancelled blood tests required for diabetes and general health checks in February 2015.

6.35 It is also surprising that Adult D's GP Surgery did not pick up on the fact that from August 2014 until his death in October 2015 he was completely disengaged from the district nurse service and as a result his leg ulcers received no attention whatsoever.

6.36 Adult D's GP advised this review that there was no failsafe system in place for patients like Adult D who did not firmly refuse services but instead maintained the appearance of co-operating without actually doing so. It is understood that Adult D would have been included within the surgery chronic disease register which should have been a vehicle for ensuring that Adult D's health needs were attended to. In the event it seems to have been far too easy for a vulnerable patient such as Adult D to simply fall off the radar of a GP practice where he was well known.

6.37 During November 2014, the OT made unsuccessful attempts to telephone Adult D to check how he was getting on with the swivel bather. She then contacted him by letter requesting he contact her if he had any difficulty in using the bather. The letter added that if she heard nothing from Adult D within two weeks, she would assume that he was managing to use the equipment and close his case to OT. Discharging a patient as vulnerable and as difficult to engage as Adult D from the service does not appear to be consistent with sound safeguarding practice.

6.38 NEAS accepted that the prolonged delay in conveying Adult D to hospital by ambulance was unacceptable. They advised this review that they anticipate spikes in demand for ambulance transport to hospital and provide integrated care and transport (ICAT) ambulances to handle this demand between 11am and 7pm on weekdays. The two daily spikes in demand are following GP morning surgery and after subsequent GP home visits. NEAS received the call in respect of Adult D at 16.57 on a Friday (one of their two busiest days of the week). This was a time of day when ICAT would still have

a backlog of patients to transfer to hospital from the spikes in demand from earlier in the day and it would be only two hours before this service ceased for the day. Some delay in conveying Adult D to hospital was therefore anticipated.

6.39 Adult D's transfer to hospital was categorised as "urgent – 2 hours". There are three categories of "urgent" transfers which are 1 hour, 2 hours and 4 hours which sit below the calls which require an emergency response. The majority of "urgent" transfers fall into the 1 hour category and 2 hour transfers will only be attended to after the 1 hour transfers have all been accomplished. However, as new "urgent – 1 hour" transfer requests are received, they take precedence over earlier 2 hour requests. At peak times this means that "urgent – 2 hours" and "urgent - 4 hours" transfers may wait some considerable time. Adult D's case was regularly reviewed and after a time was upgraded to "urgent – 1 hour".

6.40 NEAS has advised this review that they have invested in the creation of a clinical hub within their operations centre, consisting of paramedics and nursing staff which enable them to ensure priority of the highest priority calls is based on clear clinical need but should also enable them to more effectively review the appropriateness of response to other calls.

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

6.40 Please see Paragraphs 6.12 – 6.19 which set out the formal risk management process applied to Adult D's case.

To establish whether capacity was properly considered within the framework of the Mental Capacity Act.

6.41 Adult D was assumed to have mental capacity by all the practitioners who contributed to this review. However, no practitioner spoken to had assessed Adult D's capacity or was aware of any assessment of his capacity other than an attempt to assess his mental capacity in 2015 which Adult D did not allow practitioners access into his home to carry out.

6.42 Adult D was described as very articulate. His GP felt that it was possible that some practitioners might have felt slightly intimidated by Adult D's professional standing and his ability to express himself, which he was said to have used in order to "exert control over the situation". When his social worker and his GP visited Adult D on 24th April 2015 they concluded that Adult D "just about" had capacity. He declined an initial memory test on that occasion. The GP and the social worker recorded that they couldn't be sure that he fully understood what the serious consequences of his decisions to neglect himself and turn away care could be.

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

6.43 Communication between the community and clinic based district nurse service appeared far from integrated as did interaction between the district nurse service and the GP who commented to the review that "they (the district nurse service) work pretty independently from us now".

6.44 The concern that Adult D was being financially abused by his informal carer arose out of purposeful communication between the STC adult mental health team and NTW. As a result, STC were in possession of a good deal of information at that point which raised legitimate concerns that Adult D may be being financially abused. The police were then provided with what appeared to be rather a brief summary of this information about financial abuse which they then assessed in isolation.

To consider the potential relevance of the Care Programme Approach in coordinating the Care and treatment of Adult D.

6.45 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. Adult D did not receive "secondary mental health services" during the period covered by this review from NTW.

6.46 However, Adult D was assessed by an NTW CPN shortly after his period in respite ended. The CPN found him to be communicative, responsive and apologetic for "wasting the time" of the CPN. Some evidence of self-neglect was noted. Adult D's social worker was present and the NTW CPN concluded that Adult D's needs appeared to be primarily "social". It is of note that the assessment took place away from Adult D's home on 16th July 2014. Adult D had returned to his home after the deep clean on 3rd July 2014 and the district nurse had visited him on 7th July to find that his living conditions had so deteriorated that she made a safeguarding alert. The rapid deterioration in Adult D's living conditions may not have been fully apparent to the NTW CPN during this assessment.

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

6.47 There were concerns that Adult D's informal carer may have been financially abusing him. The review has discovered that the relationship between Adult D and his informal carer was quite complex. Adult D's GP was also the GP for the informal carer and the informal carer's mother. The GP's view was that the relationship was borderline abusive in that he felt Adult D exploited his informal carer by asking him to do things for him by promising beer, money etc. in return. The informal carer was said to feel

that he couldn't get away. The GP felt this had had an adverse impact on the informal carer's mental health, which the GP felt had improved since Adult D's death.

6.48 It seems likely that the relationship between Adult D and his informal carer was one in which there was a degree of abuse or manipulation on both sides.

6.49 There were periodic concerns that the informal carer may have been financially abusing Adult D who was believed to pay him £30 weekly to provide support and run errands. These concerns came to a head in July 2014 when the adult mental health team became aware that the informal carer had accumulated substantial gambling debts and had borrowed £4,500 to pay off these debts from a friend, who may have been Adult D.

6.50 STC referred this concern of financial abuse to the police who decided to take no action. The member of police staff described the process by which she assessed the allegation. Although well versed in safeguarding children issues she was less familiar with adult safeguarding at that time and, as a result, did not fully appreciate the significance of financial abuse in adult safeguarding. She assessed the allegation and concluded that a male who had capacity (Adult D) may have given money as a gift or loaned money of his own free will. On reflection, she felt she should have escalated the matter to her sergeant but decided at the time that the correct disposal was "no further action". The review has been advised that such an allegation would now go directly to the police control room so that an officer could be deployed to investigate.

6.51 However, the allegation of financial abuse was not well handled. A multi-agency discussion was absent and the key decision of whether or not the allegation should be more fully investigated was taken by a single member of police staff who lacked the expertise necessary to make such a decision.

The impact of changes

6.52 Many changes which have taken place in recent years cropped up in the conversations with practitioners. The impact of austerity appears to have taken quite a toll on the STC adult mental health team in terms of reduced practitioner numbers. This may have been a factor in this case. The chronology discloses a number of occasions when meetings or home visits had to be cancelled because Adult D's social worker had been deployed to other responsibilities at short notice.

6.53 It is not known if lower staff numbers of has impacted upon sickness levels. Sickness absence was a factor in the drift noticed in the RMM process. Nor is it known whether pressures experienced by staff have impacted upon the time available for the indispensable recording of information. Adult D's social worker was adamant that she had made, or attempted, more home visits than were recorded. Her manager supported her in this view. The district nursing sister acknowledged that she had not fully

recorded her decisions relating to the transfer of Adult D's case from the community district nurse service.

6.54 Concern was expressed about one consequence of outsourcing the provision of drug and alcohol services which was that the current provider of those services did not appear to have the appetite or capability to manage cases which carried higher risks. Consequently, it was said that, despite having outsourced drug and alcohol services some years ago, STC continued to manage higher risk drugs and alcohol cases.

6.55 It was also noted that changes in one agency can have unintended but quite profound consequences for other agencies. For example, NEAS say that their "job cycle time" – the amount of time each ambulance journey takes - has increased as a result of NHS changes including closure of local hospitals and services provision being centralised on certain sites.

Good practice

6.56 There was good practice evident in this case particularly:

- Partnership working between STC adult mental health team, the GP and environmental health prior to 2015. Environmental health commented that the referral from Adult D's GP in 2013 was "unique".

- Adult D's social worker demonstrated considerable persistence despite the difficulty in engaging with him.

- Obtaining the trust of Adult D so that he agreed to go into respite whilst his flat was deep cleaned and obtaining his agreement for the cost of the deep clean to be treated as a future charge on his property.

- The district nurse service received good support and advice on health and safety when exposing themselves to hazards on home visits to Adult D.

Findings and recommendations

Self-Neglect Guidance

7.1 At the time when practitioners were responding to Adult D's self-neglect, there was an absence of guidance to assist them. Determined, resourceful collaborative work was in evidence to persuade Adult D to enter respite whilst his flat was deep cleaned at his expense. The period of respite also enabled Adult D to be assessed and obtain appropriate medical care in a safe environment. The plan put in place to support Adult D upon his return to his flat was fairly comprehensive consisting of input from HART, district nurse and occupational therapy support, a home care package and the

replacement of his boiler. However, Adult D's behaviours were deeply entrenched and the condition of his home deteriorated rapidly. HART quickly withdrew, the district nurse service decided his home was not a suitable place to provide care for Adult D, occupational therapy provided a valuable service but then withdrew and the provider of the care package abandoned Adult D without informing STC.

7.2 After the failure of the post respite plan, practitioners appeared at a loss over what to do next. In their contributions to this review, practitioners drew attention to the lack of a process for managing self-neglect cases and on not knowing quite where to turn for advice and guidance. They now have access to the South Tyneside Safeguarding Adult Board's Toolkit for practitioners on self-neglect and hoarding. The toolkit helps practitioners to assess risk (Adult D's case would have been "high risk/critical") and then follow the "journey of support" which consists of seven stages which, in sequence, are "background", "risk and assessment", "multi-agency responses", "resources available", "therapeutic responses", "support networks" and "legal processes". Many of the elements of the "journey of support" were evident in efforts to support Adult D.

7.3 This review has been advised that in most instances practitioners do not seem to be aware of the self-neglect and hoarding toolkit at the point at which they seek to refer cases involving self-neglect, although they are then generally advised to make use of the toolkit. As yet there is no feedback available from practitioners who have used the tool kit. It is strongly skewed towards hoarding which can be a feature of self-neglect but was not in this case. The toolkit also appears to assume that the self-neglecter/hoarder will be living in rented housing which was also not the case with Adult D. The self neglect elements of the toolkit could be further enhanced to reflect learning from SARs such as this case and the earlier case of Adult C, together with learning from research.

Recommendation 1

That South Tyneside Safeguarding Adults Board enhances its self-neglect and hoarding toolkit in the light of learning from this and other SARs and research findings. The use of the revised tool kit should be promoted and practitioner feedback on its use obtained in order to further refine and enhance the toolkit over time.

Appreciation and management of risk

7.4 The risks affecting Adult D were not re-assessed as his circumstances changed. After the failure of the post respite plan, Adult D appeared to become increasingly indifferent to the serious risks to his health arising from his lack of care for himself and his home environment. In the final year of his life Adult D repeatedly turned away support. Yet the risk management plan completed prior to his period in respite was not updated.

7.5 The Risk Management Meeting process began well but ultimately did not succeed in the multi-agency management of the risks faced by Adult D because partner agency commitment to the process declined, there was considerable drift and the process was insufficiently alert to the increasing risks to Adult D, particularly that of infection to his leg ulcer arising from his disengagement from the district nursing service. Adult D's GP was not engaged in the Risk Management Meeting process through representation or by providing reports.

Recommendation 2

That South Tyneside Safeguarding Adults Board obtains assurance that the Risk Management Meeting process is an effective vehicle for managing safeguarding and other risks and that it is fully supported by all relevant partners including GP practices.

Recommendation 3

That South Tyneside Safeguarding Adults Board disseminates learning from this SAR to practitioners and in doing so, takes the opportunity to emphasise the importance of the assessment and management of risk.

District Nursing Service

7.6 When the district nurse service decided that they could no longer provide care for Adult D within his flat because the unsanitary conditions exposed him to a high risk of infection of his leg ulcer and them to dangerous working conditions, they recognised the risk that Adult D may be unable to, or choose not to, access district nursing services in a clinic setting. The arrangements they put in place to mitigate this risk did not succeed and Adult D did not access district nursing services between August 2014 and his death from severe sepsis in October 2015.

7.7 As previously stated, the EMIS system is now in place in South Tyneside to ensure that the non-attendance of vulnerable patients such as Adult D at district nurse clinics is noted and acted upon. However, South Tyneside NHS Foundation Trust which provides district nursing services, has advised this review that it would be beneficial to complement EMIS by developing standard operating procedures in order to better manage and track vulnerable patients who do not attend clinic appointments.

Recommendation 4

That South Tyneside Safeguarding Adults Board obtains assurance from South Tyneside NHS Foundation Trust that the EMIS system which has been fully implemented since the death of Adult D is a robust method of monitoring and responding to non-attendance at clinic appointments. The Board should also obtain assurance about the

effectiveness of any standard operating procedures introduced to manage and track vulnerable patients such as Adult D.

GP care to vulnerable patients

7.8 Adult D's GP provided good continuity of care to him and played a key role in multi-agency efforts to address his severe self-neglect. However, Adult D's GP surgery was ineffective in ensuring he received the healthcare he needed during the final year of his life. Systems for prompting and recording his health reviews and following up non attendance were insufficiently robust. Additionally, communication between Adult D's GP surgery and the community district nurse service was deficient.

Recommendation 5

That South Tyneside Safeguarding Adults Board seeks assurance from South Tyneside CCG that all GP surgeries have robust systems in place to ensure that vulnerable patients are offered the healthcare they need and that non-attendance is flagged and appropriate action taken.

Recommendation 6

That South Tyneside Safeguarding Adults Board seeks assurance that there are appropriate links between GP surgeries and community district nurse services.

Financial Abuse

7.9 The manner in which Northumbria Police assessed and then reached a decision in respect of the allegation of financial abuse of Adult D was not effective. The member of staff who made the decision did not appear to have been adequately trained or supported. And the decision was taken by a single agency in isolation. The system in place for considering the safeguarding alert in respect of the alleged financial abuse within South Tyneside Council was decentralised and not subject to quality assurance to ensure consistency of approach.

7.10 Both Northumbria Police and South Tyneside Safeguarding have advised this review that such an allegation would be handled much more effectively now. The police advise that such an allegation would go directly into their control room for deployment of an officer to investigate. South Tyneside Council Safeguarding has advised that they now have a single point of contact for all safeguarding referrals and that there is now a system in place to monitor quality and consistency of safeguarding decisions.

Recommendation 7

That South Tyneside Safeguarding Adults Board obtains assurance that Northumbria Police has an effective policy in place to investigate allegations of financial abuse of adults with health and care needs and that its officers and staff receive appropriate training to enable them to comply with that policy.

Recommendation 8

That South Tyneside Safeguarding Adults Board obtains assurance that safeguarding concerns in respect of financial abuse are handled in a consistent and effective manner.

Ambulance delay

7.11 Adult D waited far too long for an ambulance to convey him to hospital. He was seriously ill at the time and died four days later. NEAS has invested in an enlarged clinical hub in order to exercise more informed oversight of the management of emergency and urgent requests for ambulance services.

Recommendation 9

That South Tyneside Safeguarding Adults Board obtains assurance from the North East Ambulance Service over the effectiveness of measures they have put in place to reduce wait times for adults with care and support needs.

Failure of Pin Point Care

7.12 Pin Point Care were commissioned to provide home care to Adult D. They were a largely untried provider with no reputation for supporting higher risk service users. Selecting Pin Point Care to support Adult D, whose self neglect was entrenched, did not appear wise. The decision to commission Pin Point Care may in part reflect an absence of providers with a track record of supporting higher risk service users. However, Pin Point Care first reduced and then ceased providing support to Adult D without notifying South Tyneside Council as commissioner. This was highly irresponsible.

Recommendation 10

That South Tyneside Safeguarding Adults Board share this SAR with the Care Quality Commission in order that they are fully aware of Pin Point Care's failings in this case.

Recommendation 11 *That South Tyneside Safeguarding Adults Board obtains assurance that South Tyneside Council's arrangements for commissioning and monitoring care and support for higher risk service users is effective.*

Single Agency Action Plans

The practitioners who contributed to this SAR were able to identify changes made by their agencies as a result of the emerging learning. However, it would be of value for those agencies to now reflect on the learning emerging from this SAR overview report and advise the Safeguarding Adults Board of any changes they have made or are in the process of implementing as a result of this SAR.

Recommendation 12

That South Tyneside Safeguarding Adults Board request the agencies involved in this case to provide them with any single agency action plans they have developed, in order that the Board can obtain assurance that any necessary single agency improvements have been introduced or are in the process of being implemented.

References

(1) Retrieved from http://www.scie.org.uk/publications/reports/report46.asp

(2) ibid

(3) Retrieved from http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/

Appendix A

Process by which the SAR was conducted

Chronologies setting out relevant contact with Adult D were provided by the following agencies:

- 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 NHS Foundation Trust
- Tyne and Wear Fire and Rescue Service TWFRS)

The SAR Sub Group decided to adopt a broadly systems approach to this SAR in which there was a strong emphasis on engaging practitioners involved in Adult D's case in reflecting on their practice and helping to identify any improvements in systems. As a result, the independent author held extended conversations with relevant practitioners from the above agencies and Pin Point Care.

Based upon the chronologies and the records of the conversations with practitioners, the independent author prepared a draft report.

The independent author interviewed the family and friends of Adult D to enable them to contribute to the review.

The draft report was discussed at a practitioner learning event at which professionals who had been involved in the case contributed to the identification of learning themes and suggested changes which could be made to improve practice.

Adult D's family was provided with an opportunity to view and comment upon a late draft of the report.

A final report was prepared for presentation to South Tyneside Safeguarding Adults Board.