Safeguarding Adult Review

Overview Report

Adult D

Author: Amanda Clarke

Date: 3 January 2018

Publication Date: 13 March 2018

Adult D

"Amy"

Died November 2016

This safeguarding adults review was commissioned by the Independent Chair of Lancashire Safeguarding Adults Board (LSAB) on 31 January 2016 in agreement with the recommendation of the LSAB Safeguarding Adults Review Sub Group that the circumstances surrounding the death of an adult met the criteria for a safeguarding adults review (SAR).

Subject of the review: Adult D: **"**Amy"

Amy is not the real name of Adult D but the review will refer to her in this name to protect her real identity. The name has been chosen in consultation with Amy's long term partner.

Amy's partner "David", which is a pseudonym, again suggested by the partner himself, was able to share some personal information about Amy to illustrate the person she was.

Amy was described by David as "an independent woman, who was easy to talk to and always put others first". He said Amy "was an animal lover and a good all round person".

Sadly Amy died aged 50 years.

Legal context

Under Section 44 of the 2014 Care Act 2014, safeguarding adults boards are responsible for safeguarding adults reviews in circumstances where an adult dies as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

The decision to undertake this SAR was made by the Chair of the Lancashire Safeguarding Adults Board based on a recommendation from the Safeguarding Adults Review Sub Group.

The purpose of SARs is described in the statutory guidance to enable effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to reduce the likelihood of similar harm re-occurring.

Methodology

The methodology used was based on the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the full history of the adult or child and family is not the primary purpose of the review. Instead it is an effective learning tool for local safeguarding

adult boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken by individual agencies in the case and by the review Panel is not the focus of the reports which are succinct and centre on learning and improving practice.

However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of safeguarding boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the board may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

Following notification of the circumstances of the death of Amy in this case, and agreement by the chair of the Lancashire Safeguarding Adult Board to undertake a SAR, a review panel (to be known as the Panel) was established in accordance with guidance. This was chaired by Kristy Atkinson, Deputy Designated Professional for Safeguarding Adults and Mental Capacity Act (to be known as the Chair).

The Panel included representation from relevant organisations within Health, Adult Social Care, the Police, the GP service and the North West Ambulance Service. Information was also provided for the Panel to consider by Pendle Borough Council Housing, Health and Economic Development Services, and the Royal Society for the Prevention of Cruelty to Animals (RSPCA).

Amanda Clarke, an independent reviewer from Derbyshire (to be known as the Reviewer) was commissioned to work with the Panel and to undertake the review.

The Panel identified the review timeframe as commencing 01/08/2015 and concluding 28/11/2016, which was when Amy died. The Panel had agreed that this was an appropriate period to review recent services on the understanding that historical information would be considered and shared where relevant, and to provide context.

Full terms of reference for the review are included as Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and analysis of their involvement. These were considered by the Panel and provided opportunity for Panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The practitioners' learning event was held in September 2017 and was attended by 12 professionals. Most practitioners attending had had direct involvement with Amy. Those who had not worked directly with her were able to provide the position and perspective of the service delivered to Amy and her partner. The Reviewer facilitated the learning event assisted by the Chair of the Panel and officers from Lancashire Safeguarding Adults Board.

The event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded.

With the support of Panel members and the Lancashire Safeguarding Adult Board team, further enquiries were made with professionals who were unable to attend the learning event, and this information is included in the report.

Following the practitioners' learning event, the Reviewer collated and analysed the learning to date for discussion with the Panel. Practice issues and themes originally identified by the Panel were re-examined in the light of the findings of the review. This provided opportunity to identify issues requiring further clarification with practitioners or managers. In reviewing the findings, the Panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the Panel in advance of the Panel meeting in November 2016. The report contains learning themes for the Lancashire Safeguarding Adults Board to consider in developing an action plan to ensure learning from Amy's case is embedded in future practice.

Family involvement

The involvement of family members, where possible, in a review is critical to understanding the experience of adults who are subjects in safeguarding adults reviews and the perspective of those closest to them.

From information shared within panel meetings at the start of the review, regarding significant people in Amy's life, the Panel agreed to invite the partner of Amy to contribute to the review. Initially the Panel were told that the couple had had little or no contact with any other family members. Much later in the review process it transpired that the sister of Amy wished to participate on behalf of Amy's birth family. Therefore contributions from David (Amy's partner) and Amy's sister are included in the report where relevant.

The Reviewer and Chair met with David, Amy's partner in July 2017 to gain an understanding of the experiences of Amy of the services offered to her, from his perspective. A follow up call between the Reviewer and David, for clarification purposes took place in September 2017.

This valuable insight into the experiences of Amy, and David, was shared with the Panel at draft report stage. The information provided has been included where appropriate throughout the report, and David's views have been taken into account when identifying learning themes for consideration by the Lancashire Safeguarding Adults Board. Information provided by David within the report appears in *italics*.

The Reviewer is grateful for David's openness in his contribution and willingness to share personal information about himself to benefit the process. The Reviewer will offer to meet with David again to provide an opportunity to see a copy of the report when agreed by the Lancashire Safeguarding Adults Board.

The sister of Amy was traced and spoken to in November 2017. She said that she had little contact with Amy in recent years but that their mother did meet with Amy "quite regularly", including in the month before Amy died. The sister described Amy and her mother meeting normally in a town near to where Amy lived, usually for lunch. The mother and sister did not live locally to Amy and neither visited the home which Amy shared with David.

The sister of Amy disclosed that no member of Amy's family was informed formally about the death until January 2017, 6 weeks after the incident. This will be explored later. She explained that the family did not have any contact with David whilst Amy was alive or after she died.

The Reviewer is grateful for the information which Amy's sister has contributed to the review, and will offer to meet with her to share findings once the report has been agreed by the Lancashire Safeguarding Adults Board.

Learning from the full report will be made publically available after consideration by the Lancashire Safeguarding Adults Board of any issues affecting publication.

History and significant events resulting in the review

Amy had a number of health issues including diabetes (type 2) and epilepsy. Through parts of her adult life she was known to have had some history of drug and alcohol misuse but there was limited evidence of any substance misuse by Amy more recently.

Health records indicate that some years before the review's timeframe Amy was supported by mental health services. She was diagnosed with unspecified disorder of adult personality and behaviour (F69)[1] in May 2007, mixed disorders of conduct and emotions (F92) in April 2007, depression (F32) and alcohol misuse (F10) in August 2003. Amy was not involved with mental health services immediately prior to, or during the identified timeframe for the review.

Amy had three siblings but there is limited information known about Amy's early life. Her sister said that Amy was moved to a special school setting when she was secondary school age due to what the sister described as "behaviour problems". From the limited contact which the sister had with Amy in more recent years and from what her mother knew about Amy, the sister was of the view that Amy did have mental capacity and the ability to make her own choices. This is discussed later in the report. The family were aware of the long term relationship which Amy had with David.

Amy's partner David shared that they had known one another for around twenty five years and they had lived together as common law man and wife at the same address. David described that he had acted as Amy's carer for a long period of Amy's later life until her death. However it was known that Amy was physically able to attend appointments independently and generally made her own way around the local community.

The couple had lived together in a privately rented house with a large number of pets, mostly cats.

Within the timeframe of the review the following episodes are highlighted as significant events. A detailed and full timeline of agency involvement was carefully analysed by the Reviewer with the Panel, and was considered by professionals at the practitioners' learning event.

Significant events 01/08/2015 and 28/11/2016

[1] The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms.

On 17 September 2015 Amy was admitted to hospital after a collapse. She was diagnosed as hypoglycaemic[2]. David was noted on records as her partner and next of kin but there was no mention of him being Amy's carer. Amy was not deemed to lack capacity[3] and was therefore thought able to make her own decisions.

Amy remained in hospital for six days before being discharged home with a referral made to the specialist nurse for diabetes.

On the same day of discharge from hospital, 23 September 2015 the police attended a dispute at the home of Amy and David after David reported an argument between Amy and another woman over ownership of a cat. No offences were identified and the police advised all parties, with no further action taken.

On 28 September 2015 after a number of out of hours contacts by David, the GP attended to see David at home. He was reporting feeling depressed, suicidal but with no plans for self-harm. He also admitted to being alcohol dependant. GP records note that David was a carer for his partner who was said to be upstairs. The house was noted as being "cluttered and smells with nowhere to sit" and the consultation with David took place in an ambulance which attended at the same time. David was not considered actively suicidal. He was advised regarding his current medication and provided numbers for the local crisis team.

On 6 October 2015 the RSPCA attended Amy and David's home as a result of a referral from a member of the public regarding alleged neglect of animals. The property was described by the RSPCA as "horrendous; rubbish and clutter everywhere, human and cat faeces, lots of flies, strong smell of ammonia and excrement." Fifteen cats were noted as being in the house.

Amy was not present at the time but David agreed for the majority of the cats to be removed by the RSPCA. An Animal Welfare Act 2006 warning notice[4] was served. Due to the state of the property the RSPCA made a referral to Lancashire County Council Adult Social Care.

On 7 October 2015 a home visit took place by a social worker and a social care support officer. The house was found to be as described by the RSPCA and the boiler was discovered to be not being properly maintained by the landlord. Amy was seen and reported she had epilepsy and was insulin dependent. It was agreed with Amy that she would have a period of short term care to permit a clean-up and maintenance of the property. A referral was made at this time to local environmental health services.

As a result Amy stayed for a period of six weeks in a residential care home.

On 28 October 2015 the RSPCA revisited Amy and David's home as a follow up from the previous RSPCA referral. David disclosed Amy was in short term care. The RSPCA decision was that the property remained in too poor a condition for the cats to be returned, and David

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[2] Hypoglycaemia: when the level of glucose present in the blood falls below a set point; symptoms can include feeling weak, hungry, confusion, convulsions, loss of consciousness, www.diabetes.co.uk

[3] Mental capacity: The Mental Capacity Act 2005 governs decision-making on behalf of adults who may not be able to make particular decisions due to illness or disability, www.cqc.org.uk

[4] The 2006 Act introduced a new concept for pet owners in that inspectors can now act by advising and educating owners before their pets suffer. If advice is not taken action can be taken through a formal warning or sometimes prosecution.

agreed to sign them over. During the visit David made comments regarding his feelings and suicide which the RSPCA reported to the police.

The police attended on 28 October 2015 due to the RSPCA contact. David minimised what had been reported as said, saying he had no plans to self-harm. The police submitted a Vulnerable Adult PVP[5] (protecting vulnerable people) in respect of David which was shared with mental health services.

On 9 November 2015 the social worker visited the property again. Amy was still in residential care. The house was still in a poor state with bags of rubbish and flies present. David said he had contacted the landlord regarding the maintenance but had received no response.

On 11 November 2015 David attended the hospital emergency department reporting psychiatric problems. He disclosed he was a carer for his partner and was anxious while she was away. The mental health liaison team assessed David prior to his discharge.

On 26 November 2015 Amy returned home from residential care.

On 4 December 2015 liaison took place between the social worker and housing services. It was reported that the landlord via the letting agent would not undertake repairs until the property was sufficiently cleaned.

On 29 December 2015 as a result of an attendance at the GP when risk of falls was discussed a referral was made for Amy to the physiotherapy and occupational therapy service. It was agreed that Amy would be seen by the Community Therapy Service, which is part of East Lancashire Hospital Trust, who have a remit to see people who do not require to be seen at home.

On 4 January 2016 an agreement was made between adult social care, housing services and Amy and David that the couple would commence the clean-up of their property with rubbish bags provided by housing.

On 14 January 2016 at the Community Therapy Service assessment appointment equipment was identified to assist Amy but she was not considered a risk without it, and was viewed as physically independent. Notes from the attendance indicate Amy described David as her carer, she described the situation at home regarding the state of the property and shared her health needs. Notes demonstrate that Amy was considered to have mental capacity.

On 3 February 2016 Amy was taken to the hospital emergency department with difficulty in breathing. The day before David had also attended hospital by ambulance for chest pain and the ambulance crew responding to that call described David and Amy's house as "filthy and cluttered". David introduced himself as Amy's carer but it was noted "the couple did not appear to be coping". David was referred by the ambulance service for a carer's assessment[6] as a result of the concerns. The Carers Centre would carry out the assessment

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[5] PVP; Protecting vulnerable people (PVP) submissions are processed through the Multi Agency Safeguarding Hub (MASH) and are categorised with a level of high, medium or standard risk depending on the initial assessment of the person by the attending officers. Referral information will be shared as appropriate with adult social care and the relevant area(s) of health pertaining to the circumstances, in order that any further action required can be coordinated

[6] Carer's assessment; where carers are assessed for a decision to be made about the help and support that can be provided, www.lancashire.gov.uk

and after a number of attempted calls to make progress the assessment was eventually completed on 9 March 2016. The outcome of the assessment was for Amy to be offered respite care and for David to receive a small financial carer's allowance annually.

On 23 February 2016 due to a number of no access visits and concern that the clean-up of the house was not being progressed, housing services arranged for the property to be cleaned. The social worker was informed and subsequently advised the Community Therapy Service so that any equipment could now be safely delivered.

On 1 April 2016, following up the outcome of the carer's assessment the social worker made a referral to care navigation[7] for an agency to be sought to provide support for Amy. However, when trying to set up support this was refused by Amy who said her partner was managing the care.

On 5 April 2016 Amy informed the social worker that they did not need any further assistance with care. She said she had received support from her partner for twenty years. The social worker advised that the case would be closed and signposted to points of contact in case required in the future.

On 3 May 2016 Amy called the police as she had lost her house key and was saying she didn't know her partner's whereabouts. The call handler recorded that Amy sounded vulnerable. Telephone enquiries were made to try to locate David and there was an unsuccessful attempt to call Amy back. No police deployment was made and the police log was closed. No further contacts were received from Amy on the matter.

On 11 May Amy attended a diabetic review appointment with the practice nurse. It was noted that Amy may be self-neglecting and also that she had no basic equipment at home such as a fridge or cooker. The nurse discussed the circumstances with the clinical hub, a service which offered specialist advice and support in complex cases, which has now been discontinued. Contact was then made with adult social care out of hours service who attempted to telephone Amy regarding the concerns, but with no response. Eventually feedback was provided to the practice nurse that attempts at contacting Amy had been unsuccessful, and a request made that Amy calls adult social care herself. The nurse also wrote to Amy's landlord to request a fridge be provided as a priority.

On 4 June 2016 Amy made a request to the Community Therapy Service for a wheelchair but this was refused due to Amy being mobile and assessed as not needing one. The GP was contacted by the Community Therapy Service and gave confirmation that Amy was still mobile. Amy had told the service that she "was out most days". A similar request for a wheelchair was made by Amy in July 2016 but this was also refused on the basis that it was not required.

On 3 October 2016 a call was received by the police regarding a disturbance at Amy and David's home. David had been locked inside the house by Amy and was distressed. He was alleged to be pushing a knife through the letterbox and was angry, not at Amy but at others on the street over a previous dispute. Amy had locked him inside to prevent the situation escalating and this was the position when the police arrived. David was arrested to prevent a breach of the peace and once in police custody refused a mental health assessment by the criminal justice liaison team. This team is commissioned to support and assess service users within the criminal justice system. On refusing the formal mental health assessment at the

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[7] Care Navigation is a team within Lancashire County Council who source packages of care and support from other agencies

police station David did disclose he had a diagnosis of bipolar disorder despite there being no evidence of this within his health record. There were no concerns raised around David's mental capacity at the time of him being in custody. Whilst at the police station David did say that he was the main carer for his partner. Subsequently David was not charged as a result of his arrest.

On 11 November 2016 Amy attended the GP surgery regarding a skin infection. She was noted by the nurse to be smelling strongly of urine and very unkempt in appearance.

On 12 November 2016 the police received a call regarding an object being thrown at the window of Amy and David. The police attended and fortunately no damage had been caused. Advice and reassurance was provided to the couple, and the police visited the home of the suspect, a 15 year old, and gave advice to a parent.

On 28 November 2016 the police were called to attend Amy's home by the ambulance service. Sadly Amy was found to be deceased on a mattress in a bedroom. The house was noted to be strewn with litter and rubbish, and rooms were piled high with possessions, with little room to walk. There was evidence of alcohol cans in both downstairs rooms.

Initially due to the circumstances reported when Amy was reported to have died, including an allegation that a common assault may have occurred during the same day, David was arrested in connection with Amy's death. However, no criminal charges have been made against him and the cause of Amy's death was concluded as natural causes; pyelonephritis[8] with ketoacidosis[9], with diabetes as a significant contributory factor.

Relevant history of Amy's partner

The review Panel and Reviewer were unanimous in the decision that this safeguarding adults review should focus on Amy, the services she received and her sad death. However, due to the lifestyle and known history of the couple it is difficult not to reflect on some aspects of David's life and health, as Amy's long term partner, for which he has provided consent to be shared, to further illuminate Amy's experiences and the impact the couple's life together had on Amy.

David admitted that he had a longstanding alcohol problem, some mental health difficulties and other general health needs.

From available records for the fifteen month timeframe of the review David accessed the out of hours service and/or the hospital emergency department more than twenty times, sometimes with requests for treatment being in quick succession. Presenting health issues included reoccurring chest pain, abdominal pain, anxiety and depression.

Due to the focus and attention of the review being on Amy, services provided to David have not been scrutinised other than to provide useful context to the backdrop of other services with which Amy was involved and concerns which were identified.

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[8] Pyelonephritis (kidney infection) is a painful and unpleasant illness caused by bacteria travelling from the bladder into one or both kidneys. www.nhs.uk

[9] Diabetic ketoacidosis (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. www.nhs.uk

The Reviewer would again like to thank David for his willingness to share relevant information about himself to inform the review.

ANALYSIS: Practice & organisational themes identified

Amy had received services from a number of agencies during the period of the review. Scrutiny of the timeline, examination of information shared and reflections at the Panel meetings and the practitioner event have highlighted areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together. The following is an analysis of the themes identified:

Self-neglect

Through information available throughout the review's timeframe, some of which is outlined above, there is evidence to suggest that Amy may have been affected by self- neglect. The Care Act 2014, which includes self-neglect in the categories of abuse or neglect, explains "self-neglect covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding," Care Act 2014, 14.17. Examples of this behaviour are included in a number of records relating to the services provided to Amy. Professionals attending the practitioner event also shared information which would indicate that self-neglect and hoarding was a concern for Amy. Hoarding will be considered separately later.

It should be noted that self-neglect may not prompt a section 42[10] enquiry. Safeguarding enquiries will be examined later.

Amy was considered by all professionals involved to have mental capacity meaning she was assessed as having the ability to make her own decisions and choices. This assessment of her capacity was often noted in formal records and professionals at the practitioner event, including the GP, and social worker who had managed Amy's case, were unanimous in support of this judgement.

The Care Act is clear that "the wishes of the adult are very important, whether or not they have capacity to make decisions about their safeguarding", Care Act 14.96. However wishes need to be balanced alongside wider considerations such as the level of risk or risk to others. Some aspects of self-neglect can impact on others, this will be explored later. Adults will have different views as to how their needs can be best met and supported, and the views may alternate at different times in the adult's life. Amy did accept support, for example when she agreed to a period of residential care, but on other occasions she and David declined support.

Self-neglect is a complex issue. There is no typical self-neglect picture; each case depends on a number of factors including mental, physical, social and environmental factors. The self-neglect may be continual or a recent change possibly linked to other vulnerabilities such as loss, trauma or other significant episodes in a person's life.

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[10] Enquiry by local authority: where a local authority has reasonable cause to suspect that an adult in its area
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom. The Care Act 2014

For the fifteen month period of the timeframe it is apparent that self-neglect was a concern for Amy but the cause of this is unknown. Information from *David suggests they had lived as a self-contained unit with limited external influence, from family or otherwise, for many years.* From this information and other service records it may be presumed therefore that their previous lifestyle and environment was similar to what has been scrutinised during this review timeframe.

What is apparent regarding self-neglect within this review are two main themes; (i) identification that self-neglect was occurring by professionals involved and (ii) what positive action could be taken working alongside Amy as the person affected.

Within the timeframe of the review there are only limited points that self-neglect as a specific issue is identified. However, there were episodes when professionals noted and took action on what they witnessed at Amy and David's address regarding the environment in which the couple were living, and the physical presentation of Amy within some health appointments. The action which followed might suggest self-neglect was a concern for Amy but a coordinated response to the self-neglect was not provided.

Of more concern is the acceptance by some professionals who did visit the address, of the condition of the house, and the presentation and lifestyle of Amy. Professionals may have been unaware of what to do about what they saw or how to make enquiries or challenge in a sensitive way. The fact that Amy was judged to have mental capacity and the ability to make her own decisions and choices about her lifestyle may have added an additional complication to what action could or should be taken.

Identification of self-neglect can be subjective with judgements affected by the culture and experience of the professional, and the agency they represent. The demographic of the area may also impact on professional opinion; for example poverty, housing, perceived life choices of a particular community.

The circumstances of how Amy was living and the concerns this created through the timeline were highlighted by professionals for whom safeguarding was not their core purpose, albeit part of their responsibility, for example the RSPCA officer and the ambulance crew. As a contrast other professionals involved for whom safeguarding was a more significant and routine part of their role did not identify the circumstances specifically as self-neglect, for example the social worker, and some police officers who had cause to attend and enter the property for other reasons.

Research regarding self-neglect was published by SCIE (The Social Care Institute for Excellence) in March 2015. Self-neglect policy and practice: research messages for practitioners, Suzy Braye, David Orr and Michael Preston-Shoot, suggests "the organisational arrangements that best supported work with self-neglect included shared understandings between agencies of how self-neglect might be defined and understood, and clear referral routes for self-neglect".

Self-neglect responses will be more effective when professionals can take time to build rapport and a relationship of trust, through persistence and patience and continuity of involvement. Amy did generally have consistency with the professionals involved in her life within the review timeframe but the lack of identification of the self-neglect meant other strategies to manage the concerns were not specifically aimed at improving outcomes for Amy relating to self-neglect.

The reviewer was told that there is currently no self-neglect strategy within Lancashire Safeguarding Adults Board but work is progressing on a multi-agency self-neglect framework. The purpose of the framework is to provide a process guide for all Lancashire Safeguarding Adults Board partner agencies on how to respond when concerns of self-neglect have been identified. Initial discussion has also taken place in October 2017 regarding a self-neglect tool for use across the partnership.

Multi-agency training in Lancashire does include self-neglect but not as a stand-alone training course.

Lancashire Safeguarding Adults Board consideration 1

Lancashire Safeguarding Adults Board should consider, as part of the Board's strategic responsibility for self-neglect within Lancashire, that the multi-agency self-neglect framework is finalised and implemented as a priority to ensure self-neglect is identified and a consistent, effective response is provided across all agencies.

Lancashire Safeguarding Adults Board consideration 2

Lancashire Safeguarding Adults Board should consider collaborative work with partners to explore development of training and awareness resources to ensure knowledge of self-neglect, its identification and assessment as a safeguarding concern, and referral pathways, is consistent across the area for all professionals.

Hoarding

Hoarding is when someone has accumulated items and property to the point that it is impacting significantly on their life and others with whom they live, but who may be resistant to any attempt to declutter their home. As discussed above there is evidence within the timeframe for this review that hoarding was a concern at the home of Amy and David. Clutter, rubbish and no space to walk or stand in some rooms was recorded by different professionals. There was also evidence of animal hoarding, a subject which is less widely known. The Hoarding of Animals Research Consortium, 2013 shows criteria identifying animal hoarding includes "having more than the typical number of companion animals and failing to provide even minimal standards of sanitation, shelter and nutrition, and denial of the inability to provide this minimum care". This could be said to be the position at the address which was found by the RSPCA in autumn 2015.

Despite the Care Act 2014 including hoarding as a category of self-neglect under the heading of abuse and neglect, professionals working with individuals living with hoarding may not identify hoarding as a safeguarding concern and can often face strong resistance from the individuals involved. Many professionals are unclear of what they are legally able to do, and even whether they should be attempting to intervene at all. As with all self-neglect, hoarding is a complex issue.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), 2012, hoarding disorder is described as a pattern of compulsive behaviour, involving accumulating numerous possessions that are not really needed. The research suggests that people who severely hoard or self-neglect should be identified as in need of care and support, therefore meeting adult safeguarding criteria.

A Psychological Perspective on Hoarding, Division of Clinical Psychology, 2015 suggests people with severe hoarding difficulties are more likely to be at risk of neglecting their own physical healthcare needs. Furthermore if a person who hoards requires urgent assistance from the ambulance or fire service, difficulties could arise with access due to the hoarded possessions, which leaves the person particularly vulnerable in cases of emergency

To compare this research with Amy's circumstances shows similarities; Amy was known at times to be non-compliant with medication and clinical reviews despite having serious health conditions. Although emergency situations did not arise for Amy until her death, professionals attending inside the home did indicate access within most rooms was difficult.

Hoarding can also leave a person, and possibly others, at high risk of accidents such as falls and trips over belongings, and at risk of fire. Australian research data shows 24 per cent of fire-related deaths were of people who hoard, Steketee & Frost, 2014. Hoarding behaviour which results in routine maintenance of utilities, such as gas and electric, not taking place due to access problems leads to a higher risk of faults developing which can cause risk of fire.

The repair of Amy and David's boiler was delayed due to the state of the property and Amy did discuss her fear of trips and falls with the GP and the occupational therapy service. However hoarding, and self-neglect generally, for Amy was not identified as a concern.

As with self-neglect discussed earlier, the lack of knowledge regarding hoarding as a possible safeguarding concern was evident across most professionals providing services to Amy. In A Psychological Perspective on Hoarding a recommendation was made which said "all professionals working with people who hoard should have access to training and information about good practice to ensure competence in the assessment of and interventions for hoarding". Such awareness for the professionals involved may have enabled a more positive and supportive approach to the hoarding by Amy, and David.

Lancashire Safeguarding Adults Board is already developing a policy in relation to hoarding and a briefing on hoarding for multi-agency professionals has been produced.

<u>Lancashire Safeguarding Adults Board consideration 3</u>

<u>The Lancashire Safeguarding Adults Board when considering work with partners to develop training and awareness resources relating to self-neglect (see consideration 2), should consider development of stand-alone best practice guidance for all professionals regarding hoarding, to include identification and assessment of the issue and pathways for action when hoarding is suspected.</u>

Carers

(i) Identification of carers and carers' assessments

David, the partner of Amy *identified himself as Amy's carer* when meeting the Reviewer during his contribution to the review. There is evidence throughout a number of agency records of David mentioning being a carer to Amy, sometimes when she was present with him but other times when he was alone, for example when speaking to the emergency department at hospital and when seeing his GP.

Amy herself at times did say David was her carer, but on other occasions when in contact with services she did not, for example when admitted to hospital in September 2015 Amy said David was her partner. Amy did not describe David as a carer when involved with Adult Social Care in October/November 2015 after the referral from the RSPCA about the state of the property. During the social worker's involvement for that referral *David described himself as Amy's partner.* As a result a carer's assessment was not considered, or explored with David at that time.

It was not until February 2016 as a result of a referral from the ambulance service regarding the state of the property, that a carer's assessment was commenced with David. The assessment took place by telephone in March 2016 after a number of unsuccessful telephone contacts. It was explained to the Reviewer that it was normal procedure for telephone contact to be used as a method to complete carer's assessments.

Some recent history was obtained to inform the carer's assessment including information about the RSPCA referral and the period of respite care for Amy in late 2015. Some accurate information was included about previous observations of the state of the home. However there was limited detailed information about David's own heath needs, medical and personal history. David had shared with the Reviewer details of *his own mental health and excessive alcohol use,* but this was not included in the carer's assessment.

There was no apparent attempt to contact other involved professionals, for example the GP, to obtain a more holistic view of David and his own needs which would have enabled a more robust assessment to be completed. When speaking to the Reviewer David was happy to provide consent for information sharing to take place and there is evidence within the timeframe that consent from David in similar circumstances was forthcoming. Therefore it can be assumed that David may have been willing for other professionals to be contacted to inform his carer's assessment. The same could be assumed regarding consent for information to be shared regarding Amy. Information exchange with GPs to inform carer's assessments is explored later.

Of concern is the professional judgement of "no evidence of self-neglect" which was included in the carer's assessment. This was despite the detailed information available from Adult Social Care records which were accessed for the assessment. When the carer's assessment was commissioned the clean-up of the property had not yet occurred and the reason for the referral which led to the assessment was due to the condition of the house. It is questionable that such a judgement of no self-neglect could be made knowing the chronology of the case and without current observation or enquiry about the conditions.

As discussed above a request for consent for contact to be made with other professionals involved with David and Amy, if granted, would have highlighted some recent evidence of suspected self-neglect in terms of personal care of Amy and lifestyle.

The Care Act 14.46 states "the carer's assessment is an important opportunity to explore the individuals' circumstances and consider whether it would be possible to provide information, or support that prevents abuse or neglect from occurring, for example, by providing training to the carer about the condition that the adult they care for has, or to support them to care more safely". Whether such support would have been accepted by David is unknown but there is limited evidence that all the circumstances for David and Amy were fully explored within the carer's assessment meaning the support and information which could have been identified as required from the assessment was not offered.

Additional enquiries have been made by the Reviewer regarding carer's assessments. In Lancashire in 2016/17 5,938 carers received an assessment. Of those, 23% were undertaken by social care staff as part of a combined assessment, 4% as a separate assessment by social care staff, and 73% were completed by commissioned carers' services.

The commissioned carers' services will undertake the assessment where the carer chooses to have that assessment, separate to the person being cared for. Therefore an assessment by telephone, as in David's case is normal. There is no mention in the contract specification of where information should be obtained from, other than from the carer, or what extent the assessor ought to go to, to obtain all relevant information or to verify what has been provided.

The reviewer was told that currently all workers who carry out carers' assessments undertake the Lancashire County Council safeguarding E-Learning and there is an expectation that any safeguarding concerns should be escalated where appropriate. However this is not specified within the present contract of the commissioned carers' service.

Lancashire Safeguarding Adults Board consideration 4

Lancashire Safeguarding Adults Board should consider requesting assurance from Lancashire County Council Commissioning and Lancashire Adult Social Care that contracts for commissioned services undertaking carers' assessments include minimum expectations of what information is included in assessments, the method by which this is obtained, and how any safeguarding information which may be identified about the carer or person cared for is managed.

(ii) Being "carer aware"

On the GP records for David there was no note of his carer status. The Reviewer was told a read code for a carer can be added to the GP records but if a practice wants clinicians to be aware that a patient is a carer when they first go into the records an alert box should be added.

A carer flag is not commonly used in hospital records. However, if a person is admitted to hospital they are asked if they themselves are a carer in case there is a person dependent on them at home who may need additional support whilst the carer is in hospital.

On Adult Social Care records there is an opportunity to record that a person is a carer but in many cases the information is not easily retrievable, as in this case.

Through information gathered for the review it is clear that David did identify himself at times as a carer. However it is also clear that David had his own needs which may, at certain points in the review timeframe, have impacted on his ability to provide care. Professionals involved with Amy and David as a couple or as individuals, could have used more professional curiosity regarding the carer/ cared for position for the couple to ensure appropriate support was being offered and any risks properly assessed. Recording and highlighting the carer status of David relating to Amy may have encouraged other professionals with access to shared recording systems to enquire about the carer/ cared for relationship. Unfortunately a number of electronic systems do not have the functionality to share information with other recording systems.

Lancashire Safeguarding Adults Board consideration 5

Lancashire Safeguarding Adults Board should consider a discussion between Board partners regarding the current position for flagging records of individuals identified as carers, and opportunities for implementing a carer flag on recording systems which do not currently have the capability, in order that professionals accessing records may be reminded to be professionally inquisitive of the needs of those in a carer's relationship.

After an initial criminal investigation it was concluded that Amy died of natural causes, and that the death was not as a result of abuse or neglect. However the circumstances leading to her death and what is known about David's own health and wellbeing has resulted in consideration of research regarding carers as victims, survivors or perpetrators of inter-personal violence.

In a report for Standing Together: Domestic Homicide Review (DHR) Case Analysis, June 2016, it is highlighted that a quarter of the intimate partner homicide cases in the study, (6/24) involved an ex/current partner who was also the carer of the partner. The report suggests that "caring situations should be considered carefully by professionals in relation to the pressures that carers face but also how such contexts may facilitate abuse".

The phrase "carer aware" is used within the report specifically for health contexts but is relevant to all who work with carers. Professional inquisitiveness regarding carers enables integrated working between settings helping professionals to identify carers, consider their needs, and where necessary arrange assessments for carers to ensure that they are not placing themselves/and or the cared for person at risk.

The Reviewer was told in Lancashire a service is in place known as Carers Lancashire which specialises in supporting carers. The support includes providing information and advice and access to forums and support groups. David did disclose to the Reviewer that he was aware of the support available for carers but not until during the last year of Amy's life. This may have been due to the inconsistent description of David's partner/ carer role which both Amy and David chose to disclose to professionals involved in their lives.

Lancashire Safeguarding Adults Board consideration 6

Lancashire Safeguarding Adults Board should consider ways to increase public, and professional awareness of the carer role, and what support is available to carers in order that carers can be identified, and provided with appropriate advice and support.

Management of referrals as non- safeguarding enquiries

The referral made by the RSPCA in October 2015 to Adult Social Care was not categorised as a safeguarding alert and therefore not dealt with as a section 42 Care Act enquiry, see above.

The circumstances referred by the RSPCA officer could be identified as suspected self-neglect. However self-neglect may not always prompt a section 42 enquiry unless there is a serious risk to the health and wellbeing of an individual. Interventions on self-neglect can often be decided as more appropriate under other parts of the Care Act which focus on assessment, planning, information and advice, and prevention. An assessment should always be made on a case by case basis.

Whether the referral regarding Amy should have been identified as a safeguarding enquiry is debateable, and the complexities of dealing with self-neglect were discussed earlier. What is clear is that some positive action was taken to try to support Amy, and David, with a period of short term residential care being offered to and accepted by Amy. Steps to try to support the couple regarding the house clean up were also attempted, but carer's support was not provided due to David not describing himself, or being identified as a carer.

The social worker explained that both Amy and David were also consulted on what outcomes they hoped for as a result of the intervention. Amy expressed that she "wanted the house to be cleared and wanted to remain living in the house".

There is no threshold criteria for safeguarding within the Care Act in the hope that concerns for individuals will be assessed and managed appropriately according to the specific circumstances and needs of each person. Management oversight of decisions as to whether cases are identified as safeguarding enquiries is also very important.

However, research conducted nationally by SCIE (Safeguarding Adults: Highlights September 2017) found there is inconsistency between local authorities, and between some workers within the same authorities, when decisions are being made to carry out section 42 safeguarding enquiries. SCIE found cases will be managed as safeguarding enquiries in some areas, but not in others which can leave organisations needing to make referrals, particularly those working across different authorities, uncertain how to proceed.

This leads on to an issue of how professionals making referrals receive feedback and how they may challenge local authorities about decisions made regarding safeguarding and action taken. Professionals and safeguarding leads in particular, should be aware of what they are entitled to expect from statutory services.

The Lancashire Safeguarding Adult Board does not currently have an escalation policy for partners to use for challenging a decision or action taken. It was explained that when a safeguarding alert is raised and passed to the Multi Agency Safeguarding Hub (MASH) the allocated worker tries to contact the referrer on every occasion to provide feedback and/or to obtain further information but it is not possible to make multiple attempts to contact a referrer who may not be available.

As safeguarding enquiries are undertaken with multi- disciplinary partners including providers, it is often the case that the allocated worker will be working in partnership with a referrer. However, the Lancashire Safeguarding Adults Board are aware that referrers require more timely feedback and this is an area of work where the Board and MASH would like to strengthen arrangements.

Any member of the public, practitioner or partner can raise an issue or concern via the Lancashire Safeguarding Adults Board website. Furthermore a complaint can be raised through the Lancashire County Council complaints website or via individual partners' complaints procedures.

There is no evidence to suggest that the RSPCA wished to challenge the decision of Adult Social Care regarding the October 2015 referral but it is unclear if feedback was provided to them as an organisation raising a concern.

Lancashire Safeguarding Adults Board consideration 7

The Lancashire Safeguarding Adults Board should consider in partnership with other neighbouring local safeguarding adult boards, the development and implementation of an escalation policy to include a clear pathway for partners escalating concerns, and agreed expectations and timescales for feedback after safeguarding alerts have been made.

Information sharing: internally and externally across agencies

The importance of professionals sharing information with others internally within agencies and externally to other agencies must never be under estimated. Thematic reviews of learning from safeguarding adult reviews, including Learning from SARS: A report for London Safeguarding Adults Board, July 2017, highlight that "recommendations to improve interprofessional and interagency collaboration" are common.

In Amy's case there was evidence of some internal and external communication, and joint working. There was good continual liaison between the Community Therapy Service and adult social care to discuss Amy's needs and the chronology of the case. The Community Therapy Service also liaised well with Amy's GP regarding her mobility.

There was regular communication between adult social care, housing services and environmental health regarding the poor state of the house. However, despite it being sometimes difficult to gain access to the address, a joint visit between the housing officer and social worker would have been beneficial to compare professional opinion of the conditions when observed together, and to ensure all environmental factors were jointly considered from both agencies' perspectives.

(i) The GP service: information sharing

Routine information sharing and communication from acute health settings did take place with letters and notifications received by the GP practice when Amy, or David, had been in receipt of acute health services, for example on attending the hospital emergency department or using the out of hours service.

Amy's GP attended the practitioner event and said that he saw Amy as a patient quite frequently due to her known medical conditions. He was aware of the relationship between Amy and David, and the couple were both registered at the same GP practice which consisted of four surgeries. It was explained patients could be seen at any of the surgery locations as the records are available at all four. It is known that Amy mostly attended her local surgery which was close to her home and that she attended alone. The GP who regularly saw Amy for her appointments did not routinely see David when he needed GP support.

The GP for Amy was unaware of the concern raised by the RSPCA to adult social care and therefore had no knowledge of the poor home conditions and alleged hoarding at the address. All his contacts with Amy took place at the surgery as she was able to travel there with no assistance. The GP was aware of Amy's poor hygiene, poor compliance with medication and some possible issues with alcohol from their ongoing GP/patient relationship.

The GP also had no knowledge of Amy consenting to a period of short term care which occurred as a result of the social work involvement after the RSPCA concerns. It was clarified with the social worker that if a person has capacity, which Amy had, and agrees to the care arrangement there is no requirement to involve other professionals in the decision process. The first contact to the GP regarding the short term care was when the residential establishment requested clarification of Amy's medication. There was no other contact around that time, and the GP commented that he recalled for a brief period after the residential care had ended that Amy's appearance had improved.

The Reviewer was told that it is not routine expected practice for the level of contact between adult social care and a GP, as described above, to take place However, a two way communication between adult social care and the GP service is an opportunity for sharing of pertinent information which could inform the services being provided and planning for other support and monitoring which could be offered. Such best practice should be encouraged especially where consent is likely to be given for information to be shared. There is no indication that Amy, or David, would have refused consent for information to be shared between professionals if they had been asked, as has been discussed earlier in the report.

Furthermore the same GP service was regularly involved with David, in person and by receiving written notifications of his regular access of other acute services. This information in GP records was important in terms of informing the formal carer's assessment which was completed in March 2016, and the impact that health issues for David may have had on the assessment outcome had they been requested or shared.

Unfortunately the GP service was not consulted in any way to contribute to the carers' assessment and this is currently not expected practice. As highlighted above best practice would be for GPs to have the opportunity to contribute to carers' assessments. Expectations for carers' assessments were explored earlier.

Amy, due to her medical condition, was also regularly involved with the practice nurse at the GP surgery. *David was positive about the relationship between Amy and the practice nurse describing it as "tough love"*.

Records indicate that in May 2016 the practice nurse noted some elements of possible self-neglect for Amy including poor personal care, diet and non-compliance with medication. Amy had disclosed she did not have a fridge at home and the practice nurse was proactive in writing to Amy's landlord to share on that concern. Due to the collective concerns, after seeking advice the nurse contacted adult social care leading to the out of hours team attempting to call Amy.

There is evidence of information sharing within the GP surgery on this occasion as the GP followed up the concerns from the practice nurse when seeing Amy five days later for an epilepsy review. This was good, joined-up practice. Amy was advised by the GP to call adult social care as they had not been able to contact her, but unfortunately it appears this contact by Amy did not take place.

The Reviewer was told that monthly clinical meetings take place which GPs from all the practices are invited to attend. Safeguarding is a standing agenda item therefore there is an opportunity to share information and concerns about patients.

Amy and David as two patients within the same practice of four surgeries were never discussed at the meetings but as there had been no contact from adult social care regarding the home environment or the carer's assessment, which is explained as not expected practice, it was unlikely that the couples' needs or circumstances would have stood out as requiring additional scrutiny.

Recognising self-neglect within a short appointment usually focused on a specific medical issue is a challenge. This may have been the reason that Amy, and David, as individuals or as a couple did not warrant further attention or information exchange within the practice. Raising awareness of self-neglect across the Lancashire Safeguarding Adults Board partnership, including the GP service is highlighted for consideration earlier.

The Royal College of General Practitioners (RCGP) issued an adult safeguarding toolkit in June 2017 designed to be a source of information and practical resources for general practice. Information is included on types and indicators of abuse and practice resources such as management and storage of safeguarding information and a sample practice policy for safeguarding adults at risk of harm. It is the hope of the RCGP that the toolkit "will generate discussion both within, and outside of, general practice". The monthly clinical meetings in Amy's practice would benefit from the toolkit being explored within one of their agendas, and other practices across Lancashire could also be made aware of this useful resource for safeguarding adults.

Lancashire Safeguarding Adults Board consideration 8

The Lancashire Safeguarding Adults Board should consider requesting that the Adult Safeguarding leads for Clinical Commissioning Groups within Lancashire circulate, and encourage discussion of, the Royal College of General Practitioners adult safeguarding toolkit within all practices.

(ii) Lancashire Constabulary: information sharing

A process is in place within Lancashire Constabulary to share information regarding individuals identified as vulnerable. Protecting vulnerable people (PVP) submissions are processed through the Multi Agency Safeguarding Hub (MASH) and are categorised with a level of high, medium or standard risk depending on the initial assessment of the person by the attending officers. The PVP has three vulnerability categories of vulnerable child, vulnerable adult or domestic abuse.

Following the receipt of adult referrals a strategy discussion usually takes place after which the referral will be shared as appropriate with adult social care and the relevant area(s) of health pertaining to the circumstances, in order that any further action required can be coordinated.

During the review timeframe, Amy and David came to the attention of the police for different reasons including for misplaced keys, neighbour disputes and David's emotional wellbeing. Two of the police contacts were from external professional sources reporting concerns which occurred whilst Amy was in hospital or in short term care, therefore when she was not at home. The remaining seven calls were made by or on behalf of Amy or David. A final contact was made externally to report Amy's death.

Analysis of the police contacts revealed that a PVP submission was assessed by attending officers as not required for every contact. However, vulnerabilities such as self-neglect and hoarding could have been identified, in addition to the reason for the request for police assistance, particularly if officers did gain entry inside the address, observed the state of the premises, and had sufficient awareness of self-neglect as an adult safeguarding issue. Self-neglect was discussed earlier.

Due to the circumstances of this case the PVP process was the only mechanism for the police to share information with multi-agency colleagues regarding Amy, and David. There is no evidence to suggest alternative opportunities for communication or information sharing between the police and other agencies were available, particularly as the concern from the RSPCA was not managed as a safeguarding enquiry and did not involve any criminal allegations. No other circumstances are known relating to Amy and David, which required the police to share intelligence or make enquiries with other professionals.

When PVPs were submitted information was shared appropriately, for example after the RSPCA referral when Amy was in short term care and David threatened to harm himself and the person he suspected of making the RSPCA report. On that occasion the PVP information regarding David was shared with mental health services which were able to carry out an assessment within four days.

On two occasions when PVPs were not submitted by the police, vulnerability of Amy was identified but no actions in respect of her were taken. The first was in May 2016 when Amy reported losing her keys and that she didn't know where David was. Although described in police records as "vulnerable" no further action was taken and no police deployment was made as Amy failed to respond to follow up calls.

In the second incident in October 2016 a dispute was reported on the street with David making threats with a knife from inside the house against an unidentified person outside. Amy was also outside trying to diffuse the situation. David was eventually arrested to prevent a breach of the peace and no individuals were harmed. The police did not submit a PVP after this incident relating to Amy, or David, despite both having demonstrated some vulnerabilities during the episode.

Both occasions were missed opportunities for the police to share information with partners about vulnerability and risk, for Amy in particular. The management oversight of decisions made by police call takers and operational officers, when PVPs have not been submitted must be rigorous.

As a consequence of the arrest in October 2016, David was provided the opportunity to speak with the Criminal Justice Liaison Team[11] whilst in custody but refused their assessment. David did disclose in custody that he was the carer of Amy and that "although finding the carer role stressful he had refused carer support". This information is not known to have been shared with anyone and no PVP was submitted. David was subsequently released without charge.

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[11] Criminal Justice Liaison Teams are a pilot project based within police custody suites who can screen prisoners assessed as needing a service and offer support. The CJLT have access to systems including children's services records.

The lack of PVP submissions in some episodes where vulnerability was evident meant information about a vulnerable individual was not shared for others to be able to consider taking action, to manage further risk, or offer support. Lancashire Constabulary was inspected in 2015 as part of Her Majesty's Inspectorate of Constabulary's (HMIC) effectiveness programme. The programme was to assess how well police forces keep people safe and reduce crime. Within the programme, HMIC's vulnerability inspection examined the general question, 'How effective are forces at protecting from harm those who are vulnerable and supporting victims?'

Overall Lancashire Constabulary's operational procedures to protect vulnerable people and support victims were judged as good, Police Effectiveness, HMIC, and (Vulnerability) 2015. However the two episodes involving Amy and David, indicate that those two assessments of adult vulnerabilities were not as sound as in the majority of incidents inspected, which prevented information about vulnerable adults being shared.

Lancashire Safeguarding Adults Board consideration 9

The Lancashire Safeguarding Adults Board may consider requesting assurance from the Lancashire Constabulary Head of Public Protection that vulnerabilities in adults are being identified and appropriate action taken, with sufficient management oversight, in order that submission of protecting vulnerable people (PVP) alerts is occurring when necessary to ensure information about vulnerability is being shared with relevant partners.

(iii) Other health providers: information sharing

A number of health professionals provided support to Amy throughout the review's timeframe, in addition to the GP service. As highlighted earlier routine notifications of contacts with Amy, for example with the hospital and out of hours service, were shared with the GP practice. Other notifications of attendance, and some non-attendance at appointments relating to Amy's ongoing health conditions were also shared with the GP.

Amy's attendance at the emergency department and use of the out of hours service was not at such a frequency which would have been identified as significant and worthy of further scrutiny. David's need for such services within the timeframe was much more regular and as summarised earlier could have been considered at times to have been excessive, requiring possible follow up. The opportunity for liaison within the GP practice about Amy and David as patients, as a couple, and later as a carer/ cared for relationship, has been considered above.

The sharing of and access to electronic information and records is a complicated issue affected by confidentiality and incompatible electronic recording systems. What is clear is when professionals from different agencies can view an individual's involvement with another service this may lead to improved inter agency communication. This in turn should inform assessments and interventions, and development of a more coherent plan for supporting a person.

An example of other records being accessed which was helpful was when the Community Therapy Service first saw Amy for her assessment. The therapist was able to view the adult

social care system and saw details of the RSPCA contact and a description of Amy's home conditions, which informed the planned service provision.

The Reviewer was told that there are no current plans for a shared recording system which would enable all professionals to access the records of other agencies when required to do so. However opportunities for at least a summary record being available to view are being explored.

Comprehensive assessments

A number of assessments were completed by different professionals regarding Amy over the timeframe of the review. The carer's assessment has been considered separately earlier in the report, as has assessments of vulnerability completed by the police.

Any contact or direct practice with a person is an opportunity to assess their current needs and as Amy was an individual who was seen regularly by many different professionals there were a number of occasions for assessment to take place. Assessments, including assessments of risks, must be carried out routinely by all services involved. It has already been highlighted that assessment of Amy's circumstances relating to self-neglect and hoarding by some professionals was questionable, and reasons why have been explored.

There was evidence of comprehensive assessment with Amy when she attended the Community Therapy Service. Health issues, recent chronology and risks were explored in the assessment which was carried out.

A full medical assessment took place, as would be expected when Amy was admitted to hospital in September 2015. It is positive that social history and safeguarding, including domestic abuse, is noted as considered. At this point David was identified as a partner not a carer by Amy, and as Amy was assessed as having full capacity, information was recorded as provided by her as the patient.

The good practice of professionals for whom safeguarding is not their first priority has been highlighted earlier. The ambulance crew and the RSPCA officer on separate occasions instigated referrals after their own initial assessments of the home circumstances for Amy gave them cause for concern.

Unfortunately other professionals did not act on their initial assessment despite observations of "flies and excrement, and rubbish piled high inside the house". The impact of Amy's environment was not assessed collectively with her medical conditions, other health needs and historical context. Therefore a holistic assessment did not take place and risks could not be properly considered.

A consideration for Lancashire Safeguarding Adults Board relating to assessments of self-neglect and related risks and concerns is raised earlier.

When professionals were involved with Amy and David there was no indication given by the couple that they had retained close links with other members of their own families. Therefore there was no information requested or obtained from relatives, for example Amy's mother. From liaison with Amy's sister it transpired that Amy had ongoing and recent contact with her

mother and that the mother, with Amy's consent, may have been able to provide valuable historical context for assessments which were being carried out.

Family relationships particularly for some adults, as in Amy and David's position, are complex. Professionals should recognise the need to be inquisitive about family circumstances and the useful information that close relatives may be able to provide. There is limited evidence in records for this case that the family of Amy were ever considered as a source of support for her, or that the family position for Amy was ever sensitively explored.

The lack of professional curiosity with close relatives continued after Amy had died when her family were not traced to be informed of the death. The family heard about Amy's death by accident through the sister's work connections. It is unclear why more strenuous enquiries were not made to locate the mother of Amy as David was aware of her (the mother's) existence. Of more concern is that David, despite initially being a suspect relating to the circumstances of Amy's death, seemed to be used as the main source of information regarding Amy's wider family network, which resulted in no contact being made.

Lancashire Safeguarding Adults Board consideration 10

The Chief Constable, Lancashire Constabulary may consider it necessary to provide assurance to the Coroner that Lancashire Police officers, making enquiries on behalf of the Coroner's Office, are professionally inquisitive, and information gathered is robust and timely particularly when required to identify relatives and extended family who may be estranged from people who die unexpectedly.

There was no evidence prior to Amy's death of the need for domestic abuse assessments, known as DASH[12], to be undertaken by the police. The incident in October 2016 when David was arrested for a breach of the peace after a disturbance involving others, but not Amy, was not assessed as a domestic abuse incident. On the information examined this decision seems satisfactory. Unfortunately as described earlier a protecting vulnerable people (PVP) was not assessed as being required either, despite vulnerability being apparent within the episode.

The circumstances surrounding Amy's death however, do indicate elements of possible suspected domestic abuse on the date of death. Notwithstanding that the purpose of the review is not to investigate the cause of, or actions at the time of death the Chair of the Lancashire Safeguarding Adults Board may consider seeking further clarification from Lancashire Constabulary to ensure appropriate assessments and intelligence submissions regarding any suspected domestic abuse around the time of Amy's death have been completed. This will enable appropriate sharing of information, concerns or risks relating to individuals should this be required in the future.

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[12] The Domestic Abuse, Stalking and Harassment and Honour-based violence risk identification, assessment and management model (DASH) was endorsed by national policing leads in 2009 as the risk assessment model to support and improve the police response to cases of domestic abuse.

Lancashire Safeguarding Adults Board consideration 11

The Chair of Lancashire Safeguarding Adults Board may consider seeking clarification from the Senior Investigating Officer for Amy's death that appropriate risk assessments, intelligence submissions and other relevant documentation have been completed regarding alleged domestic abuse of Amy leading up to the death, in order that information about risks may be available to be retrieved and shared as required in the future.

Making safeguarding personal

The Care Act 2014 required adult safeguarding practice to be person led and outcome focused. This means including the person throughout the process with a focus on the outcomes an individual wants to see from any safeguarding intervention. The making safeguarding personal (MSP) agenda helps to move safeguarding practice away from being process driven to a person-led approach.

As has been reported earlier, for Amy there were no reported incidents which were dealt with as safeguarding enquiries until Amy's death, which was initially managed as a safeguarding alert. Therefore expected practice under the Care Act for making safeguarding personal did not apply. However the social worker did demonstrate some MSP focus in his involvement with Amy by involving her in decisions about what should happen as a result of the RSPCA referral and what her preferred outcome would be.

The Multi Agency Safeguarding Hub (MASH) receives all safeguarding concerns which are considered as meeting the criteria for a section 42 safeguarding enquiry. Social Workers within the MASH are trained regarding MSP principles and requirements and wherever it is possible, at the initial contact, MSP work commences with a recorded discussion about the outcomes that the individual wishes to achieve. It was explained that the recording arrangements on the adult social care system require some further development to assist and support the recording aspect of MSP work.

In addition the Reviewer was told that the safeguarding team within adult social care continue to apply MSP verbally throughout safeguarding case work, but that audit of the use of MSP generally has been challenging.

Lancashire adult social care staff have been involved in developing a tool which will provide an annual assurance statement with supporting evidence for MSP principles, to the Lancashire Safeguarding Adult Board Quality, Audit and Assurance sub group. The audit is being used in other areas and was first developed regionally by the Association of Directors of Adult Social Services (ADASS). Learning from the audits will be shared across the partnership

The Lancashire Safeguarding Adults Board Safeguarding Practice with Providers sub group has also received a presentation on the principles and requirements of MSP and particularly in regard to the MSP requirements for providers when asked to undertake a section 42 enquiry on behalf of Lancashire County Council.

In other areas regional adult safeguarding networks in consultation with ADASS have developed consistent MSP questions to be used with individuals who are involved in safeguarding enquiries. The MSP questions have been implemented and added to recording

systems to enable a comparison and benchmarking of MSP data, across different local authority and safeguarding adult board areas.

Due to the circumstances leading to the review it was not possible for the Reviewer to speak to Amy. However in trying to maintain a MSP approach as part of the review process, when speaking with David he was asked for his views on what the review should be trying to achieve and the outcome. *David was "keen for professionals to learn from Amy's case".*

Good practice

Good practice was identified during the review, by the panel, by professionals at the practitioner event, and by David. The Reviewer has highlighted positive practice throughout the report as relevant, and it is acknowledged that many professionals worked hard to support Amy.

The following good practice examples are emphasised as it is judged that more than 'sound, expected practice' has taken place, and where professional commitment, persistence and/or professional curiosity has resulted in an enhanced service.

In Amy's case the following involvement within the case is identified as good practice:

- The concern, confidence and tenacity of the RSPCA officer who reported observations made at Amy's home of possible self-neglect when attending a report of possible cruelty to animals within the property, and during subsequent visits;

- The caring and concerned nature of the housing officer who, after initial involvement with the social worker regarding the RSPCA concerns, made an unplanned and unannounced courtesy visit to Amy and David's home and served a notice to their landlord regarding a broken toilet. The officer also attempted to signpost the couple to other local support;

- The awareness of adult safeguarding processes of the ambulance crew and their ability to engage the couple to such an extent that information was obtained to raise sufficient concern for a carer's assessment referral to be made.

Conclusion

Amy's sad death was as a result of natural causes. In addition, despite Amy's known medical conditions the findings of this safeguarding adult review do not indicate that the outcome of the case could have been specifically predicted or prevented by any individual or organisation involved at the time.

A small number of professionals shared their concerns about Amy's home environment with statutory agencies. However, there were missed opportunities to identify and assess ongoing safeguarding issues for Amy, in particular self-neglect, hoarding and her general vulnerability, and for positive action to be taken which fully addressed the concerns.

The identification of Amy's partner formally as a carer was a complicated process. The subsequent carer's assessment was not comprehensive and did not include all current concerns or pertinent information which could have been available.

Many professionals were committed to trying to provide support but due to Amy being considered as having mental capacity the lifestyle and environment which Amy and David shared was seen as by choice, which proved challenging for some to enable positive change.

Scrutiny of practice always provides an opportunity to reflect on ways in which services may be further enhanced. As a result of the death of Amy there is an opportunity for Lancashire Safeguarding Adults Board and its partner agencies to consider learning from the case and ways by which services and practice may continue to be developed.

Considerations for learning

The following considerations for Lancashire Safeguarding Adults Board have been made based on the learning from the case:

1. Lancashire Safeguarding Adults Board should consider, as part of the Board's strategic responsibility for self-neglect within Lancashire, that the multi-agency self-neglect framework is finalised and implemented as a priority to ensure self-neglect is identified and a consistent, effective response is provided across all agencies.

2. Lancashire Safeguarding Adults Board should consider collaborative work with partners to explore development of training and awareness resources to ensure knowledge of self-neglect, its identification and assessment as a safeguarding concern, and referral pathways, is consistent across the area for all professionals.

3. The Lancashire Safeguarding Adults Board when considering work with partners to develop training and awareness resources relating to self-neglect (see consideration 2), should consider development of stand-alone best practice guidance for all professionals regarding hoarding, to include identification and assessment of the issue and pathways for action when hoarding is suspected.

4. Lancashire Safeguarding Adults Board should consider requesting assurance from Lancashire County Council Commissioning and Lancashire Adult Social Care that contracts for commissioned services undertaking carers' assessments include minimum expectations of what information is included in assessments, the method by which this is obtained, and how any safeguarding information which may be identified about the carer or person cared for is managed.

5. Lancashire Safeguarding Adults Board should consider a discussion between Board partners regarding the current position for flagging records of individuals identified as carers, and opportunities for implementing a carer flag on recording systems which do not currently have the capability, in order that professionals accessing records may be reminded to be professionally inquisitive of the needs of those in a carer relationship.

6. Lancashire Safeguarding Adults Board should consider ways to increase public, and professional awareness of the carer role, and what support is available to carers in order that carers can be identified, and provided with appropriate advice and support.

7. The Lancashire Safeguarding Adults Board should consider in partnership with other neighbouring local safeguarding adult boards, the development and implementation

of an escalation policy to include a clear pathway for partners escalating concerns, and agreed expectations and timescales for feedback after safeguarding alerts have been made.

8. The Lancashire Safeguarding Adults Board should consider requesting that the Adult Safeguarding leads for Clinical Commissioning Groups within Lancashire circulate, and encourage discussion of, the Royal College of General Practitioners adult safeguarding toolkit within all practices.

9. The Lancashire Safeguarding Adults Board may consider requesting assurance from the Lancashire Constabulary Head of Public Protection that vulnerabilities in adults are being identified and appropriate action taken, with sufficient management oversight, in order that submission of protecting vulnerable people (PVP) alerts is occurring when necessary to ensure information about vulnerability is being shared with relevant partners.

10. The Chief Constable, Lancashire Constabulary may consider it necessary to provide assurance to the Coroner that Lancashire Police officers, making enquiries on behalf of the Coroner's Office, are professionally inquisitive, and information gathered is robust and timely particularly when required to identify relatives and extended family who may be estranged from people who die unexpectedly.

11. The Chair of Lancashire Safeguarding Adults Board may consider seeking clarification from the Senior Investigating Officer for Amy's death that appropriate risk assessments, intelligence submissions and other relevant documentation have been completed regarding alleged domestic abuse of Amy leading up to the death, in order that information about risks may be available to be retrieved and shared as required in the future.

References

- The Care Act 2014
- The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), World Health Organisation
- www.diabetes.co.uk
- www.cqc.org.uk
- www.lancashire.gov.uk
- www.nhs.uk
- Self-neglect policy and practice: research messages for practitioners, Suzy Braye, David Orr and Michael Preston-Shoot for SCIE, March 2015
- Hoarding of Animals Research Consortium, 2013
- Diagnostic and Statistical Manual of Mental Disorders (DSM–5), 2012
- A Psychological Perspective on Hoarding, Division of Clinical Psychology, 2015
- Treatment for Hoarding Disorder Therapist Guide, Steketee & Frost, 2014.
- Standing Together: Domestic Homicide Review (DHR) Case Analysis, Nicola Sharp-Jeffs and Liz Kelly, June 2016
- Safeguarding Adults: Highlights, SCIE, September 2017
- Learning from SARS: a report for London Safeguarding Adults Board, Suzy Braye and Michael Preston-Shoot, July 2017

- Royal College of General Practitioners adult safeguarding toolkit, June 2017
- Police Effectiveness, HMIC, (Vulnerability), 2015

<table>
<tr><td colspan="2">Statement by Reviewer</td></tr>
<tr><td colspan="2">REVIEWER
Amanda Clarke (Independent)</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">I make the following statement that prior to my involvement with this safeguarding adults review-

• I have not been directly concerned with the subject adult or significant others connected to the adult, and have not given professional advice on the case.
• I have had no immediate line management of the practitioner(s) involved.
• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the terms of reference.</td></tr>
<tr><td>Reviewer (Signature)
Name

Date 03/01/2018</td><td>A.Clarke

Amanda Clarke</td></tr>
<tr><td>Chair of Review Panel (Signature)
Name
Date</td><td></td></tr>
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lancashire safeguarding adults board

Terms of Reference Safeguarding Adult Review – Adult D

Introduction
This Review has been commissioned by the Chair of Lancashire Local Safeguarding Adult Board (LSAB) in accordance with the Care Act (2014). The Safeguarding Adult Review will be undertaken as a concise Practice Review, utilising the principles of Child Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSAB will conduct the review and report progress to the Board through its Chair. Membership will include an independent Lead Reviewer and Chair and representatives from key agencies with involvement.

Role	Organisation
Independent Chair	Chorley, South Ribble and West Lancashire CCG
Independent Reviewer	Independent
Panel Member	East Lancashire Hospitals NHS Trust
Panel Member	East Lancashire CCG
Panel Member	Lancashire Constabulary
Panel Member	North West Ambulance service
Panel Member	Lancashire Care Foundation Trust
Panel Member	Lancashire County Council
Business Coordinator	Lancashire Safeguarding Adult Board
Business Support Officer	Lancashire Safeguarding Adult Board

Timeframe for the review
The review will cover the timeframe of 01/08/2015 – 28/11/2016. Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

Subject(s) of the review
Amy
David

Significant others
None

The purpose of the review is to:
1. Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSAB;
2. Examine inter-agency working and service provision for the adult and family;
3. Determine the extent to which decisions and actions were adult focused;
4. Examine the effectiveness of information sharing and working relationships between agencies and within agencies;

5. Explore assessment processes, and support available for carers who themselves may be vulnerable;
6. Examine the awareness of and response to self-neglect across agencies and whether formal self-neglect guidance/ procedures are in place;
7. Determine whether mental capacity frameworks are in place in agencies involved with the subject and whether used by professionals;
8. Ensure risks relating to domestic abuse were considered and assessed appropriately;
9. Explore professional perception of diagnosis and the impact of diagnosis, including self-diagnosis on interventions;
10. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
11. Identify any actions required by the LSAB to promote learning to support and improve systems and practice;

Tasks specific to the review panel:

1. To set the time frame for the review, see above;

2. Agencies that have been involved with the adult and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;

6. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

7. The Panel will plan with the Lead Reviewer a learning event for practitioners' to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

8. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice;

9. The Panel will receive and consider the draft SCR report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial hypotheses addressed and any additional learning is identified and included in the final report;

10. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;

11. The Panel, through the Chair and Lead Reviewer will plan arrangements for feedback to the family following the conclusion of the review but before publication;

12. The Panel will make arrangements for feedback to the practitioners in attendance at the learning event and share the learning from the review;

13. The Panel will take account of any criminal investigations or proceedings related to the case;
14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SAR report for publication;