SUFFOLK SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW RELATING TO Mr B: EXECUTIVE SUMMARY

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1. Introduction

Mr B, aged 61, who had mild learning disability, died in June 2017 from smoke inhalation during a house fire in the early hours of the morning. His friend Mr C, who lived with him, also died in the fire. The conditions in their home showed a pattern of extreme hoarding and severe neglect of cleanliness and hygiene. Mr B's personal care was also severely neglected. They were well known to a number of services, who at the time of their death were pursuing a risk management plan under the safeguarding procedures of the Suffolk Safeguarding Adults Board.

A Fire Investigation Report by Suffolk Fire & Rescue Service concluded that the fire resulted from electrical failure of a toaster. A Sudden Death Report by Suffolk Constabulary concluded there was no evidence of any third-party involvement in the fire, and that it had been a tragic accident but queried whether preventive action could have been taken.

2. The decision to conduct a Safeguarding Adult Review

Under section 44 of the Care Act 2014, the Suffolk Safeguarding Adults Board (SAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

The Suffolk SAB chair concluded that the case met the criteria for undertaking a SAR and in April 2018 a SAR Panel was appointed to undertake the review. The panel comprised senior representatives of the statutory agencies that had been involved with Mr B and was chaired by a senior manager from an agency not involved in his care. An independent person was appointed as lead reviewer and report writer. The terms of reference were to investigate:

i. The chronology of pertinent events;
ii. The reasons why actions were taken or not taken at critical points;
iii. Learning in relation to how the agencies involved worked singly and jointly;
iv. How recently introduced protocols on self-neglect pathways and three-dimensional risk assessment could have informed the work;
v. What actions might be needed to improve the care and support of people living with self-neglect, with particular reference to available research on good practice.

3. The review process

The review panel followed a review process that included:

i. Chronologies of involvement from all agencies who provided services to Mr B in the three years prior to his death, including also any earlier significant involvement:
   - East Coast Community Health Care
   - East of England Ambulance Trust
   - GP surgery
   - James Paget Hospital
   - Leading Lives
   - Norfolk & Suffolk NHS Foundation Trust
   - Suffolk County Council Adult & Community Services
   - Suffolk Fire & Rescue Service
   - VoiceAbility
   - Suffolk Police
   - Waveney District Council

ii. Further information and evaluative reflection from the agencies on the key episodes and features of their involvement;

iii. A learning event at which the perspectives of practitioners and operational managers directly involved with Mr B were sought, with the purpose of ensuring that the review's analysis and recommendations were informed by those most closely involved;

iv. A telephone discussion and a meeting with one member of Mr B's family, a cousin;

v. Discussion and analysis of the learning emerging;

vi. Formal reporting to the Suffolk SAB to inform its planning, implementation and monitoring of relevant actions across the partnership.

4. Case background

The property in which the men died was Mr B's family home, where he had lived with his parents until their death in 1992. Mr B, as an only child who had led a sheltered life, experienced their death as traumatic; he received support from his aunt and uncle, and from Adult & Community Services. At some point (it is not known when) he was befriended by Mr C and went to live with him and his wife, later returning to his family home around 2010 with Mr C as a lodger, together with Mr C's dogs and a second lodger. The property deteriorated to a filthy and soiled state, and the dogs were removed by the RSPCA in 2011. In 2013, Mr B had a stroke, which affected his mobility, speech and ability to process information. Although he still slept upstairs, he used a wheelchair when downstairs and outside. After Mr B's stroke, the second lodger left the property following episodes of violence to Mr B, but Mr C remained and became his carer. Mr B's personal care and hygiene, however, were severely neglected and he presented as dirty, severely soiled and unkempt.

The house was similarly neglected; it was very dirty, the carpets were soaked with urine and faeces, and there were large volumes of clutter, including festering household waste and hoarded objects. The two men had a complex relationship in which both at times were witnessed to be verbally abusive to the other, but with a degree of mutual loyalty and dependency that enabled their arrangements to endure. They were both reluctant to engage with services and consistently refused support with clearance and cleaning, Mr B stating that the house contained many precious possessions that had belonged to his parents. Mr C was frequently verbally abusive during contacts with professionals, and on one occasion physically threatened those visiting the property.

Mr B and Mr C were well known to services and had contact with the Police, the Fire Service, RSPCA, environmental health, occupational therapy, primary health, physiotherapy, community nursing and local authority adult social care and safeguarding services. Professional concerns during the period under review focused primarily on Mr B's personal care and on the state of the property. In November

2016 a safeguarding referral alleged maltreatment of Mr B by Mr C. This resulted in a series of strategy meetings between January and June 2017, during which efforts were made to improve Mr B's personal care and to seek his agreement to have the property cleared and cleaned.

While Mr B was sometimes willing to attend facilities where he could be showered and have his clothes washed, and he also attended his GP surgery for skin ulcer care, he consistently refused intervention to improve the insanitary conditions in his home. Attempts to ensure that Mr C provided better care for him were unsuccessful and at times Mr C actively obstructed Mr B's engagement with services. Plans for adaptations to the property could not be implemented due to difficulty in establishing Mr B's ownership.

Until 2017, the professional view was that Mr B had mental capacity to make choices about his care, treatment and living conditions. In January and March 2017, following assessments under the Mental Capacity Act 2005, he was found to lack capacity to manage his financial affairs and to make decisions about his personal care and living conditions. Efforts continued to seek his agreement to intervention, however, focusing on building a relationship of trust through which improvements could be achieved by negotiation rather than the imposition of a solution. When he died, the local authority was considering application to the Court of Protection for appointment of a Deputy to make decisions on his behalf.

5. Review findings

Analysis of the emergent learning from the review highlights a number of themes:

5.1 Assessment of need and risk

There were a number of missed opportunities in early contacts with Mr B to conduct a comprehensive assessment of his needs, thus missing opportunities to intervene, particularly in the early period following his stroke when his situation may have been more amenable to change.

The safeguarding referral in November 2016 resulted in a more proactive recognition of risk. The focus on slowly building trust and negotiating improvements with his consent demonstrated good understanding of the impact of his history and life experience. However, such an approach would only be safe if immediate risks were being effectively managed. Yet the Fire Brigade was not involved in the safeguarding strategy meetings and no fire risk assessment took place. Equally, the Police were not involved in the safeguarding strategy meetings and the intervention strategy did not address the mounting concerns about Mr C's abuse of Mr B. Thus, the safeguarding plan lacked a comprehensive focus. It also lacked momentum in terms of addressing the matters on which it did focus – personal care and the state of the property. Capacity assessments had identified that Mr B lacked capacity over decisions relating to his finances and to decisions about his living conditions, yet the strategy was to apply for a Deputyship, which could take many months, unless the request was made on an urgent basis. More proactive and explicit consideration of best interests' interventions was necessary, with consideration of a Court of Protection application if necessary, to secure their implementation.

5.2 Mental capacity

Insufficient attention was paid to mental capacity. Reliance appears to have been placed in early contacts on a presumption of capacity, rather than upon formal process of assessment, despite knowledge of Mr B's condition that could have called his capacity into question. When assessment was carried out (December 2016), it was not conducted in line with guidance on good practice. When subsequent assessments (January and March 2017, in which good practice is demonstrated) found

him to lack capacity in relation to finances and living conditions, there followed no explicit best interests decision-making process, despite legal advice that the best interests balance sheet approach should be used and a best interests meeting be held.

5.3 Mental health

It was relatively late in the process of supporting Mr B that his mental health needs were recognised. In 2017, NSFT's response was timely and productive, providing input to the mental capacity assessment and later placing Mr B on the Care Programme Approach although he had not been seen by his care coordinator by the time he died. Prior to NSFT's involvement, even when changes of mood were noted by practitioners these were not communicated to others, nor did they lead to action that could secure more comprehensive assessment of his mental health.

5.4 Approaches to service refusal

For a few year's, practitioners took at face value Mr B's assurance that he did not need support. Allied to the absence of mental capacity assessment about such decisions and failure to identify his mental health needs, this demonstrates an absence of professional curiosity and a failure to pursue the proactive engagement that was warranted by the level of risk. This was exacerbated by a culture of case closure arising from caseload and resource pressures. In later contacts, while progress was made in relation to Mr B's acceptance of personal care, plans for dealing with the state of the property took 6 months to emerge and then relied upon a lengthy process of application for Deputyship, thus failing to maintain momentum and to make more timely decisions.

5.5. The relationship between Mr B and Mr C

The dynamic of the relationship between Mr B and Mr C was a challenge to practitioners, both practically in terms of managing Mr C's influence on Mr B and less tangibly in terms of understanding the nature of their relationship and its profound influence on Mr B's behaviour. The potentially abusive treatment of Mr B by Mr C, although recognised, was not addressed in the safeguarding strategy that was implemented. Mr C's own needs were slow to be recognised, and the relatively short duration of any individually-focused engagement with him compromised the extent to which they could be addressed.

5.6 Multi-agency communication, collaboration and case coordination

Despite some examples of effective interagency working (between the Police, Environmental Health and the RSPCA in 2011, and between the Police and Adult & Community Services) there were other shortcomings (for example between the hospital and community health services in 2013, and between health and social care). From November 2016, the safeguarding strategy group became an effective forum for case communication and coordination between those agencies attending, although it was not able to resolve differences of opinion about how proactive intervention should be and its coordinating role may have delayed operational decisions that otherwise might have been made in a timelier way. But the group's effectiveness was severely compromised by the absence of key agencies who should have been part of the discussion and decision-making process – the Fire Service, the Police and the GP surgery.

5.7 Liaison with Mr B's family

More proactive communications with Mr B's cousins could have resulted in a stronger presence for them in his life. It is likely that this would have pleased him, and it could also have served to counter-

balance and possibly dilute the effect of his relationship with Mr C. It could also have introduced stronger collaboration over risk management measures to secure change in Mr B's home circumstances. While it is recognised that Mr B was a private individual, it was also known that he valued and enjoyed talking about his family, and their involvement in his care and support plans could have been initiated in his best interests.

5.8 Risks to staff

Risks to staff arose from the state of Mr B's property and his poor hygiene as well from Mr C's hostile behaviour, which included aggressive threats to staff. While recognised and responded to appropriately by some agencies at key points, these were not subject to an overall interagency assessment and strategy. Equally the outcome of this case had a high distress impact for staff.

6. Conclusion

Research evidence (Braye et al, 2014[1]) supports the approach taken during the final six months of Mr B's life - that of building a relationship of trust through which lasting change could be achieved, rather than imposing immediate solutions that could damage his identity and mental health. However, the research evidence also makes clear that such an approach must be built on a sound foundation of risk identification and management. In Mr B's case, a more comprehensive multiagency strategy was needed during the relationship-building work, notably to ensure that key agencies such as the Fire Service and Police were able to input to discussion and decision-making. Equally, Mr B's capacity was pivotal in terms of the options available to professionals. The eventual finding that he lacked capacity over relevant self-care decisions, as well as over his finances, closed certain routes of intervention but opened up others, but even then, the delay in determining ways forward in his best interests left him exposed to significant risks.

The review panel considered how the Safeguarding Adults Board's recently introduced policy on self-neglect pathways and three-dimensional risk assessment could have made a difference to how Mr B's case was managed. The panel notes the likely contribution of the policy's many positive features: it provides greater awareness of self-neglect and the options for responding to it; the risk framework and assessment tools stimulate more comprehensive risk appraisal; collective ownership of cases is emphasised. Implementation of the policy is, however, in its early days and proactive monitoring of impact will be necessary.

7. Recommendations

The review panel noted changes already made by some agencies in response to learning about their own organisation's practice. In addition, the panel made five overarching recommendations to the Safeguarding Adults Board, each comprising a number of discrete actions to be taken in short-term and medium-term timescales:

7.1 Further development of the self-neglect policy and thresholds framework to incorporate the learning from this review, notably:

i. Guidance on thresholds for referral to case conference and to high risk panel;
ii. Explicit statements on collective ownership of self-neglect cases, core membership of multiagency meetings, and nomination of a case coordinator;

[1] Braye, S., Orr D. and Preston-Shoot M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.

iii. Protocol for involvement of mental health services (and other relevant agencies) in multiagency meetings with a view to engaging therapeutic interventions where necessary;
iv. Risk matrix document to assist identification of agencies' responsibilities and timescales for completion;
v. Mechanisms to ensure senior managers are sighted on significant risks in complex cases;
vi. Guidance on working with significant others, to include identification of coercive and controlling relationships and engagement with family members;
vii. Guidance on recognising in Signs of Safety assessments how an individual's life history, bereavements and health conditions may impact on their decision-making;
viii. Guidance on assessing and managing risks to staff;
ix. Enhanced guidance on legal powers and duties to be considered, including the use of balance-sheet decision-making and consideration of court applications;
x. Protocol on the involvement of the Fire Service in hoarding cases;
xi. Short and accessible 'at a glance' guidance to accompany the policy.

7.2 Monitor implementation of the self-neglect and risk assessment policy, through

i. A sustained communications strategy across the Board's partnership;
ii. A programme of work to enhance data capture, analysis and reporting on self-neglect cases.

7.3 Improve practice on mental capacity assessment, through

i. A multi-agency case file audit to review evidence on how mental capacity is addressed across partner agencies, with particular reference to recording findings of capacity (whether through presumption or formal assessment), ensuring time specific and decision specific assessments, and assessment of executive capacity;
ii. Updated guidance where necessary in the light of the audit and ensure further training on capacity assessment in self-neglect is made available;
iii. Exploring the possibilities for missed appointments at GP surgeries and out-patients to be followed up to confirm the individual's decision is made with capacity and without coercion.

7.4 Improve service responses to self-neglect, through

i. Review documentation to ensure that risks to staff in the commissioned agency, and the availability of measures to mitigate those risks (such as protective clothing), are explicitly included on the referral form;
ii. Agencies to review their responses to self-neglect to make existing services clear and further develop specialist services to support self-neglect work;
iii. Exploration of the possibilities for a pooled budget to fund decluttering and cleaning where judged necessary in the absence of contribution by the service user.

7.5 Implement multiagency staff training, to comprise

i. Staff briefings by the Fire Service to agencies across the partnership on fire risk identification and thresholds for referral to the Fire Service, with an assessment tool for use by staff.
ii. Training in working with self-neglect and hoarding, including the development of skills in identifying and responding to risk, assessing mental capacity and using legal literacy.