SERIOUS CASE REVIEW

IN RESPECT OF AA

COMMISSIONED BY

SUTTON SAFEGUARDING ADULTS BOARD

Serious Case Review Chair: Scott Pollock

Independent Overview

Report Author: Helen Oliver

June 2014

Acknowledgements

This serious case review would not have been possible was it not for the ready co-operation of those agencies who submitted chronologies and Individual Management Reviews. The review was also supported by the London Borough of Sutton's Safeguarding Adult Team who facilitated the collation of further information. Perhaps most significant was the contribution offered by AA's family. The insight they provided has served to greatly enrich the depth and quality of the review. In doing so, they will be supporting the further learning and development by agencies working with other adults at risk in Sutton. For this we are enormously grateful.

Helen Oliver
Independent Overview Report Author
September 2013

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1. Introduction

1.1 A safeguarding adult Serious Case Review is a multi-agency review looking into the circumstances surrounding the death or injury of an adult at risk. It aims to hold agencies to account, though not individuals to blame, by identifying lessons to be learned across all organisations. While Adult Serious Case Reviews are recommended within *No Secrets*[1] guidance they are not a statutory requirement, although they are being proposed as statutory under the proposed Care Bill 2014.

1.2 This guidance in relation to Serious Case Reviews specifies that the purpose of the review is not to reinvestigate or to apportion blame but rather:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults

- To identify what those lessons are, how they will be acted upon and what is expected to change as a result

- To improve inter-agency working and better safeguard vulnerable adults through developing procedure and practice as a result of lessons learnt

The decision to undertake a serious case review was made by the Sutton Safeguarding Adult Board on 30th April 2013 following the death of AA, an 82 year old man, who died in a fire at his home on 11th April 2013.

[1] No Secrets Department of Health 2000

1.3 The Sutton Safeguarding Adults Board extends its sincere condolences to the family and friends of AA.

1.4 The Sutton Safeguarding Adults Board would also like to thank AA's daughter-in-law, who provided the review team with a valuable insight into AA's life on behalf of the extended family.

1.5 Agencies involved in the review:

- London Borough of Sutton Adult Health and Social Care
- The Old Court House Surgery
- Sutton Housing Partnership
- Metropolitan Police Service
- London Ambulance Service
- Epsom and St. Helier NHS Hospital Trust
- South West London and St. George's Mental Health NHS Trust
- London Fire Brigade

2. Terms of Reference

The terms of reference for this Serious Case Review for each of the agencies were agreed as follows:

(i) With reference to work undertaken regarding AA between 2012 and 2013, identify the role and responsibility of your agency and lead professionals within your agency, specifying timescales of their involvement

(ii) Evaluate the adequacy of assessments undertaken, the decision-making and planning by your agency concerning AA

(iii) Guidance on the management of the balance between the right to private life and duty of care, protecting the welfare of the vulnerable person as above

(iv) How were AA's medical diagnoses, mental health and care and support needs addressed by your agency?

(v) Comment on the effectiveness of information sharing with other agencies, AA and his wider family and friends and within your organisation

(vi) Identify any organisational factors, such as capacity and culture, which may have impacted upon practice in working with AA

(vii) Consider the effectiveness of your agency's response – its practices and internal processes as measured against the expectation set down in the multi-

agency policies and procedures for safeguarding adults; propose ways in which practice can be improved within your organisation; and specify how and within what timescales they will be enacted

(viii) Is the current department's response to self-neglect adequate? Does the process for managing such concerns need to be revised?

(ix) What other legal remedies should have been considered in such a case?

(x) Identify lessons to be learned from this case regarding; multi-agency working; communication; further recommendations for internal escalation processes and any other learning

3. Methodology for the review

3.1 The Serious Case Review panel was established on 15th April 2013 by the London Borough of Sutton. Members of the panel were senior representatives from the London Borough of Sutton, Sutton Police, London Fire Services and South West London and St. George's Mental Health Trust. The Safeguarding Adults Board appointed Scott Pollock as the Chair of the Serious Case Review in his capacity as the chair of the Safeguarding Adults Board's Serious Case Review Subgroup.

3.2 The Serious Case Review panel first met on 15th April 2013. At this meeting, there was a decision to appoint an independent chair, who convened their first meeting on 22nd May 2013. At this meeting the panel agreed its terms of reference and invited agencies represented to complete a chronology and Individual Management Review of their involvements with AA. The panel met on a number of other occasions to review Individual Management Reviews and to discuss the Overview Report.

3.3 While this work was underway the London Borough of Sutton commissioned an Independent Overview Report Author to write its overview report. The decision was taken to commission an independent author to maximise independence and scrutiny.

3.4 Between August and September 2013 the chronologies were combined and Independent Management Reviews were submitted to the Independent Overview Report Author.

3.5 At a meeting between the Independent Overview Report Author and the panel on 19th August 2013, it was agreed that contact would be made with AA's family to invite them to contribute their views to the review. It was hoped this would serve to verify facts contained within agencies records, draw out unmet needs and also provide insight into why AA may have responded to interventions in the way that he did.

3.6 The chair of the Serious Case Review Panel wrote to the family to request a meeting with them. On 27th August 2013 the chair received confirmation from AA's daughter-in-law, that she would like to contribute to the review and a meeting was arranged for 29th August 2013 to interview her in full. Notes of this meeting were then shared with the Independent Overview Report Writer.

3.7 Using the information provided by AA's daughter-in-law and references to AA's expressed views during interventions, the Independent Overview Report Author rewrote the combined chronology from the perspective of AA. This approach was adopted in order to ensure that the focus of the report remained grounded around his lived experience. This person-centred chronology was then cross referenced with further information contained within the Individual Management Reviews, thus providing the Independent Overview Report Author with the most holistic understanding of the circumstances, given the information available.

3.8 The Independent Overview Report Author then met with the Serious Case Review Panel and various Individual Management Review authors on 6th September 2013 to run through the initial analysis of events and to gain clarity around information gaps and inconsistencies. This was a valuable process which enabled the panel to review the actions of other agencies whilst also identifying gaps between policy notions and practice. The panel were also encouraged to reflect upon whether given a reoccurrence of a similar set of circumstances the partnership would respond in the same way or were changes required to the response. In addition this meeting also provided an opportunity to identify where

the additional agencies missed from the Individual Management Review process could be approached; for example HM Coroner.

3.9 In compiling the first draft report the Independent Overview Report Author begun by setting out a chronology of key events; the next section presented systemic analysis of these key events in accordance with the agreed Terms of Reference. The Author then developed a summary of the lessons learned and conclusion.

3.10 Chair of the Review

Scott Pollock is the Vulnerable Adult Lead for the Royal Marsden NHS Foundation Trust with a lead on safeguarding, mental capacity and older people. Scott has 18 years' experience in social and health care services. Scott has worked as a social worker and manager in adult safeguarding for a number of years. Scott is a member of the Local Authority Safeguarding Adults Board in the London Borough of Sutton and a number of other Local Authorities.

3.11 Independent Overview Report Author

Helen Oliver was selected to be the Independent Overview Report Author. She has ten years' experience of working in public protection, specialising in domestic abuse, sexual violence and safeguarding adults. She has authored several multi-agency reviews and was recently accredited by the Home Office to author and chair domestic homicide reviews. Helen is currently the Group Manager Safeguarding Adults in another London Borough.

3.12 Panel Membership

The panel was made up of representatives from all of the following agencies:

- London Borough of Sutton Adult Health and Social Care
- The Old Court House Surgery
- Sutton Housing Partnership
- Metropolitan Police Service
- London Ambulance Service
- Epsom and St. Helier NHS Hospital Trust
- South West London and St. George's Mental Health NHS Trust
- London Fire Brigade

3.13 Limiting considerations

3.13.1 It is acknowledged that the Serious Case Review Panel lacked recent experience in establishing the terms of reference for such a review and this had limited the effectiveness of the review. In particular it is recognised that:

- NHS England should have been invited to join the panel and co-ordinate the submission of a detailed Individual Management Review from the GP. That this did not happen is regrettable

- A referral was made in December 2012 by the hospital to Age UK but they were not invited to contribute to the review

- The reviewer was not able to access all of the information which had been submitted to HM Coroner, including statements by professionals and neighbours, which no doubt would have contained valuable information

- There was an over-reliance by some agencies upon recorded information within Individual Management Reviews with only some professionals being interviewed in order to gain clarity around the context within which they were formulating their decision making

- The Independent Overview Report Author was not involved in drawing up the terms of reference or in preparing Individual Management Review authors to compile their analysis. While the Independent Overview Author was able to identify and source some omissions she was not able to determine some of the finer detail of decision making

3.13.2 These omissions have resulted in the Author on occasion having to interpret gaps in detail on the basis of what seems to be most likely. However, this said, it is clear from the evidence compiled that there are some significant lessons to be learned from this case which, given that AA's circumstances are unlikely to be unique, will have wider implications for other adults at risk in the borough.

4. AA

4.1 AA was born on 18th March 1931 in Salford, Manchester. It is understood that his father was not present for much of his childhood and that instead he was brought up by his mother and grandmother. His family recall that he had two brothers and two step-sisters. During his early childhood he moved from Salford to London and from that day identified very much as a 'Londoner'.

4.2 AA married in 1952. Together with his wife he had three sons and eleven grandchildren. It is very evident from the records held by agencies that in his later years his family supported him with various tasks and also advocated for him very strongly.

4.3 AA developed a duodenal ulcer in middle age which resulted in him losing a significant amount of weight. From that point onwards he remained slight in stature.

4.4 AA and his wife moved to the three-bedroom maisonette on the 24th July 1972. The accommodation was split across two floors. They were the first tenants to live in the maisonette.

4.5 AA worked nights at Smithfield meat market for almost forty years before he retired in 1996. Throughout his life he had a keen interest in exotic animals and in his spare time he worked as an animal handler. The newspaper article published the day after his death cited that he was 'well-known in Sutton for his love of snakes and that he had kept a range of animals in the flat over the years including a puma and a chimp'. His 'claim to fame' seemed to be that he had supplied reptiles and snakes for several films, including *Indiana Jones and Raiders of the Lost Ark*. His love of animals continued into his retirement; in

particular this was demonstrated by the fondness he had for his pet dog ‘Nelly’. AA was also a talented fisherman and enjoyed many fishing trips until his mobility limitations stopped his being able to access good fishing spots. He was also a keen wood carver but eventually stopped due to ill health.

4.6 Throughout the course of this serious case review friends, family and professionals alike described AA as a fascinating and eccentric man, father and grandfather. AA’s daughter-in-law described him as a ‘born rebel’ who disliked authority and who could be cantankerous; but who was endearing and extremely lovable.

5. Sequence of key events

2008 -2011

5.1 In 2008, AA had a stroke. AA's daughter-in-law recalls that the stroke affected the right side of his body, resulting in him losing use in his right arm temporarily and leaving his right leg weaker permanently. His family also recall that following his stroke AA's behaviour became more eccentric and less inhibited.

5.2 By 2010, AA was providing all personal care and practical assistance to his wife. AA's daughter-in-law recalls that AA had been adamant that he did not want his wife to go into a home but instead wanted to care for her himself at home. During this time a Carer's Assessment was undertaken by Adult Social Services which resulted in him being offered weekly and annual respite to allow him to maintain contact with friends and to pursue his interests. It is not clear from the submitted Individual Management Reviews if AA took up this offer.

5.3 In 2010, his wife accidentally fell down the stairs at home, puncturing both of her lungs. Following this incident AA very reluctantly agreed that she should go into residential care. AA's daughter-in-law recalls that this decision 'hit him really hard' and 'had a very negative impact on him'.

5.4 In the months that followed AA visited his wife on a weekly basis, driving himself there by car. However, at some point in 2010 AA is believed to have lost his driving licence following an altercation with refuse collectors. As a result it is understood that AA purchased a motor scooter which enabled him to travel short distances, i.e. to the shops with his dog.

5.5 The loss of his car resulted in him not being able to go fishing as he was struggling to walk long distances. In turn this resulted in him spending more time at home refurbishing items that he purchased at car boot sales and selling them on.

5.6 The limited information we have from his GP reveals that during this time AA was prescribed a variety of medication for management of his cholesterol, prevention of strokes, his ulcer and an anti-inflammatory. These were prescribed to him in a dossett box.

5.7 In November 2011 AA had a fall at home. He was found lying on the floor by one of his neighbours and an ambulance was subsequently called. He was admitted to A&E where he was treated for dehydration and then discharged. Following this incident the London Ambulance Service made a referral to Adult Social Services concerned that he was living in a 'dirty, untidy and cluttered flat that made walking difficult'.

5.8 The duty social worker initially passed this referral to Mental Health Services, believing he was known to mental health services. However, upon checking it materialised that he was not so the referral was passed back to the Social Work intake team. Adult Social Services then visited him at home to assess his needs. AA's daughter-in-law was present during the assessment. AA reported that he was "perfectly all right" looking after himself.

5.9 The assessment found AA was travelling independently, shopping and was well supported by his son and daughter-in-law. However it also acknowledged that AA was forgetful with his medication and that he was also experiencing increasing difficulties getting around his flat because it was 'cluttered and this created a trip hazard'. The assessment found evidence that while his family were prompting

him to take his medication and supporting him to clean the flat, AA was not always compliant. Staff felt that AA had capacity to refuse support.

5.10 A month later, presumably following persuasion from his family, he agreed to accept an Occupational Therapist Assessment. During the assessment, professionals noted once again that the flat was cluttered and prescribed a high back chair and a bath lift to support him in transferring from his chair and also accessing the bath. A few weeks later AA returned the high back chair stating that he had purchased a new suite for his living room.

January 2012 – July 2012

5.11 On 27th January 2012 AA received a three month review of his Occupational Therapist Assessment by Adult Social Services. The outcome was that the high back chair could be returned because AA has bought a new suite, including a suitable arm chair, and that a recliner bath lift was in place which AA could use. No further action was required.

5.12 Throughout May 2012 AA had three outpatient appointments in Audiology and the eye unit at Epsom and St. Helier University Hospitals NHS Trust.

5.13 On 4th May 2012 AA was visited by the London Fire Brigade as part of their routine home fire safety checks. AA had one smoke alarm and a further battery operated smoke alarm was fitted and considerable hoarding was noted. Having also identified that AA was elderly, had mobility issues and had recently suffered a stroke, a referral was made by the London Fire Brigade to Adult Social Services. The referral stated that 'there was evidence of self-neglect and hoarding resulting in significant fire loading and adverse effect on his means of escape'.

5.14 On the 17th May Adult Social Services contacted AA by telephone to discuss the London Fire Brigade referral. During their discussion with AA he declined support. Adult Social Services fed back to the London Fire Brigade that there was 'nothing further social services could do' because he 'appeared to have capacity'. Instead, Adult Social Services advised the London Fire Brigade to contact AA's landlord Sutton Housing Partnership.

5.15 The London Fire Brigade contacted Sutton Housing Partnership on the 17th May requesting that they 'take action under the tenancy agreement to reduce the risk from fire both for AA and other residents living in the block'.

5.16 On the 22nd May 2012 two officers from Sutton Housing Partnership visited AA at home to discuss the London Fire Brigade's concerns of hoarding at the address. AA explained that the London Fire Brigade had told him that there was not a problem with the way he was living. He then became agitated and asked the officers to leave, stating "I am 82, there is nothing wrong with the way I live and … I have lived here for 35 years and no one has ever interfered". Following the visit, Sutton Housing Partnership contacted the London Fire Brigade to verify whether fire officers had said that it "wasn't a problem". The Fire Brigade confirmed that this had not been their view and that they believed there was a significant risk to AA and to other residents.

July 2012 – January 2013

5.17 On 25th July 2012 AA had day surgery on a cataract on his left eye to improve his vision. In the pre-op assessment it stated that AA had transport to and from hospital and that a relative would be looking after him in his own home. It is noted in the preceding appointment in May that there were no concerns about capacity to consent and that he was expected to be supported at home upon discharge by his family.

5.18 Between July 2012 and January 2013, Sutton Housing Partnership continued to work with AA and his family around the difficulties presented by his hoarding. This resulted in a schedule of improvement work to the property between November 2012 and January 2013 which included a deep clean of the flat. In total it seems that thirteen different jobs were carried out in his home, including work to his boiler, electrics, plumbing and double glazing. It is apparent that both his family and neighbours supported AA to report ongoing issues to Sutton Housing Partnership throughout this period. Records held by Sutton Housing Partnership indicate that AA had not expressed concern or reluctance for the work, or the numbers of contractors in his home, but rather was pleased to have the flat improved and had been actively involved in selecting the contractors.

5.19 On 11th October 2012 Sutton Housing Partnership records indicate that contact was made by the Housing Management Team to Adult Social Services about AA's hoarding. Records indicate that social services advised housing officers that social services 'didn't help with hoarding'.

5.20 On 28th November 2012, AA underwent a second surgery, this time on his right cataract. Hospital records indicate that this was a day surgery, that consent was gained from AA and that there were no concerns about his capacity to do so. Records again indicated that he would be in receipt of support from his family upon discharge. He then attended the hospital for checks on 12th December 2012 as an outpatient.

5.21 On 16th December 2012, AA collapsed at home and was found unconscious by his son. The ambulance crew attended the address by which time AA had come around and was sitting on the sofa alert and talking. AA's son explained that in the run up to the incident, AA had appeared confused, had not had an appetite for several weeks and had not been taking his medication. The ambulance crew examined AA and recorded that he appeared pale,

malnourished, dehydrated, and weak. Oxygen was administered and then the crew took him to St. Helier Hospital.

5.22 The hospital records shows that AA was admitted to the observation bay overnight where he received intravenous fluids and antibiotic treatment. The Doctor treating him recorded that he was 'alert, holding a conversation and had 'capacity to make decisions''. He was discharged the following day with his daughter-in-law's support and also referred to Age UK for support with his cleaning.

5.23 AA attended the hospital on 16th January 2013 for his second outpatient appointment following his right eye cataract surgery.

February 2013 – 2nd April 2013

5.24 In the early hours of the 12th February 2013 AA called the police alleging a burglary at his home. During the call he explained to officers that he lived alone and had a stroke two years ago. He also stated that he was disabled and that he would leave his door open so the police could enter as it was difficult for him to walk to the door. He was prioritised as a vulnerable caller and a police officer attended. AA reported to police that he had been at home sitting on his sofa when a male, aged fifteen, came into his sitting room and took his wallet from the coffee table. AA explained that he had attempted to take the wallet back but lacked the strength. A Scenes of Crime Officer (SOCO) contacted AA later that day to organise a second visit, but was informed by AA that he had found his wallet and that the young person was just a friend who had come by. Following this discussion the police recorded the incident as a no crime but recorded it on their internal Safeguarding of Vulnerable Adults (SOVA) database. No referral was made to external agencies as there was deemed to be no risk of harm at that time and no evidence of vulnerability regarding mental health or disability.

5.25 Sutton Housing Partnership carried out a home visit on 25th February 2013 to review the state of the home. They found that the property was fine but they also recorded that AA's son had moved in with him as his relationship with his wife had broken down.

5.26 On the 26th February 2013, AA contacted the police again. He alleged that between the 11th February and 26th February 2013 his camera, a dog whistle, a cigarette case, a solid silver 'pearly' ring and house keys had been stolen. He suspected his neighbour had stolen the items whilst he was out doing his shopping on his electric scooter. The police Individual Management Review report states that there was no evidence to support this assertion and it was possible that the items had been misplaced, so enquiries could not prove or disprove the allegation by AA. The Individual Management Review also notes that AA had a 'social worker' who attended with AA's son.

5.27 On 20th March 2013, two housing officers from Sutton Housing Partnership visited AA at his home again. He disclosed to the officers that his neighbour was "still bothering" him. It was evident from their visit that AA had begun to hoard again, but it is not clear what level of discussion they had with him about this. Over the next week neighbours contacted the housing partnership to report faults with the electrics and heating.

Wednesday 3rd April 2013

5.28 On the 3rd April 2013 AA was visited at home by his GP, at the request of his family, following concerns that he was refusing their help. They explained that he had been unwell over the Easter weekend and as a consequence his home had deteriorated significantly. The GP diagnosed that he had left sided bronchitis and prescribed antibiotics. The GP wanted to admit him to hospital for a place of safety and to have some intravenous fluids but AA refused.

Thursday 4th April 2013

5.29 On the 4th April 2013, the GP wrote to Social Services to raise his concerns about hoarding, where he stated that AA 'appears to have mental capacity to refuse any medical input and I feel his flat is becoming unsafe for him to live in alone. I understand that some similar issues were identified when the flats were fitted with double glazing some time ago and that workmen were unable to access the flat. I believe he has been refusing offers of help and would appreciate any input you could give… PS AA has just been admitted to hospital for a few days. Problems will arise on discharge'. This letter was not received by social services until the 9th as it was sent via post as the fax failed to transmit.

5.30 The GP also faxed a letter to the Older People's Community Mental Health Team, addressed to the Consultant Psychiatrist. The letter requested an 'urgent domiciliary visit' by a Consultant Psychiatrist or a Community Psychiatric Nurse so that they could assess whether AA required a change of medication. In his correspondence he described AA as 'stubborn and eccentric' and that he had become 'gradually less and less self-caring and although his family have tried their best to keep his flat tidy it is now in an appalling state with rubbish strewn all over the floor, such that it is difficult to take footsteps across the room or up the stair. He is also being more aggressive, throwing things around and violently refusing help from his family… I really wish to admit him to hospital for a place of safety and possibly for some IV fluids and further investigation in view of his poor state but he is refusing any admission to hospital and appears to have the capacity to do so. He is orientated in time and date and recognised me. However, he is becoming increasingly at risk being in his home with no identifiable mental issue and his family are increasingly concerned'.

5.31 Following receipt of the faxed referral the GP's concerns were discussed at the Older People's Community Mental Health Team meeting on the morning of the 4th April. Consideration was given to AA's 'severe self-neglect, low weight…possible cognitive impairment, as well as being physically unwell'.

Records of the meeting show that professionals at the meeting felt he 'did not appear to have capacity, and had no insight into any risk to himself'. The referral meeting agreed that the domiciliary visit and the initial assessment should be undertaken by a CPN Care Co-ordinator. There was also discussion around the appropriateness of the referral from the GP as the referral had stated 'no identifiable mental health issue but rather physical health, environment and social issues only', but there is no evidence of this being queried by the team.

5.32 The CPN Care Co-ordinator visited AA later that morning, in the presence of his daughter-in-law:

- Environment: The CPN Care Co-ordinator found that his home was very cluttered and that it was unsafe to walk in the property stating he was 'living in squalor… with dog faeces on the floor… completely cluttered with junk all over the floor making it unsafe to walk'.
- Physical Health: The CPN Care Co-ordinator found that AA had not been preparing food for himself and as a consequence he was found to be 'emaciated'.
- Mental Health: The CPN Care Co-ordinator did not formally test AA's cognitive function during her visit but felt that he 'might have a degree of cognitive impairment' as he could not remember the GPs earlier visit.
- Mental Capacity: The CPN Care Co-ordinator did not formally test AA's Capacity during her visit however she deemed that AA lacked the capacity to weigh up the risks he was posing to himself in this environment.
- Other: During the visit the CPN Care Co-ordinator was informed that AA had had his mobility scooter stolen some time ago and that he frequently left his front door open and had also had his wallet stolen. These alleged thefts were not raised as a safeguarding alert previously nor at this time by other involved agencies.

5.33 The CPN Care Co-ordinator concluded that the risk to AA were in relation to his “poor dietary, fluid intake and poor memory”. She then decided that rather than conduct the formal assessments, his physical health needs would be prioritised through an admission to hospital, where further assessments could be made.

5.34 Following the visit the CPN Care Co-ordinator contacted AA’s GP who arranged for his admission. Later that afternoon the CPN Care Co-ordinator was contacted by AA’s daughter-in-law who explained that AA was now refusing to attend the hospital as agreed previously. The CPN Care Co-ordinator agreed that AA’s daughter-in-law would try again to convince him and would contact the CPN again if this failed.

Friday 5th April 2013

5.35 The next morning AA was brought to St. Helier’s Accident and Emergency Department by a relative (believed to have been AA’s daughter-in-law) in order to be ‘formally assessed’. AA was admitted to the Assessment Medical Unit where the initial view of the attending doctor was that AA had ‘exacerbation of undiagnosed COPD, delirium on chronic cognitive decline and acopia leading to malnutrition’. Concerns were raised by his relative that he was exhibiting increased confused, verbal aggression, self-neglect/ability to self-care and that he was increasingly disinterested in food, drink and medication. Conversely AA was presenting as alert, able to hold a conversation and stated that he was able to look after himself go shopping and manage his own financial affairs.

5.36 The Physicians from the Assessment Medical Unit diagnosed AA with an untreated chest infection – it was thought that AA had not taken the antibiotics prescribed by his GP – so they prescribed a second course and Doctors felt that

his condition was such that he could be treated at home. The doctors did however suggest he stay in hospital as the best option for his welfare at the time.

5.37 AA then became adamant that he wanted to go home and attempted to leave but was returned by security staff.

5.38 Following this incident the physician from the Assessment Medical Unit telephoned the Psychiatric Liaison Team for advice on behalf of the consultant. The Older Peoples Liaison Psychiatric Nurse advised the doctor to consider the patient's capacity under the Mental Capacity Act and to consider a Mental Health Assessment. The nurse also advised that there was a duty liaison psychiatrist who could be contacted after 5pm but that the consultant could make a decision. Later that afternoon following the change-over of shift, the Assessment Medical Unit made contact with the out of hours Duty Liaison Psychiatrist to seek advice as AA was refusing to stay and they felt that he did not warrant an admission.

5.39 Following this discussion the Assessment Medical Unit records indicate that AA was deemed to 'have capacity', it is assumed, on the basis that they had been advised by the duty Psychiatric Liaison Psychiatrist that AA was 'known to the service and although there was a potential decrease in safety awareness AA is not putting himself at immediate risks'. However, it should be noted the Mental Health Trust have no record of this contact.

5.40 At 17:00 AA's daughter-in-law was contacted by the ward and asked to come and pick AA up. The duty Psychiatric Liaison Nurse then made a referral to the Home Treatment Team 'in the absence of any other support available late on a Friday afternoon' to visit to AA over the weekend to ensure he took his physical health medications and that his nutritional and hydration needs were being met. AA was then discharged home; records indicate that transport home was

arranged but it is assumed that AA walked home stating that his carer lived next door and had a key.

Saturday 6th April 2013

5.41 The Home Treatment Team attempted to telephone AA on the morning of the 6th April to find out if he had been discharged. There was no answer; however following liaison with the hospital it was confirmed that he had been discharged.

5.42 The Home Treatment Team then visited AA at home by a staff nurse and a Health Care Assistant at 11:30 on Saturday 6th April. It was not clear to staff under what circumstances he had been discharged, but AA stated he had been 'tricked' into going to the hospital and had not wanted to be admitted. He said that he had walked home alone in the cold weather at approximately 7pm. It was unclear to the team however if this was an accurate account of what had happened and indeed whether he had discharged himself against medical advice. Following the visit the Home Treatment Team raised several concerns:

- Environment: They were concerned about how cluttered his home was, and that it was an 'unsafe' environment. They reported a strong smell of dog faeces and rotten food. The carpet was 'covered with tools, ornaments, books, medication and lots of rubbish'. His kitchen and fridge contained 'mouldy and unused food'. The staff also noticed a small burnt area on the sofa, believed to be caused by a cigarette, and when they asked him about it he stated that it was a cigarette burn and that he smoked one cigarette a day

- Physical Health: They reported him to be 'dishevelled, very gaunt, underweight and pale'. They also identified that AA account of having taken

his medication did not correspond with what they found, so they supported him to take his medication for that morning

- Mental Health: They reported that he was not obviously confused but was displaying being 'somewhat eccentric'; for example refusing for mouldy food to be thrown away and he did not seem be aware of the dangers associated with his flat. The staff found that AA's mood was changeable, in that he could become easily irritated and angry, especially when he was asked about his needs or medications

- Mental Capacity: Staff felt that while he was orientated to time, place and person he lacked insight into his condition, although this does not appear to have formally assessed at this point.

5.43 The Home Treatment Team concluded that there were risks of malnutrition, falls, fire and further deterioration in mental and physical health. Their plan was to continue to visit him over the weekend to monitor his medication compliance and then that his case would be discussed at the mental health team meeting on Monday 8th April. They advised that two staff should attend on visits due to the health and safety risks.

Sunday 7th April 2013

5.44 AA was visited at approximately 10:00 on Sunday 7th April by a different staff nurse and Health Care Assistant from the Home Treatment Team. AA was irritable on their arrival and complained of having to come downstairs to let them in. During the visit he stated that he had not had anything to eat or had a cup of tea. The staff attempted to make him a cup of tea but there was no electricity or gas ignition. He did not appear to have any matches and could not light the gas

fire. Staff therefore improvised and gave him a glass of water and a packet of crisps that were in the kitchen. AA also informed staff that he had a neighbour who helped to care for him and that this neighbour was expected later that day.

- Environment: In addition to not having hot water or heating it was also apparent that AA continued to be unable to take his dog outside to relieve itself and as a consequence animal faeces were continuing to build up inside the flat

- Physical Health: He appeared dishevelled and again concerns were noted about his weight and it was also noted that he was 'short of breath when he moved around'. AA's medication was found to be scattered over the floor. He said that he had taken his morning tablets but staff were unable to find the new antibiotics that had been given to him

- Mental Health: Staff noted that his mood was changeable from calm, to irritated, to angry

- Mental Capacity: AA was orientated to time, place and person, in particular it was noted that he recognised the staff nurse. However, staff felt that he 'lacked insight into being unwell".

Monday 8th April 2013

5.45 At 11:00 on the 8th April 2013 AA was visited by two different Health Care Assistants from the Older People's Home Treatment Team. They had initial difficulty accessing the flat because AA did not answer the door, but eventually were told that AA was in the habit of always leaving his front door unlocked

anyway, and so they gained access. AA reportedly engaged well, and recognised one of the assistants. He was not obviously confused and was speaking normally. He was assisted in taking his medications.

5.46 During the course of the day AA's case was discussed at the weekly clinical management meeting held by the Older People's Community Mental Health Team. It was identified that AA's most prominent problem was self neglect. It was noted that reports from staff suggested that he did not have capacity regarding his own self care or his medical treatment. The possibility of an underlying dementia was discussed, but he was not thought to have a functional mental illness such as depression or psychosis. It was also noted that he had also been too agitated at times to co-operate with formal cognitive testing, and the priorities in the situation were AA's safety and physical health. The plan was to continue to support AA with his social needs through Home Treatment Team visits, to assess formally whether he had capacity to refuse to be in hospital and to refer to social services for on-going social care.

5.47 At 11:34 AA's daughter-in-law contacted Cheam Resource Centre Mental Health Services to talk to the CPN Care Co-ordinator (leaving a message with admin at Cheam Resource Centre). She expressed her concern about AA's welfare. She stated that he was not eating or drinking when left alone and that his dog was not being taken out so the flat was soiled with dog faeces. She also stated that the floors were so cluttered that it was not safe.

5.48 Later in the day, the CPN Care Co-ordinator, accompanied by a student nurse and later by the team's doctor, visited AA in his home with the intention of assessing his physical health and to ascertain what medical response would be appropriate. They also intended to assess his capacity to make decisions about his physical health care and treatment.

- Environment: The floor surrounding his sofa was noted as ‘more cluttered than ever’ with ‘medication all over the floor’. AA denied that these were his pills and showed the staff a full blister pack. AA was asked about having something to eat, to which he replied he had food in the fridge. It was difficult to get into the kitchen, but staff were able to identify that these were the same mouldy meals as before. There was no lighting or heating in the flat although there did appear to be electricity in parts of the kitchen

- Physical Health: AA was found to be in the same clothing as he had been wearing the previous week. The team assessed his physical condition and found that he appeared to be in a better physical condition, possibly as he had been hydrated in hospital the previous week. His pulse was normal. The doctor did however express concern that his BMI was probably below 14, there were signs of protein in his blood and his white blood cells were elevated

- Mental Health: When he was asked about any problems associated with his environment he became irritable and said he would ask them to leave if they kept interfering. The doctor concluded that he did not appear to have a severe gross impairment of short term memory (although this had not been able to be fully tested as the CPN Care Co-ordinator had attempted to carry out a Mini Mental State Examination but was unable to complete it because AA would not fully engage in the process). It was noted that AA was able to recognise some of the staff which further supported the lack of memory impairment

- Mental Capacity: While the Doctor did not think that he had memory impairment, she concluded that AA was not able to weigh up the risks to his health and lacked capacity to decide the management of his physical treatment. In particular when asked about his medications, he appeared to

understand what his medication intended to do, but was not able to weigh up the risks and benefits of complying with his treatment.

5.49 The team concluded that given he had been medically cleared for discharge on Friday, and had improved physically since, requesting an emergency hospital admission seemed inappropriate. Instead the doctor suggested that the Home Treatment Team and the CPN Care Co-ordinator monitor his physical health and if he deteriorated again call for medical help, and that if admitted, a formal assessment of his capacity be made in hospital.

5.50 The Doctor also concluded that given his apparent lack of memory impairment there was no need for a Mental Health Act Assessment. This was supported by the fact that AA had been compliant with accepting the involvement of the Home Treatment Team.

5.51 The doctor asserted that priority should therefore be given to AA's physical health needs and so asked the CPN Care Co-ordinator to make an urgent referral to Adult Social Services so that a package of care could be put in place to meet his needs.

5.52 The CPN Care Co-ordinator telephoned Adult Social Services at approximately 16:55 but she was informed that they would only accept faxed referrals. At 17:00 the team's Consultant Psychiatrist intervened by contacting Social services directly and insisted that AA needed a care package due to an 'identified degree of vulnerability and degree of risk around his physical and social care needs'. The issue of his capacity was also raised together the fact that 'he had no food, heating or electricity' and that his home was in a 'squalid' condition.

5.53 Adult Social Services contacted AA's daughter-in-law,who stated that she was not able to visit AA as she did not have her car but that she had arranged for emergency electrical services to attend his home and for a neighbour to provide him with a hot meal. It is also recorded that AA's daughter-in-law agreed that nothing else would be needed that night and that she would call in the morning. This discussion was relayed back to the Consultant Psychiatrist and it was agreed that the CPN Care Co-ordinator would send a referral in the morning to progress the social services assessment process and that social services would assess him the next day for a package of care.

5.54 At approximately 22.30 on the 8th April 2013, AA lit a BBQ in his living room. His smoke alarm was activated and subsequently his neighbour came into the flat. The neighbour reported that AA seemed unaware that the alarm was going off or that the flat was full of smoke and that the gas rings were also on. The neighbour was able to extinguish the BBQ, turn off the gas rings and then called an ambulance for AA.

5.55 An ambulance arrived at AA's address at 23:46 and assessed AA as requiring admission to hospital for smoke inhalation. The ambulance arrived at St. Helier Hospital at 01:00.

5.56 At approximately 00:30 the London Ambulance Service Hazardous Area Response Team[2] arrived at the address. It is presumed that the Hazardous Response Team had been mobilised in response to concerns from the Ambulance Crew around possible Carbon Monoxide contamination.

[2] The Hazardous Area Response Team is a specialist London Ambulance team of Service staff who have been trained to assess and make safe dangerous environments.

Tuesday 9th April 2013

5.57 In the early hours of Tuesday 9th April 2013, AA was medically cleared for discharge and deemed to have capacity by the Doctors in Accident and Emergency (although this was not formally assessed). An ambulance crew then took AA home by ambulance. Upon arrival it materialised that AA did not have house keys so he was returned to the hospital by the ambulance crew. Following their involvement the London Ambulance service raised a safeguarding alert with social services about the concerns that they had witnessed at his home.

5.58 At 8:15 on Tuesday 9th April 2013, the CPN Care Co-ordinator received a telephone call from AA's daughter-in-law stating that AA had been discharged because Accident and Emergency physicians had deemed him to be medically fit and felt he had capacity, but that he had then been brought back to St. Helier because he did not have a house key.

5.59 Following the telephone call the CPN went to Accident and Emergency to see AA. He appeared to recognise her and asked her to take him home, and then became irritable when she refused. He then attempted to leave but was returned by security staff and then settled.

5.60 At 9:05 AA's daughter-in-law contacted the Mental Health Team manager from Adult Social Services and stated that following the fire she did not feel that AA should go back to the flat 'as it was in a state' and expressed concern that if Sutton Housing Partnership found out they would evict him. She also explained that the family wanted AA to go into respite for two weeks to allow them to clean up his flat.

5.61 The Adult Social Services Mental Health Team manager agreed to allocate him to a social worker for an assessment and explained that the request for a respite placement would need to be discussed with senior managers; it was agreed that social services would allocate him to a social worker.

5.62 At 9:40 the CPN Care Co-ordinator contacted Adult Social Services to inform them that a capacity assessment had been carried out and that AA was unable to weigh up anything (this assessment was not written up so it is not clear what the specific decision was that was assessed). The CPN Care Co-ordinator explained that AA was also seriously emaciated and was ready to walk out of the hospital. She then explained that she was going on a visit but would call back.

5.63 Sutton Mental Health Social Work Team Manager and Prevention and Crisis Service Team Manager discussed the case and agreed for the Hospital 'In-reach' worker to see AA in A&E and report back.

5.64 At 11:28 a ward nurse from A&E spoke to an officer from the Prevention and Crisis Service, explaining that the only reason AA was in A&E was because he had no keys to his house and that his family were out and won't be home until late afternoon. She also explained that he had been brought into hospital last Friday night (5th April) but left and was again brought back by the police but refused to stay.

5.65 At 11:57 the officer from the Prevention and Crisis Service emailed the Adult Social Services Mental Health Social Work Team Manager to ask that AA be prioritised for an urgent assessment in the community. She explained that AA 'has no safety awareness and is currently putting himself and his neighbours at risk'. She explained that he required the input of a Mental health social worker 'given that his mental health needs are currently impacting on his general

well-being in the community' and that 'a care package at this stage would not address his needs given that he can manage his personal care independently'.

5.66 At 12:24 the Adult Social Services Mental Health Social Work Team Manager emailed the Prevention and Crisis Service Officer back and confirmed that the Older Persons Community Mental Health Consultant and the CPN Care Co-ordinator had advised that AA 'has a cognitive impairment'. She also explained that she had been in her team meeting but that her understanding had been that the hospital duty would pick this up.

5.67 During the day the Liaison Psychiatrist Consultant and the Accident and Emergency Sister spoke and agreed that AA should be screened for acute confusional state and dementia; but that the Consultant agreed with the physician's opinion that overall AA was not so ill that he required admission to a medical bed. The outcome of these assessments are unclear.

5.68 The CPN Care Co-ordinator discussed the situation with the Older Persons Community Mental Health Team Consultant and agreed the plan was to wait for social services to assess and provide a package of care before he returned home.

5.69 In the afternoon as agreed the social worker from Social Services Mental Health Team assessed AA in the Accident and Emergency department. During the assessment AA stated that he had been to ASDA, bought a haddock and was cooking it in the kitchen and could not understand all the fuss. The Social worker therefore concluded that AA was delusional and as a consequence 'did not acknowledge the risks he puts himself in at home'. She also agreed that AA did not have capacity to weigh up risks. However, she also noted that she was unable to assess the property as AA would not give her permission to see his flat without him going home. AA's daughter-in-law recalls that she tried to persuade

the social worker that a visit would really help them to understand how AA was living but that the social worker said that she couldn't because AA had capacity and had refused for her to visit the home.

5.70 At 15:46 the Manager of the Prevention and Crisis Service escalated AA's case for a decision in relation to the request for a temporary placement for two weeks. The referral highlighted that the purpose of the temporary placement would allow 'a period of review over 24 hours and give the family time to sort out cleaning/ clearing the property of hazards – cutting off gas' and that the plan would be to bring him home once the risks had been mitigated. She also described that the family 'were beside themselves' as 'he has not allowed them to clean/clear the property'.

5.71 Between 16:02 and 16:35 there were a series of emails between the Manager of the Prevention and Crisis Service and her seniors to clarify the legal basis for the removal; which was clarified as 'under Mental Capacity given his inability to understand the risks he poses to himself'. This email exchange identified that the Community Care and Mental Capacity Act Assessments had not been written up.

5.72 At approximately 16:00 AA slipped away from the ward and out of the hospital. At 16.14 a nurse from the Accident and Emergency called the Police asking for assistance to trace AA.

5.73 During the course of the day on the 9th April, Adult Social Services also received the letter from the GP dated 4th April and the alert from the London Ambulance Service. Both were closed by Sutton Social Services as AA was having a Community Care Assessment. This is not in compliance with the Protecting Adults at Risk Policy and Procedures. Had a safeguarding investigation been initiated it would have provided another valuable opportunity

for agencies to come together, share information and properly consider next steps.

5.74 At 17:20 AA's daughter-in-law contacted Adult Social Services to say that he had been found at his old friend's house in Sutton and requested that someone from social services come and pick him up. She explained that the police had been called and AA had refused to go with them to the hospital so they had left. Social Services explained that they could not take him anywhere against his wishes.

5.75 There is a lack of clarity over what happened next with differing accounts offered by AA's family and social services. Social services records state that AA's daughter-in-law would 'support AA at home and wait for someone to arrive as she had AA's keys and would then be going'. The notes also state that it was agreed that AA's daughter-in-law would contact the Prevention and Crisis Service team when he arrived home so that they could carry out a welfare visit. In contrast, AA's daughter-in-law recalled that she refused to pick him up and felt by doing so she would be responsible for what happened to him. She said that she asked that it be recorded in his notes that she did not want to take responsibility for this decision because she did not agree with it. She also stated that she was specifically worried about the risks to AA given the fire the night before. She therefore sent a taxi with £20 and a key to take AA home. She stated that she found this a very difficult decision to take.

5.76 AA arrived home at 17:20 and was visited by the Prevention and Crisis Service team at 22:15. AA was near the door when they arrived and it was noted that his coat was wet and he explained that he had taken the dog out for a walk. The team noted that the house was 'extremely cluttered/hoarding' they also noted that he requested a 'few times' if they had matches or lighter fuel as he wanted to make tea. The staff reassured him that he did not need matches and made him some tea. They also enquired if he wanted any food and he stated that his friend

"gave him a big meal" and he was not hungry. The staff encouraged him to settle for the night and left. It is recorded that 'as far as they could see' he did not have any matches or light source. It is understood that AA's daughter-in-law was updated and informed that a social worker would be in touch the next day.

5.77 Between 22:34 and 23:25 the senior carer from the Prevention and Crisis Service team who had visited liaised with her manager about the situation and following discussion it was decided that AA did not require a 'waking night' support.

Wednesday 10th April 2013

5.78 At 11:19 on the 10th April 2013 the CPN Care Co-ordinator from the Older Persons Community Mental Health Team contacted AA's daughter-in-law who confirmed that the Prevention and Crisis Service team had visited the night before and were continuing to work with him at home. The CPN Care Co-ordinator then contacted the Prevention and Crisis Service who confirmed that they would do two 15 minute checks daily and that they would ensure he had something to eat.

5.79 At 12:35 two carers from the Prevention and Crisis Service visited AA at home. They reported that the entrance was 'very cluttered' and there 'was dog faeces up the stairs'. As they entered they saw AA at the top of the stairs. They recorded that they asked if he was OK and he had asked them to pass him a piece of paper, but that they couldn't find it and he got increasingly frustrated with them. He then asked them to make a telephone call for him but they advised him that they could not because his phone was not working. He then said "I want you to go now and I don't want anyone coming back from your place". He then asked them to knock on his neighbour's door and ask her to come in to see him. The staff agreed to post a note through her door but would not knock. He also asked

them for the telephone number for Sutton's police as he wanted to report AA's daughter-in-law for stealing his pension. The carers told him that he should dial 101 and ask to be put through. The carers then left.

5.80 The Manager of the Prevention and Crisis Service then escalated their concerns in writing. The email they wrote stated that service had visited and that 'the house is not habitable and no care provider will enter… the carers had to climb over mounds of rubbish/hoarding to get to him which is mingled with dog faeces… and that in the light of day it was 'even worse''. They also described that AA was able to 'strongly verbalise he does not want anyone in his home' and that he wants the police as AA's daughter-in-law 'has taken all his money and he has no phone'. She then advised that physically he appeared 'able' but 'restricted by environment'.

5.81 During the day on the 10th April, Adult Social Services received the Accident and Emergency Alert which AA had raised around the financial abuse allegation.

5.82 During the evening of the 10th April a second fire occurred in AA's house. It was believed that it was caused by old food catching alight under his kitchen grill. A neighbour realised there was a problem and entered the house to extinguish it. AA was angry with his neighbour and became verbally abusive towards him and asked him to leave. Given that AA was alright and the fire had been extinguished the emergency services were not contacted.

Thursday 11th April 2013

5.83 The next morning AA's neighbour contacted Sutton Housing Partnership, firstly by telephone and then in person, to alert them to the events of the night before and requested that they visit him to repair the faulty boiler which they

believed was the reason for his fire-setting. During the course of the morning Sutton Housing Partnership visited the home and reinstated the heating and hot-water.

5.84 At 09:10 AA's daughter-in-law contacted social services to ask if there was a 'Safeguarding' in relation to AA. Social Services confirmed that they would be looking into the concern and would be back in touch with her.

5.85 At 11:45 the CPN Care Coordinator and a team member visited AA. It was not clear whether he had eaten but the flat was warm. During their visit the Prevention and Crisis Service arrived. On their way out both teams were approached by a neighbour who alerted them to the fact that AA was now also refusing help from them following the fire the night before. The CPN Care Co-ordinator advised the neighbours to contact social services with any concerns.

5.86 The CPN Care Co-ordinator then contacted social services and stated that having just visited AA he looked physically better than he had done but that there were concerns about the property and fire setting. Social Services confirmed that they would be visiting AA the next morning to conduct a capacity assessment and that if he was deemed to lack capacity they would arrange for a best interest meeting the following week. The CPN Care Co-ordinator confirmed she would make herself available for this meeting. It was agreed that the interim plan was for the Prevention and Crisis Service to continue to visit him twice daily and that a Safeguarding Alert be raised by the Prevention and Crisis Service as AA had accused his daughter-in-law of taking his money.

5.87 At approximately 14:32 a Housing Officer from Sutton Housing Partnership contacted social services because they were 'extremely concerned' about AA's wellbeing. They explained that it had been relayed to them, via neighbours, that he 'had no central heating in his property and that he was lighting charcoal fires

… and that the client was a hoarder and had lots of paper inside the property'. They also raised concerns that although they were attempting to repair the electrical fault at his home the 'heating may go off' .Social services attempted to forward the call to the allocated social worker but they were not available so instead they logged this as a safeguarding alert on their systems. It is also understood that during the afternoon a housing officer from Sutton Housing Partnership also contacted the London Fire Service to request a visit to the property because of their previous involvement, but the outcome of the discussion is not recorded. There is no record of the call within the London Fire Brigade chronology of events and so this discussion could not be verified.

5.88 At 19:30 AA was visited for the second time that day by workers from the Prevention and Crisis Service to check his welfare and provide him with food and drinks. When they arrived a friend was with him. The workers enquired if AA wanted something to eat. He responded by kicking a pile of hoarding/ rubbish out of the entrance to the kitchen and walking in there with them.

5.89 Upon entering the kitchen one of the workers noticed that four gas rings on his cooker were alight – she leaned over and turned two off and AA responded by saying "what are you doing that's what keeps me warm and I can do it myself I'II show you", and he proceeded to turn the other two rings off.

5.90 The workers then supported him to make a coffee but he declined food. AA then went back into the lounge with his friend. After a short time his friend offered to see them out. As they were walking out staff asked his friend if he could persuade AA to have something to eat – his friend said he likes Big Macs and that he would go and get him one of them. The staff then left.

5.91 The same night AA's three sons and three daughters-in-law all met in North London to discuss how best to support him moving forward.

5.92 At approximately 22:00 LFB were notified that a fire had broken out in AA's house; neighbours called 999 at 22:00:57 and reported that that the flat was on fire and that AA was still inside the property. Emergency vehicles, including a Fast Responder, a Hazardous Area Response Team and two ambulances, were dispatched between 22:02 and 22:24. The first vehicle arrived on scene at 22:06:58.

5.93 AA was found on the first floor of the maisonette by fire officers but his injuries were such that he was pronounced life extinct at 22:40.

5.94 At 22:04 the police were called to attend.

5.95 AA's daughter-in-law recalled that she and her husband were contacted by a neighbour's daughter shortly after the fire broke out and told that AA was out of the fire. However, in the course of the review the neighbour's daughter was contacted and confirmed that AA's son had asked if his dad was out of the house and that she had said that she thought he was out of the fire but she was not at the scene of the fire.

5.96 In the meantime police officers had arrived at his son and daughter-in-law's home address and following discussion with their son learned that she was not at home so were given her mobile number. The police then contacted AA's daughter-in-law, who was on route to AA's flat, and notified her that AA had not survived.

6. Findings

This section seeks to analyse the interventions that were offered to AA by various professionals and then summarises the overall response by agencies against the terms of reference. Care has been taken to avoid hindsight bias and outcome bias by focussing on what information was known by the partners at the time and by focusing upon the examination of how and why events occurred, what information was shared, what decisions were made and actions that were taken or not taken. Where appropriate this section also considers whether different decisions or actions might have led to a different course of events.

2008 – 2011

6.1 A key event in AA's life came in 2008 when he suffered a stroke. Information on the impact of this stroke upon AA is limited by a lack of information provided by the GP. However accounts from his family and information contained within his hospital records indicate that AA experienced temporary loss of feeling in his right arm and a permanent loss of strength in his right leg. It is not clear whether he suffered any direct cognitive damage from the stroke, but his family were very clear that there was a notable change to his personality after the stroke which may suggest that he did. However, given the lack of information obtained from his GP it is not possible to ascertain if this was appropriately assessed or treated. The only real reference that is made to AA's interactions with his GP prior to April 2012 are contained within the GP's letter to the Coroner, where it is noted that AA had been an 'infrequent visitor' and had 'often been reluctant to take medical advice'.

6.2 By 2010, AA began to come to the notice of Health and Social Care agencies as the primary carer for his wife. During this time he was formally assessed as a carer and the outcome of the care assessment was that he was offered respite, however is not clear from the submitted Individual Management Reviews if AA

took up these offers. It is evident from these interactions that AA was fiercely protective of his wife and wanted to continue to care for her at home for as long as he could. AA's daughter-in-law recalls that AA had been adamant that he did not want his wife to go into a home particularly because he did not trust those in positions of authority.

6.3 Later that year on the 4th December 2009, his wife had a fall at home and was admitted to St. Helier. She was discharged on 8th January 2010 but readmitted a week later, following which she was transferred to a Mental Health bed. Following a period of leave, which failed and saw her yet again readmitted to St. Helier and transferred back to the Mental Health bed, concerns around her mobility and safety were raised and it was felt that placement would be an appropriate option. Fearing for her continued safety at home, AA reluctantly agreed that she should go into residential care. She was placed in a care home in April 2010. It is noted that the terms of reference for the review did not go back to 2010 so it is unclear if those services who had worked with Mrs AA took the time to review AA's needs following this significant event, which would have been warranted in such a case.

6.4 It is noted that at the time that AA and his family agreed to place Mrs AA into residential care her prognosis was bleak; however in the passage of time his wife's physical condition improved. Given this, it is possible that AA's perception of agencies and the trust he had in them would have been further damaged.

6.5 AA's daughter-in-law recalls that his wife moving into a care home 'had a very negative impact upon him' and he 'became more eccentric'. She also stated that his existing tendency to hoard 'began to increase' in the absence of his wife, who one can assume had previously supported him to keep this impulse under control. This hoarding is likely to have been worsened by his decision to refurbish items from car boot sells in order to then sell on, as presumably he was carrying out this work within the home. It is unclear if Sutton Housing Partnership conducted landlord checks of his home during this period, as prior to 2012 they

did not routinely record this; however if they did not it was potentially a missed opportunity to identify hoarding and intervene at an earlier point.

6.6 The chronology sets out that AA lost his driving licence following an incident involving a dust cart. It seems that this was a deliberate act which may have indicated a personality change in AA. It is unclear whether consideration was given to a possible deterioration in mental health being the cause of this incident.

6.7 The next time that AA came to the attention of agencies was in November 2011 when he had a fall at home and was found by a neighbour. Following admission to the Accident and Emergency department, the London Ambulance Service made a referral to Adult Social Services, concerned that he was hoarding and self-neglecting. Adult Social Services then visited him at home to assess his needs. The assessment is recorded in the social care records as commencing on 1st November and being completed on or by 15th November. The actual date of the assessment is unclear. AA reported that he was “perfectly all right” looking after himself.

6.8 The assessment acknowledged that AA was forgetful with his medication and that he was also experiencing increasing difficulties getting around his flat because it was ‘cluttered and this created a trip hazard’, although AA is recorded as stating that he could “manage just fine”. However there was no indication within the assessment of any Mental Capacity assessment or challenge to the fact that, although AA was stating that he could manage, his environment did not reflect this. It was recognised that he was not always compliant with his family’s prompts around medication and cleaning. The adult social services visit concluded that AA had capacity to refuse support. It is clear that this was not the result of a specific test of AA’s decision making in this area but was based on a general presumption of capacity. Therefore the only tangible outcome of this visit appeared to be that an OT Assessment was requested.

6.9 Given the presenting complex issues of forgetfulness and hoarding, this outcome would not be expected post an assessment of a person living in these circumstances.

6.10 The assessment showed concerns about self neglect and this was considered to be a risk if AA's family were no longer able to offer the level of support they were currently providing. There is evidence of family involvement in the social care assessment but the details of their involvement are not clearly recorded.

6.11 It should be noted that the outcome of the assessment, in terms of the Fair Access to Care Criteria, was moderate – high.

6.12 The Occupational Therapist assessment took place sometime later and assessed him as requiring aids for transferring from his chair and into the bath. However it failed to identify any needs in relation to moving around his cluttered flat to undertake domestic routines. This suggests that the wider issues were not effectively communicated or taken onboard by the Occupational Therapist.

6.13 It is evident from involvement with AA that all agencies failed to implement the Mental Capacity Act. All agencies were working on the presumption that AA had capacity or indeed did not have capacity to refuse help and intervention. By failing to carry out a Mental Capacity Act assessment in a timely manner and by following AA's wishes, agencies did not consider if he understood the risk involved in his decision making.

6.14 This involvement also suggests that Adult Social Services and all other partners involved in providing care for AA were not considering alternative legislation in relation to self neglect and hoarding, including:

- the Health Services and Public Health Act 1968
- National Assistance Act 1948 s21, s29, s47
- National Health Service and Community Care Act 1990
- NHS Act 2006, s. 20
- Public Health (Control of disease) Act 1984, Part 2a
- Public Health Act 1936, Section 83
- Environmental Protection Act 1990, Schedule 3
- Mental Health Act 1983
- The Mental Capacity Act 2005

6.15 It is also noted that this is not set out in any locally agreed protocols around self neglect and hoarding which serves to provide a procedural framework for this work elsewhere

January 2012 – July 2012

6.16 Records indicate that a review of the occupational therapist assessment took place on 27th January 2012; however there is no detail of whether the environment had deteriorated further or whether his refusal of support was revisited. Given that when the London Fire Brigade visited in May they raised concerns, one can assume that AA had continued to hoard and that professionals entering would have been in a position to raise this concern but did not.

6.17 During the first week of May 2012 records show that AA had three outpatient appointments in Audiology and the eye unit. As stated in the summary of key events it is not clear from the records held by agencies whether the cataracts impacted upon his ability to self-care at home. Agencies should consider whether

the self-neglect which ensued may have been identified at this point if staff had enquired as to how he was coping at home.

6.18 A week later AA was visited at home by the London Fire Brigade and then made a referral to Adult Social Services concerned about the hoarding. Following contact with AA, Adult Social Services deemed that AA had the mental capacity to refuse support to address his hoarding and so social services deemed that they had no powers to enforce action. They encouraged the fire service to contact his landlord Sutton Housing Partnership. Records do not capture how his capacity was assessed and again, regardless of whether he had capacity, social services still would have been able to co-ordinate an intervention (as set out under paragraph 6.14) given the level of risk to AA and also to other tenants. Social services would also have had a duty, under NHS Community Care Act 1990[3] to continue to offer support on a regular basis to AA and it would have been considered appropriate for social services to have co-ordinated a multi-agency self-neglect intervention.

6.19 As advised, the London Fire Brigade contacted Sutton Housing Partnership, requesting that they take action under the tenancy condition to reduce the risk from fire both for AA and other residents. Sutton Housing Partnership then visited AA at home to discuss the fire services' concerns. While initially it seems that AA attempted to question the reported view of the fire service, he did appear to engage with his Landlord to address the situation and as such legislative powers were not required and the fire service left Sutton Housing Partnership to co-ordinate the interventions. Moving forward it is suggested that a multi agency vulnerable adults panel will be implemented where there are concerns of fire loading that may pose a risk to third parties to discuss the progress of interventions and agree an action plan for progression to reduce the risk to the individual and third parties. It is also noted that this intervention could have been more efficient if fire officers who attended had taken photographs or conducted a

[3] Neglect is not limited to neglect perpetrated by others

recognised clutter rating assessment as this could have then be shared with the landlord to avoid delays in gathering their own evidence. London Fire Brigade acknowledge that they could have also liaised with Mental Health Services or the GP other than the single agency, Social Services, who they did liaise with.

6.20 On 25th July 2012 AA underwent surgery on the first of his two cataracts. It is noted in that during the preceding appointment in May they had assessed that there were no concerns about capacity to consent and that he was expected to be supported at home upon discharge by his family. However, it is not clear if this was revisited in July.

July 2012 – January 2013

6.21 It is evident from the chronology that between July 2012 and January 2013 Sutton Housing Partnership worked with AA and his family to address the difficulties associated with his hoarding. This is to be commended, as no doubt it would have significantly improved AA's living environment.

6.22 The chronology indicates that on 11th October 2012 the Housing Management team at Sutton Housing Partnership contacted Adult Social Services to request an assessment for AA as they were concerned about his hoarding behaviour. The records held by the Housing Partnership indicate that they were advised by a member of staff within social services that they 'didn't help with hoarding'. This represents the third missed opportunity for social services to revisit the situation with AA and offer him support in accordance with NHS Community Care Act; if consent was not achieved they could have considered supporting partners to co-ordinate an alternative response to AA's self-neglect and hoarding.

6.23 The chronology also evidences that throughout the works that took place in AA's property, Sutton Housing Partnership addressed the issue of hoarding to enable maintenance of the property to take place. AA was supported by his family, and indeed his neighbours, to report on-going issues. This suggests that he had a strong network of support around him during this time who could have been utilised by services to ascertain whether the hoarding was worsening and to offer opportunities for agencies to engage.

6.24 In November, AA underwent his second operation, this time on his right cataract. Hospital records again indicate that this was a day surgery and that consent was gained from AA and that there were no concerns about his capacity to do so. The records also indicate that he would be in receipt of support from his family upon discharge and so social services were not required to be notified.

6.25 On 16th December AA collapsed at home and was found unconscious by his son, who explained that he had appeared confused, had not had any appetite for the last month and had not taken his medication. The ambulance crew examined AA and recorded that he appeared pale, malnourished, dehydrated and weak. He was then taken to St. Helier A&E department. The discharge notes taken by the Doctor treating him in A&E show he had 'capacity to make decisions' and he was discharged the following day with his daughter-in-law's support. It is not clear, however, whether the doctor considered sharing information with other agencies particularly in the light of his confusion. It also brings into question the level of emphasis that agencies place upon the accounts of relatives, when really this should be supplementary information. It is also evident that the hospital made a referral to Age UK for help with cleaning for short term which may imply that a referral to Adult Social Services may have been warranted at this point.

6.26 In January 2013 AA attended the hospital for his second outpatient appointment following his right eye cataract surgery. There is no indication that AA was a high risk and so he was not questioned in relation to the admission the

month before. This indicates that information may not have been shared across departments. While this does not necessarily indicate a missed opportunity it may suggest information sharing was not sufficiently developed to enable every contact with AA to count, which research indicates is critical in ensuring success around cases of self-neglect.

February 2013 – March 2013

6.27 On 12th February 2013 AA called the police to report an alleged a burglary at his home. He reported that he had witnessed a young person stealing his wallet and described himself as disabled. The police correctly prioritised him as a vulnerable caller and attended without any significant delay. The next day when another police office contacted him to arrange to come around and gather additional evidence AA stated that that he had found his wallet and that the young person was just a friend who had come by. This was the first and only time that a SOVA was recorded by police in relation to AA. It is not clear if any other actions were taken to verify his explanation with others or whether police officers gave any consideration to his mental capacity or to whether he was being coerced in any way to change his account of events. The police were asked to reflect upon whether the new 'Adult At Risk Come To Notice' system which is now in place would have brought greater scrutiny to this type of decision. The new process records matters that relate to a vulnerable adult where there is a risk of harm, to enable this information to be available to police and shared with adult social services. In itself it would not make an investigating or supervisory officer consider mental capacity or coercion. On reflection the Police acknowledge that the SOVA (pre ACN process) could have been forwarded to Social Services but believe this would have been around him leaving his door unlocked.

6.28 Ongoing safety beyond the crime investigation itself was considered by the Police, with crime prevention advice given and a follow up visit made by the local Safer Neighbourhood Team (SNT). However, when the SNT called, AA was not in and a note was left with contact details.

6.29 Records from the Sutton Housing Partnership reveal that by the 25th February AA's son was staying with his father as his marriage had broken down.

6.30 On the 26th February AA contacted the police again stating that he had identified that a number of his possessions were missing. He was not sure when they had been taken but suspected it was between the 11th and the 26th February. The Police Individual Management Review reports that there was 'no evidence to support this assertion' and 'it was possible that the items had been misplaced' and as such enquiries could not prove or disprove the allegation. The Individual Management Review also refers to AA having had a social worker who attended with his son; however it is not clear who this social worker would have been as at this time as he did not have an allocated social worker. In hindsight this allegation should have prompted the completion of a Safeguarding alert so that agencies could have come together to explore the allegation, assess his needs and develop a protection plan if necessary. The matter was investigated by the police and the possible suspect researched, together with reassurance visit by local SNT.

6.31 On 20th March 2013 during a visit by two housing officers from Sutton Housing Partnership, AA disclosed that his neighbour was 'still bothering him'. Similarly the housing officers did not raise a safeguarding alert with adult social services, which would have been warranted given the circumstances. It was also evident from the visit that AA had begun to hoard again, despite the extensive deep clean which had taken place just four months before. It is not clear from the records what level of discussion they had with him about this, how they intended to proceed or if they shared their concerns with Adult Social Services. Over the next

week neighbours contacted the housing partnership to report faults with the electrics in AA's home, which the partnership dealt with in apparent isolation to the issues of the hoarding.

Wednesday 3rd April 2013

6.32 On the 3rd April AA was visited at home by his GP who diagnosed left sided bronchitis, prescribed antibiotics and advised AA to attend hospital to have some intravenous fluids; but he refused. Records indicate the GP felt that he 'appeared to have capacity' so did not pursue it. It is unclear if the GP conducted a formal assessment of his capacity or whether it was speculation. It is notable that if an assessment at this stage had indicated that AA lacked capacity to make a decision about his admission, the GP would have been in a position to make a 'best interest' decision. Given that the GP felt that AA was 'increasingly at risk being in his home' the outcome was likely to have been an admission. It is also recognised that, although not ideal, if the GP had doubted his capacity but had been unable to formally assess, he could have approached other agencies for advice and guidance over the Mental Capacity Act, including asking another agency to complete the assessment, or applied to the Court of Protection.

Thursday 4th April 2013

6.33 The following day the GP wrote to Social Services to raise his concerns about AA's hoarding and requesting their 'input'. There appeared to be a significant delay in social services receiving this alert as the fax would not transmit and so was posted instead. It is likely that this delayed the input of adult social services and that moving forward alternate methods of referring information should be acquired at the practice. It is also noted that the letter itself is vague about what the GP expected of social services, which may indicate that he was not clear about the role of social services in such a case.

6.34 The GP also faxed a letter to the Older Peoples Community Mental Health Team to request an 'urgent domiciliary visit' by a Consultant Psychiatrist or a Community Psychiatric Nurse so that they could assess 'whether he required a change of medication'. Again the GP expressed that he had really wished 'to admit him to hospital for a place of safety and possibly for some IV fluids and further investigation in view of his poor state' but he had not pursued this approach as AA had refused any admission to hospital and appeared to have the capacity to do so and was orientated in time, date and person. As stated above it is unclear if this had been ascertained via a Mental Capacity Assessment or whether this was speculation. It also indicates that the GP may have placed too much importance upon AA being orientated to time place and person as opposed to undertaking a decision specific assessment. Again it is also noted that the referral is vague about what the GP expects of mental health services, particularly given that he also noted that he had 'no identifiable mental issue', which may indicate that he was not clear about the role of mental health services in such a case.

6.35 Following receipt of the faxed referral the GP's concerns were discussed at the Older People's Community Mental Health Team morning meeting. It seems that there were discussions around the appropriateness of the referral from the GP but there is no evidence of this being queried by the team. This may have been a missed opportunity for the team to manage their response to the GP referral.

6.36 Following the meeting the CPN Care Co-ordinator visited the patient and assessed that GE was 'emaciated and was living in squalor'. During this assessment the CPN Care Co-ordinator deemed that there was evidence of 'short term memory problems' and that he "did not appear to have capacity". This was the first time that any professional had assessed him as not having capacity and should have signalled a change in approach where a best interest decision is made under the Mental Capacity Act.

6.37 While the CPN Care Co-ordinator agreed that AA should attend the hospital it seems that he later refused and the emphasis shifted to his daughter-in-law to convince him to attend. Persuasion by the family was seen as the least restrictive option by the CPN Care Co-ordinator. However had the CPN considered the Mental Capacity Act and considered the role of 'decision-maker', the CPN Care Co-ordinator would have had the ultimate responsibility to ensure that her best interest decision was carried out. Given the lack of reference to the best interest decision within the Individual Management Review it is assumed that the CPN did not consider the MCA or their functions under the Act.

6.38 It is also apparent that the CPN prioritised AA's physical care needs as they were most pressing. This may have limited the mental health assessment; and formal assessments relating to his mental capacity and mental health were not fully completed. The role of CPN (CPN have responsibility to assess physical health care needs too) is to co-ordinate mental health care and treatment, and to communicate with other agencies such as social services around issues beyond this remit. This may indicate a breakdown in the managerial oversight of staff as it demonstrates a lack of adherence to the operating procedures which could have been picked up via supervision or made clearer during the referral meeting discussion.

6.39 During the assessment it was also noted that AA had had his mobility scooter and his wallet stolen at an earlier time in the year. These allegations of theft should have resulted in a safeguarding alert to adult social care and or a report to the police when they occurred. If these had have been raised it may have provided an opportunity to bring partners together to discuss the case and in doing so the wider issues facing AA, although these would not have been specifically safeguarding concerns, since Protecting Adults at Risk of Abuse: the Pan London Adults Safeguarding Policy and Procedure states 'Self-neglect does not come under the scope of these procedures – which relate to circumstances where there is a person or agent, other than the adult at risk, who is causing significant harm'. The borough could have considered the SCIE report on Self

Neglect and used it within the Safeguarding Adult procedures. Had it been applied in this instance, there may have been a different outcome.

Friday 5th April 2013

6.40 Following the agreement to attend hospital for an assessment, AA attended St. Helier Hospital the next morning and was seen in the Assessment Medical Unit. The GP refers to having contacted the hospital medical consultant on the "in-take" team who agreed to accept him.

6.41 The initial view of the attending doctor within the Assessment Medical Unit appeared to be that AA had undiagnosed COPD and delirium as a result of chronic cognitive decline. This may suggest that the doctors suspected that he was suffering from Dementia. The Individual Management Review from the Hospital Trust states that staff then undertook a Dementia assessment which supports this assumption. However it is not clear what the test found.

6.42 The initial doctor also noted that he suspected that AA may have been exhibiting 'acopia' which was leading to malnutrition; this infers that he felt AA was 'failing to cope' (not actually a diagnosis) and the impact was that he was not eating properly. In this case the use of the term 'acopia' appears to have overshadowed a diagnosis of his underlying issues.

6.43 While it is noted in records that during AA's assessment in the Assessment Medical Unit his relative expressed concerns around his increasing confusion, verbal aggression, self-neglect/ability to self-care and his disinterest in food, drink and medication, it is not clear how professionals responded to this information.

6.44 While professionals appeared to recognise that they should consider the Mental Health Act and the Mental Capacity Act, its actual application remains unclear within the records. While they reached their decision that he had capacity in consultation with the duty Older Persons Psychiatric Liaison Nurse, it is not clear if they conducted a formal capacity assessment. The records indicate that they were informed that AA was 'known to the [mental health] services and although there was a potential decrease in safety awareness AA was not 'putting himself at immediate risks''; the evidence on which the duty Psychiatric Liaison Nurse based this assessment of risk is also not clearly contained within the information submitted by the Trust. The Mental Health Trust have no record of this consultation between the hospital and the Older Persons Psychiatric Liaison Nurse.

6.45 While the decision to discharge was pending, the duty Psychiatric Liaison Nurse decided to make a referral to the Home Treatment Team to arrange visits to AA over the weekend. The purpose was to ensure that he took his medication and that his nutritional and hydration needs were being met. This action indicates that professionals working with AA recognised that AA would face some risks should he be discharged back into the community unsupported.

6.46 The report to HM Coroner notes that the duty Psychiatric Liaison Nurse felt that a referral to the Home Treatment Team was the only option available in the absence of any other support available late on a Friday afternoon. However, the assumption that there was an absence of an alternative was not correct and instead a referral to social services out of hours Emergency Duty Team should have occurred at this point, as they had a duty of care in relation to his social care needs. This suggests that professionals may have lacked clarity around the remit of Social Services Emergency Duty Team, indicating that work is required to ensure that awareness is increased.

6.47 The referral to the Home Treatment Team by Assessment Medical Unit staff was not appropriate because the role of the team is to offer an alternative to admission to a psychiatric bed for those with mental health needs and at this stage AA had no such diagnosis. It is also evident that this referral to the Home Treatment Team was not overseen or sanctioned by the manager of the service via the established referral process. It can be deduced from this referral that staff either did not fully understand the criteria and referral process or that they chose to ignore it in order to access the service. This may suggest that staff felt under pressure to discharge, in part because of AA's refusal to remain, and in part because of the lack of an alternative intermediate facility locally.

6.48 The interventions on the 5th April also highlight the inherent difficulties experienced by staff in assessing capacity of individuals, particularly when individuals present as orientated in time place and person, but exhibit indications that they may not have mental capacity to understand and weigh the risk associated with specific decisions and/or the cumulative effect of such decisions.

Saturday 6th April 2013

6.49 The Home Treatment Team struggled to ascertain AA's whereabouts and the circumstances surrounding his discharge. This suggests that that communication between the Hospital and Home Treatment Team had not been effective. The Duty Psychiatric Liaison Nurse consulted with the Home Treatment Team, but at the point where she went off duty, no decision had been made to either admit or discharge AA. Following the visit the Home Treatment Team raised several serious concerns about his physical state and his environment. However it is not clear how these concerns were escalated given their seriousness. Rather, it appears that professionals drew back agreeing to manage the situation over the weekend until services were back on line. However the partnership should consider whether its expectation would have been for a more proactive response

given that he was believed to 'lack insight into his condition' and 'did not seem be aware of the dangers associated with his flat'.

Sunday 7th April 2013

6.50 AA was then visited at approximately 10:00 on Sunday 7th April by a different staff nurse and Health Care Assistant from the Home Treatment Team. It is unclear whether this change in personnel affected the ability of staff to establish and maintain rapport with AA, although it is recognised that the Home Treatment Team are not in a position to provide the same staff during every visit as they run a 24/7 service. During this visit, in addition to the on-going concerns about AA's physical health, staff also noted that he was 'short of breath when he moved around'. Given his frailty and the unsatisfactory environment it is unclear why he was not admitted to hospital.

6.51 It is also noted that during this visit that AA did not have gas ignition or electricity, which, given that weather reports indicate that it was between 6-9˚c outside, would not have been an ideal environment for a man of his condition.

6.52 While it is acknowledged that staff improvised by giving him a packet of crisps and a glass of water, agencies should reflect on whether this was an appropriate response.

6.53 Also of note was that staff were not able to ascertain if AA had taken his medication. Given that this was their primary function brings into question whether efforts should have been made to escalate the response.

6.54 Staff also noted that during this visit AA 'lacked insight into being unwell' and his mood was changeable; both indicators to support a view that he was not in a position to make the decision to remain at home. This suggests again that there was a missed opportunity to consider a best interest decision under the Mental Capacity Act. As staff did not act on their concerns, this appears to suggest that staff were not aware of what they should do and/or were not clear about how other services could have intervened at this point to support them.

Monday 8th April 2013

6.55 The chronology outlines that there were various discussions within Mental Health Services during the course of the day on the 8th April 2013. It is evident again that priority continued to be given to his physical health above his mental capacity. It should be acknowledged that addressing AA's physical needs could have had a potential positive impact on his mental health / capacity. However, it is apparent that once professionals felt that his physical condition had improved they did not re-prioritise a review of his capacity.

6.56 Professionals determined that AA did not have a severe gross impairment of short term memory. However professionals were unable to assess his memory fully (because he would not engage) so based this assessment upon his ability to orientate to person. In addition they did not have to fully explore his Mental Health because he was compliant with the Home Treatment Team intervention. However, this did not appear to have taken into consideration that he had refused to co-operate with the memory assessments which would indicate that he was not compliant.

6.57 The interventions suggest that mental health services retreated into a 'comfort zone' of exploring 'traditional' mental health options to admit to hospital for physical care; to admit for a psychiatric assessment or to detain under the Mental

Health Act. During these discussions concerns were frequently documented that AA did not have mental capacity regarding his own self care or his medical treatment. Under such circumstances professionals should have made a best Interest decision under the Mental Capacity Act.

6.58 This intervention may also suggest that staff were not always able to recognise the potential significant risks associated with a man who lacked capacity to self care remaining in such an environment.

6.59 It is apparent that Mental Health Services encountered inflexibility in the referral process in referring the case to Adult Social Services and subsequently required escalation: which happened within a period of hours . While it is accepted that agencies have processes that they require are followed, we see an example of how, without the tenacity of stakeholders, referrers concerns might not be heard effectively: although in this instance the escalation was rapid.

6.60 Upon receipt of the referral, the social services Social Services contacted AA's family to establish his immediate needs. While it is acknowledged that relatives should be contacted in order to gather information, it appears that the team was solely reliant upon their account of his situation, where perhaps a visit would have been warranted to effectively discharge their duty of care.

6.61 Later that night AA lit a BBQ in his living room, his smoke alarm was activated and subsequently his neighbour came into the flat. The neighbour was able to extinguish the BBQ, turn off the gas rings and then called an ambulance for AA. It is noted that despite the London Ambulance Service sending a Hazardous Area Response Team to assess for possible $CO^{2,}$ the London Ambulance Service did not share this information with the London Fire Brigade, which may have been a missed opportunity to engage London Fire Brigade in minimising future fire risks.

Tuesday 9th April 2013

6.62 In the early hours of Tuesday 9th April 2013 AA was medically cleared for discharge and deemed to have capacity by the doctors in Accident and Emergency. There is no record of how the doctors reached their view of capacity which one would have expected. It is commendable that the ambulance crew returned AA to the hospital when it became evident that he did not have house keys and also that they raise a safeguarding alert with social services about the concerns that they had witnessed at his home.

6.63 Over the next seven hours professionals from the hospital, mental health services and adult social services worked to gain agreement to get AA into respite while his family could clean the flat. There appeared to be a lack of clarity around who was doing what which may have been compounded by the ongoing involvement of mental health services. The result was that despite discussions across agencies no formal assessment of his mental health or his mental capacity was effectively documented and as a consequence no agreement was achieved before AA seized an opportunity to leave. Given that professionals knew that AA was reluctantly there, expediency should have been identified as a key issue.

6.64 Social care professionals felt it necessary to carry out separate assessments, despite the accounts of other professionals that indicated AA lacked capacity and that he would be at risk if he returned to his home. However, it is unclear how the information provided to social care on AA's capacity influenced social care professionals as there was no evidence that others professionals had carried out a formal assessment of capacity.

6.65 Despite adult social services assessing him as lacking capacity, it is evident that they still sought to gain his permission to visit his home; when legally they could have visited the home in his best interest. The Mental Capacity Act 2005 does require people who are assessed as lacking capacity to be involved in decision making and in this instance it appears there staff were working on the assumption that until a formal assessment of capacity was carried out AA's wishes were being adhered to. This also signalled an opportunity for social services to alert his landlord Sutton Housing Partnership to the concerns, but this did not happen.

6.66 It is apparent that professionals did not adequately anticipate that should AA go home he may present a continued fire risk to himself and other residents. This again was a missed opportunity to seek support from Sutton Housing Partnership and also from the London Fire Brigade.

6.67 During the course of the day Adult Social Services also received the letter from the GP dated 4th April and the alert from the London Ambulance Service. Both were closed by Sutton Social Services as AA was having a Community Care Assessment. This is not in compliance with the Protecting Adults at Risk Policy and Procedures. Had a safeguarding investigation been initiated it would have provided another valuable opportunity for agencies to come together, share information and properly consider next steps.

6.68 At 17:20 AA's daughter-in-law contacted Adult Social Services to say that he had been found but that the police were refusing to return him to Accident and Emergency. This indicates that information about his lack of capacity had not been effectively shared with police. The police worked on the assumption that AA had capacity and his behaviour did not indicate a need for him to be removed to a place of safety, nor would they have any legal powers to do so, unless they considered that he was at risk of harm to himself or others.

6.69 There is a lack of clarity over what happened next with differing accounts offered by AA's family and social services. Social services records state that AA's daughter-in-law would 'support AA home and wait for someone to arrive as she had AA's keys and would then be going' and that AA's daughter-in-law would contact the PACs team when he arrived home so that they could carry out a welfare visit. In contrast AA's daughter-in-law recalled that she refused to pick him up and felt by doing so she would be responsible for what happened to him.

6.70 AA arrived home at 17:20 and was visited by the PACs team at 22:15. Given what had happened the night before the risk of fire setting should have been a priority set out in their care plan. However, even though it was noted that he requested a 'few times' if they had matches or lighter fuel as he wanted to make tea it seems that no action was taken to consider removal or to monitor him over night (especially given that he had said that he had just returned from a walk). Rather staff employed a tactic of reassuring him that he did not need matches and then settled him for the night. Following the visit this issue was escalated but the decision was that a waking night support was not required. While a fire was not started that night it seems that this was an unacceptable risk to take and that it may have influenced assumption about his capacity to stay overnight unsupported moving forward.

Wednesday 10th April 2013

6.71 On the morning of Wednesday 10th April the CPN Care Co-ordinator contacted the Prevention and Crisis Service who confirmed that they would do two 15 minute checks daily and that they would ensure that AA had something to eat. At this point it is unclear why the mental health services remained involved given the lack of identified mental health need and the support package had been commenced through the Prevention and Crisis Service team.

6.72 At 12:35 two carers from the Prevention and Crisis Service visited AA at home. During the visit the staff confirmed serious concerns about his living conditions but were requested to leave by AA. It seems that at this point Prevention and Crisis staff were working on a false assumption that AA had capacity, despite the referral to the service being explicit about his lack of capacity. This indicates that information sharing failed in some way within the Prevention and Crisis Service. Critically had staff responded to his refusal of service by making a best interest decision the outcome may have been that he would have been removed at this point.

6.73 It is also noted that Prevention and Crisis staff did not support AA sufficiently to obtain access to a telephone or to proactively respond to his concerns around financial abuse. It is also evident that he had asked them to knock for his neighbour and they refused. It is unclear why such a decision was made, given that the neighbour may have been able to support AA to accept help.

6.74 Records indicate that following the visit the Prevention and Crisis Service escalated their concerns to management; however the outcome of the email is not clearly documented. It is also noted that the Prevention and Crisis raised a safeguarding alert around this time in relation to AA's allegation of financial abuse by his daughter-in-law. However, interim action taken by the service to safeguard him was not evident.

6.75 During the day on the 10th Adult Social Services received the A&E Alert which AA had raised around financial abuse allegation. Further information was requested on what happened in relation to this allegation but at the time of compiling this report information had not been received.

6.76 During the evening of the 10th April a second fire occurred in AA's house. A neighbour entered the house to extinguish it. It seems that AA did not require medical assistance but rather saw his neighbour's intervention as an intrusion and so asked him to leave. Emergency services were not notified.

6.77 The next morning AA's neighbour contacted Sutton Housing Partnership, firstly by telephone and then in person, to alert them to the events of the night before and requested that they visit him to repair the faulty boiler which they believed was the reason for his fire-setting. In response Sutton Housing Partnership visited the home and attempted to fix the electrical fault. Later that day Sutton Housing Partnership contacted adult social services to alert them to the concern that the heating may go off again. If the heating had gone off again it is reasonable to surmise that that there was an increased risk of AA attempting to use alternative methods to keep warm, however this does not seem to have been acted upon by social services. Being unable to forward the call to the allocated social worker the concern was logged as a safeguarding alert on their system. Given the seriousness of this concern it seems that this should have been escalated to senior managers who would have been able allocate resources to respond to the concern; i.e. increase supervision or make a decision to remove in the absence of the allocated social worker.

6.78 It is also understood that a housing officer from Sutton Housing Partnership contacted the London Fire Brigade to request a visit to the property because of their previous involvement. London Fire Brigade have no evidence of this; however it is possible this contact was made via email, as on the 15th of April, Sutton Housing Partnership received a delivery failure email notice. The outcome of the discussion is not recorded, neither is it contained within the London Fire Brigade Individual Management Review. It is difficult to know whether the London Fire Brigade would have been in a position to offer an immediate intervention on this information but it does bring into question whether an opportunity was missed at this point.

6.79 Records also indicate that during the day AA's daughter-in-law contacted social services to ask if there was a 'safeguarding' in relation to AA. Social Services confirmed that they would be looking into the concern and would be back in touch with her. Given that this is believed to have been in relation to an allegation of financial abuse made by AA against his daughter-in-law this response was appropriate.

6.80 At 11:45 that day the CPN Care Coordinator and a team member visited AA. Again it is not clear under what remit the Older Persons Mental Health Team were acting given that they had deemed him not to have a mental illness.

6.81 During their visit they came across the Prevention and Crisis Service and both were then approached by a neighbour who alerted them to the fact that AA was now also refusing help from them following the fire the night before. The neighbour was requested to contact social services herself. It would have been appropriate for staff to have acted on this information by contacting the allocated social worker and also the London Fire Brigade themselves.

6.82 It is also apparent that at this point social services had confirmed that they would be visiting AA the next morning to conduct a capacity assessment, and that if he was deemed to lack capacity they would arrange for a best interest meeting the following week. Given the level of concern being raised around fire-setting it is concerning that greater urgency was not afforded to this, particular given that other professional were stating that he lacked capacity and was at high risk in his current environment should another fire occur.

6.83 At 19:30 AA was visited for the second time that day by workers from the Prevention and Crisis Service to check his welfare and provide him with food and drinks. Upon entering the kitchen one of the workers noted four gas rings on the cooker were alight – she leaned over and turned two off and AA responded by

saying “what are you doing that’s what keeps me warm and I can do it myself I’II show you”, and he proceeded to turn the other two rings off. While it is acknowledged that staff assured themselves that the gas rings were turned off, it is not clear if steps were taken to verify that the heating was working and then explain the risks of using the gas rings to keep warm. If this dialogue had taken place it may have become evident that a best interest decision was required.

6.84 At approximately 22:00 the LBF were notified that a fire had broken out in AA’s house; neighbours called 999 at 22:01 and reported that that the flat was on fire and that AA was still inside. Emergency vehicles (including a Fast Responder, a Hazardous Area Response Team and two ambulances) were dispatched between 22:02 and 22:24. The first vehicle arrived on scene at 22:06:58. AA was found on the first floor but his injuries were such that he and was pronounced life extinct at 22:40: it is unclear which professional made this pronouncement.

6.85 AA’s daughter-in-law recalled that she was contacted by a neighbour shortly after the fire broke out. On route to AA’s house she was contacted by the police who notified her that AA had not survived.

6.86 It is evident from discussions with the family that while they felt supported by the police there was some confusion between CID and the officers who attended AA’s daughter-in-law’s home address about whether the family had been informed of his death. It is also regrettable that when the police contacted AA’s daughter-in-law via mobile phone from her home address. Her son was within earshot and was then unsupported by his parents when he heard that his grandfather had died in the fire.

Analysis of Agency Involvement

6.87 London Borough of Sutton Adult Social Services

6.87.1 There were several missed opportunities dating back to November 2011. The London Borough of Sutton Adult Social Services had no protocol at this time for supporting people who Self Neglect. This is of particular concern because of the level of risk other professionals were describing, not only to AA but also to other residents. In particular they failed to continue to offer support on a regular basis to AA but instead closed the referral. There is also evidence that the range of legal options available to the Local Authority in relation to self-neglect and hoarding were insufficiently explored with the London Borough of Sutton Adult Social Services, missing several opportunities to develop a multi-agency approach where all information could be shared and all legal options could have been considered. While it is accepted that self neglect is a complex issue, there is a legal framework which staff should have been aware of, or if they were in any doubt, legal advice should have been sought.

6.87.2 This Serious Case Review has highlighted inadequacies in the assessment and management of AA's various social care needs at different times and subsequently earlier opportunities to intervene were not taken and the inherent risks continued to increase. There is no doubt that at least in last few weeks of his life AA was an individual with multiple health needs (physical and potentially psychiatric) and about whom there were concerns in respect of living conditions, self neglect, fire-starting and safeguarding. There was a need to clearly identify and record his vulnerabilities and support needs at the start of the intervention; however it is clear that this assessment process was not effective in establishing this. The situation merited a robust and proactive approach involving a recorded holistic assessment of needs and risk, which if shared across agencies would have resulted in a more accurate assessment for all of the disciplines and agencies involved in AA's care.

6.87.3 It is apparent that between the 8th April and 11th April 2013 the emphasis for Adult Social Services was on developing a package of care to manage the risks but AA was unwilling to engage. While it is acknowledged that AA refused services it is not evident that the service balanced this against the need to respond to the level of risk.

6.87.4 The Individual Management Review cites that there was a lack of clarity over whether or not AA lacked mental capacity to make decisions and so the approach taken by Adult Social Services was to assume that AA had mental capacity in these areas.. While it is acknowledged that the Act dictates that it must be assumed adults have capacity to make decisions, unless indicators suggest the person may be impaired, which would have led to a Mental Capacity Act assessment, in the case of AA at least two professionals from Mental Health Services felt that he did lack capacity in this area which should have lead to a Mental Capacity Act assessment. Although this was planned, there needs to be reflection on the speed in which it was made.

6.87.5 While it is recognised that the Mental Capacity Act requires that professionals make an assessment of capacity before carrying out any care or treatment, it is noted that this meant that while domiciliary support was initiated to supervise him for fifteen minutes twice a day, decision making around whether he should remain within his home environment was effectively deferred until the 12th April. This timeframe or interim measure was not appropriate given the seriousness of harm that could be caused by the presenting risks. It is not clear if resources played a part in this decision but it is clear that the service failed to effectively respond to the indicators of risk.

6.87.6 It is also noted that if Adult Social Services had felt a quicker assessment had not been possible because of his non-engagement, legal advice should have been sought in relation to his Mental Health and/or if necessary an application made to the court of protection.

6.87.7 Whilst recognising the significant challenges faced by professionals there needed to be greater emphasis on exploiting the opportunities which presented for working positively with him and working to understand and minimise the resistance. This needed in part to include exploration of his reasons for declining support, services and treatment as well as supporting his understanding of what the likely outcomes of refusing treatment and services might be. Advocacy may have offered a way of engaging more effectively, as could using the plight of his pet dog as a lever to encourage him to understand the impact of his environment.

6.87.8 There is evidence of insufficient acknowledgement of the concerns expressed by his family and neighbours and evidence that the family were responsible for much of the information sharing as opposed to staff actively seeking their views on matters. Perhaps the only exception being on the 8th April when the Emergency Duty Team contacted his family to ascertain his immediate needs and to determine if they were required to visit him. On this occasion Adult Social Services appear to have been solely reliant upon the views of AA's relatives in determining whether they needed to visit him out of hours. While family should be consulted it should not detract from service's duty to assess someone's needs directly with them.

6.87.9 There are several examples of insufficient escalation of concerns witnessed by staff who worked with AA. In particular, it is of considerable concern that staff did not effectively share information internally, with the London Fire Brigade or the Sutton Housing Partnership in relation to the continued risk of fire that AA exhibited, given his use of the gas rings to keep warm, his continued requests for matches and the fact that the environment in which he was living would have accelerated a fire and compromised his means of escape. In addition, the decision taken by the Prevention and Crisis Service not to arrange for a waking night arrangement on the 9th April potentially set the precedent for the rest of the week.

6.88 The Old Court House Surgery

6.88.1 The GP surgery did not submit an Individual Management Review but rather submitted copies of three letters; one which had been faxed to Mental Health Services on the 5th April, another which had been sent to Adult Social Services on the 5th April 2013 and then the other which had been sent to HM Coroner after AA's death. In addition the GP was not represented on the Serious Case Review Panel. Therefore the review has had very little information in relation to AA's physical health before the 5th April nor been privy to any conversations that AA had with primary care services.

6.88.2 From the information that has been available it is evident that the GP failed to expediently escalate his concerns to Adult Social Services, due to an issue with a fax transmission. Records indicate that this resulted in a delay of four days.

6.88.3 There was also a lack of clarity in the letter to Adult Social Services and Mental Health Services particularly in relation to his mental capacity and mental health. While it is likely that the GP intended the referral to act as a prompt for assessment his references to AA 'appearing to have capacity' and 'no identifiable mental issue' was interpreted as fact as opposed to supposition.

6.89 Sutton Housing Partnership

6.89.1 There is evidence that Sutton Housing Partnership escalated concerns to Adult Social Services on two occasions. Had a Safeguarding Adults Board Multi-agency self-neglect protocol existed within the borough of Sutton, the Housing Partnership may have been in a better position to challenge the

response that they received. It is unclear, in the face of a refusal, if the Sutton Housing Partnership sought any legal advice or escalated the issue.

6.89.2 It is evident that on the 11th April Sutton Housing Partnership was the only agency to have referred their concerns to London Fire Brigade, although it is unclear what the outcome of this referral is as London Fire Brigade have as previously stated no record of this contact.

6.89.3 There is evidence that the Sutton Housing Partnership responded to concerns around the maintenance of the property raised by AA via his family and neighbours in a timely manner. It is evident that the Sutton Housing Partnership maximised their engagement with family members to support AA to trust staff and comply with their requests without the need for legal remedies. There is also evidence that the agency knew that this was a commitment which would require ongoing support, review and rapport building and they set about doing this.

6.89.4 It is noted that information about his increased risk in April 2013 was not effectively shared with Sutton Housing partnership when it should have been, but rather was shared by a neighbour. While it is evident that the family may have not wished to draw attention to his behaviour, fearing that AA may have faced eviction, this does not account for why other agencies negated to share this important information with them, especially given that AA and third parties were potentially at risk.

6.90 Metropolitan Police Service

6.90.1 The Metropolitan Police Service had several involvements with AA as both a victim of alleged burglary and also when the hospital alerted the police to him 'absconding' from the ward.

6.90.2 It is recognised that at the time of the alleged burglaries the Adult at Risk Coming to Notice system had not been fully implemented; however the existing SOVA process and compliance with the Protecting Adult at Risk policy and procedures, which the Metropolitan Police Service had signed up to in January 2011, was not complied with. As an 'Adult at Risk' the police should have raised a safeguarding adult alert about AA with Adult Social Care in relation to the allegation raised. On reflection the Police did not consider AA to be an "adult at risk" at this time.

6.90.3 In addition, the decision to 'no crime' the allegations of burglary based on an explanation that he had 'found his wallet' could have warranted further exploration. Although it is acknowledged that at the time of this incident the Police has no indication regarding any impairment of AA's capacity and therefore again did not consider him to be an "adult at risk"

6.90.4 It is evident from the chronology that when AA absconded from A&E on the 9th April that the police had no reason to question AA's mental capacity; no information regarding capacity was shared when they were notified he had absconded from A&E.

6.91 London Ambulance Service

6.91.1 London Ambulance Service demonstrated compliance with the Protecting Adults at Risk policy and procedures by raising appropriate alerts when they identified concerns. However, the review has highlighted that they negated to share information with the London Fire Brigade on the 8th April when they attended the address and identified that a fire had been accidently started. This may have facilitated some targeted risk reduction work by the Fire Brigade.

6.92 Epsom and St. Helier University Hospitals NHS Trust

6.92.1 There is evidence that in December 2012 Epsom and St. Helier University Hospitals NHS Trust referred AA to Age UK for help with cleaning for the short term. This may indicate that at this point a referral to Adult Social Services was warranted.

6.92.2 There is evidence within this review that Epsom and St. Helier University Hospitals NHS Trust staff appropriately consulted with the GP, multidisciplinary teams and psychiatric liaison community team to seek advice regarding AA. However, it appears that the decision to discharge him by ambulance in the early hours of 9th April may have been made in isolation and on a presumption that he had capacity.

6.92.3 The review also highlights that Epsom and St. Helier University Hospitals NHS Trust staff advised AA to stay in hospital and/or accept more help in the community; however the effectiveness of this is likely to have been limited by his apparent lack of capacity. This would suggest that professional optimism may have been present around AA's Mental Capacity, which indicates that the

Trust may need to work to enhance professional competency in relation to implementation of the Mental Capacity Act.

6.92.4 The review identified opportunities for all agencies, including Epsom and St. Helier University Hospitals NHS Trust, to improve their internal application of Mental Capacity Assessments, as the legislation was designed to empower those in health and social care to do capacity assessments themselves, rather than rely on expert testing by psychiatrists or psychologists.

6.92.5 The review also identified opportunities for all agencies, including Epsom and St. Helier University Hospitals NHS Trust, to improve understanding in relation to community care legislation and self neglect legislation, so that they can advocate on patient's behalf and refer effectively.

6.92.6 There is evidence that decisions were recorded and that information was shared with various agencies, although it is noted that in December 2012 when staff identified that he had needs around cleaning, a referral would have been warranted to adult social services.

6.92.7 There is evidence that staff appropriately offered advice, information and support to AA's family and consulted with them appropriately to elicit information about AA.

6.92.8 The review also identifies that Trust complied with the Safeguarding Adults Policy and Procedure when on 9th April they appropriately raised an adult safeguarding alert following an allegation of financial abuse.

6.92.9 The review has exposed that hospital staff were working within a context of knowing that the admission criteria for hospital bed is rigid. This is understandable and, coupled with a lack of intermediary step down beds in the community, meant that the options available for staff upon discharge were limited.

6.92.10 The Trust raised concerns with the appropriate agencies and family members regarding AA's self neglect, the package of care on the community was reviewed and the Trust enquired into the amount of care provided by the Mental Health community services.

6.93 South West London and St. George's Mental Health NHS Trust

6.93.1 The review identifies that while South West London and St. George's Mental Health NHS Trust acted outside of their remit in supporting AA through the Home Treatment Team, they should have made a referral to Adult Social Services via the Emergency Duty Team. Given that AA's circumstances were not entirely unusual it is difficult to understand how staff would have been unaware of the arrangements for out of hours adult social services; which in turn may suggest a wider systemic issue around oversight of compliance with agreed procedures. It is also apparent that the service which was provided did not support him in the same way as an adult social service intervention could have done. It is also likely that even after the case had been referred to adult social services, continued involvement led to confusion around which service was leading interventions.

6.93.2 Mental Health Assessments were not fully completed, yet they went on to inform decision making which was consequently potentially flawed. Mental Health Services were not able to carry out a comprehensive assessment of his mental health because AA did not engage with assessments. Because AA

was not engaging, the Mental Health services could have considered other approaches to complete a Mental Health assessment. Based on the assessment which was completed, the Mental Health Trust did not consider AA to be detainable under the Mental Health Act. It is not possible to know what a full mental health assessment would have revealed. It is also noted that given the complexity of the issue legal advice should have been sought.

6.93.3 Mental Health interventions did not initially prioritise fire risk as they were not aware of the risk identified by the London Fire Brigade who would have been able to support them in this work.

6.93.4 It is also apparent that South West London and St. George's Mental Health NHS Trust gave little or no consideration to AA's hoarding being a possible symptom of an underlying mental illness.

6.93.5 While it is acknowledged that the referral by the GP on the 4th April was vague it does seem that the reference that the GP made around 'appearing to have capacity' and 'no identifiable mental issue' was interpreted as fact as opposed to supposition.

6.93.6 The review identified that South West London and St. George's Mental Health NHS Trust made a decision to prioritise AA's physical care needs above his mental health needs; Physical health impacts enormously on mental health and therefore the need to treat any physical health condition is paramount before a clear and accurate assessment of mental health and capacity can be made. However, it is evident that once professionals felt there had been improvement in his physical health, they did not effectively expedite the formal assessment of his mental health and capacity.

6.93.7 There is also evidence that indicated that mental health services did not comply with safeguarding procedures in relation to the allegations raised in relation to AA's scooter being stolen. On reflection, the Mental Health Trust did not consider making a safeguarding referral as the incident had been reported to them by AA's daughter-in-law and had taken place some weeks before their intervention.

6.93.8 In addition South West London and St. George's Mental Health NHS Trust self identified the following learning from the case:

6.93.8.1 The referral process within OPCMHT needs to include a robust screening of referrals to ensure they are appropriate. If there are queries about the referral then the OPCMHT needs to discuss with the referrer to clarify OPCMHT. In this case the GP does not identify any specific mental need however given the circumstances of the case it is understandable why the GP would want to have an assessment of the patient's mental state.

6.93.8.2 The OPCMHT CPN undertook a domiciliary visit in good time however it was focussed initially on the patient's physical health care needs. The initial assessment would have been better focussed on the patient's capacity to make decisions about his care needs and a joint assessment with social services would have been best option with consideration of the need for assessment under s47 CCA.

6.93.8.3 The GP had referred jointly to social services and the OPCMHT and there was no communication between the two agencies at that time. This is missed opportunity and there is no formal inter-agency mechanism for

information sharing and decision making (Braye). There is no mention of the housing association that provided the patient's accommodation.

6.93.8.4 There is important information from the family that has not been recorded on RIO about the patient's stolen scooter, front door being open and having his wallet stolen. It is not clear which agency (if any) held this information, and it provided an opportunity for a safeguarding investigation to consider the patient's risks.

6.93.8.5 The OPCMHT remained involved and the HTT provide a service despite no mental health need being assessed. Whilst this demonstrated good intent and compassion, it was also outside of the remit of the service, and a multi-agency response needed to be secured.

6.93.8.6 The OPHTT did what they could over the weekend of the 6-8th April however the tasks they undertook were outside their operational policy and should have been the responsibility of other agencies (e.g. social services). It was late on Friday afternoon when the patient left St. Helier, and agencies need clearer understanding of the services available out of hours, and how these may be accessed in urgent or emergency situations.

6.93.8.7 The patient's capacity to make decisions about his care, treatment and admission to hospital were not full established or recorded during this time. The OPCMHT, Liaison Psychiatry and OPHTT all had opportunities to formally assess under The Mental Capacity Act and to consider the options available subsequent to that assessment.

6.93.8.8 The OPCMHT engaged with the patient's family and listened to their concerns on most occasions. The level of risk the patient presented increased and was flagged up by the family. Similarly, there was missed opportunity to share information of the fire risk increasing when Care Coordinator was told by the neighbours of the fire in the patient's flat the night before. Information sharing at that time may have presented opportunity for consideration of additional actions, possible under MCA or MHA. Other legal remedies or options were not considered. The referral by Liaison Psychiatry to COPTT did not follow operational policy requirements.

6.94 London Fire Brigade

6.94.1 It is recognised that the London Fire Brigade's Home Safety Check was very successful in identifying the risks associated with AA's hoarding to himself and others. This case provides compelling evidence of the usefulness of such checks, which no doubt protect many adults at risk living in London every year from fire. It is however also noted that this intervention could have been more efficient if fire officers had taken photographs or conducted a recognised clutter rating assessment, as this could have then be shared with the landlord to avoid delays in gathering their own evidence. LFB have commented that it is impracticable to carry camera on front line fire appliances. There is now the clutter rating index which was disseminated in 2013; this has been shared with our partners and all fire crews have access to it for a point of reference. This should allow partners to work from the same point of reference.

6.94.2 It is evident that London Fire Brigade appropriately referred their concerns around hoarding to Adult Social Services; however had a Safeguarding Adults Board Multi-agency self-neglect protocol existed within the borough of Sutton the London Fire Brigade may have been in a better position to challenge the response that they received from Adult Social Services. It is unclear, in the face of a refusal, if the London Fire Service sought legal advice or escalated

the issue via the Safeguarding Adults Board. London Fire Brigade believed that Adult Social Services at the time had primacy for the care of AA.

6.94.3 It is also unclear if the London Fire Brigade adequately assured that the risk that they had identified to third parties as well as AA had been adequately addressed by the Landlord; it is suggested that a planned review would have provided some level of assurance and possible leverage.

6.94.4 The chronology also identified an inconsistency, in so far as Sutton Housing Partnership recorded that a Housing Officer contacted London Fire Brigade on the 11th April, but this did not appear in the London Fire Brigade chronology of events as London Fire Brigade have stated there is no record of this contact.

7. Lessons to be learned

7.1 Self-neglect

7.1.1 While it is noted that national guidance is lacking in relation to self-neglect, the Safeguarding Adult Board should develop a local protocol which clearly sets out when self-neglect becomes a safeguarding issue and a framework to manage those cases that do not hit a threshold of safeguarding. The absence of a partnership Self Neglect Protocol meant that there was a lack of guidance on the management of self-neglect cases. As a consequence there is evidence that professionals failed to strike the right balance between the rights to private life with the duty of care to protect the welfare of an adult at risk. It is noted that the Sutton Safeguarding Adult Board have not developed a self neglect protocol for the borough; if one would have existed this would have provided a framework in which the concerns associated with AA's self neglect and hoarding could have been managed. Consideration could also be given to the establishment of a 'risk-enablement panel' model.

7.2 Mental Capacity

7.2.1 The Mental Capacity Act was misapplied on several occasions by professionals. This indicates that the partnership should improve understanding across agencies and monitor its implementation more consistently through improved quality assurance and supervision.

7.3 Assessment of need

7.3.1 Assessments lacked formality given the seriousness of the risks identified. The legal basis for decision making and the possibilities for legal action in the context of the presenting needs and risks were also not fully explored. In addition the timescales bore no relation to the level of implied risk/concern and that level of concern had often not been clearly quantified or analysed. In light of this, Health and Social Care agencies should review their quality assurance processes and their mechanisms for flagging the urgency or response required.

7.4 Working culture

7.4.1 There was an apparent “rule of optimism” with professionals exhibiting an ‘it will be all right’ approach. The Safeguarding Adults Board should review how they can support staff to more effectively identify heightened risk triggers.

7.5 Organisational

7.5.1 Systems did not work effectively as there was a lack of integrated systems evident through the interventions with AA. This was particularly apparent between the police, hospital, adult social services and mental health services who, with the exception of a couple of individuals, seemed focussed on delivering their particular service in relative isolation to other services. The Safeguarding Adults Board should review how the share information around complex self-neglect and ‘capacity’ cases.

7.6 Commissioning

7.6.1 The review did not include any analysis by the local CCG who would have been newly responsible for commissioning mental health services and the acute services. However it is apparent that one opportunity to raise a safeguarding alert was missed and the issue was not reported which would have been within the contract. The CCG and London Borough of Sutton Commissioners should consider whether they have adequate safeguarding clauses within their contract and whether their existing scrutiny of delivery around safeguarding is robust.

7.7 Risk Assessment

7.7.1 The review highlights a thematic issue around the lack of risk assessment in relation to mental capacity, fire risk and hoarding. While it is acknowledged that mental health risk assessments were utilised by some services there was evidence that the risks were not always translated from records into a risk assessment and then action. There is also a distinct lack of risks being shared between agencies so that a full picture can be gained and a holistic and multi-agency risk assessment made. The Safeguarding Adults Board should review their current mechanisms for identifying and responding to risk and to individual residents who are presenting with a high level of risk to self and others. The panel have suggested to the Board that they could establish a mechanism where any agency can call a multi-agency risk assessment meeting, similar to children's services. The Board are considering taking this forward as part of the Safeguarding Adults Strategy.

7.8 Training

7.8.1 From the action of professionals, skills gaps are evident in relation to health and social care legislation, fire safety and safeguarding. The Safeguarding Adults Board should review their training strategy to ensure that training on these issues is available to multi-agency staff.

7.9 Working conditions

7.9.1 The review has not identified any issues in relation to staff pressures, vacancies or high turnover within services. However it would be naïve to assume that staff across agencies were not under pressure with significant demands on their time.

7.10 Resources

7.10.1 It is notable that some professionals felt that services were not available over the weekend which resulted in those professionals attempting to maintain a status quo until the next working day. It is also evident that AA experienced significant numbers of different staff attempting to engage with him at home, particularly in relation to the Home Treatment Team and Prevention and Crisis Service. It is possible that this was due to shift patterns etc. but his ability to establish rapport may well have been impacted by this. The Safeguarding Adults Board should review this issue.

7.10.2 An apparent lack of intermediary step down beds in the community needs to be explored by commissioners as if this service had existed it may have been a viable option for AA instead of discharge back home.

7.11 Recording

7.11.1 There is evidence from the quality of the records submitted that information systems were not always updated and the outcomes of interventions were not consistently captured. The Safeguarding Adults Board should look to gain assurance around the quality of agency recording.

7.12 Management systems

7.12.1 There are examples of practitioners not escalating critical decision. This indicates that existing leadership and accountability structures require review to ensure that practice on the ground is compliant with agreed protocols.

7.13 Staff Morale

7.13.1 There is no evidence that staff morale was low.

7.14 Inter-agency communication

7.14.1 There were numerous breakdowns in communication within and between agencies during the intervention with AA. An example includes the communication of AA's lack of capacity to the Prevention and Crisis Service. It is unclear how this occurred but it is evident that staff, working with him in his last days, were assuming that he had capacity to make decisions, which given what we know was not the case. It is evident that much of the information sharing that did take place was facilitated by his family and neighbours rather than directly between agencies. It is also evident that the lack of continuity in

staff may have impacted upon both information sharing and AA's ability to establish trust and rapport.

7.15 Advocacy

7.15.1 It is clear that AA's family and friends advocated for him strongly. However it was not consistently evident that professionals, who should have been his primary advocates, were advocating for his rights in the same fashion. It is noted that Independent Mental Capacity Advocacy (IMCA) was not considered at any point during the intervention, which given that there were concerns raised around financial abuse, would have been advisable. The Safeguarding Adults Board should review the uptake of IMCAs and if necessary consider communication to raise awareness.

7.16 Communication with the family

7.16.1 There is evidence that professionals did liaise with AA's family but it is not always evident that they acted on the concerns they raised. It is noted that the family tended to be initiating communication. The Safeguarding Adults Board should review how effectively agencies communicate with families.

7.17 Person-centred

7.17.1 The lack of insight into AA's history and reasons for making decisions/ taking or failing to take action is striking and represents a failure to engage in a person centred way in the assessment of need and risk. The Safeguarding Adults Board should review how effectively agencies are measuring

engagement with service users and measuring outcomes against service users' expressed goals.

7.18 Effectiveness of interventions

7.18.1 Between the 4th April and the 11th April multi agency professionals did not act upon concerns that AA lacked capacity to manage his care needs at home. At several junctures opportunities to act in his best interest were not taken and as a consequence the risks associated with his incapacity were not managed effectively. This indicates that agencies are not effectively supervising staff to comply with the Mental Capacity Act.

7.18.2 A lack of clarity around the relationship between self neglect and mental health was not fully explored by professionals.

7.18.3 The Safeguarding Adults Board should review how effectively agencies are instructing their staff around these issues and consider the development of local multi agency guidance.

7.18.4 Agencies need to be clear when referrals to police may need to be made by other agencies and their role in supporting vulnerable residents to do so. AA made an allegation that his daughter-in-law was stealing his pension; advice to him was to call 101 (as referenced in para. 5.79 relating to another allegation).

8. Conclusion

8.1.1 While it is well documented that there were missed opportunities to support AA to address the concerns around his self-neglect and hoarding in the months preceding April 2013, it is clear that during the last week of his life AA was visited at home by *at least* twenty-three professionals. Records indicate that many of those professionals identified that the environment that AA was living in was not suitable and also that there were concerns about his mental capacity to safely remain there. However, while risks were recorded and discussed within and, on occasion, across agencies AA remained in his home.

8.1.2 Whilst there was speculation about AA's mental health state, there was no formal diagnosis of an '...impairment of, or a disturbance in the functioning of, the mind or brain' (Section 2(1) MCA 2005). One was suspected, but no action was taken to formalise this or to take action under the Mental Health Act. Social services provided social work and social care services to AA from the time of referral on Monday 8th April until AA's death on Thursday 11th April, under S47(5) of the NHS and Community Care Act (1990).

8.1.3 In conclusion, given the numbers of professionals who identified and shared information around AA's hazardous environment, fire-setting and suspected lack of mental capacity to understand the risks, it is arguable that there was a significant risk of serious injury from a fire and his home environment.

8.1.4 The review has highlighted that the Mental Capacity Act, which is designed to protect individuals who lack capacity, was misapplied in this case. Firstly because agencies did not conduct timely and formal assessments; secondly because some agencies presumed capacity despite reasonable concerns that

he lacked capacity; and finally because opportunities to make best interest decisions were not taken.

8.1.5 While it would be over simplistic to state that AA's death was categorically preventable, if services had been effective in removing him into respite, or some such intervention, the risk may have been minimised and he may not have died in a house fire. The method for doing this lawfully, however, would have required a formal mental capacity assessment, which was planned for Friday 12th April, followed by working with AA.

8.1.6 It is also apparent that had services come together when self neglect and hoarding first became apparent, the risks associated with AA lighting fires to 'keep warm' and 'cook food' are also less likely to have occurred.

8.1.7 It is therefore the conclusion of this review that if different interventions had been used in response to those risks the outcome may have been different.

9. Next Steps

9.1 The Serious Case Review Panel is invited to consider the findings set out in this report and then collectively develop an improvement plan which can be monitored by the Sutton Safeguarding Adults Board.

10. Addendum – Recommendations and Action Plan

10.1 The recommendations following the Serious Case Review were decided in agreement with the London Borough of Sutton Safeguarding Adult Board. An action plan was developed and will be monitored through the Board and the Local Authority Serious Case Review Steering Group. The function of the Steering Group will be to ensure actions are completed in an agreed timescale and to ensure appropriate and timely dissemination of lessons learned.

10.2 The panel acknowledge that since the incidents surrounding AA's death, many of the agencies have addressed areas of practice to minimise the risk of similar events occurring again to other residents in the borough and have not waited on the outcome of the review to take these actions.

11. Appendix one: Action Plan

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	BY WHEN What further action is needed?	PROGRESS RAG
1. Sutton Safeguarding Adult Board should develop a local protocol which clearly sets out when self-neglect becomes a safeguarding issue and a framework to manage those cases that do not hit the threshold of safeguarding.	To review existing policies and protocols available and develop a borough wide protocol.	Safeguarding Adult Board Lead for protocol: Patrick Hopkinson/ Self-neglect and Hoarding Task and Finish Group	Have a clear process for staff in all agencies to follow when they identify people who may be at risk of harm as a result of self neglect	Protocol is under development by the Self-neglect and Hoarding Task and Finish Group. In the interim, all reports of hoarding and self neglect are recorded as safeguarding alerts.	Final draft developed by **July 2014**. Final draft for SSAB approval at **October 2014 Board** followed by launch event and implementation Monitoring will be on-going	G
2. The Safeguarding Adults Board should complete a training needs analysis to identify the training needs of all agencies pertaining to the implementation of the Mental Capacity Act.	To review current Mental Capacity Act Training Provision and to develop a Mental Capacity Act teaching programmes with a focus on practical implementation and making it accessible to all agencies	Safeguarding Adult Board training subgroup	To improve understanding across agencies and monitor its implementation more consistently through improved quality assurance and supervision.	Reported to SSAB quarterly Training program for mental capacity act in place as part of safeguarding training. Additional funding obtained for MCA/ DoLS training for Sutton contracts and commissioning staff and for over 200 hospital staff, to be provided by	Analysis of mental capacity training has been completed. Monitoring of multi-agency delivery will be ongoing by training subgroup NHS England have made additional funding available to address MCA	G

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	BY WHEN What further action is needed?	PROGRESS RAG
				end of September 2014	training and this additional training will be commissioned in 2013/14 NHS England are about to launch training resources for Safeguarding, MCA and DoLS which will be made available to all agencies in the borough (launch date to confirmed)	
3. All partner agencies should review their training plans to ensure that appropriate training on health and social care legislation, fire safety and adult safeguarding is available to their staff.	For all agencies to develop training plans and to report these back to the Safeguarding Adults Board.	All agencies through the Training subgroup	Improve the legal literacy on hoarding and self neglect of staff	April 14: Legal literacy included in the Self-Neglect and Hoarding protocol, to be approved by SSAB in July 2014 Fire awareness and safety training provided by London Fire Brigade to 207 staff (87 LBS/ 120 external) Ongoing monitoring	Multi-agency review completed May 2014 Report on review and training plans to Serious Case Review Monitoring Group **July 2014**	G

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	BY WHEN What further action is needed?	PROGRESS RAG
				through the Serious Case Review Subgroup. Mental Capacity Act Practice skills and legal framework training provided to social work staff on 11th April and on 12th June		
4. The Safeguarding Adults Board should review professional development opportunities for staff to ensure their competence in identifying risk triggers, rather than relying on 'rule of optimism'.	To review current risk assessment training and tools to ensure this is reflected in all future risk training programmes.	Safeguarding Adult Board Quality and Training subgroups	Staff are more able to recognise, respond to and record assessments of risk	Sutton Council risk tool reviewed. Revised processes and systems to be in place by end of June 2014. Multi-agency safeguarding practitioner forums in place	Training on hoarding, self neglect and mental capacity includes risk assessment, risk assessment tools, risk planning and escalation Reported to SSAB by **July 2014** On-going monitoring through audits and line management and training subgroup	G

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	BY WHEN What further action is needed?	PROGRESS RAG
5. The Safeguarding Adults Board should review information sharing in relation to people presenting with complex issues, self-neglect and 'capacity' concerns.	To review and re-launch the information sharing protocol.	Safeguarding Adult Board	Staff have a greater understanding of the need to share information and have agreed process to follow in high risk situations	Information sharing is taking place. Communication sub-group established to develop a multi-agency communication strategy	Ongoing review of all high risk cases by the multi-agency high risk panel/ Community MARAC, which will met in May 2014. Progress report to SSAB by **July 2014** On-going monitoring by serious case review subgroup	G
6. The Safeguarding Adults Board should review their current mechanisms for identifying and responding to risk and to individual residents who are presenting with a high level of risk to self and others.	Set up a hoarding and self neglect task and finish group.	Safeguarding Adult Board	Recognise the risk to individuals and their neighbours from hoarding and noting that it may be a symptom of other mental health issues. To ensure that identified risks are being shared between agencies so that a full picture can be gained and a holistic and multi-agency risk assessment can be made. Hoarding and adults at risk is	Multi agency group has been set up to develop a hoarding and self neglect protocol.	Ongoing review of all high risk cases by the multi-agency high risk panel/ Community MARAC, which will met in May 2014. Progress report to SSAB by **July 2014** On-going monitoring by serious case review subgroup	G

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			a high profile across all agencies and staff are clear of all process and tools to support their practice with people who hoard are living with high level of risks.			
7. To review Multi Agency working with high risk cases, to identify a key worker or lead professional, which will enable the adult to establish rapport and develop a relationship of trust.	Agreeing a Multi Agency approach to working with residents who present with high risks.	Safeguarding Adults Board to agree a mechanism or panel to review high risk residents.	Improved multi-agency working and communication and reduce duplication of interventions Care planning across all agencies is multi-disciplinary and care plans and risk management plans are shared.	Adult mental health risk panel already in place. Board have discussed setting up a high risk panel or community Adult MARAC. Safeguarding Board to agree way forward. Multi agency group has been set up to develop a hoarding and self neglect protocol. Within this, tools will be developed to support multiagency working including shared risk assessments and care plans.	Ongoing review of all high risk cases by the multi-agency high risk panel/ Community MARAC, which will met in May 2014. Progress report to SSAB by **July 2014** On-going monitoring by serious case review subgroup	G
8. All partner agencies should give the Safeguarding Adults Board assurance that they have mechanisms in place to monitor and ensure the quality of	All agencies to review their record keeping processes and practices and report this back to the Safeguarding Adults	All partner agencies	Improve the record keeping across all agencies.	Sutton Council processes and practices reviewed. Revised processes and systems	All Partners have completed a safeguarding adult audit which	G

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their record keeping.	Board.			to be in place by end of June 2014.	includes quality assurance and governance for record keeping, which has been reviewed by SSAB. Report back to the SSAB at the meeting in **July 2014** This will be an annual event	
9. All partner agencies should review their escalation policies and procedures to ensure critical decisions are escalated timely and appropriately. This should be fed back to the Adults Safeguarding Board for assurance.	Agencies to report to the Board on their escalation process, when there are concerns about people in high risk situations.	All partner agencies	Agencies have an agreed escalation process and staff are made aware of the process	Supervision processes are in place across organisations. Whistle-blowing policies are in place.	All Partners have completed a safeguarding adults audit which includes assurance in relation to escalation processes, which has been reviewed by SSAB. Report back to the SSAB at the meeting in **July 2014** This will be an annual event	G

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10. All partner agencies should give the Safeguarding Adults Board assurance that they have mechanisms in place to review how effectively they are skilling their staff around assessment of capacity, risk assessment and the relationship between mental health and self neglect, and to consider the development of local multi agency guidance.	Agencies to report to the Board on their appropriate training and the feedback and review mechanisms to ensure the training is working. The Board to consider developing multi agency guidance if there are gaps in the above.	Safeguarding Adult Board	Effective training and review processes to ensure robust skills in assessment of capacity, risk assessment and the relationship between mental health and self neglect.	Legal literacy included in the Self-Neglect and Hoarding protocol, to be approved by SSAB in July 2014 Fire awareness and safety training provided by London Fire Brigade to 207 staff (87 LBS/ 120 external) Ongoing monitoring through the Serious Case Review Subgroup. Mental Capacity Act Practice skills and legal framework training to social work staff on 11th April and on 12th June	SSAB to agree change of format in reports provided by all agencies to include evidence of training and training outcomes in relation to MCA, risk assessment, self neglect and hoarding, To be discussed at the SSAB **July 2014**	G
11. To engage GPs in future SCRs.	Future SCRs should ensure that, where GPs are involved, that through NHS England, they are invited to participate in all stages of the SCR Process.	Safeguarding Adult Board / Sutton CCG	To enable valuable health information to be shared.	All SCRs involve GPs	April 2014 Review of effectiveness by the Serious Case Review Monitoring Group by **October 2014**	

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12. Partner agencies need to be clear when referrals to police may need to be made and their role in supporting vulnerable residents to do so.	Development of multi-agency protocol on when to refer to the Police and information sharing regarding vulnerability.	Safeguarding Adult Board Training subgroup	Understanding of how to assist a vulnerable adult if informed of a potential crime. Understanding of the role of the police and what they can and cannot do.	Included in safeguarding training	Reported to **SSAB July 2014**	G