Safeguarding Adults Review

Learning from the circumstances of the death of 'May'

Kate Spreadbury

Lead Reviewer

September 2019

Contents

1. Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Herefordshire Safeguarding Adults Board (HSAB) in response to the circumstances surrounding the death of 'May'. 'May', not the person's real name, died at the age of 67 on the 4th February 2019. from heart disease, her heart was noted to be enlarged post-mortem.

1.2 At the time of her death May lived alone in a one bedroomed flat which can be described as extremely 'spartan' with no bed, little furniture or food on the premises, she did not use heating or cooking facilities and had no TV or phone. May spent most of the day outside and told various professionals that she often walked six to eight miles per day. She was a white UK citizen born in Hereford. May's life history has been hard to ascertain, but after her death her landlord was able to establish that May had been married twice and had a child. The whereabouts of these family members are currently unknown.

1.3 This review is conducted in accordance with section 44 of the Care Act 2014 and the Herefordshire Safeguarding Adults Board Procedures. Section 44 (i-v) of the Care Act 2014 stipulates that a SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and (b)condition 1 or 2 is met.

(2) Condition 1 is met if— (a) the adult has died, and (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if— (a)the adult is still alive, and (b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.

*(4) An (*sic*) SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).*

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— (a)identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases.

On 12th February 2019 the Herefordshire Joint Case Review subgroup decided that condition 1 was met,

'All agencies agreed that this case met the threshold criteria for a SAR for the following reasons under the Care Act S44 criteria:

- *The adult had needs for care and support*
- *There is reasonably cause for concern about how the Safeguarding Adult Board members worked together to safeguard the adult.*
- *The adult has died and we know or suspect that the death resulted from neglect (self-neglect)'.*

The lead reviewer was commissioned on the 13th March 2019 and the SAR activities commenced on this date.

2. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 Timeframe: The SAR covers the time period **January 2016 to 4th February 2019**.

2.2 The **specific areas of focus** for the SAR are:

The review should take a broad, organisational learning approach and reflect on current practice realities.

2.2.1 Consider state benefits and other payments which May could access.

2.2.2 Reflect on whether any agencies involved considered or should have considered the issue of self-neglect.

2.2.3 Did professionals undertake capacity assessments, given that they are decision and time specific?

2.2.4 Did practitioners use their professional discretion and curiosity to see past May's decisions and recognise that she may have benefitted from further engagement/intervention?

3. Methodology

3.1 The methodology used in this review seeks to promote a thorough exploration of the events prior to May's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. All agencies considered within the SAR work in complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

3.2 Activities undertaken during the Review process have included: submission and collation of chronologies from the agencies involved, examination of documentation as appropriate,

identification of key episodes and exploration of these episodes through a learning event with the agencies and personnel involved with the case, follow up questions to specific agencies.

3.3 The following agencies have contributed to the Review:

- Herefordshire Wye Valley NHS Trust
- Herefordshire Clinical Commissioning Group (representing GP services)
- Herefordshire Local Authority
- West Mercia Police
- Social Housing Provider
- The Department of Work and Pensions (correspondence only)

4. Relevant history prior to the time in scope

4.1 Since 2000 May had lived in an HMO or 'house of multiple occupation'. She spoke fondly about aspects of her furnished room in the house. She did not have to worry about bills as the rent was all inclusive, she had a bed and there was a warm fire. May attended her GP surgery in 2006 and was described as experiencing an '*anxiety state'*, this was said to be longstanding and she had a reclusive lifestyle. She told her GP that she '*felt angry but quite sad'*. In 2006 she had been an inpatient in hospital, for reasons unknown, but had refused home monitoring or further interventions. May received a Notice to Quit from her HMO landlord on the 24th November 2014 and approached Home Point in Hereford, she saw the Housing team and was advised that the Notice was invalid. The landlord reissued the Notice on the 3rd December, giving May the correct two months' notice to leave her home. The landlord informed May that they intended to live there themselves. May's housing needs and banding were assessed via the Housing Options Wizard and she was determined to be eligible to bid for a one bedroomed property. On the 6th February 2015 she bid for and was offered a sheltered housing flat which she accepted. May could have bid for any one bedroomed property in Hereford but accepted the first offer. She subsequently told her new landlord, (the social housing provider) that she felt 'forced' into the tenancy. She said that the sheltered housing flat '*did not suit her lifestyle'.*

4.2 May became a tenant of the social housing provider on the 16th February 2015 and moved straight into the property. The social housing provider tenant income officer noted that May was anxious about moving and felt pushed into the decision. She had no debts, always used cash and was anxious about bills. May had an income at this time which comprised of a pension and pension credit she began claiming in 2012. May's pension was £70.45, under the full pension entitlement and indicated perhaps that she had not had employment and paid a full national insurance stamp. The social housing provider's income officer arranged housing benefit for May, noting that she would be fully covered by this,

minus the flat alarm charge which was £1.10 a week. The alarm was part of the structure of the flat and rental terms, it could not be disconnected. The social housing provider offered May a financial inclusion referral to support her with paying bills, to maximise her income and help her decide how to manage her money. May declined this but agreed to be referred to another housing group for support. This basic support would have lasted only a short time if May in fact accessed it, we do not know if she did. The social housing provider noted that May did not want second-hand furniture and so no referral was made for her to access this. May stated that she '*usually sleeps on the floor'*. The social housing provider also noted that May was not used to bills and demonstrated great anxiety about setting up energy and other household services, social housing provider staff helped her to arrange household services, they also resolved errors made in setting up her housing benefit without telling May that there were problems with the payment in order to avoid increasing her anxiety. May was notified that she would need to pay the flat alarm charge, but this payment was not needed initially as she had 'overpaid' rent whilst waiting for housing benefit to start.

5. Time in scope – key episodes.

5.1 Introduction. Key episodes in May's life during the time in the scope of the SAR are summarised below. There was no contact between May and any agency between the 28 September 2017 and the 4th February 2018, the day that May's body was found.

5.2 January 2016 – January 2017

5.2.1 May was still unhappy living in the sheltered housing flat after almost a year of living there and attempted to arrange a move back into shared accommodation in January 2016**.** May told the Home Point drop in service that she had difficulties with the utilities (gas/electric) in her flat and was receiving bills that she could not understand as she did not use any electricity or gas, she also could not use her television. Home Point cannot arrange moves to shared accommodation and advised May to look for a shared house herself.

5.2.2 The social housing provider converted May's tenancy into an 'assured tenancy' a week later. Although the Housing Officer noted that May still had no furniture and that there was no heating on in the flat, the property was clean and tidy and her rent fully paid up, her tenancy had been maintained. May was offered help again via the financial inclusion officer and the 'Energy Extra' scheme but refused, stating that she had money and did not need any help. May is reported as saying that '*She does not want to live there and stated that it does not suit her lifestyle but she is stuck in a situation not of her choosing'***.** She was recorded as getting '*quite cross*' with the Housing Officer.

5.2.3 In March 2016 May attended her GP surgery as her legs were swollen and red, she was also noted to have high blood pressure. May did not use the prescribed treatments but returned to the surgery in May having developed cellulitis, a painful infection which would

have compromised her ability to walk long distances. May attended the surgery throughout May and had no further flare up of cellulitis. She told the surgery staff that she hated her flat and did not sleep in a bed.

5.2.4 In July 2016 May was taken to accident and emergency at Wye Valley Trust by ambulance after '*acting strangely'* in a local café that she attended regularly. Ambulance staff thought she looked thin and unkempt with '*possible confusion'*. In the Accident and Emergency department May was found to be '*alert, orientated to time place and person and good concentration. Bloods taken but refused chest x-ray. Offered admission due to possible failing kidney but refused*'. The consequences of refusal were explained to May and she was thought to have the mental capacity to make the decision to refuse, there was no reason to doubt her mental capacity. May was advised to keep drinking water and an offer was given to return to A&E anytime. May's GP surgery was advised of her attendance and of her blood test results.

5.2.5 Whilst May did not use gas energy, she did admit social housing provider gas engineers to service the boiler. An engineer attended her flat in June and again in the November, emailing the social housing provider after the November visit to express his concerns about May's unwillingness to use her heating and habit of sleeping on the floor as she had no furniture. The social housing provider housing officer made a note to follow the concern up but it is unknown if this happened.

5.2.6 In December 2016 the social housing provider noted that May was in arrears for her alarm charge. The social housing provider was aware that May '*is known to suffer from anxiety'* and so decided that she should be visited to discuss the alarm charge arrears face to face rather than send a letter which may worry her.

5.3 January 2017 – January 2018

5.3.1 Between **January** and **September 2017,** the social housing provider made twenty-five visits to May's flat. May was not at home on any of these occasions. The Customer Account Manager left a card asking May to contact her on each occasion. A statement of arrears for the alarm charge was posted to May in January and in July 2017 and a copy put through her letter box in May 2017.

5.3.2 By February 2017 the social housing provider Customer Account Manager was aware that May was '*out every day from early till late but does sleep there'.* On the one occasion when the social housing provider was able to speak with May she said that she did not wish to live in the flat and was offered a 'termination of tenancy' form to complete to end her tenancy if she wished.

5.3.3 By September 2017 May's use of the property was in doubt and the social housing provider sent her a letter to request contact within seven days or it would be assumed that she no longer lived in the property, the landlord would take steps to enter the property and

re let it. Two external visits were made by the social housing provider to confirm that the property was secure, meter readings and the movement of small objects in the kitchen confirmed that May was still using the flat, it was not abandoned. The social housing provider Enforcement Officer attended May's flat with the gas engineer in October 2017. The social housing provider noted that there was no furniture in the property and that May slept on rugs on the living room floor. May advised the social housing provider that she was out of the property from 6am to 6pm but returned each night in order to sleep somewhere safe. She did not use the heating or gas and only used electricity to boil the kettle. She had little food in the flat, mostly snacks that could be prepared using the kettle. May declined support and was reported to be angry that support from social care was suggested because *'she chooses to live differently'*. May again said that she did not see why she should pay for the alarm charge as she did not use it but agreed that once she had received a statement, she would come into the social housing provider office to pay, however she did not do so. The social housing provider Customer Account Manager continued to call at the flat regularly but May was never at home. The Manager's concern was that May's debt should not get any higher or create a risk of the landlord taking court action to reclaim the outstanding sum.

5.4 January 2018 – February 2019

5.4.1 Adult Social Care received three referrals regarding May in March 2018, two from the West Mercia Police and one from the West Midlands Ambulance Service NHS Foundation Trust.

West Mercia Police made a referral after locating May following a missing persons referral from an old friend. She told the police officers that she '*was happy with her lifestyle'* but officers noted her concerning living conditions. May was reported by officers to be '*compos mentis'* and clean, she was angry and did not want to engage with officers, she did not let them into her flat. The police made a referral to Adult Social Care and Health (ASC) which was received on the 5th March**.**

The ambulance service made a referral to ASC after May was taken to hospital having developed hypothermia during the night in her flat**.** Her living conditions were documented within the referral. May was admitted to hospital due to the ongoing very cold weather and her living conditions. The acute trust documented that there was a '*High likelihood of readmission and injury if sent home. Medical impression was hypothermia on background of no heating and safeguarding'* May told Trust staff that she had not had any heating for three years and went to shops in the day to keep warm. She was also having chest pains. May had a range of tests and investigations whilst an inpatient in hospital, staff also noted that she was fully independent in self-care, and that she left the ward for long periods during the day but returned to sleep in a hospital bed. May was seen by the hospital social work liaison team at the request of the ASC Advice and Referral Team (ART) manager as a result of the referrals from the Police and Ambulance Trust. May was noted to have no need

for support with personal care or meal preparation, and indeed did not wish to have any support from ASC. She was noted to have no telephone and to be unable to afford heating but did not want any advice from benefit advice services. May also said that her home was 'substandard' but said that it was pointless speaking with her landlord as she would just be rehoused in the same type of tenancy. May was discharged on the 6th March after being confirmed as medically fit after three nights in hospital.

The police visited May again on the day of her discharge from hospital having been told by a neighbour that she had not been seen for a few days and had been admitted to hospital with hypothermia. May told the police that she faced '*extreme financial difficulties, to the extent she won't put heating on, spends whole day walking and visiting churches, shops in order to keep warm. Kept in hospital for 4 days to recover. Sleeps on concrete floor'*. May gave consent for the attending officers to refer to ASC and to also share the information with her GP. These actions were undertaken, and on the 7th March ASC received a further referral from West Mercia Police reporting that May had developed hypothermia after not being able to afford to put her heating on, she had no furniture and slept wrapped in her clothes.

5.4.2 Two duty workers from the ASC City Locality team went out to visit May on the 8th March, they contacted her GP prior to the visit who reported that May's last visit to the surgery was in May 2016 and that she had no prescription medication or mental health issues. The two duty workers did not find May in but spoke with her neighbours who advised that May did not uses any facilities in her flat and had very little furniture and that this appeared to be '*her choice'*. After discussion with their senior practitioner the duty workers returned very early the next day, May was not keen to invite them in but did so reluctantly. The duty workers found it hard to engage May in conversation, she wanted them to leave and kept them near the door. They undertook a risk assessment by observing May and her environment and noted that the property was sparse but clean with a kettle and 'basic food' present. There were no concerns regarding her physical appearance. She was sleeping wrapped in rugs and clothes and not directly on a bare concrete floor, she had a rail of well-kept clothes which she said she had found at charity shops, she showed the duty workers how she intended to wrap herself up in a coat at night to keep warm. May was able to engage in conversation and was '*orientated to time place and person and there was no cause to question her mental capacity*'. The staff members recorded that they discussed what support May felt she needed, she said that she did not like living in her flat and did not use any of the facilities or have the heating on. The duty workers gained May's permission to speak to her GP and recommended to their senior that referrals should be made to 'the social housing provider' about May's options to move, and a referral should also to be made to a *'community connector.'* A 'community connector' was a specific role in ASC in which a social care officer was assigned to work with people who appeared socially isolated, the officer would take a person centred and strengths based approach to address issues of social isolation through increasing the person's access to the community. The two duty

workers who spoke with May report that they concluded that she needed to be allocated to the section of the team that addressed long term work as the issues they had identified could not be resolved within the 24-48 hours timescale for the duty workers to fulfil.

These recommended actions did not take place, May's case was 're prioritised' and no information was passed to The social housing provider or allocation made for further work by ASC. The rationale for this decision was not recorded at the time, however Herefordshire Council have subsequently undertaken an internal management review of the decision making in May's case and report that ' *At the time of the visit, May was clear that she did not want anything other than to move. Staff advised May to contact the social housing provider for support with this. May then reported that she had already done this herself. Staff also reported that calling cards from the social housing provider were seen inside the premises and so they were satisfied with May's response. Following the initial safe and well visit, the social care practitioners were satisfied that there was no immediate risk to May. May presented as having low-level needs, which were met in the form of signposting, advice and information'*.
The review identified that Council protocols on recording and case closure had not been followed, a full review of the decision making (triage) process followed and staff have subsequently been trained in following the correct procedures.

5.4.3 The social housing provider were not made aware of the concerns about May, the police or ambulance referrals or the visit from ASC staff. They did not know that May had hypothermia. The social housing provider Customer Account Manager continued to visit and leave her card but did not find May at home until catching her in the street outside her home in July 2018 and using the opportunity to ask May about paying her alarm charge**.** May said she was aware she had not paid it nor her standing charge but had no intention of paying the charge. May said that she didn't want to be in the property but had nowhere to go. The Customer Account Officer advised her that the matter may end with legal action, May is reported to have said '*good, she would love her day in court'*. The next day The social housing provider sent May a letter advising that if she did not pay then notice of possession would be served on her, after no response from May a letter of notice of seeking possession was posted through May's letter box as she was not at home. Her arrears were £114, the total of the £1.22 per week unpaid alarm charge, the social housing provider possession team was asked to consider legal action for recovery of debt or property but in the event did not pursue this.

May was seen by the social housing provider's Enforcement Officer on the 28 September, the Officer noted: '*Property sparse with no furniture as such. Tenant sleeps on living room floor on pile of blankets. She stated she hated the property and did not live there but merely slept there every evening. She said she was forced to take it. She rejected the assertion that she was in arrears and refused point blank to pay towards a service she didn't use (alarm charge). She was advised about potential court action and she said that she didn't want that*

to happen. When asked what her defence would be for not paying, she said that she wasn't even sure she would turn up'.

May denied that she had any physical or mental health problems and declined any referrals for support in maintaining her tenancy or with financial issues, she said that she didn't need any, she was managing well and lived the way she wanted to live.

5.4.4 May was found deceased in her flat by the police on the 4th February 2019 after reports that she had not been seen for some time. She had died of 'natural causes', reportedly whilst getting dressed to go out. May had £16,000 in her bank account and £500 in cash in the flat.

6. Analysis of the Key Episodes

The following themes have been identified from examination of chronologies and in reflection and discussion with staff at the learning event:

Making Choices: Capacity and Capability

Person centred approaches to understanding the person and their perspective.

How agencies understand their own role and that of other agencies.

6.1 Making choices: Capacity and Capability: May had no choice about leaving the property in which she had resided for the previous fourteen years. Housing could only offer her a choice of tenancy in a one bedroomed flats and did not offer support to find a shared house, a tenancy being a secure option for many people. May was clear that she did not want a flat, she would prefer another HMO which would '*suit her lifestyle,* i.e. would entail less responsibility and pressure to manage a household, and she took active steps to try to secure this choice in January 2016. She was advised to make her own arrangements but was given no advice or support as to how to go about finding a new shared house. May appears to be unable to make other arrangements by herself and continued to complain that she felt 'trapped' in a flat which gave her a tenancy.

We know little of May's previous lifestyle choices, did she sleep in a bed in her previous accommodation? HMOs are usually furnished. Had she always walked up to eight miles a day or had this behaviour arisen because of her unhappiness at her accommodation? May did appear to continue many of her previous routines in her flat, she used only an electric kettle which she may have previously had in her room, she only had Pot Noodles in the flat, she had not previously had to pay for energy or an alarm. Whilst May could not exercise choice about her accommodation, she could exercise choice about how she used the accommodation although this appears partially to be an adaptation to unhappy circumstances rather than a positive 'lifestyle' choice.

May was clear with health practitioners that she did not welcome intervention, but she would accept certain help after negotiation with the practice nurse at the surgery. When May decided that she had a health problem she went for help. It was noted at the Review Learning Event that May could have chosen not to get into the ambulance in July 2016 but did so, and she chose to go to the GP surgery when she was in pain. She may have felt overwhelmed in the busy hospital setting however and appears to have wished to leave without further interventions.

May emerges from the accounts of her life during the SAR scope as a person who has capacity to make choices and is self- determining but struggles to act on her decisions in a way that supports her own wellbeing. Her assertion that she does not want to be in the flat and would prefer shared accommodation was not explored, it was not an option that Housing Options can support her with and although her landlord understood that she wanted shared housing they also could not supply this and decided to focus on helping her to maintain the tenancy that she had, but did not want.

6.2 Person centred approaches: Health staff, both in primary and secondary care, demonstrated sustained efforts to support May with her health needs, these were sometimes successful and sometimes not. May had the mental capacity to make decisions about how she lived and what support she wanted to accept regarding her health and tenancy, but agencies did not engage in conversations underpinned by professional curiosity to understand why May made these decisions. People who attended the Review Learning Events did not know why she walked all day, whether this may have been associated with previous trauma or mental health issues, they were aware that she had an extended informal support network comprised of the shops, bookmakers and cafes that she frequented, but based this knowledge on observation rather than any enquiry about the systems of support may could tolerate in her life.

May was consistent in her assertion that her accommodation did not meet her needs, she expressed this to the social housing provider, health professionals, the hospital social worker and ASC duty workers. In terms of accommodation support she was offered options that supported her tenancy in a flat that she did not feel suited her needs but was not offered support to find an option that would suit her expressed needs. She was invited to engage in the solutions offered by agencies, but her own solution does not appear to have been explored with her.

The social housing provider was determined to support May to manage her tenancy but were frustrated in their attempts to act as a responsible landlord and prevent May's debt from escalating, good practices by a landlord. The social housing provider attendees at the learning event talked about feeling May was '*stubborn*' as she resisted their offers to help her clear her debt or get 'support' from social care. May was seen as '*strong willed'*. Generally, the social housing provider had no concerns about her; she went out and '*did her own thing'* and lived her life as she wanted to. Over the time considered within the SAR May

and her landlord appear to have adopted fixed positions toward each other, no further exploration of what type of accommodation May would wish for took place and May appeared to have adapted her lifestyle to her circumstances, whilst still refusing to engage with any support to maintain her tenancy.

The social care assessment of May's needs whilst she was a hospital inpatient appeared to observe the principle of May's self-determination but appears to be focused on problem solving and advice, no professional curiosity was evidenced about why May lived as she did. May once again asserted that she did not wish to live in her flat and was assessed as having no care and support needs, but the underlying reason for her hypothermia was not explored. The Care Act 2014 (s1.1) specifies **'***The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being'*. Section 1.2 of the Act defines 'well-being',

in relation to an individual, means that individual's well-being so far as relating to any of the following—

(a)personal dignity (including treatment of the individual with respect);

(b)physical and mental health and emotional well-being;

(c)protection from abuse and neglect;

(d)control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);

(e)participation in work, education, training or recreation;

(f)social and economic well-being;

(g)domestic, family and personal relationships;

(h)suitability of living accommodation;

(i) the individual's contribution to society.

Section 1.3 of the Act asks the local authority to have regard to

'*a) the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being; (b)the individual's views, wishes, feelings and beliefs;*

(c)the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist;'

An awareness of the wellbeing principle and the local authority general duty could have shifted the emphasis of the conversation away from 'needing or accepting support' to a focus on May's unhappiness about her accommodation and her attempts to change her situation. We cannot know what impact any support to May to make those desired changes would have made, but the failure to explore May's wellbeing meant that she had no opportunity to benefit from further advice on how to take her real identified concerns forward and act upon her decisions.

6.3 How agencies understand their own role and that of other agencies.

The ASC duty workers who attended May on the 9th March were tasked with undertaking a timely welfare visit to risk assess and ascertain that May was 'safe and well', reporting back their findings to their senior in order for further action to be considered. They appear to have performed this function well, ascertaining May's thoughts and wishes, her capacity to make decisions and her plans to avoid a further risk to her vital interests, i.e. her plans to keep warm at night. This was difficult given that May did not wish to speak with them. They did listen to May's unhappiness regarding her accommodation but assumed that May was working with the social housing provider to change her situation and that the social housing provider was aware of her predicament, simply because they saw the calling cards that The social housing provider had left on so many occasions. The workers made recommendations to their senior '*Permission gained to speak to GP. Refer to Hereford Housing re options to move. Refer to community connector.'* The staff had listened to May's expressed need, to move accommodation, and had also thought that May was isolated and needed support for the longer term to be able to identify and change her situation, they attended to her general 'wellbeing'. These recommendations were not acted upon as May was seen as a 'low priority' for ASC, having only a housing need and having been signposted to discuss this with the social housing provider. Because of the presence of calling cards the assumption was made that the social housing provider were aware of May's situation and no contact was made with them. ASC is a high demand service and seniors must make decisions about referrals and allocations in order to focus resources on those in most pressing need. However, a conversation with the social housing provider may have challenged the assumption that they were aware of, or in a position to assist May to move, and in addition would have given them the vital information that May's inability to adapt to her situation had caused her to experience hypothermia, this could have promoted a more preventative approach to her situation.

The social housing provider had no information from other agencies to challenge them to change their approach to May and continued to see her as stubborn and strong minded. The social housing provider focus was on May's refusal to pay her alarm charge and the potential for court action to be taken. They did not know that other agencies were concerned for her or that her health had been put at risk through her own behaviour. Such information could have been used to provide a 'respectful challenge' by the social housing provider to May regarding her ability to manage her situation without endangering her own vital interests. As a landlord the social housing provider appeared content that May kept her property clean and her rent was up to date and accepted that her way of life was a 'choice.' It was reported to be unlikely that she would be evicted because of her refusal to pay the alarm charge. Had May not refused to pay her alarm charge it was unlikely her landlord would have been involved with her so closely.

6.4 A number of positive practices by agencies have been identified within the SAR**.** At the start of her tenancy the social housing provider staff noted May's distress and her anxieties

and took steps to work with her in a way that would support her. They identified that she was struggling and offered the appropriate referrals, one of which, to a housing group, she appeared to accept.

Agencies reported their concerns in accordance with agreed protocols. The social housing provider gas engineer promptly reported his concerns to the landlord which could have enabled the Housing Officer to have a further discussion with May to try to understand her perspective on the flat and how she used it. The ambulance and police services demonstrated good practice in making referrals to ASC about a woman who was living in such sparse circumstances and who had experienced hypothermia. The Acute Trust also demonstrated good practice in admitting May and exploring her health needs as thoroughly as they were permitted to do by May. May did not need to be admitted but in the face of a high risk of further harm to her vital interests the Trust took a precautionary approach to her wellbeing.

7. What has changed since January 2016?

7.1 West Mercia Police now have a Police representative sitting with the adult referral team in adult social care, several times a week. This enables better information sharing to inform decision making about adult safeguarding concerns.

7.2 The social housing provider merged with another housing group. As part of that merger a Safeguarding Policy was developed taking the best practice from the three landlords within the group. The amalgamated provider has a Designated Safeguarding Lead and Deputy Lead to cover each local authority in the group. A safeguarding register for each local authority is also kept, recording any safeguarding referral made by the social housing group, this allows referrals to be tracked, updated and outcomes chased up if necessary. A Safeguarding Advisory Group has also been set up which meets quarterly and is attended by the Designated Safeguarding Leads and Deputies, the Advisory Group has an independent chair who has extensive safeguarding experience with both adults and children. The group discusses best practice, looks at themes and learning from the safeguarding referrals made and also has started to produce briefings for the social housing teams about specific aspects of safeguarding. The Trades teams have also recently received refresher training which has included how to raise a concern. The housing Learning and Development Team have qualified safeguarding trainers within the team who deliver safeguarding training. We now include a question about safeguarding in all recruitment interviews.

7.3 'Community Hubs' have been developed and are expanding throughout Herefordshire, these can offer advice and guidance to people with a range of concerns and may well have been able to assist May in identifying how to get the accommodation she wanted. Community Hubs have a role to play in connecting

people to agencies that can help and are consistent with section 1 and 2 duties of the Care Act 2014.

7.4 The GP surgery May attended has since employed a safeguarding lead. The lead will follow up any element of concern which might indicate self-neglect or harm, whether notified by a discharge letter or by the observations of clinical staff. The CCG has noted that this post has enhanced the ability of GP and primary care services to prevent harm.

8. Findings and Learning Points

8.1 It is important to note that the lead reviewer and participants at the learning event did not find any connection between May's death and any failure of multi-agency response to her circumstances. However, the quality of May's life was affected by the way in which her needs and decisions were interpreted by a range of agencies and the lack of interagency discussion about her predicament.

We will consider in turn each of the questions posed in the SAR Terms of Reference below:

8.2 *Consider state benefits and other payments which May may have been able to access.*

May is reported to have told the police in March 2018 that she was unable to afford heating. May was in receipt of both a state pension and pension credit during the time considered by this SAR. The DWP have confirmed that her income was £167.25 per week at the time she died. May had a large amount of savings, over £16,000. If May had decided to use energy in her flat, she could have easily done so. May was offered referrals to agencies for support to claim any further benefits throughout the period in scope, she declined these offers.

Learning Point 1: It is important to engage a person in discussion about their rationale for non-use of essential services. This may not in itself effect any change but may contribute to an understanding and further conversation about why the person has made these choices.

8.3 *Reflect on whether any agencies involved considered or should have considered the issue of self-neglect.*

The agencies who attended the learning review considered the possibility that the issue of May's self-neglect had been missed during each of the consecutive time periods of the Review.

8.3.1 Agencies were concerned that they may use different criteria when thinking about self-neglect, May's struggle to care for her legs in 2016 might be seen as an indicator that her mind set or way of life made her prone to self-neglect, but would only need to be referred onto ASC if she did not respond to the primary care staff's attempts to support her and her condition did not improve. This struggle was not reported to ASC in March 2018 however, merely the fact that she had not attended the surgery since 2016. Agencies agreed

however that not having a bed to sleep in, not using heating and hypothermia could be considered as stronger indicators of a risk of self-neglect.

8.3.2 Agencies thinking about self-neglect also involved factoring in two concepts, the person's mental capacity to make decisions about self-care and wellbeing (see 7.4 below) and their right to live a '*preferred lifestyle'* which may be odd to others but is their '*choice*.' Attendees at the learning event described behaviour which might be seen as '*eccentric*' in Hereford but that people '*had a right to live*' without state interference. This statement is acceptable and reflects a self-determining approach to rights, however it should not be an untested assumption. Not all of May's behaviour was from choice but from the necessity of living in circumstances she was struggling to cope with and felt angry and frustrated about. She chose to live in shared accommodation with her bills paid, heating and TV available, she struggled to adapt to an environment where she had to deal with this herself and was unable to find a way forward for herself. She did not choose to live like this and as a result neglected her own needs. A person's continual refusal to accept support in the face of concerning circumstances needs further exploration (Preston Shoot 2018)**.**

8.3.3 Each agency had a 'snapshot' of May and, as the risks to her wellbeing were low, had no reason to share information about her until March 2018. At this point the assumption that May was somehow working with the landlord to resolve her situation could have been tested via information sharing by gaining May's consent to do so or on the basis of May having hypothermia, a risk to her wellbeing. May wanted to move accommodation very much and may well have consented for the local authority to talk to her landlord, she consented for information to be shared with her GP on this occasion.

Learning points 2 and 3

Learning Point 2. Indicators that a person may be prone to self-neglect can be usefully recorded in primary care and future social care and clinical responses could take account of this risk indicator. Risk must also be considered in the context of age and known information about health needs.

Learning Point 3. Professionals must reflect on their assumptions that a person is making an active and positive choice to lead a preferred lifestyle.

8.4 *Did professionals undertake capacity assessments, given that they are decision and time specific?*

No capacity assessments were undertaken during the scope of the Review. However, there is nothing in the evidence provided or discussions during the learning event to suggest that May did not have decisional capacity at that time. May did struggle to act on her decisions, she appears to be unable to navigate the challenges involved in changing her accommodation, the key factor that may have made a difference to her wellbeing and

quality of life. Her 'capability' rather than her mental capacity was an area which needed to be considered. May was capable in many other ways, having devised ways of staying warm and taking herself to seek medical care when she felt this was needed.

Learning Point 4. A person may have capacity to make a decision, but struggle with the capability to act upon the decision. Capacity to make a decision should not lead us to assume that a person can carry the decision out without support.

8.5 *Did practitioners use their professional discretion and curiosity to see past May's decisions and recognise that she may have benefitted from further engagement/intervention?*

8.5.1 As in 8.3.3 above, practitioners often had a snapshot of May's predicament and until March 2018 no reason to share information with each other. However, what is striking about May's story is the number of times she told individual agencies that she did not like living in her flat but how her central need to move to different accommodation was not explored further. A 'housing need' that does not fit into the range of accommodation available via Home Point appears to become invisible and it is not evident who might see themselves as responsible for helping May resolve her predicament. Without listening to and understanding how May adjusted to living in circumstances she felt unhappy about meant that her landlord service moved from an early position of being concerned about her anxiety and distress to seeing her as 'stubborn' and 'strong minded'. We do not know what enquiries primary health services made about her lack of a bed, but the brief contacts the police had with May do show attempts to understand her rationale for having no heating and living the life she did.

8.5.2 Hospital Social Care practitioners do not appear to have used a 'wellbeing' informed approach to May's needs and did not respond to her statement that she had tried to move accommodation and failed. Social Care practitioners should have been knowledgeable about options that could support May to act on her own self-determined solutions.

8.5.3 The ASC duty workers who saw May at home in March 2018 were concerned that May's situation needed to be explored further but as duty workers were not able to engage over a period of time to do so. Their recommendation of further allocation was not acted upon as May was deemed 'low priority' and she was identified as having only a 'housing need'. No thought was given as to how that need would be met and the assumptions made about her relationship with her landlord, or indeed what the role of the landlord was, were not tested before her case was closed.

8.5.4 May's reported behaviour indicates to the lead reviewer that she found it hard to trust others, she had a strong need for routine which included walking to cope with unknown issues and a lack of capability to address her own accommodation needs. She was self-determining and knew what she wanted, her problem was that her voice was only heard as a person who was objecting and wished to be left alone and the extent of her adaptation to

an unwelcome lifestyle not understood. The fact that she was capacitated to make decisions led practitioners at the learning event to want to support her right to live her life as she wished, Braye et al (2014) caution that in self neglect work

*Where capacity is present, there is strong professional commitment to supporting an individual's autonomy in choosing their own way of life; however, the perceived professional commitment both to promote dignity and exercise a duty of care means that competing imperatives drive professional goals. (p*5).

In May's case there were no attempts to discover how she did wish to live her life, only assumptions that this was her preferred lifestyle.

Learning Points 5, 6 and 7

Learning Point 5. The concept of 'wellbeing' and how we need to actively promote this must be understood by all agencies working with adults in Herefordshire. A 'whole systems' approach is necessary, attention to wellbeing in our thinking and professional assessments can ultimately be preventative of crises as well as supporting a good quality of life for the people we work with.

Learning Point 6. We must not rely on overarching concepts to explain elements of a person's behaviour that should cause us to be concerned about them. Ideas about preferred lifestyle or even the concept of 'eccentricity' can blunt professional curiosity and respectful challenge.

Learning Point 7. We need to be curious about what other agencies do, understanding our respective roles and how we can work together to meet the wellbeing needs of the people using our services.

9. Recommendations to Herefordshire Safeguarding Adults Board

Herefordshire Safeguarding Adults Board is recommended to:

9.1 Seek assurance from agencies across Herefordshire that the general statutory duty to promote the wellbeing principle is understood. (Learning point 5)

9.2 Promote and seek assurance that adult safeguarding and mental capacity act training, development and supervision in all partner agencies in Herefordshire emphasises:

- The importance of engaging a person in discussion about their rationale for non-use of essential services. (learning point 1)
- The need to reflect on, and when needed challenge, assumptions that a person is making an active and positive choice to lead a preferred lifestyle (learning point 3)

- The importance of avoiding overarching concepts such as 'preferred lifestyle 'or 'eccentricity' to explain elements of a person's behaviour that should cause us to be concerned about them. (learning point 6)
- An understanding of the difference between decisional capacity, executive capacity and capability (learning point 4)

These points can also be referenced within the forthcoming publication on Professional Curiosity.

9.4 Engage Housing provider partners to engage actively in the work of the Herefordshire Safeguarding Adults Board. This will contribute to increasing all agencies' understanding of roles and the pathways to meet accommodation needs.

10. Recommendations to individual agencies:

10.1 Housing are recommended to review their adult safeguarding policy with regard to indicators of self-neglect with regard to learning points 1,3,4, and 6.
10.2 Housing are recommended to take an active part in the work of the Herefordshire Safeguarding Adults Board.
10.3 Herefordshire local authority ASC is recommended to ensure that staff have an understanding of the work of housing providers and consider the potential of involvement where concerns relate to the housing environment, and to understand options for referral for support in a range of accommodation issues that affect the person's wellbeing. (learning point 7)
10.4 Herefordshire CCG is recommended to consider the concept of recording indicators of potential self-neglect in relevant situations, gaining the consent of the person involved and defining appropriate actions to be taken in specific situations where this information is relevant. Once it has completed these considerations to make recommendations to GP and primary care services in its' area. (learning point 2)

11. Glossary of terms used

A and E - Accident and Emergency Department

ART – Assessment and Referral Team

ASC – Adult Social Care and Health

HMO – Houses of Multiple Occupation

HSAB – Herefordshire Safeguarding Adults Board

NFA – No Further Action

SAB – Safeguarding Adults Board

12. References

Braye, S; Orr, D; Preston -Shoot M, (2014) Report 69 'Self-neglect policy and practice: building an evidence base for adult social care' Social Care Institute of Excellence

The Care Act 2014 accessed on [20/06/2019] at http://www.legislation.gov.uk/ukpga/2014/23/section/1/enacted

Care and Support Statutory Guidance (updated 28 October 2018) accessed on [22/06/2019] at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Preston-Shoot, M (2018) 'Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change' Journal of Adult Protection Vol. 20, Issue. 2, pps 78-92 Brighton.