Leeds Safeguarding Adults Board

TALK TO ME, HEAR MY VOICE

Safeguarding Adults Review (SAR)

Mr B

Approved by the Leeds Safeguarding Adults Board at it's meeting on 27th January 2020

LEEDS SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULTS REVIEW

Mr B

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Independent Reviewers

27th January 2020

Table of Contents

Mr B: SAFEGUARDING ADULTS REVIEW

1. OVERVIEW OF THE CIRCUMSTANCES THAT LED TO THIS REVIEW

1.1. Mr B died aged 64 on 10th March 2018. The causes of death were multiple organ failure, septicaemia, gangrenous feet, peripheral vascular disease, alcohol excess and self-neglect.

1.2. Mr B had been known to Leeds and York NHS Partnership Foundation Trust in 2004/2005 and was diagnosed with psychosis, including auditory hallucinations, in 2004 and 2015, alongside anxiety and depressive illness. His GP referred him to mental health services again in 2016 because of his erratic behaviour and self-neglect. Records at this time noted very poor housing conditions, with a lack of heating and security concerns. He spent much of his time walking the area around his home and local people were familiar with him regularly spending time on a bench outside a local supermarket. West Yorkshire Police Service (WYPS), social workers and people in the community reported concerns about his neglected state, including foraging for food from bins, dirty and torn clothes and very poor hygiene. Assessments described Mr B as being unkempt. Two deep cleans of the property were undertaken.

1.3. He was admitted to mental health hospital in November 2017 and a mental capacity assessment found that he was able to understand concerns regarding his mental state and the rationale for inpatient admission under the Mental Health Act 1983 (section 2). He was able to retain information. However, he lacked insight into his mental state and minimised concerns about his state of self-neglect. This lack of insight, the assessment concluded, meant that he was unable to weigh in the balance the risks and benefits of continued admission and the treatment plan.

1.4. On discharge on 18th December 2017 he was diagnosed as having "mild cognitive decline secondary to alcohol excess." No mental capacity assessment appears to have been undertaken prior to his discharge. The plan included a deep clean of his home and purchase of a new bed, care coordination under the Care Programme Approach, support from both a social worker and a community mental health nurse, and referral to podiatry. He was keen to return home but there was no hot water or heating and no occupational therapy home visit took place to assess his functional abilities.

1.5. There was a five-week delay in the GP receiving a hospital discharge letter. Mr B did not attend a podiatry appointment on 25th January 2018 and no further follow-up by this service occurred, his case being closed with notification back to the GP. Although the risks from self-neglect and poor nutrition remained significant, the post-discharge support plan was compromised. Mr B was not seen between 5th January and 21st February 2018. As the chronology in section 4 outlines, the contacts that did place did not trigger a reassessment of the case, despite two alerts about Mr B's behaviour and appearance from a local pharmacy, which resulted in the GP making an urgent referral back to the Community Mental Health Team on 31st January . When that team did make contact with him later in February, concerns about self-neglect and the condition of the property were raised with A&H Mental Health, but it appears that the case was seen as involving long-standing issues rather than requiring an urgent response.

1.6. On 8th March 2018 Mr B was found collapsed by a local shop and admitted to hospital via Accident and Emergency, where he died two days later.

2. THE STATUTORY DUTY TO CONDUCT A SAFEGUARDING ADULTS REVIEW

2.1. The Leeds Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

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

2.2. The SAB also has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. In both circumstances, abuse and neglect includes self-neglect[2].

2.3. Board partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[3]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. Leeds and York Partnership NHS Foundation Trust, having undertaken a mental health mortality case record review, referred Mr B's case to the SAB for consideration of whether a SAR should be commissioned. The referral noted a history of severe self-neglect to physical health alongside low mood and prior episodes of depression and hallucinations and identified potential concerns that agencies might have been able to work together more effectively to protect Mr B from the deterioration in his physical health that led to his death.

2.5. On 18th December 2018 Leeds SAB Executive Group initiated a scoping exercise to determine whether the criteria for a SAR were met. This scoping exercise enabled the construction of an initial chronology through contributions from the main services that had been involved with Mr B. The scoping exercise also obtained the mental health mortality case record review completed by Leeds and York Partnership NHS Foundation Trust, which had also found criticisms in how agencies had worked together and rated care overall as poor.

2.6. On 4th April 2019 Leeds SAB Executive Group decided that the criteria for a mandatory SAR had been met and independent reviewers and overview report writers were commissioned to undertake the review.

[1] Sections 44(1)-(3), Care Act 2014

[2] Chapter 14 of the Statutory Guidance to the Care Act (DHSC, 2018) lists self-neglect as one of the circumstances that constitute abuse and neglect.

[3] Section 44(5), Care Act 2014

3. THE REVIEW MODEL

3.1. The SAB Executive Group wished to undertake a proportionate review that analyses the case through the lens of evidence-based learning from research on self-neglect and the findings of other published SARs on adults who self-neglect. Specifically, the focus was to be on learning from good practice and from missed opportunities, using the following terms of reference:

3.1.1. To review agencies' understanding of self-neglect, the risks arising from it and their responses to it;
3.1.2. To review how well agencies who had contact with Mr B identified and communicated risk, escalated concerns and worked to build trust to understand and support him;
3.1.3. To review how agencies responded to his lack of engagement;
3.1.4. To reflect on how agencies worked together to complete and act on mental capacity and risk assessments, and to support Mr B with care packages in the community;
3.1.5. To reflect on discharge planning and community follow-up when safeguarding concerns have been identified;
3.1.6. To reflect on how agencies engaged with and addressed concerns expressed by members of the public;
3.1.7. To review how agencies recorded their assessments and involvement with Mr B;
3.1.8. To reflect on how agencies used safeguarding referral pathways and legal options for intervention;
3.1.9. To review the extent to which practice conformed with local policies and procedures;
3.1.10. To review the extent to which practice reflected evidence from research and other safeguarding adult reviews.

3.2. The review covers a 3-year period, between 1st January 2015 and 10th March 2018. The approach chosen was a review model that involved:

3.2.1. Chronologies of involvement from all agencies who had contact with Mr B during the period under review. In addition, they were advised to identify and summarise any information they considered significant regarding their involvement with Mr B prior to the review period;
3.2.2. From the combined chronology, the reviewers identified specific issues and questions that the agencies involved were asked to respond to and comment on;
3.2.3. A learning event with practitioners and operational managers from agencies involved with Mr B, with the purpose of seeking their perspectives on the key episodes of the case. Discussions sought to analyse learning from this case through the lens of evidence from research[4] and other SARs[5], from which has emerged a

[4] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.
Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect*. Leeds: Skills for Care.

[5] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection* 17 (1), 3-18.
Preston-Shoot, M. (2016) 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work.' *Journal of Adult Protection* 18 (3), 131-148.

framework for effective work with adults who self-neglect. The focus was therefore on identifying the facilitators and barriers with respect to implementing what has been codified as good practice;

3.2.4. Thematic analysis of the learning themes emerging from all the available information;

3.2.5. Drafting of a report for Leeds SAB to inform its planning, implementation and monitoring of relevant actions across the safeguarding partnership.

Thus, a hybrid methodology has been used, designed to provide for a proportional, fully inclusive and focused review.

3.3. The following agencies provided information to the review:

- Forward Leeds
- Leeds and York Partnership NHS Foundation Trust (L&Y)
- Leeds City Council – Adults and Health (A&H)
- Leeds City Council – Housing (LCCH)
- Leeds City Council - Communities and Safety
  (a) Environmental Services
  (b) Anti-social Behaviour Team
- Leeds Community NHS Healthcare Trust (LCH)
- Leeds Irish Health and Homes (LIHH)
- Leeds NHS Clinical Commissioning Group (CCG)
- Leeds Teaching Hospitals NHS Trust
- RSPCA
- West Yorkshire Fire and Rescue Service (WYFRS)
- West Yorkshire Police Service (WYPS)
- Yorkshire Ambulance Service NHS Trust

3.4. In terms of family involvement in the SAR, Mr B was divorced from his wife and had two daughters with whom he had little or no contact. In line with statutory guidance on implementation of the Care Act 2014, attempts were made to locate his daughters to ascertain whether they wished to be involved in this review. However, no addresses could be retrieved to enable contact to be made. It is understood Mr B had family in Ireland from whom he was estranged.

Preston-Shoot, M, (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection* 19 (2), 53-66.

Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on self-neglect: addressing the challenge of change.' *Journal of Adult Protection* 20 (2), 78-92.

Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice', *Journal of Adult Protection,* 21 (4), 219-234.

4. CASE CHRONOLOGY OVERVIEW

The purpose of this section of the report is to establish a clear, chronological narrative of events as they unfolded over time.

Events prior to the review period

4.1. Police records contain information about historic offences between 1972 and 2004, relating to benefit fraud, theft, assault, harassment and being drunk and disorderly. Mr B had been registered with his GP practice since 2002. Medical records contain historic information relating to anxiety and depression, inflammation of the digestive tract and alcohol dependency. He is recorded as having been unkempt in 2005. He was discharged by mental health services in 2005/6 following missed appointments. There was no Adult Social Care involvement between 16th September 2013 and 23rd March 2015.

Events during the review period

4.2. On 12th March 2015 an annual Housing visit took place, followed up with a further visit on 16th April.

4.3. On 23rd March 2015 GP1 saw Mr B in surgery with a history of epigastric pain. He was examined and was noted at the time to be "unkempt." The GP discussed with Primary Care Access Line (PCAL), who would see Mr B on surgical assessment and arrange transport. There is no discharge letter with regard to this entry in the electronic patient record. It is not clear what the medical assessment and treatment plan was.

4.4. The same day the Ambulance Serviced referred Mr B to A&H. A crew had been concerned that Mr B was struggling with his property and hygiene; there were cats and hoarded rubbish. A duty social worker spoke to Mr B about the concerns raised. After long discussion Mr B declined assessment and did not wish the referral to be taken any further. No concerns about capacity were recorded by the social worker. The referral was closed.

4.5. On 25th March 2015 the RSPCA attended Mr B's home in response to welfare concerns for his six cats and requested Police assistance to facilitate entry to the premises, as Mr B was not at home. On Police arrival the property was found to be insecure, no force was required to enter and the RSPCA removed the cats. Home conditions were described as very poor, with clutter, mould, ammonia smells, dirty floors and faeces in the bath. It was thought that Mr B was in hospital. The attending Police officers made enquiries with the neighbours regarding Mr B's whereabouts; the neighbours confirmed that they had seen Mr B out and about, but it was not known if he had left hospital. Telephone enquiries to locate Mr B with Bedboard (Leeds and Wakefield) did not show him as an in-patient. While these enquiries were being conducted, Mr B returned home and was described as agitated and aggressive. He was interviewed two days later at the house of a friend's house described as an "appropriate adult"[6].

[6] The Police & Criminal Evidence Act 1984 requires an appropriate adult to be present when a child or mentally vulnerable adult is in policy custody. Their role is to ensure that the detained person understands what is happening to them and why.

4.6. On 26th March 2015 a Housing Support officer (LCCH) completed a safeguarding referral due to self-neglect. This did not proceed as Mr B refused support.

4.7. On 14th April 2015 following a referral, the details of which are not available, the case was opened to the A&H Initial Response Team[7]. An attempt to contact Mr B by telephone was unsuccessful. A staff member made unsuccessful cold calls with a housing support officer on 28th April, 5th May, 15th May and 20th May. After the abortive visit on 5th May a letter was sent advising of the planned visit on the 15th. After that unsuccessful visit a voicemail message was left for Mr B.

4.8. On 15th May 2015 Leeds A&H requested a welfare check for Mr B from WYPS, informing them that Mr B had been recently referred to them by Housing, that Housing had said that he was unable to look after himself, that they were unsure if he had family or friends, and that had been around to the property and been told by a neighbour that Mr B had not been seen for a few days. Enquiries were made with Leeds Bedboard, which did now show Mr B an in-patient. A Police officer attended Mr B's home and having received no answer spoke to a neighbour, who advised that Mr B had been seen leaving the address 20 minutes previously, looking fit and well, with no concerns raised. The Police updated A&H of this outcome on 18th May 2015 (with the delay in updating due to the A&H caller not appearing to be working the weekend and no other contact number/person being provided). Police systems do not record whether, as a result of the recent referrals by Housing to A&H, the local authority proceeded to the next stage of determining whether the threshold for intervention was met and whether any further action was required.

4.9. On 24th May 2015 Mr B received an Adult Community Resolution for taking food through a locked grille from a cafe.

4.10. On 3rd June the same two Housing and A&H practitioners undertook a home visit. There was no answer but on ringing Mr B's mobile phone the ring tone could be heard inside. As the door was open, the practitioners entered the property to check that Mr B was safe and well. He was not at home. They agreed that a deep clean was necessary.

4.11. On 13th June 2015 Mr B received a second Adult Community Resolution for taking food. These were crimed as 'burglary other' offences, intended as a response to deal swiftly with low level offending where the following criteria are met: victim agreement (desirable); offence seriousness – summary; offender admits responsibility and has little or no previous offending history.

4.12. On 2nd July 2015 the same two practitioners visited again. Mr B was at home. The reason for the visit was explained and concerns raised. Mr B informed them there were no concerns, confirmed he was OK and asked them to leave.

4.13. On 9th July 2015 a social worker requested a mental health assessment from the GP. The GP advised that Mr B had to consent. A Housing support officer relayed concerns about Mr B to the GP and received no response. (The GP surgery has noted that this contact is not documented in GP records.)

[7] The Initial Response Team was renamed the Rapid Response Team during the period under review here.

4.14. On 15th July 2015 the practitioner from the Initial Response team visited again with the Housing Support Officer. This followed a member of the public, who was leaving food on the doorstep, reporting a safeguarding concern. Mr B was in but refused them entry and refused a request to visit another time. This appears to have been reported the following day to a social worker, who contacted the GP to see if Mr B had been seen recently.

4.15. On 24th July 2015 a gas engineer visited for an annual gas check, which it was not possible to complete due to the state of the property. Gas enforcement followed on 2nd September with a court order on 8th September. It has not proved possible to trace the gas utility company for further details.

4.16. On 31st July 2015, WYPS Neighbourhood Policing Team officers arrested Mr B at home on a warrant in relation to a RSPCA animal welfare prosecution. The WYPS contribution to this review states that upon entering the house, they were confronted by a "messy household" and a "tab end pile at the bottom of the stairs that was as tall as the officer". Both officers were concerned at the conditions and checked the kitchen to see if he had food, which he did. When asked whether he needed any help he declined. He was observed to be frail and spent only seven minutes in Police custody after which he was transported home again. An officer persuaded Mr B to give his consent for a referral to be made to A&H and the referral was emailed through to A&H that day.

4.17. On 31st July 2015 Mr B was convicted in his absence under the Animal Welfare Act 2006 and was sentenced on 4th September. Cats were removed from his possession and he was disqualified from owning animals for five years.

4.18. On 4th August 2015 the A&H Initial Response Team practitioner made an unsuccessful visit with a mental health social worker, leaving a note to say they would visit again the following week. A further visit on 12th August was also unsuccessful. As the door was open they entered the property to check if Mr B was safe but he was not there. They noted hoarded rubbish, which presented a fire hazard and they left a telephone message for him.

4.19. On 26th August 2015 the case was transferred within A&H to a neighbourhood team due to Mr B's lack of engagement and allocated to a social worker, who visited on 10th September with the Housing Support Officer and a worker from Environmental Services. Mr B was in and allowed them into the property, but once again explained he did not need any help. A quote for a deep clean to be arranged.

4.20. On 14th September 2015 LCCH referred Mr B to Great Places but the referral was not accepted because Mr B did not have a mental health diagnosis.

4.21. On 16th and 17th September 2015 the house was deep-cleaned by Leeds City Council Environmental Services, following referral for pest control (cockroaches and dermestid beetle). In addition, cigarette butts were spread across all floors, with mountains of ash piled high, and used tea bags were piled high in the kitchen; there were faeces in the bath and surrounding areas. Follow-up visits were conducted on 25th September and 2nd October, after which the case was closed.

4.22. On 21st September 2015 the social worker made an unsuccessful attempt to contact Mr B by telephone. Two days later a repeat call was successful and a visit arranged, taking place on 24th September. WYFRS also attended to fit 3 smoke alarms and assess fire risks. Mr B then asked them to leave but the social worker was allowed to stay and made some inroads to build a relationship of trust. Mr B agreed the social worker could visit again.

4.23. Mr B was not at home when the social worker visited on 6th, 7th and 8th October. A joint visit with WYFRS on 13th October was also unsuccessful and a message was left for Mr B on his mobile asking him to make contact. Further visits to Mr B were unsuccessful on 11th November, 25th November (phone), 3rd December (phone), 7th December and 14th December. The case was closed on 15th December due to lack of engagement and a view that Mr B had capacity in relation to his care needs.

4.24. On 22nd March 2016 WYPS records note that a civilian member of staff reported her concerns for an elderly male that she had noticed walking past her office, early in the morning at about 0600 hours and at around 1600 hours each day. She did not know his identity and had wondered if he was being asked to leave his accommodation and left to wander the streets. She was also concerned about his appearance and whether his welfare needs were being met. Her concerns included that he was wearing "the same clothes, jeans (wet/mud up to knees) holey worn out trainers, threadbare old grey coat. He looks to be in his 60's but could be much younger/older. He shuffles when walking. He gives the appearance of a rough sleeper but has no bags with him. He walks in all weathers." Subsequently WYPS connected these concerns with Mr B and on 3rd April spoke to Mr B. It is recorded that there were no concerns. (An earlier visit had not been made because there had not appeared to be immediate concerns for Mr B's safety and there had been other operational incidents.)

4.25. On 16th April 2016 the annual Housing visit took place.

4.26. On 18th April 2016 A&H received a telephone call from a concerned neighbour. Due to Mr B recently having been deemed to have capacity around his welfare and the case closed, no further action was taken. The neighbour did not have Mr B's consent for the referral to be made.

4.27. On 9th May the A&H Rapid Response Team[8] received another call from a member of the public expressing concern. The same day a housing officer reported to A&H that after the deep clean the previous year the house was in a terrible state again and raised concerns about Mr B's physical and mental health. A duty social worker telephoned Mr B, leaving a message inviting contact.

4.28. On 11th May 2016 GP2 saw Mr B at home following a referral the previous day from A&H, reiterating concerns about his deteriorating health. The GP documented the home as very unkempt, with no carpets, empty cigarette packets and Dosette boxes in the kitchen. Advice about smoking was given, Mr B being described as a moderate smoker between 10-19 per day. In view of his current medication and social care concerns, GP2 planned to refer Mr B back to mental health services, to which Mr B agreed at the time.

[8] This is the team formerly referred to as the Initial Response Team, now renamed by A&H.

4.29. On 25th May 2016 L&Y records contain the outcome of a referral meeting noted by an occupational therapist. Reference is made to a capacity assessment in April 2015 (not available in a search of records) finding that Mr B had capacity to make health and wellbeing decisions. The decision from the meeting was to offer gate-keeping assessment by a social worker in the CMHT and nurse or occupational therapist at his home address.

4.30. On 9th May 2016 a Housing officer reported to A&H that after the deep clean the previous year the house was in a terrible state again and raised concerns about Mr B's physical and mental health. A duty social worker telephoned Mr B, leaving a message inviting contact. On 1st June the case was allocated to a Rapid Response Team social worker who wrote making an appointment for 7th June.

4.31. On 4th June 2016 a Neighbourhood Watch Co-ordinator requested a welfare check for Mr B from WYPS. A number of concerns for his living conditions and welfare were reported and he had been seen wandering the streets in a dishevelled state. The log was allocated to a PCSO to attend his address, check on his living conditions and make a social care referral. Two PCSOs attended Mr B's address and when there was no answer they entered through the unlocked door, finding the house to be in a mess and noting that Mr B was "possibly a hoarder". There was a letter from A&H in view, stating that they would be paying him a visit on 7th June with a Housing worker. The outcome of the welfare check was emailed to the Neighbourhood Watch Co-ordinator. The Police record does not note whether a referral was made to A&H, however the letter they had seen had provided evidence that A&H and Housing were already intending to undertake a visit.

4.32. On 7th June 2016 Mr B was not at home when the social worker and housing support officer worker visited by appointment. As the door was unlocked they entered the property to see if he was in/safe but he was absent.

4.33. On 10th June 2016 L&Y records note a telephone call from a Police officer to express his concerns about "extreme neglect." The officer is recorded as wanting to go to the house to see Mr B and to know if he could use section 136 (Mental Health Act 1983). He was told that this approach was not probably going to be the solution unless there was an imminent threat to life/limb and a concern about mental health.

4.34. On 13th June 2016 a Police officer made a safeguarding referral in respect of Mr B by email: "*I believe Mr B has previously had dealings with social care, however, refused any assistance. Concern has been raised regarding Mr B recently by local councillors and residents, as he can be regularly seen wandering the streets in a dishevelled state and covers a considerable distance each day. I have spoken to Mr B regarding this. He states he is okay and happy with what he is doing daily. I asked him regarding his general living conditions, which initially he insisted he didn't require any assistance, before stating that he would like some assistance. I understand that not too long ago he was also assisted with his flat being cleaned. Please could I ask that someone attempt to make contact with Mr B to discuss further any issues he may have? I am happy to attend with someone if required*." The A&H contribution to the scoping undertaken after the SAR referral notes that the criteria for a section 42 enquiry were met. One was not undertaken, however.

4.35. On 14th June 2016 the social worker and housing worker visited again. Mr B was in the property but refused access, shouting at them to leave.

4.36. On 15th June 2016 L&Y records note an email communication from the social worker/AMPH reporting on the two visits made with the Housing officer. Two days later a community psychiatric nurse attempted a visit with the social worker. Mr B was not in but the house was in a severely neglected state with rotting food, used teabags, piles of letters on the floor by the door. On 23rd June L&Y records note that Mr B was again not in, a note being left for him. The plan was to take the case to a MDT meeting.

4.37. Also on 15th June 2016 WYPS received a response to their safeguarding referral from the social worker, who reported having visited on 7th June and, with the Housing officer, entered Mr B's home in his absence. On the second visit on 14th June Mr B had refused them entry, saying he was unwell. He had agreed that they could return the following week. The social worker had contacted his GP, who confirmed Mr B had a history of gastro problems and had last been seen at home on 11th May. The social worker also reported having received concerns from members of the public and had asked a community mental health nurse to join them on their next visit.

4.38. On 17th June A&H 2016 records note a joint visit by the social worker and a community mental health practitioner. Mr B did not answer and the door was unlocked, so they entered the property to see if he was safe but he was absent.

4.39. On 21st June 2016 the social worker and housing officer found Mr B at home. He did engage and agreed for the social worker to make a referral to Reablement for help with personal care and to make a further visit for full assessment. The social worker noted in the records that Mr B was deemed to have capacity in relation to his care and support needs, but no capacity assessment was recorded.

4.40. On 23rd June 2016 an email to the community mental health nurse from the social worker reported on the self-neglect concerns and a discussion with Mr B about his clothes and need for a bath, which he had agreed with. Concerns about him leaving door unlocked had also been discussed and Mr B had shown his key and agreed to lock the door. He had agreed to the reablement team visiting him every day but subsequently he did not engage and reablement was not pursued. He refused a re-referral to fire service regarding keeping his electric heater switched on; he did not see this as a hazard.

4.41. On 1st July 2016, the social worker discussed with the Police the use of legal powers (under section 17, Police & Criminal Evidence Act 1984) to enter Mr B's property. The Police advised that only Police officers were authorised under this legislation in situations where it was necessary to save life or limb and that requests to check on someone's safety should be routed to the 101 service.

4.42. Following referral to WYFRS, joint visits were attempted with Housing Leeds on 6th July but Mr B was not at home. On 11th July 2016 a joint visit by the social worker with a Reablement case officer, Housing officer and WYFRS also found him absent. On the same day WYPS recorded that officers were concerned that Mr B was deteriorating.

4.43. On 14th July a joint visit with the Reablement case officer also found Mr B not at home. On both these visits his door was open so the property was entered to see if Mr B was safe/in.

4.44. On 15th July 2016 a Neighbourhood Police Officer requested a mental health assessment of Mr B by the L&Y Crisis Team. The officer had been attending an unrelated incident when she came across Mr B on the roadside. She considered that he needed mental health assessment and obtained his consent to be transported to a police station. WYPS are unable to say what prompted the officer to stop and assist Mr B as they are no longer with service. A community mental health nurse attended and completed a risk assessment. L&Y records indicate there was "no clear evidence that he lacked capacity." He was aware that he could ring 999 if he was unwell or felt unsafe and agreed to do this; he had a functioning mobile. He agreed that the community mental health nurse could see him again on 18th July with a doctor at home and was taken back home by WYPS.

4.45. On the same day, L&Y records indicate receipt of an email via a social worker from a member of the public concerned about Mr B. The details in the email included Mr B walking in all weathers in a "*frightful state (almost tramp-like). He has been wearing the same clothes for months. His ripped trousers are literally falling off him. He could do with a bath or two, a shave and haircut and most importantly, some TLC*." The social worker's email described the extent of the risk – "*only clear areas are his bed and an area of the sofa, cluttered elsewhere in the house and mouldy food in a fridge which is not working.*" L&Y records indicate that the social worker believed he was a great risk now. The email resulted in liaison with an Approved Mental Health Professional, liaison with WYPS and discussion about whether Mr B had a mental disorder and whether section 136 (Mental Health Act 1983) could be used. There followed the assessment documented immediately above. The records state that: "*Given that police are concerned and that Mr B appears to be in need of care, and appears to the officer that Mr B is suffering from a mental health disorder, then section 136 would apply*."

4.46. On 18th July 2016 L&Y records note a joint community psychiatric nurse and psychiatrist visit but Mr B was not at home. They are recorded as having discussed lack of signs of mental ill health and that a social care package was needed. WYPS records note that an officer saw Mr B in the local community and reminded him of the appointment which he appeared to have forgotten. WYPS subsequently received an update from the community mental health nurse stating that Mr B had "eluded" them. This communication further noted that when the nurse had seen Mr B previously, she "*could not see any signs of acute or ongoing mental illness and as you mentioned, you were reluctant to use 136, as there were no apparent mental health concerns and that Mr B is making a choice about his lifestyle. I appreciate the degree of self-neglect is worrying. If there was a suspicion that he lacked capacity last Friday, I would have acted then. But actually, he appeared orientated and although he gave little away I presumed capacity. The plan from this morning is for me to contact the GP surgery to ask them to see him, as he has a physical health problem and to refer back for social services support. It may be that there needs to be a best interests decision. In the meantime, if you feel that his mental health is deteriorating and he appears to be at increased risk, please consider street triage/136 and take to [named place] for assessment - he wouldn't necessarily be detained further, but he would be assessed*."

4.47. On 19th July 2016 LCCH records note that Mr B had been assessed by mental health and that it was assumed that he had capacity with no major mental health issues identified other than memory problems. LCCH staff informed the GP of the WYPS involvement and the concerns about his mental health and wellbeing.

4.48. On 20th July 2016 the social worker made an unannounced visit but Mr B was not at home.

4.49. A professionals' meeting took place on 28th July 2016, convened by a senior social worker and attended by staff from Housing, A&H and WYPS. The GP and the Reablement team were invited but did not attend. The community mental health nurse was not present. Mr B had failed to keep appointments with twice weekly visits from A&H. His clothes were better but he was still dishevelled and declining offers of help. A&H agreed to carry out a risk assessment and to request another mental health nurse assessment. Reablement services were possible but Mr B would have to consent. Following the assessment at the police station on 19th July 2016 by the mental health crisis team, where his capacity was assumed and he had no major mental health issues other than some memory problems, WYPS officers were going to request another capacity assessment in his home. Those present agreed that Mr B suffered from self-neglect. He had allowed his home to return to its current state of uncleanliness after the previous deep clean. Referrals had been made to the WYFRS but they had as yet been unable to find him at home despite appointments. Police officers within the local area would be made aware of Mr B but as he had not done anything unlawful they were unable to detain him. Housing agreed to help Mr B resolve welfare benefit issues by ensuring he attended a GP appointment and then the Job centre.

4.50. Also on 28th July L&Y records note ongoing liaison with WYPS and the social worker about gaining more clarity on mental health needs and capacity. The social worker was keeping the community mental health nurse informed about the likelihood of eviction by Housing, who were willing to wait until after the nurse's visit to the house.

4.51. A&H records note that a professionals' meeting was held on 8th August 2016 (attendance is not specified and the meeting is not mentioned in notes provided by other agencies). It was felt that Mr B had capacity. The Community Mental Health Team were to visit Mr B again, which WYPS would facilitate, to assess mental health, identify a clear diagnosis and complete a full capacity assessment. Feedback would be given to the GP who would be asked to visit. WYPS would consider use of section 136 (Mental Health Act 1983) if the circumstances justified it. The social worker would discuss Reablement again with Mr B. A further meeting was to be arranged for 2-4 weeks' time to update and review the plan of action. (There is no record of the review meeting having taken place, although interagency liaison did continue.)

4.52. On 12th August 2016 a housing support officer (LCCH) delivered a food parcel. Throughout August 2016 LCCH staff were active in supporting Mr B with DWP. It was noted that the house had deteriorated since the last deep clean.

4.53. On 16th August 2016 the housing support officer referred Mr B to West Yorkshire Finding Independence Project (WYFI), who agreed to identify support services to help Mr B. (However, on 29th November 2016 WYFI advised LCCH that he did not meet their

criteria as he was not homeless, did not have an addiction, was not engaged in reoffending behaviour and was not mentally ill.)

4.54. On 19th August the social worker spoke with Mr B outside his flat. Mr B declined services. The social worker felt Mr B had capacity.

4.55. On 25th August 2016 the housing support officer raised concerns with Mr B's GP, doing likewise with his social worker on 5th September.

4.56. On 1st September 2016 the case was transferred within A&H from the Rapid Response Team to a neighbourhood team and allocated to a social worker for long term involvement.

4.57. On 2nd September 2016 the social worker updated the community mental health nurse about the concerns held by mental health, social work, housing, a local MP and the police. The social worker advised the nurse that Housing had referred Mr B to WYFI, and that he was felt to have capacity by the social worker following discussion with him about his clothes and personal self-care concerns.

4.58. On 6th September 2016 the social worker made an unannounced call to Mr B home with a colleague. Mr B was not in and the flat was unlocked. A message had been left at the area office to say that Mr B would not be at home but if the social worker wanted to see him he would be on his usual bench outside the local supermarket. The social worker went there, spoke to Mr B and arranged to see him at his home.

4.59. The same day a neighbourhood police officer, having sent an enquiry to the local Health Centre about Mr B's mental capacity, received an email from the A&H practitioner to whom Mr B had been allocated for long-term involvement. It stated that: "*I have worked with Mr B in the past - I have also assessed him as having full mental capacity and he just chooses to live the way he does. I have tried numerous times to contact him over the last two days, to no avail. I am awaiting to speak with the GP. He has recently issued Mr B with a sick note for, anxiety, depression and self-neglect. I will be heading over to [the local supermarket] today and this is where he is usually sat, fingers crossed we can make some progress at this time, although I am doubtful*." An update informed the officer that Mr B had been seen outside the local supermarket and he had agreed to be seen at his flat the following day.

4.60. Around 7th September 2016 there is reference to the social worker considering whether to convene another professionals' meeting.

4.61. Between 20th and 27th September there were numerous house visits and phone calls to Mr B by the social worker with no response. The flat door was locked and Mr B had not been seen at the local supermarket.

4.62. On 26th September 2016 a community mental health nurse wrote to Mr B, including: "*I think that you able to make a decision about how you choose to live, although others may not agree with you*." This appears to have been in the context of numerous updates from other people describing various contacts with Mr B. The same community mental health nurse wrote to the GP on 27th September following an assessment, stating: "*I felt he had capacity at this point and was making an informed decision about his lifestyle. [A named police officer] was of the same opinion*." He was

discharged by the Community Mental Health Team on 27th September, with re-referral an option. A letter was sent to Mr B offering further support if necessary with contact numbers given.

4.63. On 29th September 2016 the social worker made a home visit. Mr B was not at home but the social worker encountered him walking back with shopping. Mr B advised he was ok and that he did not want any help with anything.

4.64. On 7th October 2016 WYPS Officer expresses concern that people were buying Mr B food. His welfare benefits had been stopped but Housing staff had this in hand. He was not engaging with social work. The community mental health nurse was reported as saying that Mr B had capacity regarding his way of life and needs.

4.65. On 10th October 2016 the social worker visited with a housing support officer and a fire safety officer. Mr B was not happy about the visit and once again advised he did not need any help and that he wanted to be left alone. WYFRS records note clutter and waste in the house and describe Mr B as an unsafe smoker. Mr B was observed to have "*mental health issues*" and was due or undergoing a "*mental health capacity assessment*." There were four existing smoke detectors in the property; WYFRS fitted a fifth in the lounge as a primary smoking location. Mr B declined the offer of fire retardant materials and it is not clear whether this was revisited with him at any point.

4.66. On 11th October 2016 WYFRS raised concerns with the housing support officer, who advised that the outcome of a Mental Health Act assessment by A&H was awaited. On 21st October 2016 the housing support officer again raised concerns with A&H. Mr B had been seen sitting outside a local supermarket in the rain and cold.

4.67. On 2nd November 2016 a practitioner from the Dementia and Mental Health Liaison Team conducted a joint visit with the social worker. Mr B was not in. L&Y records indicate that neighbours were raising concerns, hence the team's involvement. Mr B appeared to be keeping his door locked. During November there was ongoing liaison between the social worker and the Dementia and Mental Health Liaison Team regarding his memory and need for assessment, including risk assessment. There were ongoing concerns cited about Mr B sitting in the snow and cold.

4.68. On 23rd November the same practitioners called again. Mr B was seen walking locally and he told the social worker he would not be in today and did not want to see anyone. The visit was then cancelled.

4.69. On 28th November 2016 the LCCH housing support officer received an email from A&H confirming that Mr B had had a mental capacity assessment and it was believed that he had the capacity to decide how his needs were best met and how he was living. A&H advised that he would be referred to a mental health worker to assess his mental health and to help assess his mental capacity and memory. On 29th November 2016 the housing officer raised their concerns with A&H.

4.70. On 8th December 2016 a community mental health nurse from the Dementia and Mental Health Liaison Team met with Mr B and a housing support worker. Records held by L&Y contain the statement: "*presentation appears to be similar to previous contact with mental health services in that no evidence of mental illness but concerns regarding his self-neglect.*" The same records indicate that the social worker was

suggesting the need for a meeting with all other professionals to address the issues (there is no indication that this happened). The nurse notified LCCH that Mr B had capacity; he was reported as having stated he was ok and did not require support despite often sitting outside in the cold.

4.71. On 30th November 2016 a member of staff at the local supermarket contacted WYPS to say that they had not seen Mr B for several days. It was established that Mr B was in hospital and the referrer was notified.

4.72. On 5th December 2016 Housing liaised with WYPS to provide an update on Mr B's situation. The social worker was suggesting a multi-agency risk assessment if a proposed mental health and mental capacity assessment did not happen.

4.73. On 13th December 2016 the housing support officer raised concerns with WYPS that known criminals were associating with Mr B.

4.74. On 15th December 2016, supported by a housing officer, Mr B was seen in the GP surgery by a nurse sister. He requested a sick note and a general health check; his only concern was reflux. He had bloods taken and was given a flu vaccine. The blood test revealed that he was borderline diabetic. He was to be referred to a diabetic nurse for diet control.

4.75. On 10th January 2017 the housing support officer raised their concerns with A&H and chased up a risk assessment by A&H to ascertain whether Mr B had capacity.

4.76. On 19th January 2017 the social worker made an unannounced visit but Mr B was out.

4.77. On 30th January 2017 the GP, housing officer and social worker met. Referral back to the Community Mental Health Team for assessment of his mental health and mental capacity was agreed because of his behaviour; he was sitting outside in the cold and wandering.

4.78. The LCCH contribution to the scoping document put together after the SAR referral notes that in January 2017 a decision was made at the HM Court and Tribunal Service that Mr B was no longer entitled to employment and support allowance as he had not shown good cause for failure to attend or submit to a medical examination. He could continue to claim job seeker's allowance.

4.79. On 1st February 2017 patient records note that a GP attended a multiagency meeting at the surgery with staff members from A&H and LCCH. The following concerns in relation to Mr B are recorded: his lack of engagement and denial of any physical and mental health problems; walking at night and sitting on a bench outside a local supermarket with people giving him food and sugary drinks; unkempt clothes and reports that he is soiling in the bath at home; his home being still a mess despite council-funded deep-cleans; leaving cat food in a bowl despite a cat dying many months previously; not attending his employment and support allowance assessments so his welfare benefits would be stopped; refusing to attend a return to work course. Mr B had had a capacity assessment and been deemed to have capacity. There is no date recorded as to when this assessment was undertaken and in what context within the GP's electronic patient record. The outcome from the meeting from a GP perspective

was to refer Mr B back to the Community Mental Health Team for a further assessment and consideration of his mental capacity. A copy of this referral exists in the electronic patient record detailing the above concerns along with another GP requesting a further assessment regarding Mr B's capacity and whether a multi-disciplinary team approach regarding his ongoing condition should be undertaken.

4.80. On 14th February 2017 with L&Y records note liaison between the Dementia and Mental Health Liaison Team and the Community Mental Health Team regarding deterioration in Mr B's situation. There was liaison with the social worker for information about assessments she had completed with Mr B and any other concerns. Referral was made for an Approved Mental Health Professional to arrange a mental health assessment with a view to Mr B being admitted to an inpatient ward; concerns were expressed about his memory, not engaging with any form of cognitive assessment as the rationale. It was noted a warrant might be required to gain entry to his home.

4.81. On 23rd February 2017 L&Y records note discussion between the Dementia Team and Mr B's community mental health nurse following re-referral by the GP. The entry on the record reads as follows: "*DS has long standing issues with housing conditions and vulnerability. His property is in a very poor state - reports of him defecating in the bath and leaving food out for a cat that died several months ago. Mr B is well known to LCC Housing department as well as police. He is well known in the local area and will spend a lot of time walking between local supermarkets. There is a local Facebook page that has commented about his appearance and concerns by local people. He has a history of drinking but not thought to be current issue. It has not been able to assess him cognitively. Social services and GP asking for assessment again - agreed to call out ad hoc today and try catch Mr B at home or out about. Tried home address first - Mr B was at home - very brief assessment. Mr B has substantial beard growth and looked very dishevelled - his clothes were very dirty and flat entrance was in a poor state - he was not obviously intoxicated - he denied any problems with his mood or mental health but could not recall meeting or seeing [named practitioner] before. He then closed the door asking us to go away*." There was discussion as to whether a more assertive approach was required by the Community Mental Health Team. This was to be discussed with the consultant at a forthcoming MDT meeting, to explore whether use of the Mental Health Act 1983 might be more appropriate than continued efforts to engage by a community mental health nurse.

4.82. DS was seen on 8th March 2017 in the GP practice. He attended for a repeat sick note and stated he was due to be seen by community mental health on 10th March in his own home. GP3 noted at the time that Mr B was unkempt.

4.83. On 14th March 2017 LCCH records note that the GP had requested a further assessment. On 16th March L&Y records indicate there was an attempted assessment by a consultant. In a subsequent email to a consultant in the Older People's Mental Health Service, it is stated that: "*It's been impossible to engage him in any kind of assessment in the community – myself [consultant], [named] community mental health nurse and [named] dementia liaison practitioner have all been trying to see him but he refuses to speak to us or let us into his house*." A plan was put in place for a Mental Health Act 1983 assessment.

4.84. On 23rd March 2017 L&Y records note a further attempted assessment by the same consultant, this time with a social worker/Approved Mental Health Professional.

There are detailed consultant notes of this encounter, as follows: "*Mr B took some time to answer the door and, as before, was very uncooperative, refusing to let us in and reluctant to speak to us at all, repeatedly asking us to leave; insists he is fine. Says he is looking after himself well and has no problems. Doesn't agree that people in his neighbourhood are concerned about him. No recollection of seeing me before, can't remember the name of his social worker although stated "that's right" when told of this. Wouldn't answer other questions from me. Remains extremely unkempt, long dirty hair, beard and nails, stained clothing unchanged from previous visit last week, house from what we could see dirty with piles of rubbish/papers. Did engage a little better with questions from [named] social worker although still uncooperative, would answer briefly but then suddenly shout "is that it? Can you go now?" When asked by [social worker], stated he did not like speaking to doctors but would speak to [social worker] on his own if he visited again. When asked directly by [him] if he would accept another deep clean of his property and other support at home stated that he would (not clear whether he meant this or just wanted us to leave). Impression - limited information to go on. Some lability in affect with explosive outbursts but doesn't appear overtly depressed. No clear evidence of psychosis. Does appear to have some cognitive impairment which may indicate an early dementia but is uncooperative with assessment. He is certainly at significant risk of self-neglect and harm to his own health but this appears to be relatively longstanding for last few years (albeit was not like this ten years ago when attending appointments at [named location] with [named doctor's] team). Would warrant further assessment of his mental state in hospital. Refusing informal admission or community psychiatric input; however apparently agreeing to further social worker input, a deep clean and potentially care package. This may address the risks of self-neglect and harm to his health (if he does indeed accept this). Would be worth exploring this before concluding that attempts at community treatment have failed and that he requires detention under MHA. Plan – no recommendation made for detention today. [Named] social worker will try to visit again next week. If Mr B does not accept any input from social services in the community then at that stage there will be no alternative to inpatient assessment - will organise further MHA assessment as needed*."

4.85. In April 2017, Mr B's case was transferred from A&H neighbourhood services to A&H Mental Health for more specialist involvement.

4.86. On 5th April 2017 the housing support officer circulated Facebook comments and requested an updated capacity assessment from A&H. L&Y records indicated that the comments had been posted by a member of the public, Mr B having been seen defecating in public. A communication between a community mental health nurse and social worker agreed that they would each attempt to visit him and discussed his deteriorating presentation. Attempts were documented on 7th and 12th April without success.

4.87. On 10th April 2017 Mr B was discussed in a MDT meeting with the consultant present. It is documented in L&Y records that due to poor engagement with community services, ongoing risks of exploitation and self-neglect, Mr B was due a further Mental Health Act assessment that week.

4.88. On 10th April 2017 A&H Mental Health recorded that the Community Mental Health Team made a home visit. The home was relatively clean, with evidence of food

and recent change of clothing. In addition it was established that a neighbour was providing informal support daily (i.e. lunch).

4.89. A multi-agency meeting was held on 26th April 2017 but WYPS and A&H staff did not attend. It was noted that Mr B's circumstances had not changed since LCCH first opened the case in 2013. He remained unwilling to engage. It was agreed that LCCH would send a final appointment letter.

4.90. On 3rd May a worker from the Community Mental Health Team made an unsuccessful home visit. Mr B was not at home again on 9th May but was found at the local supermarket. He was visited at home the following day and offered support with benefits.

4.91. On 5th May 2017 due to lack of engagement with the social worker, the case was formally transferred to A&H Mental Health (Community Mental Health Team) for more specialist involvement.

4.92. On 5th May 2017 a Housing manager requested a social care assessment (section 9, Care Act 2014) from A&H. This appears to have resulted in an agreement to organise cleaning and assist Mr B with welfare benefits. On 11th May the annual Housing visit took place.

4.93. Following the Mental Health Act 1983 assessment in March 2017 it appears that Mr B may have engaged since, on 12th May 2017, L&Y records contain an email to the consultant, social worker and dementia & mental health liaison practitioner suggesting that Mr B could be discharged by the community mental health nurse. He was said to be engaging with the social worker. The Dementia and Mental Health Liaison Team also discharged Mr B.

4.94. Discontinuation of benefits resulted in a deterioration being identified in Mr B and he was referred back into mental health services on 9th June. On 12th June Mr B was at home and was offered support to call DWP. Mr B refused support but agreed to another visit the next day, when he was supported to contact DWP. The Community Mental Health Team worker agreed to liaise with the GP for a sick note. Finances in general were discussed and Mr B showed no evidence of lacking capacity in relation to this. He agreed to a referral to Irish Health & Homes for outreach support. Once benefits were reinstated he was once again discharged from the Community Mental Health Team.

4.95. On 19th June 2017 the social worker in the Community Mental Health Team referred Mr B to Leeds Irish Health and Homes (LIHH) in order "*to resist community pressure to have Mr B removed as he is deemed a nuisance outside [the local supermarket*)". LIHH followed this up with the social worker on 26th June, learning that Mr B was deeply distrustful of authority figures. LIHH had a waiting list.

4.96. On 8th July 2017 A&H advised LCCH that it was suspected that Mr B was making a lifestyle choice.

4.97. On the 12th July 2017 it is recorded in WYPS and GP patient records that Mr B had been seen in the community by a Police officer. The officer had enquired if Mr B was ok, Mr B responding that he was "*a bit chesty*". The officer asked if he needed help

or an ambulance, Mr B responding no. The officer contacted the GP Surgery. An appointment was offered at the surgery for later in the month. L&Y records indicate concern being expressed by WYPS to the Community Mental Health Team about his physical health. An MDT meeting discussion is referenced.

4.98. On 13th July 2017 A&H Mental Health Team recorded two visits. The first did not find Mr B at home or in known locations. He was at home when visited later.

4.99. On 24th July 2017 Leeds Irish Health and Homes (LIHH) were able to allocate Mr B's case but when a LIHH staff member saw Mr B outside the local supermarket with the social worker on 28th July he refused to engage with their support services. L&Y records note that he agreed for LIHH to remove some rubbish and to clean kitchen.

4.100. On 27th July 2017Mr B refused to attend an arranged GP appointment with a Community Mental Health Team worker. The GP was informed. The following day a home visit with Irish Health and Homes was successful, enabling them to undertake an assessment. Support with tenancy, domestic tasks and personal care was discussed.

4.101. On 7th August 2017 a Community Mental Health Team MDT discussion took place with the community psychiatrist about concerns regarding Mr B's personal care. It was agreed that not all least restrictive options had been tried and to see if Mr B would first engage with Irish Health & Homes before considering a Mental Health Act assessment.

4.102. On 10th August 2017 A&H Mental Health Team report that Mr B was seen outside the local supermarket. On 15th August an LIHH staff member and social worker visited Mr B at home and tried to clean some of his property which was in a poor condition. On 18th August there was a home visit as Mr B was not accepting support from Irish Health and Homes.

4.103. Also in August 2017 the local authority cut back a privet hedge that was blocking a public ginnel.

4.104. On 5th September 2017 the LIHH staff member visited again with the social worker to try and support Mr B to clear some rubbish. Mr B was "*not in the mood*" and asked them to leave. He agreed they could return at a later date. Mr B had not yet signed a consent form. The LIHH staff member and social worker planned a further visit on 23rd October but this was cancelled.

4.105. On 15th October 2017 WYPS investigated Mr DBfor urinating in a public place and took no further action after enquiries.

4.106. On 16th October 2017 the Outreach Team[9] advised LCCH that they had received several enquiries about Mr B.

4.107. On 26th October 2017 A&H Mental Health recorded another visit again to challenge Mr B regarding his engagement with support. Mr B agreed to accept and

[9] A team of outreach workers delivers street-based support to people who are rough-sleeping or begging anywhere in the Leeds area. The support addresses issues such as homelessness, mental/physical health, substance misuse, benefits and offending behaviour, and takes place during unsociable hours in order to maximise its reach.

engage in support. On 13th November the consultant psychiatrist at an MDT meeting agreed to a planned Mental Health Act assessment. There followed one further visit to attempt to persuade Mr B to accept support.

4.108. On 17th November 2017 a Mental Health Act assessment took place at Mr B's home. L&Y records contain the following entry: "*I believe he does meet the criteria for admission to hospital for a period of assessment under s2 of MHA. Adamantly declines inpatient admission and has not engaged in any attempts to assess/treat him in the community. Alternatives to admission such as putting in a social care package to address the risks of self-neglect have failed. Second doctor believes given Mr B's statement that he would accept a clean of his house that he should be given time to see if he will engage with this. History suggests he won't - we had a Mental Health Act assessment with a similar conclusion several months ago and there has been no progress in putting in any social care interventions. However, no recommendation made for admission today. Plan - will reconvene for further MHA assessment if/when he fails to engage with further attempts to address the risks of self-neglect in the community.*" L&Y records also note that the consultant suspected that Mr B had alcohol-related cognitive impairment, was in poor physical health and at high risk of self-neglect. Repeated concerns from councillors, WYPS and the public are noted as is his habit of sitting outside a local supermarket and asking for food. He was very unkempt, is refusing to engage and is rejecting help from his GP and Housing. His benefits have stopped and eviction was possible because of the condition of the property.

4.109. On 23rd November 2017 a further Mental Health Act 1983 assessment resulted in Mr B's admission to hospital under section 2[10]. L&Y paperwork for admission contain the following entry: "*B was known to mental health services with a history of anxiety and depression. There have been concerns over his mental state and severe neglect. Mr B has been living in squalor condition for many years. He has also been consistently refusing to accept help with his house which is in a dire state. During assessment, Mr B admitted that he suffered from depression and anxiety in the past and that he had experience auditory hallucinations. He, however, is adamant that he is fine and that he is not suffering with depression. He denies any problems with his sleep or appetite. He somehow recognises poor state of his house but admits lacking motivation to change or seek help. He appeared very unkempt with dirty clothes. His house is nearly unliveable state. His only concerns are about him not receiving his benefits money. There are concerns that his cognition is declining and this needs to be assessed. He seems to be depending upon others' generosity for his food. He has recently refused to go to general hospital when there were concerns regarding his physical health. Looking at his dosette box, he is either non-concordant or taking more than prescribed medication. His current state of living is thought to be due to underlying depression or cognitive impairment. Hence, Mr B needs a period of assessment in hospital and he became loud when hospital admission was mentioned to him. This admission is necessary to prevent further deterioration in both his physical and mental health; he seems to lack insight and capacity to consent to voluntary admission.*"

4.110. On 24th November 2017 a mental capacity assessment noted: "*DS was able to understand the concerns regarding his mental state and the rationale for the inpatient admission under the MHA; he was able to retain the information as detailed above; he*

[10] A&H Mental Health records indicate that the first medical recommendation was signed on a visit on 20th November. A full application to detain was made on 22nd November.

lacked insight into his mental state, he stated he was not unwell in his mental state and minimised the concerns regarding his state of self-neglect; due to his lack of insight he was unable to weigh in the balance the risks and benefits of a continued admission and the treatment plan". L&Y records contain the practitioner's conclusion following this assessment, namely that Mr B did not have capacity to consent to admission and the ongoing treatment plan.

4.111. On 28th November 2017 the housing support officer requested an urgent case conference.

4.112. A Care Programme Approach meeting was planned for 12th December 2017 to discuss his admission and his future accommodation and care needs. In the CPA Wellbeing Recovery Plan, held by L&Y, it states that: "*DS is currently detained under section 2 of the MHA. He is aware of his detention and aware of his rights. Since admission it has been deemed that Mr B does have capacity*." LCCH records indicate that A&H funded laundry and a deep clean, and that Mr B was complaint with medication, treatment and nutrition in hospital. LCCH records note advice that Mr B was alcohol dependent but that there was no evidence of mental illness. Reablement and an occupational therapy assessment were planned, along with support from LIHH.

4.113. On 12th December 2017, following a telephone call from the social worker, the LIHH staff member visited Mr B on the hospital ward to arrange support post discharge.

4.114. On 15th December 2017 LCH received a referral from a GP for podiatry, Mr B's nails being described as black and overgrown. He received an appointment for 25th January 2018.

4.115. Mr B was discharged from psychiatric hospital on 18th December 2017 following a few days' home leave. L&Y records note that he was settled in mood and mental state, pleasant with staff. The discharge summary sent to the GP states that Mr B underwent a period of assessment for his mental health whilst on the ward; there was found to be no evidence of mental illness. Chest X-ray and head CT scan found that no acute medical treatment was required. He was diagnosed with mild cognitive decline secondary to alcohol misuse. The assessment concluded that Mr B improved in terms of his personal care with prompting; he was discharged from the Section 2 but remained as an informal patient prior to his discharge. Upon discharge the enablement team were due to visit every afternoon for six weeks. The discharge meeting was attended by Mr B's social worker and community mental health nurse. The social worker advised that Mr B's property had been cleaned by the council and it was therefore appropriate for Mr B to be discharged back to the community with Community Mental Health Team follow up.

4.116. A discharge risk assessment was completed prior to discharge. The outcome as recorded in L&Y records contains the following entry: "*No signs of depression mood, Mr B denied depression. Concordant with medication. Memory issues related to previous alcohol misuse. Diagnosis of COPD, refused NRT and deemed to have capacity to make this decision. Susceptible to infection in the past due to severely neglected home. Home deep cleaned and now suitable to live in – new bed purchased, and deep cleaned. Care co-ordinator in place to provide 7-day follow-up. Hygiene improved, states Mr B was prompted by staff to tend to personal care and staff assist him in maintaining his bedroom. Nutritionally, ate and drank well on the ward. Further risk*

assessment needed, and discussion with MDT. Referral to dentist, dietician and podiatrist."

4.117. On the day of discharge the social worker and the mental health practitioner conducted a joint home visit. Mr B was more kempt, but it was cold in his flat, with one oil heater. The gas was still capped. Only the lounge and kitchen were seen. Mr B agreed to purchase an oil heater and two bins. It was planned to see him on follow-up visit later that week with joint visits to continue.

4.118. On 19th December 2017 the social worker visited. Mr B was happy to be at home. An oil heater and bins had been delivered.

4.119. On 22nd December 2017 the LIHH staff member visited Mr B at home. His home looked better, having been deep cleaned. He was not interested in attending a lunch club.

4.120. A planned joint visit on 29th December 2017 by the social worker with a Community Mental Health Team practitioner was postponed because of severe weather. Mr B could not be contacted on his mobile. A further visit on 4th January 2018 was postponed as the social worker was not available and it had been agreed that visits would be joint visits.

4.121. A&H Mental Health records note a home visit on 5th January 2018. The home was tidy, however Mr B's appearance was unkempt. He was supported to purchase a TV.

4.122. On 17th January 2018 the local pharmacy expressed concerns to the GP practice about Mr B's change in behaviour; Mr B had urinated in the pharmacy. The pharmacy reported Mr B had recently been in hospital because of his mental health and had been discharged. The GP practice did try to contact Mr B but with no response.

4.123. On 25th January 2018 L&Y send a discharge letter to the GP. The letter stated that there was no evidence of mental illness but mild cognitive decline due to alcohol misuse. A CT scan had revealed mild cerebral atrophy with small vessel ischaemia in keeping with previous alcohol excess. Mr B denied being mentally unwell but was said to have recognised his state of neglect. The discharge summary also refers to a history of cannabis use and to gastritis and oesophagitis secondary to alcohol abuse.

4.124. A&H Mental Health records for 28th January 2018 note that the allocated worker was on extended leave in February. The Community Mental Health Team and Mr B's care coordinator were aware.

4.125. On the 29th January 2018 the pharmacy once again expressed concerns to the GP practice about Mr B. Mr B's hands had been observed to be engrained with excrement and he was described as very unkempt. The GP did attempt to make contact with Mr B but again there was no response. An urgent referral was made back to Community Mental Health on 31st January 2018.

4.126. On 7th February 2018 the LIHH staff member sent a St Patrick 's Day card requesting Mr B to make contact.

4.127. On 8th February 2018 A&H records contain an entry by an area worker that Mr B was looking unkempt again. This does not appear to have triggered a response.

4.128. On 15th February 2018 a visit by the Community Mental Health Team practitioner was unsuccessful in seeing Mr B.

4.129. On 21st February 2018, in the absence of Mr B's allocated worker from A&H Mental Health, who was on extended annual leave, another social worker from the Mental Health Unit visited Mr B. No information about the content of this visit has been provided to the review.

4.130. On 22nd February 2018 L&Y records note a visit to Mr B by the Community Mental Health Team practitioner, a previous visit on 15th February having been unsuccessful. The social worker was on annual leave. Mr B's flat was in poor state, he was dishevelled, there was no food in fridge, which was mouldy and dirty, and there was no adequate heating. His feet were in a poor state but he denied that they were painful. His engagement was superficial and he became agitated when questioned. There was evident self-neglect. Compliance with medication appeared erratic. Due to concerns the Community Mental Health Team practitioner contacted Mental Health Social Work duty and were advised a social worker had seen Mr B only yesterday.

4.131. On 23rd February 2018 the LIHH staff member saw Mr B at home. He did not look well, was very unkempt and appeared to be regressing. He declined regular visits. The staff member planned to discuss the case in supervision.

4.132. On 28th February 2018 there was a discussion between the community mental health nurse and the social worker about the state of the property, the issues being seen as chronic rather than acute. The nurse planned to visit again. In the absence of the allocated worker the A&H Mental Health records note that another worker visited the home on 28th February.

4.133. Bad weather on 1st March 2018 meant that a planned visit did not occur. There was no answer when Mr B was called on his mobile phone by the community mental health nurse. The following day the A&H Mental Health records contain an entry that Mr B was outside the local supermarket and refusing to come inside. The note states that Mr B had capacity.

4.134. On 8th March 2018 Mr B was found collapsed by a local shop and admitted to hospital via Accident and Emergency. His feet were found to be gangrenous. The following day the community mental health nurse gave information about Mr B's case history, including the difficulties with engagement, to ward staff. Mr B died in hospital on 10th March 2018.

5. THEMED ANALYSIS

The following section addresses the learning that arises from the SAR reviewers' integrated analysis of the information submitted by agencies and the perspectives of practitioners and managers who attended the learning event. This learning is mapped against markers of good practice constructed from research evidence on self-neglect and from the extensive body of learning from SARs in which self-neglect is a feature. Thus it compares what took place in Mr B's case with the available evidence on 'what good looks like'[11].

The good practice model (which is located for reference at Appendix 1) comprises four domains, each comprising a number of elements. These are used to structure the analysis that follows:

- Domain A: Direct work with the individual;
- Domain B: The work of the professional team around the individual – communication and case coordination between those involved;
- Domain C: The organisational contexts within which the work of the professional team takes place;
- Domain D: The interagency governance infrastructure provided by the SAB.

5.1. Domain A: It is recommended that direct work with the individual shows the following features:

5.1.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes.

Agencies' demonstrated good practice in this regard in a range of ways:

a) L&Y note that staff often sought out Mr B in the local area if there was no answer at home. This was "*common practice*." LCCH also note that staff sought out Mr B in known local locations.
b) LCCH staff supported Mr B to attend the Job Centre on four occasions and the GP practice once.
c) After the December 2017 hospital discharge, the housing support officers engaged with Mr B on an almost daily basis outside a local supermarket.
d) A&H have acknowledged that during 2015, although it was well known that Mr B walked around the local area (the GP surgery had told the social worker that he could walk for miles), no attempt was made to find him. On 6th September 2016 a social worker did find Mr B at a local supermarket, and on 19th January 2017 searched for him there and locally.
e) A&H Mental Health have indicated that the allocated worker regularly explored the surrounding area, going to known places that Mr B would frequent, and that the worker tried where possible to arrange visits around Mr B's preferences, often after 4pm at his request.
f) WYPS, commenting on the work of PCSOs in neighbourhoods, state: "*This work by the NPT (Neighbourhood Policing Team) to engage with Mr B and*

[11] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice', *Journal of Adult Protection*, 21(4), 219-234.

other people in similar circumstances involves building a rapport with the person by talking with them, asking questions, establishing any needs or if there are any concerns and signposting them to appropriate services offered by partner agencies or third sector organisations."

g) WYPS also sought out Mr B when he was not at home. They comment: "*Mr B did not spend a great deal of time at his home address. Mr B's regular spot to sit in [named town] was on a bench outside [the supermarket] in view of, and less than 20 metres from, the front of [the town's] Police Station. He was seen most days when sat on his bench by everyone from NPT officers and patrol and response officers, who started or ended a tour of duty at the Police Station. When Mr B was not in his usual spot, he walked miles and had a regular walking route that took him past [another] Police Station, which resulted in officers and staff who worked from there having contact with him. An officer commented in interview that it was not difficult to find Mr B and that when other agencies could not locate him, the NPT would pass messages to Mr B from partner agencies to remind him of appointments, or assessments that had been arranged for him. The NPT would also relay messages from Mr B regarding his missed appointments back to the partner agencies involved. When police officers were requested to carry out welfare checks due to Mr B not being in his usual spot, or not at home when partner agencies were attempting to carry out visits, the necessary and appropriate enquiries were undertaken with neighbours and the Leeds Bed board*."

Despite the good practice noted above, at the learning event one theme explored was the challenge of "finding Mr B the person." Participants expressed the view that Mr B engaged in conversation on a superficial basis. Although he did build up relationships with some staff, there was insufficient emphasis on moving beyond pleasantries. There remained, therefore, a lack of knowledge about what were his "drivers." What was important to staff (such as hygiene) may not have been important to him. Changes of staff (the number of housing officers for example engaged with him) disrupted continuity.

5.1.2. A combination of concerned and authoritative curiosity, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills

a) The SAR referral information indicates that there were many GP attempts to contact Mr B via telephone, text, letters and through other professionals. However, apart from a home visit on 11th May 2016 in response to a failed telephone call, it is not clear that the GP undertook proactive follow up when Mr B did not make contact or attend.
b) There is evidence of empathetic concern for Mr B from many of the agencies who had contact with him, as well as from members of the public and indeed from the supermarket outside which he often sat.
c) While some agencies showed persistence in seeking to build a relationship there were changes of personnel (for example through transfers of his case between teams in both A&H and L&Y) that could have militated against the continuity that would have been important in building trust.
d) At the learning event those present offered several suggestions for getting to know the person and building a picture of how Mr B saw his world. Talking about animals, for instance, since Mr B had cats as pets; whether he saw his

house as a home, given the condition into which it had fallen; his work history as an Irish migrant to this country, what he left behind in Ireland, his experiences as an Irishman in Leeds in the context of an increasingly dispersed community.

5.1.3. When faced with service refusal, a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage

a) A&H has commented that throughout the period under review all professionals involved worked well together in trying to engage with Mr B in a way he found acceptable.
b) The agencies involved all responded to the immediate issues presented by Mr B's state of health and way of life, but their focus did not extend to seeking out information about his history, life experiences and cultural identity as an Irish migrant in the city, or engaging him in discussion about matters that could have cast light on what was influencing his behaviour. The focus of enquiry was placed primarily on mental health and mental capacity as possible causes and while of course those features were vitally important a more rounded picture of Mr B as a person through his history did not emerge. An example of this arose at the learning event, where discussion took place of the importance of engaging with Mr B's cultural heritage and experience in understanding his actions, particularly his habit of walking. For example, it was observed at the learning event that he may not have regarded "keeping house" as his responsibility. Going on long "rambles" may have been part of his cultural background and identity. LIHH were involved only late on in this case but if involved in earlier multiagency discussions could have offered support to Mr B and to staff working with him regarding his cultural identity, behaviours and isolation.
c) There are explicit statements in the chronology that Mr B was making a lifestyle choice. It is unclear how this determination was reached, on the basis of what evidence, particularly in the absence of mental capacity assessment (considered later in this analysis). At the learning event there was recognition that executive capacity is an essential consideration in self-neglect work. The question for the review is whether this repeated emphasis on lifestyle choice ultimately left him at significant and likely risk of harm.

5.1.4. A picture of the person's history and life experience

a) The CCG contribution on behalf of the GP practice notes that Mr B was "*not an easy historian in relation to his life*." The GPs were aware that he was separated from his wife but were unsure when this occurred. Other family dynamics were not known to the GPs.
b) L&Y also observes that he shared very little about his life. A 2004 assessment had recorded that he had split from his wife ten years previously and that he was at that time in contact with his daughters in London. This contact was subsequently lost for unknown reasons.
c) A&H also commented that it was difficult to obtain personal history because Mr B did not readily engage.
d) LCCH understood that he had been drinking heavily since his divorce.

e) A&H Mental Health knew that Mr B was originally from Ireland and had moved from London to Leeds over 20 years previously. During the Mental Health Act assessment no Nearest Relative was identified as it was established that Mr B was divorced and had two daughters thought to be living somewhere in Ireland but no contact details were available and Mr B could not provide any further information.
f) The WYPS NPT Team and response officers who worked from the local Police Station all knew Mr B as his regular "spot" was sitting on a bench outside the local Supermarket, which was very close to the local Police Station, chain smoking and watching the world go by. He was also known to walk miles during the day and had often been seen walking around the local area at all hours of the day and night. He was greeted daily by the NPT as they patrolled around the Town Centre. He was asked how he was and what he had been doing, as well as checking if he had food and money. One Officer did engage him in deeper conversation and Mr B told him that he was from Ireland, that his wife had died, that he had no family and that he used to drink, but no longer drank alcohol. This officer also formed the impression that Mr B was a proud man, not in the context of his appearance, or being house proud, but in being too proud to accept help. Mr B was not known to have any substance misuse issues but did smoke cigarettes.
g) One risk assessment (possibly February 2017 but undated) records Mr B as having been born in Ireland and as having worked installing TV cables in the Leeds/Bradford area.
h) A greater appreciation of his cultural background was gained at the learning event from LIHH and would have been very informative for those working with Mr B. This may have helped those involved to have made greater sense of his behaviour and to have engaged with him in ways that were meaningful to him.

5.1.5. Recognition of, and work to address, issues of loss and trauma in a person's life experience

a) Little was known about Mr B's early life, but what was known indicated some ruptured relationships – divorce and loss of contact with his two daughters as well as with wider family in Ireland. There does not appear to have been any focus on how these experiences might have affected him and/or shaped his behaviour.

5.1.6. Recognition of, and work to address, repeating patterns

a) There were four deep cleans in the time period under review, a repeating pattern of deep cleans followed by regression. This pattern, while securing some short-term improvement, merely continued a strategy that was not effective in securing change, but this did not appear to trigger reappraisal of the strategy.
b) There was extensive liaison between agencies, including many joint visits, many of which found Mr B absent but his doors unlocked. This did not appear to trigger a reappraisal of risk. The pattern of visits remains essentially the same until the November 2017 hospital admission. Following discharge, however, the pattern continued, with little effective contact being made.
c) DS's non-engagement was a repeating pattern and had been the reason for his discharge by mental health in 2005/6. The social worker had 8 unsuccessful

home visits between 14th April and 23rd July 2015, contacted the GP for support in making contact, and received concerns from a local councillor specifying where Mr B could be seen in the community and expressing concern about his drinking and wellbeing. This is a pattern that could have triggered a safeguarding enquiry or other form of multi-agency plan, well before the later decline in Mr B's health.

d) At the learning event it was observed that the basic plan throughout had been to get to the point where Mr B would engage and maintain contact, and that this plan was repeated, perhaps because it was unclear what an alternative plan might have been. Those involved were attempting to engage with Mr B on his terms. The learning here is that, where patterns repeat and cases appear "stuck" or "stalled", a detailed multi-agency risk assessment and mitigation plan is required.

5.1.7. Contact maintained with people who are reluctant to engage (rather than case closure) so that trust can be built up

a) LCCH (Housing Support) have commented that it was not their practice to close cases when there were concerns about welfare. That was their approach to this case, hoping that Mr B would engage. For the duration of their involvement in this case, there were five housing support officers and 3 housing officers, with case management history, handovers and internal discussions. There are numerous visits recorded by LCCH and other agencies, with attempts also to find him in his known local locations when he was not at home.
b) GPs saw Mr B on four occasions, three in the practice and one at his home.
c) LCH, considering non-attendance for podiatry in January 2018, commented that a person would be discharged following one DNA "*as per guidance*." It is not clear how much information LCH had about Mr B's situation, but if anything about his history or circumstances was known then clearly greater discretion might have been exercised to pursue this aspect of his care more proactively.
d) LCCH has staff guidance on no access and legal remedies.
e) The CCG has referred to BMA guidance being followed by GPs with three contacts attempted in response to DNA. The CCG also observed that the GP practice has its own adult safeguarding policy.
f) L&Y has guidance for staff on poor engagement and its DNA procedure now include communication with other agencies about risks.
g) WYFRS has stated that it refers non-engagement back to partners. Re-referral is encouraged if risk factors alter or increase. This means, however, that a case might be closed if the person fails to engage with partners also.
h) The A&H has stated that its workforce is well versed in dealing with people who are reluctant to engage. They are supported by policy and procedure as well as by colleagues (Team Managers/SARMS) in working effectively with people. It is acknowledged that one approach does not suit all and from the records it is clear in this case that multiple approaches were used to attempt to engage with Mr B.
i) WYPS maintained continuity through three neighbourhood police officers. Mr B was generally seen by the same Police officers and PCSOs. All the staff who worked from [the local] Police Station were aware of Mr B and took the time to greet him and engage him in conversation. There is clear evidence of

continuity of a relationship with Mr B. Additionally, there was consistency of one officer who was involved in making the referrals to A&H, liaising with partner agencies and attending the professionals meeting.

j) WYPS has guidance for officers in relation to non-engagement. Their contribution to the SAR states: "*In respect of adults who self-neglect, are reluctant to engage who and who do not enter the criminal justice system, the West Yorkshire Police Safeguarding Vulnerable Adults Policy 2015 states that Officers and Staff must be confident about: identifying vulnerable adults from the first point of contact; recognising situations and specific risk factors that influence vulnerability; and responding appropriately, whether this is to prevent further abuse or investigate an incident. This includes identifying adults who don't fit the definition of a vulnerable adult and fall outside of this procedure, e.g. adults who self-neglect*." "*It should be recognised that where non-engagement exists, this may prompt a withdrawal of services and support from agencies attempting to be involved. However, non-engagement should be seen as a heightened risk factor and prompt more persistence with engagement*." "*In Mr B's case, his non-engagement did not deter NPT officers or other Police officers from persisting to engage and help Mr B and obtain his consent to make referrals to partner agencies that could assist him such as A&H or Health Agencies*."

k) On 15th December 2015 the A&H social worker closed the case as Mr B had not engaged and he was deemed to have capacity. This decision does not appear to have been discussed with other agencies. In light of repeating patterns, this is questionable practice. On 18th April 2016 A&H took no further action after a neighbour expressed concern. There was no reappraisal of the case; it was assumed the situation was as before and well-known. Again this was questionable practice.

l) At the learning event, it was observed that some people and cases need more time spent on them, and that this was a supervision and management issue, but tightly regulated and very busy statutory services might not always offer the required flexibility to look at the "bigger picture", withdrawing when they have "done their bit."

m) Thus, a mixed picture emerges. Some services went beyond normal protocols in an attempt to support Mr B, such as Housing not taking enforcement tenancy action. Others followed their normal procedures.

5.1.8. Comprehensive risk assessments, especially in situations of service refusal

a) WYFRS received a referral from Housing Leeds on 23rd June 2016 but Mr B could not be seen until 10th October. Even allowing for the fact that Mr B could be hard to find at home, this delay seems not to account for the risks within his situation. And while at the visit Mr B declined the offer of fire-retardant bedding, there appears to have no attempt to pursue this further with him at a future point.

b) LCCH observe that the gas meter had been capped for several years but it is unclear whether this was because of debt or customer choice. A gas engineer did not reinstate the heating on 13th December 2017, prior to Mr B's discharge from hospital, because of the cap. This was apparently discussed with the social worker but no follow-up appointment was arranged or further action agreed. This was a missed opportunity.

c) By the time of the risk assessment for hospital discharge on 18th December 2017 Mr B was an informal patient. The risk assessment states that there was no evidence of a history of significant risk behaviour, which in the context of the case seems a surprising judgement. The assessment records significant risk of severe self-neglect and nutritional neglect, and high risk of relapse. It records low risk regarding his physical condition, wandering, exploitation by others and polypharmacy. Some of these judgements seem surprising also, especially given he was diagnosed with COPD and had rejected nicotine replacement therapy for his smoking and was recognised as having a history of severe self-neglect, domestic risk, wandering and alcohol abuse. It notes that, prior to a deep clean, his accommodation had been ill-suited, which had rendered him susceptible to infection. It records social isolation, dehydration risk and concern expressed by others. It notes that his hygiene had improved since admission but that he sometimes needed prompting and assistance. It observes that he had memory problems but no sign of depressive mood. 7-day follow-up by the community mental health nurse was recommended but, as the chronology reveals, this did not happen. Further risk assessment and MDT discussion were recommended.

d) A further risk assessment is dated 22nd February 2018. It largely repeats the December 2017 assessment, for example keeping unchanged the assessment of significant and low apparent risks. However, it notes that there was a history of significant risk behaviour and that severe self-neglect was both historical and current. It states that his accommodation was showing signs of relapse following the earlier deep clean but the action plan does not seem to have addressed this sign of deterioration. The assessment notes that Mr B was continuing not to engage. A further risk assessment and an MDT discussion is recommended, again as before.

e) A partially completed risk assessment and management tool has been submitted for the SAR. It is undated but may have been completed around February 2017. The RAG risk rating template is blank. It appears that the social worker, GP, housing support officer and Dementia and Mental Health Liaison Team practitioner may have contributed. Immediate concerns are set out, along with some mention of the cumulative pattern of the risks identified. He was assessed as making unwise decisions and as having full capacity regarding his care needs. The risk assessment concludes with decisions that the GP would refer him back to the Community Mental Health Team for reassessment, WYPS would conduct welfare checks and Housing would support him.

f) He was assessed as borderline diabetic in December 2016 but there is no reference to a planned referral to a diabetic nurse having been followed through.

g) L&Y and A&H staff discussed the case following relapse after the December 2017 discharge. A&H saw the situation as a long-standing problem, not requiring an acute response. Without a reappraisal, this seems complacent, and raises questions about the level of understanding about self-neglect.

h) The absence of gas/heating was a risk factor throughout but especially when discharged from hospital in December 2017 and the advent of bad weather that prevented home visits. It was only partially dealt with when Mr B agreed to buy a heater. The social worker did not follow through on the absence of gas with the utility company/social housing.

i) The Mental Health Mortality Case review gives "*good care*" for risk assessment and for care during admission, and "*excellent care*" for the initial review in hospital (November/December 2017) but only "*adequate care*" for ongoing care and "*poor care*" for discharge and overall.
j) The theme of recognition and management of risk was explored in some detail at the learning event, with particular focus on whether explicit risk management agreements were made and followed through, and whether there was sufficient management oversight of the risks in this case. Feedback indicated that a lack of understanding of self-neglect was one barrier; another was the erratic contact with Mr B, which contributed to the difficulty in conducting assessments; a third was that Mr B could become angry when staff attempted to raise concerns, when sometimes the only option appeared to be to withdraw.

5.1.9. Where possible, involvement of family and friends in assessments and care planning

a) In the time period under review there was no contact with any member of Mr B's family.
b) There was occasional contact with neighbours who appear to have been looking out for him, leaving him food and aware that he was often out.
c) From the learning event it emerged that people in the community were known to like him and were concerned about him. On occasion it appears that people became frustrated with him, for instance when he would throw away food given to him outside the supermarket. It is not clear that the potential for a more organised community support strategy was explored.

5.1.10. Exploration of family dynamics, including the cared-for and care-giver relationship

a) This was not a relevant consideration here, given Mr B's absence of family contact.

5.1.11. Thorough mental capacity assessments that include consideration of executive capacity

a) While Mr B was in hospital in November and December 2017 the L&Y records state that he was first assessed as not having capacity in relation to his admission and treatment. By mid-December there is mention of him being deemed to have capacity, but it is not clear that this is the result of a capacity assessment. There is no indication that a capacity assessment was undertaken prior to his discharge.
b) The L&Y records do not contain any assessment of the implications of his diagnosed "mild cognitive decline secondary to alcohol excess" for his decision-making skills following discharge. There is no apparent consideration of executive capacity.
c) The LCCH contribution to the SAR states that housing staff are not qualified to carry out mental capacity assessments.
d) The LCCH contribution to the SAR records a mental health assessment in July 2016 that assumed Mr B had capacity with no major mental health issues other than memory problems.

e) The L&Y contribution to the SAR records repeated attempts to assess capacity but that Mr B was repeatedly unwilling to engage. It might have been expected that discussion of referral to the Court of Protection or to the High Court (Inherent Jurisdiction) would take place.
f) The CCG found no evidence in the GP patient record that Mr B lacked capacity and no evidence that the GP practice carried out a mental capacity assessment as this was "*not indicated*."
g) The responses provided by A&H confirm that mental capacity was considered at each contact with him and also considered in discussions with other professionals within the agencies involved during this time.
h) The A&H Mental Health response observed that in November 2017 a statement of capacity was completed whilst Mr B was detained under the Mental Health Act 1983 and at that time the consultant on the ward had indicated that Mr B was assessed as suffering from depression. The specific question was in relation to Mr B's capacity in relation to deep cleaning his home and returning to live there following discharge. It was recorded that Mr B had capacity and was willing to allow a deep clean and accept support post discharge.
i) WYPS has stated that officers did not carry out any assessments of Mr B's mental capacity. Officers were aware of four findings by other agencies that he had capacity (for what is not specified by WYPS). "*From engaging Mr B in conversation, one officer stated that Mr B knew where he was, where he had been, where he was going, what he was doing and that he knew and remembered the NPT Officers that regularly patrolled the neighbourhood town centre. Although, these conversations were not assessments of Mr B's mental capacity or health, he did present as orientated and alert with the NPT Officers. Combining the knowledge of the previous mental capacity assessments that had deemed Mr B to have mental capacity and his day to day engagement with NPT Officers, there was an assumption that Mr B had capacity to either refuse or accept assistance and support from West Yorkshire Police and the other agencies he was in contact with*."
j) In a written communication to WYPS the community mental health nurse had presumed capacity in July 2016.
k) There remains the question of what is, and what did those involved understand by, "*mild cognitive decline*" associated with alcohol misuse. It is unclear whether this was viewed as evidence of alcohol-related brain disease, and whether the impact on his executive capacity was considered.
l) Mental capacity assessment was a theme explored in detail at the learning event. Amongst the views expressed were the need for greater understanding and more nuanced assessments of capacity, especially executive functioning in cases where people's expressed determinations are not followed through in their behaviours. A wider recognition of individuals' previous experience on their behaviours, mental capacity and decision-making was seen as advisable. It was acknowledged that the appointment of an Independent Mental Capacity Advocate might have been helpful in this case, and that referral to the Court of Protection could have been considered as a response to the repetitive concerns about self-neglect.
m) This case illustrates a key challenge in adult safeguarding, namely how to strike the balance between respecting autonomy and keeping someone safe. Depriving Mr B of his liberty in order to keep him safe might not have been a proportionate intervention but equally it was hard to assess his cognition

because he would not keep appointments and the risks consequent on where and how he lived were significant. At such times, multi-agency planning, informed by consideration of all legal options, including referral to either the Court of Protection or the High Court, is essential.

5.1.12. Careful preparation at points of transition, for example hospital discharge and placement commissioning

a) L&Y observe that discharge planning in December 2017 did not appear to have included any action relating to the gas being capped and there being no hot water in the accommodation.
b) There is no indication in the hospital notes that a formal mental capacity assessment regarding his self-care was undertaken at the point of discharge.
c) Plans for joint visits by the social worker and Community Mental Health Nurse following the December 2017 discharge were not followed through because of severe weather and annual leave.
d) There was an OT assessment on the ward, dated 8th December 2017, which concluded that Mr B required minimal support to shower and was independent in cooking. He was able to structure his time and routine. It was concluded therefore that there was no need for a home assessment. Given that hospital wards add to a patient's routine and given the case history, this seems to have been a missed opportunity to assess Mr B in his home environment.
e) The CCG concluded that the GPs were not directly involved in discharge planning for Mr B. A preliminary discharge letter was received from L&Y dated 15th December 2017 indicating medication change. A comprehensive discharge summary was sent to the GP surgery, dated 25th January 2018, following his discharge on 18th December, quite a delay. There were no identified actions for the GP in the discharge plan.
f) The hospital discharge plan in December 2017 appears to have included enablement team visits daily for six weeks but this did not happen. The plan also appears to have envisaged support by Irish Health and Homes but there is no record of a visit between 22nd December 2017 and 23rd February 2018. The discharge plan does not appear to have been revisited.
g) The Mental Health Mortality Case Record Review is (rightly) critical of the discharge to a property without hot water in December and the four week gap between visits (due to snow and annual leave). In the context of known living conditions and likely relapse, this criticism seems appropriate.
h) Assessment prior to discharge concluded that there was a significant risk of self-neglect and nutritional risk but a low risk of physical health deterioration. The contingency plan was social worker, community mental health nurse and Emergency Duty Team contact. This contingency plan is not activated and there was no meaningful plan to mitigate the assessed risks.
i) Hospital discharge and subsequent events were a key theme explored at the learning event. It has already been noted that the discharge plan was not followed through. It was observed that Mr B was cooperative when in hospital, agreeing to remain after the mental health section expired and consenting to improvements to his accommodation. Greater attention might have been given in discharge meetings to contingency planning, given that the history of the case would have suggested the likelihood of risks returning and escalating.

5.1.13. Thorough assessments for care and support, care plans and regular reviews

a) A&H have advised that on 9th September 2015 a support assessment was carried out, with referral to Positive Pathways (a support agency that supports people who are having difficulty managing where they live due to issues connected to their mental health). Positive Pathways responded by advising they could not support Mr B because he had not been formally diagnosed with a mental health issue. There is no evidence that the plan was revisited.
b) In June/July 2016 Reablement was discussed and offered to Mr B, initially being accepted but then later declined.
c) In February 2017 a supervision discussion in A&H resulted in a recommendation to carry out a Risk Assessment Management Tool together with the community mental health nurse. This record remained in draft to enable alterations to respond to Mr B's changing circumstances due to the difficulty engaging with him.

5.1.14. Thorough mental health assessments and care planning

a) LCCH staff raised concerns about Mr B's welfare and requested mental health assessment from the GP. A social worker is also recorded by LCCH as requesting a mental health assessment from the GP. In both instances the GP indicated that consent from Mr B was required. This would not have been the case if a Mental Health Act assessment was being suggested. This raises questions about whether there was sufficient clarity about what was being requested.
b) L&Y were responsive to requests from other agencies to become involved in assessing Mr B's mental health and in providing him with ongoing support. On most of the occasions on which Mr B's mental health was assessed, including assessments under the Mental Health Act 1983, the outcome was to maintain a 'least restrictive alternative' approach, continuing with attempts to secure support in the community. This remained a pattern during 2017, until November when the lack of any progress resulted in admission under section 2 of the MHA.
c) Around 12th December 2017 there appears to have been a CPA meeting and action plan, followed by a hospital discharge. Given the history and known risks in this case, more assertive follow-up may well have been appropriate.
d) The rationale for the November 2017 admission has been stated by A&H Mental Health as follows: "*There have been concerns over many years about Mr B's self-neglecting behaviour and the condition of his property. Mr B has refused to engage with any support offered even though he recognises the need to sort out his flat. There have been queries whether Mr B's lifestyle is due to a depressive illness or a dementia type illness related to history of alcohol use or a more progressive type of dementia. What is certain is that without a proper assessment Mr B will soon be evicted from his home and given his poor physical health there are genuine concerns he will not last the winter. On the 23rd November Mr B was willing to come into hospital but I believed once on the ward he would have if informal made attempts to leave the ward especially when restricted from smoking and I did not feel this was appropriate. Therefore an application under section 2 was completed*." Mr B in fact remained on the ward following the expiry of his section 2 detention, demonstrating a degree of compliance with treatment and care that could

perhaps have been more effectively transferred to the community with more proactive post-discharge follow up.

5.2. Domain B: It is recommended that the interprofessional team around the individual shows the following features:

5.2.1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker

a) Despite the extensive liaison between agencies that took place, no lead agency or key worker to coordinate efforts was appointed.
b) There was a practice of joint visits involving LCCH, WYPS, WYFRS, A&H, CMHT, Dementia and Mental Health Liaison. The rationale for this has not been articulated, but in any event Mr B's response was often reported to be one of non-engagement, whether visits were solo or joint.
c) The CCG concludes that there was evidence of effective communication regarding his health and wellbeing between the GP practice, mental health services, A&H and Housing, both written and verbal.
d) L&Y also observes that there was liaison and information-sharing between the Community Mental Health Team and A&H.
e) WYFRS observes approvingly that Housing Leeds seconded a staff member into WYFRS to assist with home fire safety checks. This is stated to have improved communication between the two organisations and enabled joint visits.
f) A&H comment that the records indicate that social workers liaised extensively and communicated effectively with WYPS, the GP practice, WYFRS, Mental Health, Housing Leeds, Environmental Services and the local Councillor.
g) A&H Mental Health observed that there was ongoing communication with Housing to maintain his tenancy and to arrange for a deep clean and repairs when he was in hospital. Health staff in L&Y were consulted and involved in decisions about ongoing support. Information was also shared with WYPS, the GP, Irish Health and Homes and DWP regarding Mr B's wellbeing, maintaining his tenancy and access to benefits.
h) WYPS notes that from 13/06/2016 through to 14/03/2018 there was regular and consistent liaison by an officer with A&H regarding Mr B. This took place by e-mail and telephone and included a multi-agency professionals' meeting convened on 28/07/2016.
i) WYPS refers to liaison with Leeds Housing through local tasking meetings that were attended by the NPT, Housing and A&H. These meetings were a place for agencies to bring issues that required attention and for discussion to take place. It was at one of these meetings that a local councillor raised concerns for Mr B.
j) WYPS notes that on 06/09/2016 an officer liaised with all relevant agencies (including a housing support officer) currently working with Mr B and helping him sort out his benefits by ensuring he attended his doctor's appointments and the Job Centre when required.
k) WYPS offer the following observations about inter-agency communication. "*From reviewing Mr B's case, the multi-agency working was facilitated predominantly by e-mail and by telephone, with the first professionals meeting being convened on 28/07/2016. This meeting resulted in actions for A&H and Mental Health. This was followed by a subsequent meeting on 01/02/2017*

that was not attended by [the officer who had attended the previous meeting], as he was on rest days. It is notable that there are no minutes of the professionals meeting scanned and attached to the Niche Occurrence that was created to record the multi-agency working in respect of Mr B and the officer spent time chasing the outcome of the allocated actions in September 2016. Professionals meetings regarding vulnerable adults would benefit from being properly minuted (if this was not done at the time) and the minutes provided to the involved agencies. Leeds would benefit from the introduction of an Adult Safeguarding MASH, or MARAC type process that would provide a structure for safeguarding concerns for adults to be referred to for multi- agency discussion and action setting. This would provide a level of oversight and accountability to ensure that all agencies were consistently working together and were clear on each other's roles and responsibilities and ensure that actions allocated to agencies were completed in a timely manner."

l) WYPS has provided a description of the roles and responsibilities of PCSOs and then offered the following observation: "*In respect of Mr B, he broadly sat outside of the NPT's remit. He was not perceived to be causing problems in the town centre, i.e. he was not drunk or engaging in aggressive begging and he was not the apparent victim of any offences or a prolific offender. The aim of the NPT would be to address immediate safeguarding and welfare needs by seeking medical attention or making a referral to the EDT and making referrals to other agencies who were best placed to support Mr B on a longer-term basis, which is what the NPT did in Mr B's case. [An officer], in interview, commented that it was not uncommon for him to deal with people in similar circumstances to Mr B and that in his experience the nature of the NPT workload has significantly changed and the onus is now on vulnerability with approximately 60% relating to mental health and 40% relating to crime. A significant proportion of welfare checks are allocated to the NPT to undertake where there are no immediate safeguarding concerns or risks to life or limb. This work by the NPT to engage with Mr B and other people in similar circumstances involves building a rapport with the person by talking with them, asking questions, establishing any needs or if there are any concerns and signposting them to appropriate services offered by partner agencies or third sector organisations*."

m) LIHH left messages for the social worker in August, October and November 2017 about Mr B. There appears to have been some delay in the social worker responding according to LIHH records.

n) There was a five week delay between hospital discharge (December 2017) and the GP receiving a discharge letter.

o) The SAR referral and scoping information indicates that GP records note communication with other professionals – social work, pharmacy, housing, mental health – regarding Mr B's wellbeing, hygiene, appearance, mental health and housing. However, there is no lead agency or key worker so no overall communication and too often no meaningful plan.

p) The Mental Health Mortality Case Review notes that there was compassionate decision-making and good communication between professionals but the strategies adopted failed to improve his situation.

q) The apparent absence of a collective multi-agency strategy was a focus of discussion at the learning event. Many people were involved in this case; some staff attending the learning event suggested too many. It was agreed that the appointment of a lead agency and key worker would have been helpful and

appropriate, to coordinate interventions, facilitate information-exchange and ensure that multi-agency meetings reviewed and updated risk mitigation plans. A view was expressed that an Adult MASH would be helpful for cases similar to that of Mr B.

5.2.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture

a) LCCH received information from a local councillor about Mr B but no complaints from neighbours.
b) L&Y contribution to this SAR indicates that when concerns are received from members of the public, staff are expected to make a clinical decision based on the information received.
c) The LCH contribution to this SAR states that no information was received that would raise concerns. In the context of this case, that is perhaps surprising.
d) The A&H contribution to the SAR observes that there was extensive involvement by the local ward councillor responding to constituents' concerns, who was updated regularly by email and telephone by the housing support worker and social worker. Safeguarding alerts were also received from the public and responded to via an assessment, with links made with Housing/Police/GP/Mental Health. All these contacts were compliant with relevant data protection.
e) The WYPS contribution notes that within the timescales of this review, there were a number of concerns reported by WYPS employees and members of the public in relation to Mr B. Some of these concerns were raised by councillors in partnership meetings that were attended by one of the officers who knew Mr B.
f) The local community has its own Facebook page; Mr B was familiar to many of the town's residents and was mentioned on Facebook regularly. The community Facebook page alternated between expressing sympathy for Mr B and unmitigated hostility. For example, people used to regularly give him food and hot drinks, whilst he was sat outside the local supermarket and he had been known to throw the food offering into a bin, which caused upset; the episode was subsequently documented on the Facebook page. At the other extreme, following the initial outrage of his burglary offence, where he stole food, this resulted in regular hot drinks, food and food parcels being given to and left for him in his regular spot outside the supermarket. The NPT were aware of the Facebook page and no offences were identified in respect of any hostility that was documented on the Facebook page.
g) WYPS notes that on 29/07/2016, Housing provided a timeline of support that they had offered Mr B, this was scanned and attached to the Niche Occurrence.
h) Information about concerns was shared between agencies but there is no meaningful plan that was followed through.
i) At the learning event participants expressed concern that staff uncertainties about the lawfulness of information-sharing remains a barrier to multi-agency working.

5.2.3. Comprehensive referrals

a) LCH has commented that the referral for podiatry from the GP in December 2017 indicated that there was a history of mental health/learning disability with some neglect and also alcohol use but no additional information was provided. Fuller information might have enabled reflection on how to respond when Mr B did not attend the scheduled appointment in January 2018.
b) WYFRS observed that the referral from Housing Leeds was clear about the extremely dirty and untidy property, the absence of smoke alarms and smoking risks. The referral also noted that Mr B could have difficulty communicating effectively so a joint visit was recommended because of his history of verbal/physical aggression.

5.2.4. Multi-agency meetings that pool information, share assessments of risk and mental capacity, agree a risk management plan, and consider legal options

a) LCCH notes two multi-agency meetings at which A&H staff were not present.
b) L&Y commented that the challenges of this case were taken to a cause for concern MDT meeting to use that forum to discuss the case.
c) A&H commented that the outcome of the professionals' meeting that a further meeting should be arranged for 2-4 weeks' time did not happen. However, there was ongoing communication between the agencies involved.
d) A&H Mental Health confirmed that Mr B was discussed at weekly MDT meetings. A CPA/discharge meeting was held in December 2017.
e) A multi-agency meeting convened by A&H was held on 28th July 2016. This meeting gave rise to subsequent updates between the agencies on the work being carried out with Mr B.
f) A social worker was said to be contemplating a professionals' meeting in early September 2016. One finally took place at the end of January 2017 and yet the pattern of concerns had continued unabated, with no multiagency forum.
g) WYPS note that it would have been helpful for minutes of multiagency meetings to be taken and circulated to all agencies.
h) It was suggested at the learning event that this case required a greater sense of ownership of the risks and agreed actions, which a system of regular multi-agency risk management meetings could have provided.

5.2.5. Use of policies and procedures, for example for escalation of concerns or for working with adults who self-neglect

a) The A&H Mental Health response to the review commented that there was no specific guidance on working with people who prove hard to engage. In the absence of specific guidance, an assertive outreach model is frequently employed relying upon the Keys of Engagement.
b) WYPS in their contribution states that: "*In respect of adults who self-neglect, are reluctant to engage who and who do not enter the criminal justice system, the West Yorkshire Police Safeguarding Vulnerable Adults Policy 2015 states that Officers and Staff must be confident about: identifying vulnerable adults from the first point of contact; recognising situations and specific risk factors that influence vulnerability; and responding appropriately, whether this is to prevent further abuse or investigate an incident. This includes identifying adults who don't fit the definition of a vulnerable adult and fall outside of this*

procedure, e.g. adults who self-neglect." "It should be recognised that where non-engagement exists, this may prompt a withdrawal of services and support from agencies attempting to be involved. However, non-engagement should be seen as a heightened risk factor and prompt more persistence with engagement." WYPS conclude, however, that officer awareness of self-neglect and safeguarding policies was minimal. Equally, it concludes that officers would not have acted differently in their engagement with Mr B had they been aware of specific policies.

c) WYPS has commented that the West Yorkshire Police Safeguarding Adults policy states that concerns about a vulnerable adult may be alerted to the District Safeguarding Unit or that a direct referral may be made by use of the Form 263 to Adult Social Care (A&H). This form is available on the Force's electronic database and can be downloaded, completed and emailed by all staff. Enquiries in the course of the review have indicated that in the Leeds District no use is made of the Form 263 and referrals to A&H are made by free text email from an officer's individual force email account to a Social Care mailbox. Enquiries in other districts indicate that the form also has limited usage.
d) LCH commented that staff are aware of how to raise a safeguarding alert under procedures and have access to the LCH safeguarding team for advice.
e) One agency commented in the course of this review that staff were aware of the Leeds SAB policy on self-neglect when, in fact, such a document has not yet been finalised or published.

5.2.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy

a) In the L&Y records there is no evidence that staff considered raising a safeguarding referral regarding Mr B. No safeguarding issues were noted in hospital discharge planning, despite risk assessments previously noting risks of self-neglect.
b) LCCH have indicated to the review that the capping of the gas meter could have been raised as a safeguarding issue in 2015.
c) As the CCG contribution observes, the pharmacist did not make a safeguarding alert in January 2018, only passing on concerns to the GP, indicating that pharmacies can be a missing link in the safeguarding chain.
d) The CCG also observes that although the GP practice communicated with A&H, no specific safeguarding referrals were made.
e) WYFRS observes that no consideration appears to have been given to raising a cause for concern in this case.
f) LCCH notes that on 26th March 2015 a safeguarding referral was made. Mr B's response appears to have been to refuse engagement. This was prior to implementation of the Care Act 2014 in April 2015 but raises the question of whether, post-implementation, local authority staff now fully understand that safeguarding enquiries may proceed even in the absence of consent;
g) LCCH commented that staff raised many concerns about Mr B but it does not appear that (with the exception of the concern noted above) they raised these

as referrals for a section 42 safeguarding enquiry. Given what was known about Mr B, they might appropriately have done so[12].

h) A&H commented to the review that the role of safeguarding was considered in relation to Mr B's self-neglect. A Risk Assessment Management Tool was completed and risk management response implemented. There were also the 4 safeguarding alerts: by a member of the public, 16th June 2015, the outcome being referral for assessment; by WYPS, 12th August 2015, the outcome being a risk management response; by a member of the public, 9th May 2016, the outcome being referral for assessment; and by WYPS, 14th June 2016, with a risk management response. There were no referrals from A&H staff, however, and no enquiry under section 42 (Care Act 2014) was conducted despite repeating patterns in the case.
i) The A&H Mental Health response noted that after the case was transferred to the Community Mental Health Team no formal external safeguarding referrals were received. However, concerns raised regarding risk were addressed as part of ongoing risk management responses and as part of a multi-agency approach, involving Housing, CMHT and Community Psychiatrist.
j) WYPS has stated that "*numerous safeguarding referrals were made to A&H throughout West Yorkshire Police's contact with Mr B and a referral was made to the Crisis Team and information shared with his GP*." The chronology gives the details: 31st July 2015 (but this does not seem to have been a specific safeguarding referral); 13th June 2016 (it is not clear that the officer was asking for a section 42 enquiry); and 15th July 2016 (but this was to the Crisis Team with respect to his mental health).
k) When Mr B relapsed after the December 2017 hospital discharge, no-one triggered a safeguarding referral. His feet were seen to be poor, podiatry had not been able to see him, and the support plan on discharge had not materialised, partly because of the weather and annual leave and partly because he did not engage.
l) It is possible, as reflected at the learning event, that the absence of protocols and procedures regarding self-neglect, different understandings about what is squalor, over-reliance on the concept of lifestyle choice and uncertainty about when self-neglect is a safeguarding issue might all have contributed to the failure to use section 42(1) Care Act 2014 as the means for coordinating a risk management approach.

5.2.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy

a) The chronology provides some evidence of legal options being considered.
b) On 10th June 2016 a police officer consulted L&Y about whether the police could appropriately use section 136, Mental Health Act 1983 in the light of concerns about Mr B's extreme neglect.
c) The LCCH SAR contribution refers to their staff not being qualified to carry out "mental health capacity assessments." WYFRS also makes reference to Mr B undergoing a "*mental health capacity assessment.*" This conflates two different assessments.

[12] LCCH have noted that they rely on the specialist services to advise on routing concerns to safeguarding.

d) LCCH has commented that staff did not take legal action as this was felt to be disproportionate. Mr B had complex needs and the aim was to support him and enable him to sustain his tenancy.
e) The CCG has commented that there was nothing in the patient record to instigate use of legal powers.
f) A&H have commented that a record on 1st July 2016 confirms that a social worker discussed with WYPS the use of legal powers to enter property and use of section 17, Police & Criminal Evidence Act 1984, for 'saving life or limb'. Police advised that only police officers are covered by section 17 and any request to check on someone's safety should be phoned through to 101. A&H further stated that, although there is no record of formal legal advice being sought, it is clear from the recordings that good discussions took place between all agencies involved, including the Police who were able to advise on the legal options available.
g) It should be of concern that social workers and housing officers were entering a property without consent, uncertain whether they had lawful authority to do so.
h) The A&H Mental Health response noted that in August 2017 a Mental Health Act assessment was discussed as part of an MDT but it was felt that all least restrictive options had not been exhausted at that time. On 17th November 2017 Mental Health Act assessment was considered again and 2 doctors were arranged to assess Mr B. Neither doctor made a medical recommendation at that time. On 22nd November another Mental health Act Assessment was arranged and Mr B was detained under section 2, Mental Health Act.
i) There is no record of any agency considering referral to the High Court or the Court of Protection as the risks in Mr B's situation became repeated and escalated.
j) The legal powers that were considered by the Police in this case were section 17, Police & Criminal Evidence Act 1984 and section 136, Mental Health Act 1983. The exercise of both these powers is relative to the degree of risk or harm posed by the person in respect of whom the powers are exercised. One police officer recalled that partner agencies were keen to have discussions about the Police exercising their power under Section 136 due to difficulties in locating Mr B to undertake a mental health assessment. This officer was of the view that Mr B did not meet the threshold for the Police to detain him under Section 136 and to do so would have infringed his human rights. WYPS suggest that in respect of the Police powers under section 136, there appears to have been some confusion by A&H and the Community Mental Health Team about what and when this power can be used by a police officer – i.e. the belief that Mr B could be detained by a police officer under section 136 because the Community Mental Health Team were struggling to locate him to undertake an assessment and that any such detention "*wouldn't automatically mean detention*', with the reason for the s.136 being to facilitate an assessment. WYPS, referring to College of Policing (2019) guidance, set out clearly the key features of section 136, including that it does in itself constitute a detention and that the Police must always consider the least restrictive option. They consider this could have been done by facilitating a mental health assessment at a time and place suitable to Mr B without having recourse to powers under section 136.
k) WYPS comment on the Adult Community Resolution Orders (May 2015). "*Issuing an Adult Community Resolution for Mr B in respect of these burglary*

offences was appropriate and in line with Force policy. Adult Community Resolutions do not routinely entail liaison with other agencies, however, this does not mean that liaison and referrals would not take place in such circumstances. In Mr B's case, there was no liaison in relation to the Burglary offences, or referrals to any other agencies. This is understandable, as Mr B had no previous history or a pattern of stealing food or begging for food. However, it should not be assumed that this would always be the case. All the NPT Officers and Patrol spoken to during the course of this review were acutely aware that some people steal food because of poverty. Where a person was regularly stealing food or begging for food, this would prompt further enquiries into their circumstances and the necessary and appropriate referrals would be made to A&H, or Children's Social Care. The circumstances that prompt such referrals may not be as overt as stealing food. When an Officer attended at Mr B's home address to exercise a warrant for a RSPCA prosecution, he observed the disorderly state of the house, specifically checked Mr B's kitchen cupboards to check if he had food (food was seen in the cupboards) and made a referral to Adult Social Care due to his concerns about Mr B's living conditions and whether he was coping."

l) WYPS also comment on a further criminal matter: "*B's circumstances were also considered when he was a suspect for Section 66 (Exposure), Sexual Offence Act 2003. He had been seen by a mother and her child whilst urinating in public. The officer investigating the case liaised with the NPT Ward Manager for the area where Mr B lived …(who) advised that no further action be taken in respect of the investigation, that Mr B had continued involvement with A&H and health agencies and that he would not have intentionally exposed himself in public. On this advice, the officer finalised the case as not being in the public interest. Had Mr B had a previous history of indecently exposing himself in public, the investigation would not have been finalised at that point*."

5.2.8. Clear and thorough recording of assessments, reviews and decision-making

a) The CCG contribution to the SAR observes that although the GP record contains details of a multi-agency meeting attended by the GP on 1st February 2017, the record does not note any date for the mental capacity assessment reported as undertaken by the Community Mental Health Team, or in what context it was conducted.
b) The L&Y contribution makes several comments about records. A search failed to find a capacity assessment apparently done in April 2015. A consultant refers to a capacity assessment undertaken by a social worker in August 2016 but no copy of the assessment could be found. It was thought case notes of discussions in February and March 2017 could be fuller. Information about events preceding the November 2017 Mental Health Act assessment request was limited because of the absence of paper records that could not be traced.
c) WYFRS acknowledge that the case records in this case did not indicate the primary room of sleep and do not highlight whether there were burn marks on bedding that would indicate that fire retardant bedding was required.
d) LCH informed the GP practice that Mr B did not keep his podiatry appointment on 25th January 2018 but there is no indication of what the response to this information was. It could have been illustrative of further risks of self-neglect.
e) A&H responses to the review confirm that formal assessment documentation relating to some mental capacity assessments is missing, apparently due to

the IT issues experienced at that time. A&H has also confirmed that some information may have been lost when records were migrated from one system to another.

f) It has not been possible to trace records relating to visits from gas engineers and enforcement orders. Therefore the chronology of gas visits is missing. It appears that the gas had been capped for several years. This was discussed by the social worker when Mr B was in hospital but no follow-up appears to have been arranged. It is possible (but unclear) that the absence of gas may have been raised in the context of safeguarding in 2015.
g) Prior to hospital discharge in December 2017 the social worker discussed the absence of hot water and heating with Mr B but there is no record of discussion regarding how he would manage his hygiene needs in this context.
h) WYPS note that minutes of the multiagency meetings attended were not circulated.
i) The Mental Health Mortality Case review rates the quality of recording in L&Y as "*adequate*".

5.3. Domain C: It is recommended that the organisational contexts within which the work of the interprofessional team takes place show the following features:

5.3.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case

a) L&Y observe that discussion may have been held in supervision but this is not routinely documented on the electronic patient record system.
b) LIHH records indicate that the support worker attempting to engage with Mr B in February 2017 concluded that they should take the case back into supervision for discussion, given the difficulties encountered.

5.3.2. Support for staff working with people who are hard to engage, resistant and sometimes hostile

a) The review has not identified relevant information from any agency on the support provided to staff. It does appear that practitioners sought professional support from each other through cross agency consultation and discussion, and at times joint visits.

5.3.3. Specialist legal and safeguarding advice

a) No legal advice was sought by L&Y, LCCH or the CCG.
b) The A&H Mental Health response stated that: "*In terms of self-neglect staff have liaised with legal services where appropriate. The safeguarding and risk managers were routinely liaised with to ensure that all legal options had or were being explored.*" The case record, however, does not record that legal advice was sought or what that advise might have been.
c) WYPS did not seek any legal advice in respect of Mr B. Legal advice in respect of criminal matters is provided by CPS. The offences for which Mr B was a suspect (two burglary offences that resulted in Adult Community Resolutions and the Outrage to Public Decency) resulted in no further action to be taken. None of the offences required CPS advice on a charging decision.

5.3.4. Case oversight, including comprehensive commissioning and contract monitoring of service providers

a) This review has not identified relevant information from any agency on commissioning and contract monitoring.

5.3.5. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds

a) L&Y confirm that the target for advising GPs of hospital discharge is 24 hours. In Mr B's case, it took five weeks after his discharge in December 2017 before the full discharge details were sent to the GP.
b) L&Y note changes in ward leadership and staffing vacancies at the time of Mr B's admission in November 2017, with high bed occupancy also.
c) L&Y report that in 2016 the Community Mental Health Team case coordinator caseload was around 65 patients. In December 2017 it was between 40 and 50 cases and the staff member concerned was the only Band 6 community mental health nurse for older people.
d) L&Y observes that in early 2018 the social worker was away on leave for one month. Arrangements for an alternative practitioner to visit were not made until 21st February, by which time Mr B had not been visited since 5th January, despite multiple reports of concerns about him during this period that would have indicated deterioration in his condition. It appears also that the agreement for visits to be jointly conducted by A&H Mental Health and the Community Mental Health Team resulted in no visits taking place when either was not available.
e) LCCH notes that workloads were high but manageable. There was some reorganisation of housing services and management of housing officer support.
f) WYFRS purchased a new recording database and provided training on it for officers.
g) A&H commented that in light of the IT difficulties that existed at the time in 2015/16, practitioners having access to the manual file might have been useful.
h) A&H Mental Health response commented that social work caseloads were between 20-25 cases.
i) WYPS comment as follows: "*Since 2010, West Yorkshire Police have had a budget cut of £140m and the loss of around 2000 Police officers and staff due to the Government austerity measures imposed on Police funding. The Road Map for Change demonstrates some of the projects and reviews that have been undertaken to transform how West Yorkshire Police delivers its policing services*." (The Road Map was provided in their contribution) "*In 2017, Neighbourhood Policing was subject to a project review to formulate a new blueprint. This included plans to bring greater emphasis on problem solving and engagement in local communities and the creation of a joint Police and partnership tasking." "An officer commented in interview that the Police lost resources around the time that everyone else lost their resources. He did say that the nature of the work and engagement that the NPT undertake has changed significantly away from crime to dealing with vulnerability and mental health issues in the community. In light of this it is apparent that we may have to review our policies to reflect the true work that the NPT carry out on a daily basis*."

5.4. Domain D: it is recommended that the interagency governance structure provided by the SAB demonstrates:

5.4.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect

a) WYFRS commented that staff have basic awareness of self-neglect principles.
b) LCH commented that there has been a significant increase in understanding self-neglect following training and conferences.
c) LCCH commented that there has been safeguarding training but staff had not indicated specific awareness of locally agreed policies.
d) The CCG commented that the GP practice was aware of Leeds adult safeguarding procedures but perhaps not of any specific policy on self-neglect.
e) L&Y commented that the NHS Trust had been actively involved in review of the SAB's safeguarding procedures, including self-neglect. Staff had received training on self-neglect and associated risks. Guidance had been provided for escalating high risk concerns to A&H where engagement was lacking.
f) A&H staff have access to the SAB website and any guidance available on self-neglect. This is an interesting observation to be raised as Leeds SAB does not currently have locally agreed procedures for handling cases of self-neglect, so it is not clear why A&H would believe staff had access to one.
g) The A&H Mental Health response to the SAR commented as follows: "*During that specific period the majority of front line staff were aware in general terms that self-neglect had come into our safeguarding responsibilities via the Care Act. At that point most social workers hadn't had specific training around the policy itself. It seems that staff were reasonably clear that workers wouldn't necessarily have massively changed their practice as a result. Adult Social Care had arranged for conferences and legal update sessions for staff with regards to self-neglect. Sessions were held in team meetings and area fora but these focussed more on practical approaches as opposed to Board policy itself.*"
h) WYPS concludes that officer awareness of self-neglect and safeguarding policies was minimal. It also concludes however that officers would not have acted differently in their engagement with Mr B.
i) Leeds SAB did not have a policy on self-neglect at the time of the case and one has yet to be developed and approved.

5.4.2. Workshops on practice and the management of practice with adults who self-neglect

a) While one or two agencies mentioned that staff had had training in self-neglect, this does not appear to have been under the auspices of the SAB.

5.4.3. Learning from the SAR process

a) The SAB has not completed any previous SARs in cases of self-neglect since implementation of the Care Act 2014. A serious case review was published in 2009 (Mrs P), which concerned an older woman who died in a house fire. Therefore limited previous learning locally is available against which the SAB can review change. However, learning this present review, alongside learning from a second review in a self-neglect case that is also in progress, will provide important benchmarks against which future practice can be evaluated.

6. CONCLUSIONS

This concluding section summarises the learning that has emerged from the SAR, mapped (as is the analysis in the preceding section) against the benchmarks of the good practice model. At the learning event those present were clear that the case of Mr B was not unique and that there were systemic issues on which learning could focus as a driver of change.

6.1. Domain A: Direct work with Mr B

6.1.1. There is evidence of a strong person-centred approach – attempting to meet Mr B on his own terms, in his preferred location and at his preferred times. Some agencies including some of those for whom home visits (rather than street contacts) were the norm did adapt their practice as time went on and became more proactive in seeking him out. He was a very visible presence in the local community and the WYPS was able to use its own community presence to build contacts with Mr B and sometimes to facilitate his contacts with other agencies. However, as was recognised at the learning event, enabling independence must be balanced with a focus on what was happening and what was underlying the risks in the case. It is possible to over-prioritise independence.

6.1.2. While some features of Mr B's earlier life history were known to some agencies, this knowledge does not appear to have informed agencies' understanding of his behaviour. While viewing his way of life as a 'lifestyle choice', little curiosity was shown about the possible earlier life influences on that apparent choice, beyond questions relating to his mental health and mental capacity. Although it was known that Mr B had experienced relationship difficulties, little attention appears to have been paid to loss or trauma, or indeed other events that could have shaped his behaviour.

6.1.3. Equally, it emerged at the learning event that Mr B's cultural heritage could have played an important role in shaping both his behaviour and his response to agencies' concerns for him, but this focus was not apparent in how agencies viewed his situation while working with him. Although Irish Homes & Health who visited Mr B several times between July and December 2017, did not succeed in engaging him in ongoing support, it is clear that this agency's involvement in multidisciplinary discussions that sought ways forward during 2017, could have been significant in shaping effective strategies for support. Put another way, cultural competence is important if staff are to avoid unconscious bias and broaden their skills in reaching out to the person.

6.1.4. Practitioners from most agencies showed empathetic concern for Mr B, and in some cases (notably WYPS and LCCH) considerable persistence in keeping in contact with him. In other agencies, the potential for building a relationship of trust was at times compromised by case transfers that broke continuity of contact. His refusal of services was sometimes taken at face value – at one point his case was closed by A&H because of his non-engagement and Podiatry closed his case in January 2018 after just one missed appointment. Even where greater persistence was shown, for example during consideration of his mental health and mental capacity in late 2017, this persistence did not carry forward into the work undertaken with him following his discharge and in the weeks prior to his death. The WYPS staff guidance on non-engagement explicitly and helpfully states that

whereas non-engagement can prompt agencies to withdraw, in some cases it should be seen as a heightened risk factor and prompt greater persistence. The circumstances in the Mr B case suggest that a multiagency policy on non-engagement in self-neglect cases may be of value. It also suggests a focus on whether time constraints because of workloads and agency policies inhibit engagement with people with complex needs.

6.1.5. It is apparent that the focus on his autonomy and lifestyle choice did restrict consideration of wider options for intervention. For example, there is little evidence of the potential for enforcement being considered once his mental health and mental capacity had been explored. This is not to say that enforcement would have been an appropriate way forward, but possible avenues could have been considered, even merely to rule them out.

6.1.6. Intervention seems to have been characterised by 'more of the same' – repeating patterns of unsuccessful visits over long periods of time, repeated deep cleans to remedy extreme squalor in his property but without significant change to what happened in between. This pattern continued even after the opportunity created by the pivotal episode of his hospital admission in November 2017. No safeguarding enquiry took place at any point and it is not clear that his self-neglect was construed as a safeguarding issue.

6.1.7. The risks in Mr B's situation were recognised, but action to mitigate those risks did not always follow. Sometimes this was as a result of Mr B's non-cooperation with offers of support, but at others (such as following his hospital discharge) the level of risk seems not to have been fully recognised or articulated. This is particularly apparent in the period following his hospital discharge in December 2017, during which the anticipated follow-up did not take place at a time when Mr B's health, and the conditions in which he was living, deteriorated quickly. Equally, as noted at the learning event, risk assessment in a hospital environment may paint a false picture. The risks for Mr B arose when he was living in the community. What was required was a focus on what would help to reduce the risks after discharge. As was also recognised at the learning event, a focus on sustaining change in the longer-term is necessary once immediate risks have been addressed and/or care and support needs met. Perhaps too, as again was highlighted at the learning event, it is easier to focus on risk when this arises from a source outside the person. It can be more confusing when the risk arises from self-neglect. Having time and skills to develop an understanding of each situation, and to try to help the person recognise the risks, represent a more effective approach than what sometimes occurred in this case – people coming in and then leaving. A sustained focus on risk management planning, perhaps reframed as safety planning (as in L&Y), is essential and must involve the person wherever possible.

6.1.8. There is not infrequent mention of mental capacity in the information provided to the review by agencies. For the most part capacity is stated as having been assumed rather than tested, as was recognised at the learning event. There is mention of three formal capacity assessments: one by L&Y in April 2015 where he was found to have capacity in relation to health and wellbeing decisions; one by A&H in the autumn of 2016, where he was found to have capacity in relation to how he was living); and one in November 2017 on Mr B's understanding of his admission to hospital and treatment, where he was found to lack capacity. At all

other points, capacity appears to have been assumed on the basis of discussion with Mr B or what had been communicated by other agencies. Three further issues of concern arise.

- No mental capacity assessment was undertaken prior to Mr B's discharge from hospital in December 2017, despite an assessment undertaken only a few weeks earlier having found that he lacked capacity at the point of admission.
- The impact of Mr B's "mild cognitive decline" on his decision-making ability does not appear to have been considered. There is increasing recognition of the impact of frontal lobe impairment on decision-making in the moment (as opposed to in abstract discussion), such that the National Institute for Clinical Excellence has issued guidance that recognises the need for 'real-world observation' in some circumstances in order to achieve a full picture of an individual's capacity.
- One agency has stated that staff are not qualified to undertake capacity assessments, raising some concerns about the agency's understanding of staff responsibilities in relation to evaluating capacity in relation to decisions on which they would be seen as the decision-maker under the Mental Capacity Act 2005.

6.1.9. DS's mental health was regularly considered during 2017, with a number of visits responding to requests from other agencies and some ongoing involvement by the Community Mental Health Team. Given the long history of his self-neglect, and his long-established reluctance to engage with support, earlier admission to mental health hospital may have been appropriate – it is clear that the treatment undertaken in November/December when he was finally admitted, was to some degree effective in improving his condition, but was marred by inadequate follow-up on discharge. However, as highlighted at the learning event, ethical dilemmas arise when considering both mental health and mental capacity, not least how to balance autonomy with a duty of care, and when it might appear necessary to intervene in someone's private life. It was thought that a forum in which cases can be discussed when such issues are repetitively raised would be helpful. It should also be noted, as commented upon at the learning event, that the Community Mental Health Service has been redesigned, with caseloads reduced. Auditing the impact of this change would seem appropriate.

6.1.10. DS's admission to hospital in November 2017 was clearly a pivotal point that created an opportunity for change. That it did not do so is regrettable and indicates missed opportunities around the hospital discharge and follow up. Mr B was discharged to a property without a gas supply, hot water or adequate heating in the middle of winter, the planned enablement service was not provided, the practitioners' planned follow-up visits did not take place, the discharge and risk management plan was not monitored or reviewed. While there is no guarantee that Mr B would have remained more compliant had follow-up been more proactive, it would at least have maximised the opportunity created by his improved health and nutrition at that point and enabled practitioners to secure stronger engagement from him going forward.

6.1.11. While Mr B's needs for support were recognised, and some attempts were made to secure appropriate support, it is not clear that a Care Act 2014 assessment was recorded by A&H. In any event, support attempts were repeatedly

frustrated by Mr B's reluctance to engage with the provision offered, other than on the basis of regular deep cleans.

6.1.12. Participants at the learning event also questioned where Mr B's physical health needs were being monitored and met. He may have been hard to engage in the sense of attending appointments or being at home for scheduled meetings but he was not out of reach. Perhaps meeting him where he was and inviting him to walk to an environment where an assessment could take place would have enabled a more consistent focus on his physical wellbeing.

6.2. Domain B: Interprofessional and interagency practice with Mr B

6.2.1. There was a considerable amount of information-sharing and joint working between the agencies involved with Mr B. In many respects the case shows good evidence of the recognition that a number of agencies had a contribution to make, and strong willingness on the part of practitioners to call in others, and to respond proactively to requests for involvement. Nonetheless, at the learning event, a view was expressed that statutory agencies should develop a greater understanding of the role of third sector agencies, and also of the contribution to safeguarding from the RSPCA and pharmacy. The key issue here is that there was no single location to which all agencies were able to refer as a coordinating presence. Such a location could have been provided by a single agency acting as case coordinator, or by a multiagency discussion forum that all parties attended – or ideally both. This was a view consistently communicated by those attending the learning event, expressed as the need to identify a lead agency, avoid silo working, coordinate diverse involvements and know there is a lead organiser. Although there is reference to MDT meetings within mental health services, there were only two wider multiagency meetings, and those did not draw the necessary attendance to provide an effective forum for full discussion of the strategic direction with the case. The plan to continue them did not materialise, perhaps because of the absence of a case coordinating agency, leaving a period of 18 months during which there was no focal point for the efforts of all those involved.

6.2.2. Participants at the learning event were advised that the local authority and CCG were working together to establish a panel for cases that involve hoarding. The local authority also holds a three-weekly accommodation group meeting where cases of self-neglect and safeguarding can be discussed in a multi-agency forum. It was unclear how inclusive of agencies this group meeting is. Housing appears to have developed a multi-agency panel with respect to hoarding. Broad support for a panel at which complex (self-neglect) cases can be discussed was expressed at the learning event but it will be important to avoid duplication of pathways into various panels, which can be confusing for practitioners. Legal advice needs to be available to panel members.

6.2.3. There is some evidence of the development of co-location as a means of strengthening working together between services. For instance, WYPS have a community mental health nurse for advice when working with an individual with mental health issues. The learning event heard that more multi-disciplinary teams are being developed, alongside single agency initiatives such as peripatetic practitioners in LCH. It was suggested that a summit would be useful to map these initiatives, which at the same time would raise awareness of what is now available

when working with people who self-neglect and invite consideration of remaining gaps in provision or barriers to effective working together.

6.2.4. DS was highly visible in his community. It appears that his appearance and behaviour drew both concern and consternation – there is reference at one point in June 2017 (in the L&Y referral to Irish Health and Homes) to the community's wish to have him removed as his presence outside the supermarket was a nuisance. But there is also consistent evidence of more supportive encounters, providing him with food; after his death members of the public left flowers on the bench on which he used to sit, and it is understood that his funeral was crowd-funded by the local community. The involvement of significant community presence is not infrequently a feature of self-neglect, where finding the right person as a bridge can be a powerful intervention. It is not clear that agencies considered the potential for a more organised community support strategy.

6.2.5. With regard to the use of relevant policies and procedures, it appears that guidance on working with people who are reluctant to engage may prove a useful addition to multi-agency policies, and that such guidance may usefully draw on models used in mental health services. WYPS have identified that officers' awareness of self-neglect and safeguarding policies was minimal, although in terms of police actions with Mr B the relevant policies would not have required any different approaches from those employed. Equally, they find that little use is made in the Leeds district of the standard form for making direct safeguarding referrals to A&H (Form 263); the form also has limited usage in other districts.

6.2.6. Despite a number of safeguarding referrals from different parties, none of these explicitly triggered the duty to enquire under section 42 of the Care Act 2014 (although LCC Adults & Health have clarified that referrals that receive a risk management response can be considered as having received a response under section 42). Even more numerous were the general concerns raised about Mr B's welfare that were not raised or responded to as safeguarding issues. This raises questions about levels of safeguarding literacy across the partnership. At the learning event concerns were also expressed about the lack of feedback once safeguarding referrals have been sent.

6.2.7. There is some evidence of legal rules being explicitly considered. The Mental Health Act 1983, Mental Capacity Act 2005 and Police & Criminal Evidence Act 1984 are all referenced at various points, along with reference to LCCH enforcement powers and criminal matters in which Mr B was involved. There was appropriate discussion at various points between practitioners from different agencies. One agency missing from such discussions is Environmental Services, who, given he was repeatedly deemed to have mental capacity, might have considered the public health implications of the conditions in Mr B's home.

6.2.8. A number of the agencies involved have commented on the absence of records that they would have expected to be available, and in some cases on the quality of the records located. This has made it difficult for them to evaluate the actions taken and in some cases has left some matters within this review inconclusive. In other cases, it has made it difficult for agencies contributing to the review to verify and provide evidence for what is claimed – for example that staff sought legal advice, when records make no mention of having done so, or what advice was

given. The documentation submitted to the review at times contains inaccuracies and inconsistencies. It is hard to overemphasise the importance of accurate, thorough and contemporaneous recording to agencies being able to give clear and defensible accounts of their decision-making both within and between agencies.

6.3. Domain C: Organisational support for work with Mr B

6.3.1. There appear to have been some organisational constraints during the period in which staff were working with Mr B: some pressures on teams in some agencies, changes of leadership, staffing vacancies, high caseloads, and the overall impact of ongoing austerity measures. Equally, it is not clear what level of management scrutiny the work being undertaken with Mr B received. Little mention is made of supervision discussions, and at one critical period (in early 2018, following his discharge from hospital in late December 2017) no cover arrangements were made in the planned absence of the mental health social worker for a prolonged period. The local authority have explained that the care coordinator was aware of the social worker's absence and was expected to take the lead during this period, and that Irish Health & Homes were also involved. There is no evidence, however, that any visits by any party were attempted between 5th January and 15th February, despite an urgent referral from the GP to Community Mental Health on 31st January, with the result that the discharge follow-up plan was severely compromised. Mention is made of bad weather having been an additional factor at this time, raising questions about what arrangements are in place to ensure that essential work can continue during winter weather events that can, to a certain degree, be anticipated.

6.3.2. A consistent request to emerge from the learning event was the need for inter-agency training on working with people who self-neglect, to raise levels of awareness and of skills in building rapport and raising difficult issues. Another was the need for tools with which to assess risks in relation to self-neglect. A third was a suggestion for the development of reflective practice networks at which complex cases can be discussed between practitioners, managers and specialists in mental capacity and mental health assessments, safeguarding and law, and the latest research on best practice reviewed. It will be important, however, to ensure that it is possible to apply the learning derived in the organisational settings to which staff return. With its partners the SAB will need to seek reassurance that organisational and multi-agency systems are aligned to enable the implementation of best practice. It is for precisely that reason that this SAR has been organised around an evidence-base.

6.4. Domain D: The SAB's contribution to work with Mr B

6.4.1. With regard to the role of the SAB and its leadership of practice in self-neglect, the SAB has not to date issued specific policy and procedures on multiagency work in cases of self-neglect, or guidance on related issues such as working with those reluctant to engage. Thus agencies have been working in a procedural vacuum which will have contributed to some of the features of practice with Mr B observed in this review. Remedying this position must be a priority for the Board.

7. RECOMMENDATIONS

7.1. In line with the terms of reference for this review, the recommendations that follow are intended to contribute to improvements in how agencies respond to individuals where there are significant levels of self-neglect. The recommendations are designed to stimulate measures to strengthen future interagency safeguarding practice. In addition some individual agencies, in their submissions to this review, have set out changes they have already implemented within their own organisation. These changes are listed in Appendix 1.

7.2. Arising from the analysis undertaken within this review, the reviewers recommend that the Leeds Safeguarding Adults Board should:

7.2.1. Produce and disseminate multi-agency procedures for working with people who self-neglect, such procedures to draw on research evidence and SAR learning and to include the process for convening multi-agency panel meetings and for escalation of concerns;

7.2.2. Commission multi-agency training on self-neglect, legal literacy (including powers of entry and information-sharing), unconscious bias and mental capacity assessments;

7.2.3. Review the need for a multi-agency information-sharing protocol with respect to adults at risk of significant harm;

7.2.4. Produce and disseminate multi-agency advice on best practice with adults who do not engage and/or who disengage from services;

7.2.5. Review hospital discharge protocols on safe discharge, to ensure that robust home assessment is undertaken and appropriate follow up built into discharge plans for adults at risk;

7.2.6. Review with all partner agencies what policies are required with regard to the impact of winter and adverse weather on adults at risk;

7.2.7. Provide a means by which statutory agencies can access advice from the culturally specific agencies in the voluntary sector, such as Irish Health and Homes, to improve the cultural competence of staff;

7.2.8. Raise awareness about the detailed information required when making referrals to services, focusing especially on risk;

7.2.9. Request that West Yorkshire Police Service provides clarification for partner agencies on when welfare checks are considered appropriate, and that West Yorkshire Police and Leeds City Council Adults & Health together provide guidance for staff on the interface between police welfare checks and safeguarding enquiries under the Care Act 2014;

7.2.10. Request that West Yorkshire Police Service ensures that adult at risk notifications are made to Leeds City Council Adults & Health in appropriate circumstances;

7.2.11. Request that Leeds City Council Adults & Health undertakes an audit on its decision-making on referrals for section 42 enquiries;

7.2.12. Audit standards of recording across the safeguarding partnership to ensure that it is clear how decisions have been reached, when, in consultation with whom and why;

7.2.13. Review its membership in terms of links with the RSPCA and with pharmacists;

7.2.14. Map service developments and single and multi-agency provision with respect to adults who self-neglect and, at a summit, consider what refinements and further developments are advisable in light of learning from this and other SARs;

7.2.15. Provide seven minute briefings as a means of disseminating learning from this SAR and of raising awareness of its policies and procedures;

7.2.16. Produce and monitor a partnership-wide action plan to implement the recommendations arising from learning in this SAR;

7.2.17. Audit progress on implementing learning from this SAR after one year from completion of the action plan.

APPENDIX 1

BEST PRACTICE IN WORKING WITH ADULTS WHO SELF-NEGLECT:
AN EVIDENCE-BASED MODEL

DOMAIN A: DIRECT WORK WITH THE INDIVIDUAL	1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes
	2. A combination of concerned and authoritative curiosity, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills
	3. When faced with service refusal, a full exploration of what may appear a lifestyle choice, with detailed understanding of what might lie behind a person's refusal to engage, e.g. loss and trauma often lie behind refusals to engage
	4. A picture of the person's history and life experience
	5. Recognition of, and work to address, issues of loss and trauma in a person's life experience
	6. Recognition of, and work to address, repeating patterns of behaviour
	7. Contact maintained with people who are reluctant to engage (rather than case closure) so that trust can be built up
	8. Comprehensive risk assessments, especially in service refusal
	9. Where possible, involvement of family and friends in assessments and care planning
	10. Exploration of family dynamics, including the cared-for and care-giver relationship
	11. Thorough mental capacity assessments that include consideration of executive capacity
	12. Careful preparation at points of transition, for example hospital discharge and placement commissioning
	13. Thorough assessments for care and support, care plans and regular reviews
	14. Thorough mental health assessments and care planning
DOMAIN B: THE WORK OF THE INTER-PROFESSIONAL TEAM AROUND THE INDIVIDUAL	1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker
	2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture
	3. Comprehensive referrals between agencies
	4. Multiagency meetings to pool information, share risk and capacity assessments, agree risk management plans, consider legal options
	5. Use of policies and procedures, for example for escalation of concerns or for working with adults who self-neglect
	6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy)
	7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy
	8. Clear and thorough recording of assessments, reviews and decision-making

DOMAIN C: THE ORGANISATIONAL CONTEXTS WITH WHICH THE WORK OF THE INTERPROFESSIONAL TEAM TAKES PLACE	1. Supervision that promotes reflection and critical analysis of the approach being taken to the case
	2. Support for staff working with people who are hard to engage, resistant and sometimes hostile
	3. Specialist legal and safeguarding advice
	4. Case oversight, including comprehensive commissioning and contract monitoring of service providers
	5. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds
DOMAIN D: THE INTERAGENCY GOVERNANCE STRUCTURE PROVIDED BY THE SAB	1. Development, dissemination and auditing of the impact of policies and procedures regarding self-neglect
	2. Workshops on practice and the management of practice with adults who self-neglect
	3. Learning from the SAR process