Safeguarding Adult Review

Mr B

Overview Report

March 2020

Independent Author – David Byford

Chapter 1

1.1 Introduction

1.2 This Safeguarding Adult Review (SAR) for Mr B, was commissioned by Slough Safeguarding Adults Board (SAB) which, is now known as Slough Safeguarding Partnership.

1.3 Mr B became known to Slough Adult Social Care (ASC) in 2009. At the time of this SAR he was 69 years old and lived alone. He had originally come from the USA. He suffers from arthritis, chronic obstructive pulmonary disease (COPD) and has a degenerative spinal condition.

1.4 Over the summer of 2018, safeguarding concerns were raised by his GP Practice, Thames Valley Police (TVP), South Central Ambulance Service (SCAS), Housing Regulation Service (HRS) and the Royal Berkshire Fire and Rescue Service (RBFRS) regarding Mr B's chronic self-neglect and hoarding. He had also been living in uninhabitable home conditions. His flat was littered with bags of faeces and he had rat infestation. Despite the efforts of individual professionals working with him, his self-neglect and hoarding significantly impacted his health and wellbeing which deteriorated significantly**.**

1.5 In August 2018 he was transferred to Salt Hill Care Centre (SHCC) a care home. The care home reported that he arrived dressed in a tee-shirt, with faeces on his skin with open wounds and sores on his body and also reported that there were maggots coming from his feet (as referred to in the ASC North Team report to this review). When he arrived at SHCC he was given a thorough wash. They discovered his sores covered the area of his bottom and down to his legs. He was bleeding from his bottom, privates and both legs which were swollen and covered with sores. At the nursing home Mr B received care and support. At the time of commissioning this review he was reported to be safe and well.

***Comment: Subsequent information obtained for the review from a representative from SHCC who examined a photograph taken at SHCC on the day, states they "Were not sure if they are maggots or just peeling skin". This statement does not clarify whether Mr B did not have maggots at the time, in contrast to the original record made on his examination at SHCC where it is recorded, he had. Regardless whether he had maggots or not, what can be confirmed, Mr B received appropriate care and treatment for his wounds and sores.*

1.6 Mr B's case was referred to the Slough Safeguarding Adults Review Panel (SARP) by the RBFRS subsequently on the 21 January 2019 and a scoping exercise was carried out by agencies represented on the SARP.

1.7 A decision was made by the SARP on the 14 February 2019 to recommend to the SAB Independent Chair who, agreed with the recommendation that Mr B's case met the criteria for conducting a SAR.

1.8 Slough Safeguarding Partnership want to learn about what improvements can be made to reduce the risk of a serious deterioration in a person's health and home conditions to adults at risk in the future**.**

1.9 During the process of completing this review, it was disclosed at a practitioner's event held for Mr B, that he had discharged himself against professional advice in April 2019.This was referred to operations. A multi-agency safeguarding meeting was convened and confirmed that his needs were being met. This is referred to in Chapter 3).

1.10 <u>Executive Summary</u>

1.11 Purpose of the Safeguarding Adult Review

1.12 The purpose of a Safeguarding Adult Review is not to re-investigate or to apportion blame. It is: -

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work to support adults at risk.
- To review the effectiveness of procedures.
- To inform and improve local inter-agency practice.

1.13 Legislation, Guidance and Definitions

1.14 The Care Act 2014 defines the safeguarding duty in relation to adults who: -

- Have need for care and support (whether or not the local authority is meeting any of those needs).
- Is experiencing, or at risk of, abuse or neglect, and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

1.15 The Care Act 2014 is significant legislation for Adults. There were changes made to the legislation in April 2015 that includes responsibilities for promoting wellbeing, a focus on prevention, personal budgets, eligibility criteria and support for carers.

1.16 The Care Act 2014 also says: "SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult". As In Mr B's case, "SABs must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult" (Care Act Guidance: 2014)

1.17 Voice of Mr B

1.18 The voice of Mr B is detailed within the conclusions in Chapter 5.

1.19 Family involvement

1.20 There has been no family participation and details of family members were not known for the purposes of the review. Mr B's family were not in contact with Mr B nor involved with his care.

1.21 Diversity

1.22 Mr B was from the United States of America. Culture and diversity was not identified as a significant feature within agency submissions to the SAR.

1.23 Abstract of Findings

1.24 This SAR has identified the following three findings which resulted in four overview report recommendations discussed within Chapter 3 in the analysis of Mr B's interaction with professionals. (See also Findings and SAR Overview Report Recommendations in Chapters 4) as follows: -

- Finding 1. MASH, Police Adult referrals and assessments.

- Finding 2. Adopting a Multi-Agency pathway to understand and address self-neglect, environmental issues and hoarding.

- Finding 3. Communication and Sharing Information.

1.25 Adult Safeguarding Principles – Sharing Information

1.26 There are six adult safeguarding principles practitioners need to take into account when dealing with a safeguarding adult case which are: -

- Empowerment - People being supported and encouraged to make their own decisions and informed consent.

- Prevention - It is better to take action before harm occurs.

- Proportionality - The least intrusive response appropriate to the risk presented.

- Protection - Support and representation for those in greatest need.

- Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse**.**

- Accountability - Accountability and transparency in safeguarding practice**.**

Comment: There is evidence the six principles above were being applied by professionals but there was learning identified and is detailed within this SAR.

Chapter 2 - Initiation of the Safeguarding Adults Review

2.0 Terms of Reference (Summarised)

2.1 The Safeguarding Adult Review Panel (SARP) is concerned there may be lessons to be learnt that partners could have worked together more effectively to protect Mr B. The group is concerned to establish if a failure to share information may have contributed to deterioration in his condition and to understand if learning from this case might provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, The SARP hypothesised that a focus on multi-agency information sharing including the Slough Risk Tool may enable practitioners to share information in a structured way taking the lead when necessary. The group agreed that there are likely to be areas of good practice in relation to individual practitioners but the main purpose of the SAR is to improve partnership working.

2.2 **Scoping Period.** The focus is on learning about whether such situations can be prevented in future by improvements in partnership working. Collective impact on the life of

Mr B is a strong feature of this review. Each agency is accountable for its own performance and has addressed any performance issues in house. This review is not about identifying deficits in individual performance, nor is it about blame. It is about our collective responsibility to continually strive to work together on how we can improve.

2.3 Timespan. The review timespan is from the 1 May 2017, when the GP raised concerns until 1st September 2018, two weeks after Mr B's admission to the nursing home.

2.4 Aim. The SARP aim is to establish learning and deliver impact from the learning as rigorously and swiftly as possible.

2.5 Objectives. At the end of the process the final report will have answered the following questions raised by the SARP on behalf of the SAB and putting Mr B at the centre of learning.

2.6 Key Questions

Did agencies communicate with each other, if not, why not?

Were Mr B's views established, clearly understood and acted upon, if not, why not?

Were there examples of good practice?

Can such situations be prevented in future by improving in partnership working?

How this will be achieved?

SAR Author comment: The above questions together with questions posed in a template provided for agencies (see Phase 1 and 2 below) and discussed in the practitioner's multi-agency analysis event that was held, have been addressed and analysed in the Findings and SSAB Overview Report Recommendations. Any learning will be included within an Action Plan which will follow the completion of this review.

2.7 Phase 1. *(Additional questions posed for agencies).*

2.8 Each partner agency involved was invited to complete a chronology of significant events and to complete a report answering the following questions**;**

Were your services communicating with other services being provided to Mr B, (if not, why not?)

Did professionals in your agency who provided services to Mr B establish Mr B's views and were those views recorded, understood and acted upon?

Were there examples of good practice seen in your agency?

How can your agency improve how it works with partner agencies? (Can such situations be prevented in future by improving in partnership working?)

2.9 Each partner agency, when completing their account above, confined themselves in their reports to accounting only for their service area.

2.10 Phase 2

A multi-agency analysis event was held involving those agencies who provided reports and practitioners. The event analysed the information provided and heard views which were incorporated in to the overview report.

2.11 Phase 3 – Drafting of SAR

2.12 The SARP had initially planned for the Safeguarding Partnership Manager to draft the report. This was not possible due to extended sick leave so this report was written by the Independent SAR Author.

2.13 Governance, Scrutiny and transparency.

2.14 The SAB/Safeguarding partnership Independent Chair provided challenge and scrutiny on the process to ensure delivery is rigorous and without prejudice. The SARP panel has signed off this report and it ishas been??? submitted to the Safeguarding Partnership Leaders' group for sign off.

2.15 Phase four: Implementing the learning

2.16 Each agency is accountable for delivering the learning they have established as a result of their individual contributions to this review and will create action plans to reflect this. Following sign off from the SARP, these action plans will be shared with the SAB Quality Assurance (QA) sub-group who will monitor implementation for one year. Multi-agency recommendations will be similarly shared with the QA sub-group and monitored. The QA sub-group will provide updates to SARP at agreed intervals. Both groups will include this in their forward plans and appropriate learning will be incorporated into the safeguarding partnership strategic plan 2020-2023,replacing the business plan).

2.17 Independent SAR Author

2.18 Mr David Byford was commissioned as the Lead Reviewer for the SAR. He has no previous involvement in the case or with any person or agency concerned within the SAR process for Mr B.

2.19 Methodology

This Safeguarding Adults Review used a proportionate methodology and individual analysis by each involved agency with the involvement of a multi-agency practitioner's analysis event to encourage reflection and learning.

Chapter 3 – Analysis of Mr B's interaction with professionals.

3.0 Relevant contact with Mr B outside the SAR scoping period

3.1 Outside the scoping period set for the SAR for Mr B but relevant, in November 2016 police attended another nearby address on a matter unrelated to Mr B. Whilst conducting enquiries, officers noted that the windows to his flat were covered in condensation with dirty net curtains. Officers looked through the window and saw the interior of the flat was in a very poor condition with accumulated rubbish on the floor and old food on surfaces not having been cleared away. Mr B appeared at the window and spoke to the police officers. He presented as dirty and unkempt. Mr B would not engage with police and stated he did not need any help and would not provide his details. Police carried appropriate checks and identified his details and confirmed he lived at the address.

3.2 Police followed up their concerns for Mr B and made an adult safeguarding referral. The report was reviewed by the Police Multi-Agency Safeguarding Hub (MASH) but as there was no suggestion of lack of capacity and no consent for the referral by Mr B it was concluded that the referral did not meet the threshold for a referral to Adult Social Care or the Community Mental Health Team (CMHT) as Mr B had not given consent**.**

Comment: Police were so concerned, regarding Mr B's presentation and the poor hygiene and state of his property, for them to make a referral. It suggests the TVP MASH should not have closed his case for the reasons given without fully considering the wider aspect of the case. It seems premature as the circumstances warranted a referral to ASC. There was no risk assessment conducted, such as contacting his GP for instance. Considering the outcome of events for Mr B resulting in this SAR, this was a warning and missed opportunity to show more professional curiosity. As this review identifies, it requires a multi-agency response for a person displaying the concerns police recognised. (The Police remit and threshold for referring adult protection referrals needs to be subject to review as outlined in Finding and Recommendation 1 within Chapter 4).

3.3 From February 2017 and throughout the scoping period of the review process Mr B had regular contact with the Housing Regulation (HR) Services who were assisting him with a landlord dispute and with water leaks and electricity issues in his home. HR officers maintained good contact and continued to support him with communication difficulties in liaising with ASC as Mr B was requesting a mobility scooter. They issued a Schedule of Works to Mr B's landlord regarding hazards in the property which was later complied resulting in the hazards being removed. HRS closed the case in August 2017. It is not recorded if the Housing Sustainability Team was involved in Mr B's case and the review has not been informed how long Mr B had lived at the premises.

3.4 Background of events within the terms of reference and the identified concern for Mr B

3.5 In May 2017 there was an unplanned home visit by a District Nurse (DN) as his GP had requested urgent blood tests. Mr B declined the visit but agreed for the DN to return the following day. The DN reported there was some clutter on the surfaces in the main room of his home and there was a strong smell of cigarette smoke, with nicotine stained curtains. The room was dark as the curtains were closed with a lamp giving some light.

3.6 Mr B's GP first made a referral regarding concerns for him in May 2017 and wrote a letter to Slough ASC following a home visit to treat a chest infection. These concerns related

to the state of his property he had personally observed at the home visit. The GP confirmed Mr B had agreed to the referral and would speak to a Social Worker (SW). A SW did visit Mr B who agreed to an assessment of his needs and support provided was around support with housing repairs, bathing, welfare benefits information around housing benefits and Extra Care Housing. He had a support plan (Creative Support) and an advocate at that time. The ASC report indicates that hoarding was not noted as an aspect that Mr B required to be helped with. However, in the CCG report to this review, the GP made a further referral after another home visit as he was concerned about Mr B's hoarding in the home and lack of lighting. Mr B, at the same time, had requested the GP to support to move home. (Hoarding is discussed further in the Findings in Chapter 4).

3.7 Mr B chose not to fully access the DN service. It was evident Mr B had an aversion to having his blood taken as reported by DN's who attempted to carry out this procedure. In June 2017 he declined to have his blood taken, agreeing the DN could take it on another occasion. He refused attempts by DN's to take further blood tests. As a result, the DN service informed Mr B's GP of his refusal and as a result of this he was discharged from the DN service.

3.8 In March 2018, the GP made a referral to Occupational therapy (OT) for Mr B for an assessment for assistance in the home**.**

3.9 In May 2018, Mr B contacted HRS as he had no water in the property. His HR officer contacted the waterboard, who confirmed repairs works were being carried out in the area, and when the water was turned back on, he reported he had no hot running water. He further reported that he was concerned the landlord was going to evict him as the landlord's son had moved into the flat next door. He was offered housing advice if an unlawful eviction was to take place and what he needed to do. He wanted to move out of the property, so a referral to the Housing Demand Team was made but he then later confirmed to HRS he did not wish to move.

3.10 On the 12th June 2018, Housing received a call from Mr B as he was annoyed the OT had visited and asked him the same questions as others had and questioned "Do they hold records or talk to each other?". He confirmed to the HR officer all he 'needed' was a mobility scooter. He again complained about his landlord and son and the changes they had made around their property and was concerned about getting evicted. He was offered housing advice, but Mr B was angry HRS did not have a handover with SBC (ASC) which HRS confirmed they did in their SAR submission.

3.11 At the beginning of July 2018, his HR officer visited Mr B's property. It was agreed with Mr B that action would be made for HRS to speak with the debt collection company who were writing to him instead of his landlord. HRS advised the company of the correct address for the landlord. They also contacted Housing Demand regarding re-assessing Mr B for alternative accommodation; contacted ASC regarding the need of a mobility scooter, assistance with cooking and tidying his accommodation and spoke to Mr B regarding court action of his landlord re-converting a flat back to a garage. All actions were carried out by HRS.

3.12 On the 25th July 2018 the concerns for Mr B heightened. SCAS were called to his home at the same time as his GP called and who spoke with a paramedic on the scene. Mr B had been found on the floor by a pharmacist who delivered his medication. He reported to professionals at the time that he had been in the same position for six days. The GP and the SCAS ambulance crew on scene advised him that he needed to go to hospital for treatment, but he declined. As a result, a paramedic assessed he had the mental capacity to make his own decision and, on this basis, a best interest decision to take him to hospital, could not be made but an SCAS referral was made to ASC. ASC have confirmed that a Safeguarding Episode/Enquiry was opened following this referral. He was visited and this started the chain of events that led to his admission to SHCC where the degree to which his health condition deteriorated became clear. ASC confirm this was appropriate and good practice by ASC and suggest was probably the action that initiated the saving of his leg or life. It is however the view of the SAR Independent Author the action taken by his GP, SCAS, TVP, HRS and other agencies in the review also contributed to his health and wellbeing.

3.13 Request for an MHA**:** The GP continued to display good practice as had the other emergency services and practitioners. He was concerned that Mr B's physical condition could continue to deteriorate if he was not transported to hospital which he refused to do. Mr B was informed of the risk of not going to hospital. The GP advised him to contact '999' emergency services if became unwell. The GP further contacted the Community Mental Health Team (CMHT), Common Point of Entry (CPE) by telephone requesting a crisis referral as he was refusing to go to hospital against medical advice. His home was found to be cluttered, with faeces, debris and empty beer cans scattered on the floor. It is not known if ASC were informed of this GP request to CMHT (See Finding in Chapter 4). It is recorded by Berkshire Healthcare Foundation Trust (BHFT) on checking SBC RiO (file management system) on this day and also it was recorded that Mr B had a history of anxiety and depression and that he could be verbally abusive and difficult to engage with services.

3.14 The Mental Health Practitioner (MHP) taking the call advised the GP (who recorded his request as refused) that he needed to visit Mr B and make a capacity assessment and if necessary, make a best interest decision with regard to hospital admission. The GP was advised if Mr B needed a Mental Health Act (MHA) Assessment, the CPE should be contacted again regarding a referral to an Approved Mental Health Professional (AMHP).

3.15 The GP went to visit Mr B on the same day and was again shocked by the state of the property. It was extremely cluttered and dirty and due to a lack of access the GP had to speak to Mr B on the doorstep. He asked Mr B to go into hospital as it was highly likely he had kidney failure, but he again refused. He was advised if he stopped urinating or felt unwell, he was to ring the emergency services using '999'.

3.16 The GP made a prompt referral regarding the situation to Royal Berks Fire and Rescue Service (RBFRS) for a Home Fire Safety Check as he was so concerned the property was unsafe for both Mr B and a possible risk to his neighbours.

3.17 This was followed with a GP safeguarding referral on the same day to Slough ASC and a SW was spoken to. The SW informed the GP, Mr B had been assessed by ASC previously in June. It was reported he had been rude to the SW so a decision was made that there were not any services that could be provided by ASC. The GP again raised his

concerns about the state of Mr B's property. ASC advised the GP they will review their decision not to provide services.

3.18 The RBFRS, at the request of the GP, attended Mr B's home. They also shared their concern with their Safeguarding Coordinator who, on the same day made a referral to the ASC Emergency Duty Safeguarding Team. RBFRS followed up their attendance and arranged for a Safe and Well Technician to visit the property on the 2nd August 2018. (The technician subsequently shared concerns about the unsafe environment to the ASC Emergency Duty Safeguarding Team; referring to hoarding; the home as a fire hazard; uninhabitable living conditions; bags of faeces and the infestation of rats).

3.19 On the 26th July 2018, HRS received a call from Mr B who said he had put his back out and had not eaten or drunk anything for the past six days. He said that police were at the property and he did not know why. He further confirmed paramedics attended the day before and requested him to go to hospital, but that he had refused to go. He was concerned police were going to 'smash' his door in. HRS communicated with ASC by telephone and email. They also spoke to a manager as there had not been an immediate response to their contact. The HR Officer also contacted police who confirmed they had been called to the property by SBC.

Comment: It is suggested by ASC that a series of unwise decisions can be risk assessed and referred to the High Court under their Inherent Jurisdiction. This should be done by the decision maker, in this case the GP. There was however an opportunity due to the concerns to call a safeguarding Multi-Agency Meeting. This would be good practice to ensure all participating agencies could consider and resolve the concerns regarding Mr B. Any professional involved in the case can call a multi-agency discussion under current policies. (See Communication Finding 3).

3.20 Mr B wanted to know from HRS what was happening as no one in ASC had visited him. He had a number for an OT which his HR officer called who confirmed the service to him was now closed. He stated the HR officer was the only one he could get through to.

3.21 It was confirmed on the same day that TVP Police had been called by Slough Borough Council (SBC) to Mr B's home address following a report he had collapsed. On arrival officer's spoke to him through the letterbox as he could not get up to allow police access, so entry was forced. He stated the RBFRS and SCAS had attended the previous day, but he had refused help as he did not want to leave his home. The police officers called SCAS who triaged the call over the telephone stating they would not attend as they had attended the previous day under similar circumstances. SCAS informed police, they had submitted an urgent referral to ASC.

3.22 Referral 3 by Police**:** Police identified a number of safeguarding issues relating to Mr B's appearance and living conditions at the visit and also submitted an adult protection referral as Mr B had consented for this to be done.

Comment: It is clear there was good communication between GP, ASC, MHT, SCAS, TVP, RBFRS and HRS Officer and appropriate referrals made. SCAS contacted the police and also the GP Practice to find out if they had received the referral from them for a mental health assessment and left a message for a return call. No MCA was ever conducted, and no rationale has been recorded.

3.23 The HR Officer received a phone call the following day from Mr B. He confirmed he was feeling better but did not have the strength to go to the kitchen to get a drink or make food. He had no contact from ASC and asked if the HR Officer could get him some water

and visit. It was agreed with Mr B, that the HR Officer would contact ASC. Several calls were made to ASC without success, so the HR officer sent an escalation email and contact was made with ASC management. It was confirmed Mr B's issues were down to lifestyle choices and as such his GP should be taking the lead on the case which was closed to ASC on the 10th June 2018.

3.24 The HR officer confirmed that Mr B stated that he needed support such as a mobility scooter to assist him with his shopping and home help for cooking and cleaning. This information was emailed to his SW but had received no reply. (Apparently the SW was out the office most of the month). ASC confirmed Mr B's case would be re-opened under the safeguarding team as confirmed by the GP referral made to ASC.

Comment: It is unclear both to the HR officer and to this review whether Mr B knew his case was closed to ASC and why he was not being visited by a SW. (See Communication Finding in Chapter 4).

3.25 ASC response to referrals: To follow up the referrals of concern ASC SW's conducted a home visit on the 31st July 2018. Prior to visiting him they spoke with Mr B on the telephone where he said he was very hungry as he has not had solid food for a week. SW's obtained a food voucher and bought him sufficient food to last him for the rest of the week. This was good practice. At the home it was identified that his home needed urgent cleaning; there were flies and 'heaps of rubbish' all over his flat.

3.26 Capturing Mr B's voice:SW's listened to his requests and advised him that cleaning agencies will be approached for a price quote and the appropriate arrangements will be made as soon as possible for him. He was appropriately asked why he had refused to go to hospital and disclosed a phobia about going to hospital. Aware of previous concerns, he was asked whether he wanted the DN to attend, considering the issues he had had previously in relation to obtaining a blood sample from him. He said he would agree once his flat was first cleaned and was willing to allow carers to support him but only until his health improved as at the time he could barely stand and could not walk.

3.27 The SW's offered him the use of a commode to help keep his flat clean. He was advised to use a commode (which he had not used before) due to his physical inability to walk to his toilet in his flat, rather than using his lounge as a toilet which he was doing. He was informed his carers would empty it for him. He was asked whether he could pay for the cleaning but expressed he only had his state pension but was prepared to pay a contribution towards the cleaning. A SW completed a safeguarding investigation form for contact for him and an Occupational Therapist referral was sent to the Community OT on the 31st July 2018.

3.28 Several days later, on the 6th August 2018 a physiotherapist contacted Mr B in order to arrange a review appointment. Mr B stated he was waiting for the deep cleaning of his flat and had no space to complete physio exercises and did not think it would improve his chronic back pain, so declined the offer at that time.

3.29 An allocated SW (ASW) made daily phone calls (not detailed in ASC report) to Mr B who was also provided with the ASW direct telephone number which was good practice. ASC were at the same time searching for available agencies to work with him.

3.30 On the 3rd August 2018, the HR officer and RBFRS made a joint visit to the property. The barrel of the front door had been removed so the door did not lock. The property was in really poor condition. Mr B confirmed a SW visited and topped up his electric key and confirmed he would be getting a cleaner. He also confirmed that he wanted to now move out. RBFRS left some fire-retardant bedding, pyjamas and throws for his chairs and confirmed they would be carrying out a safeguarding referral due to the condition of the property. The HR officer agreed to progress Mr B's move and contacted his SW and Housing Needs for a move. He also contacted Mr B's landlord regarding fitting a new barrel and enquiring if there was a valid a gas safety certificate for the premises.

3.31 0n the 8th August 2018 the ASW visited him as he had telephoned asking for a visit. He appeared settled but said he was hungry. The ASW got him some food and drink and was informed the cleaners were coming the following day. He had a few cans of beer with him which he told the SW a friend got for him but did not answer when asked why he did not ask his friend to get him some food. He then reported someone came into his room during the night (even though his doors remained locked at that time) and stole his food whilst he was asleep.

3.32 Even though Mr B had been asking and waiting for a deep clean of his home it took the ASW a long time from the 31st July until 9th August 2018 to persuade Mr B to accept clearing his flat up to a habitable standard. He did not think it was necessary. The ASW told him the only way carers can go in help him was to allow his flat to be cleared and cleaned. On the 10th August 2018 the ASW managed to find a company willing to carry out the work. The ASW visited him on this day to see how the cleaning went after the cleaners had finished. He was happy with the work done but only allowed the cleaners to clear his passage way and some parts of his room (lounge). Mr B was the decision maker and the cleaners only removed what he allowed them to move. All bags of human waste matter and rubbish were successfully removed together with most of the combustible items in the premises.

3.33 The ASW carried out a joint visit with an OT assistant (OTA) from the Rehabilitation Service (RRR) who took Mr B a commode and 'Zimmer' frame. Mr B was too weak to stand up and transfer to the commode and was at risk of falling if he stood up to use it. He was reported to be stuck in his chair where he had been opening his bowels. Mr B reported he did not have any food, gas or electric so the ASW went to local shop and bought him a sandwich and paid for gas and electricity for him. This was good professional practice by the ASW supporting Mr B**.**

3.34 On the 13th August 2018 an OTA ,having spoken to the OT Manager, was advised that Reablement Assistants (RA) are not to work in such conditions as it was not a safe environment for their staff to work in. Mr B was asked what he would like from ASC and said he would like food so that he can build his strength back and have someone to help him with personal care.

3.35 The OTA explained to him there was not enough space in the flat to support him or provide equipment in his home. An interim short-term admission reablement support placement in a local care home with community physiotherapy was being considered, until he could build up his strength, and carers to support him were arranged but, he declined the offer. An agreement for the Highways Unit was given and he was offered an opportunity for

short term admission. Due to lack of vacancies and the urgency, this was not possible. Mr B was reluctant, but his ASW was instrumental in him subsequently accepting advice for a placement.

Comment: There was an agreement for a Package for Care (POC) however, considering the state of Mr B's environment, PPBT declined dealing with the request. At the time they were unable to source carer providers due to an unsafe working and manual handling environment at Mr B's home. A plan for his ASW was to try and get an agency to see Mr B at home and to look at arranging a 'meals on wheels' service for him. There is no doubt that practitioners were attempting to ensure Mr B received care and support, but he was reluctant to accept help and his environment was considered unsafe and unhealthy for carers to work in.

3.36 ASC followed up the referrals as detailed within this report, to provide care and support for Mr B. The GP recalls: -

- In early August the GP called Mr B to review medication he had prescribed for his constipation. Mr B disclosed he was now receiving help with cleaning his property. ASC had not informed the GP Practice as a follow up of action taken following the GP referral**.**

- The GP was later informed on the 15 August 2018 in a telephone call from Slough ASC, the hallway to Mr B's flat had been decluttered and ASC had arranged respite care for him at Salt Hill Nursing Home.

Comment: The GP's professionalism, persistence and good practice of care for Mr B was a key reason why ASC reopened Mr B's case, and supported by other agencies with appropriate referrals which ensured action to safeguard him was taken. ASC stated that his case was not closed. The case was identified as safeguarding by ASC when the referrals identified a change in his physical health. But both the GP and Housing Officer were informed by ASC staff the case had been closed due to his behaviour. There is no criticism of ASC as they promptly addressed the safeguarding issues when Mr B's case was referred, and his health concerns and environmental issues shared.

3.37 Mr B's admission to Salt Hill Care Centre on the 16th August 2018 and the treatment and care provided.

3.38 The ASW's persuading Mr B to leave his property was challenging as having agreed to go into SHCC, when transport arrived on the 16th August 2018, it took over an hour before he decided to leave his home. His reluctance to accept help which was to protect and care for him was a constant concern for practitioners who tried to work with him. In the practitioners event, he was described as quite difficult to work with and intimidating. Practitioners reported he often blew his cigarette smoke in a practitioner's vicinity, when they were at his home trying to assist him.

3.39 The perseverance of the ASW prevailed to ensure Mr B received appropriate care and support for his health and wellbeing. He was eventually transferred to SHCC and on his arrival they immediately gave him a thorough wash which 'he had not had for a very long time'. It was at this stage staff discovered the consequences of his significant self-neglect (a possible aversion to medical intervention of hospital and needles) and his health condition as described previously in Chapter 1 was first identified by practitioners. The Home Manager (HM) agreed to register him with the SHCC GP who referred and asked for a 'proper assessment' of his medical condition from WPH on the 18th August 2018. It was anticipated that his wounds were going to take more than a month to recover. The SHCC GP confirmed he was suffering extreme dehydration and severe infection. He was prescribed and completed three courses of antibiotics.

3.40 The SHCC GP further made a referral to The Hub, a Leg Ulcer Clinic (LUC) for Mr B's chronic leg ulcers and wounds. Mr B was seen in the Vascular Assessment Clinic in September 2019. A vascular surgeon suggested there was a chance he could have lost the use of his legs, or even have a leg amputated. Both his lower legs were oedematous with dry flaky skin with superficial leaking ulcers on dorsum of the right foot. The clinic informed SHCC via a letter for weekly dressings with modified compression dressing and to start on a low dose of Aspirin.

3.41 Outcome and current position

3.42 In March 2019, Mr B's current ASW emailed HRS regarding the condition of Mr B's property who agreed to carry out a joint visit on the 3rd April 2019 to carry out an inspection of the property agreed. This was because Mr B was stating he wanted to leave SHCC and return to his home. The SW did not attend as arranged as he had to cancel the visit. An email was sent from the SW and asked HRS to check if there were current electrical issues with the property; contacted the landlord directly to get them to have the electrical supply and system tested and to produce an electrical conditioning report prior to Mr B moving back to his home. The HR Officer states as discussed and agreed with Mr B, ASC and RBFRS there were a lot of the issues within the property a result of his tenant lifestyle and the SW and other practitioners will be working with him to address the issues.

3.43 Update since he returned home. In June 2019 Mr B was referred to the Community Matron (CM) Team. He was visited and a full assessment completed by the Community Matron on the 13th June 2019 and placed on the list to be reviewed at a Cluster meeting.

3.44 The role of the CM is to work with complex patients to prevent hospital admissions. This includes taking them to Cluster meetings and working closely with ASC and involving other appropriate services to manage the patients' health and social needs within the home.

3.45 Since the initial visit, the CM has been contacted and had interactions with him on four separate occasions. He is working with the CM to resolve severe back pain which he stated is happening because he is more active around his home. He has a cleaner in place who also does his shopping once a week. He also has a carer visiting once a day to help with personal care and his breakfast. He is considered not a housebound patient and appears to be able to work with the CM.

3.46 Mr B's health needs are currently being managed and he is also being seen by the DN Service and by the Lower Limbs Service.

3.47 Once the seriousness of Mr B's case was known and referrals were made this led to a positive outcome which has been effective to protect and support Mr B which required a multi-agency response. A clear pathway should be developed for practitioners in dealing with cases such as Mr B's, in the future. (See the Findings and SAR Overview Report Recommendations in Chapter 4).

Chapter 4 – Analysis of the Findings and suggested SAR Recommendations

4.0 This chapter outlines the findings identified from the analysis of professional practice and agency submissions to the process. They are produced for consideration by the Slough Safeguarding Partnership to reflect and implement any learning from this SAR. The findings contain suggested SAR Overview Report Recommendations that overarch, encompass and support Individual Agency Recommendations which have come from the analysis of the reports submitted and from the multi-agency practitioner analysis learning event. The Findings and SAR Overview Report Recommendations are as follows: -

Finding 1 – MASH adult referrals and assessments

What are the issues?

In 2016, (which is outside the timeframe for the review but significant to this SAR) TVP officers made a referral regarding Mr B's presentation and the state of his property. An adult protection concern was created and submitted with full details by the officer's concerns. This was reviewed by the police but was not referred to Adult Social Care or CMHT (Community Mental health Team) as Mr B had not given consent. TVP record that the Police Multi-Agency Safeguarding Hub (MASH), a TVP staffed resource for adults, did not accept the referral, as it did not meet their threshold. The rationale given was that Mr B had not agreed to the referral and he had capacity to make that decision. The Police MASH unit do not normally make contact with other agencies. They consider whether to refer to ASC if they feel an incident meets the threshold. This may indicate their remit is limited as concerns regarding him and the condition of his home was still apparent in 2018.

What should be considered? The TVP policy for adult referrals needs to be reviewed to ensure they consider the wider aspects of a case. In Mr B's case the facts justified an adult referral from the TVP MASH to ASC. The decision not to refer was a presumption, which, in the circumstances, required a further risk assessment of a person displaying self-neglect, environmental and possible hoarding concerns. This may have been a missed opportunity. There should be some flexibility in the application of thresholds, for instance, an attempt to verify and speak to his GP, as he may have had health and social care problems which an onward referral would address. Slough Safeguarding Partnership needs to be assured by TVP that adult referrals and their thresholds are reviewed, and effective sharing of information is addressed to safeguard adults in the future. This aspect of the front door of adult referrals needs to be correct to support the next level of safeguarding as suggested, if the recommendation in Finding 2 below is accepted for a multi-agency pathway for assessment, guidance and action is agreed. SBC can meet with the current TVP MASH Adult Lead to support this review to consider thresholds.

It is recommended Slough Borough Council with Thames Valley Police assure the Slough Safeguarding Partnership they will conduct a review of the TVP Multi-Agency Safeguarding Hub Adult threshold for referral and risk assessment process, to ensure flexibility and professional curiosity to verify information without making assumptions, assuring Adult Safeguarding cases are appropriately shared with Adult Social Care.

Finding 2 – Adopting a Multi-Agency pathway to understand and address self-neglect, environmental issues and hoarding

What are the issues? A significant element of self-neglect and hoarding is the risk the behaviour poses to vulnerable adults including members of the public, family or professionals working with the adult, which was a concern in this case. It is said that self-neglect is a behavioural condition in which an individual's neglect to attend to their own basic needs such as personal hygiene, treating a medical condition and keeping the home environment safe to carry out normal activities. It can be as a result of mental health problems, trauma, social and medical issues etc or from personal choice. It affects people from all backgrounds and walks of life**.**

What information is available and what should be considered? Multi-Agency working
The complexity and diverse nature of self-neglect and hoarding in research suggests that multi-agency risk assessments and responses is more effective than a single agency response. In this review, Housing Regulation Service staff had a good understanding with Mr B when he was not apparently receiving support from ASC and care providers. From the conversation with Mr B, conducted subsequently for the SAR, the need for practitioners to build a rapport with the adult to understand their self-neglect and hoarding behaviour is vital. With a multi-agency approach, a joint consideration and assessment of risk from Mental Health Services and Adult Social Care may have prevented the serious deterioration in Mr B's physical health and for others in future cases. There was no indication Mr B had a mental health condition, although the GP and SCAS raised the possibility of a Mental Capacity Assessment (MCA) which did not take place and may have been addressed in a multi-agency discussion or meeting as alluded to previously if held for Mr B (See Para 4.3 Key lines of enquiry regarding MCA's).

Berkshire Multi-Agency Adult Safeguarding Policies and Procedures, June 2016 have adopted the Association of Directors of Adult Social Services (ADASS) Pan London Multi-Agency Policy and Procedures, which outlines guidance for self-neglect and hoarding. Self-Neglect is not defined, but the Care Act states it comes within the statutory definition of abuse or neglect, if the individual concerned has care and support needs and is unable to protect him or herself. The Department of Health (2014), defines it as, 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'. Symptoms of Mr B and awareness of available guidance will support a practitioner in their role to recognise and address. There are Pan Berkshire Procedures and the Hoarding and self-neglect policy is being written and Slough now have the Berkshire procedures on line for access and information.

The CCG identified that the GP may have benefited from requesting the implementation of the East Berkshire Multi-Agency Risk Framework for Mr B. A recent Slough SAR for Mr A 2019, and supported within this review, makes a recommendation to implement the Slough Multi agency Risk Tool 2019 to address this aspect. This is vital guidance for Slough Safeguarding Partnership to implement. Action is currently being undertaken to ensure the guidance is rolled out throughout the Local Authority. It is clear practitioners in Mr B's case recognised the concerning behaviour of self-neglect he displayed due to his own presentation and the uninhabitable, fire risk environment he resided in which was compounded by his hoarding habit. This is a Slough policy for situations where Safeguarding

is not indicated. This report endorses the need for multi agency commitment to work with people who are complex under Safeguarding or under the Multi Agency Risk Tool (2019).

Attempts by practitioners to help him would often be met with a refusal not to accept professional advice given to improve his health and well-being. Mr B did sometimes engage with practitioners and the reason sometimes for his reluctance not to was never fully explored. It is reported by practitioners he could be confrontational and spoke his mind and intimidated some practitioners on occasions by his behaviour. There is a need to reassure practitioners and give them the knowledge and support to deal with persons such as Mr B, to learn to understand and build a rapport as he had with several practitioners.

Hoarding is the build-up, saving and acquiring of numerous items regardless of their value. The person may hoard, because they may be anxious about throwing items away or find it hard to decide whether to keep an item or not; behaviour displayed by Mr B when his home was being cleaned. It has elements of mental health. ASC report hoarding was not noted as an aspect in Mr B's case, but this was raised as a concern at the practitioner's event held and referred to in CCG and SCAS reports. Both agencies made referrals to ASC referring to his hoarding. In June 2017 his GP made a further written safeguarding referral after another home visit as he was concerned about the hoarding in the home and lack of lighting. He had to conduct a conversation on the door step with Mr B as the GP could not gain reasonable access to his property. In July 2018 SCAS attended his home address to him falling where Mr B refused treatment. They made a safeguarding referral and ASC were spoken to by the ambulance crew who were at the scene. They raised both a safeguarding referral and also contacted Mr B's GP also whilst at the scene recording, 'Patient is a hoarder'. Furthermore, HRS from March 2017 had concerns regarding the condition of Mr B's property in relation to hoarding and him being a smoker.

Comment: It is the Independent Authors opinion that the information provided to this review confirms Mr B was considered a hoarder and supports the recommendation below.

Mr B's open wounds were only identified after he was bathed at SHCC and they may have not been visible to untrained practitioners and carers. A DN may have recognised the likelihood of pressure sores or wounds and worrying health issues due to his static nature and medical issues if, he had allowed them to attend his home to obtain blood samples. He however continued to refuse to have his blood taken, due to an aversion for needles and a reluctance to go to a hospital and never disclosed his health issue to any practitioner to the review.

Environmental Health Service (EHS) Practitioners should be aware of the EHS who have a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premises are affecting or could be affecting neighbouring premises as was the circumstances muted by practitioners in July 2018. The powers used do not rely on a presumption the individual affected by such intervention lacks mental capacity. EHS have a crucial role as a frontline service in raising concerns and early identification. In addition, where properties are verminous (as suggested) or pose a statutory nuisance, EHS can take a leading role in such cases managing the necessary investigation. This is confirmed by a safe and well technician in August 2018 in relation to hoarding, fire hazard and uninhabitable conditions such as bags of faeces and rat infestation. This followed a referral made by the Fire and Rescue service in July 2018 following attempts by SCAS to enter the property).

It is recommended that Slough Safeguarding Partnership commission a review on behalf of Slough Borough Council to develop a clear multi-agency pathway and formal system and process for the information and support of practitioners; to provide a guidance in dealing with vulnerable person displaying self-neglect, involving potential health concerns, environmental and hoarding issues; ensuring a robust multi agency response, with the need for multi-agency commitment to work with people who are complex under Safeguarding or under the Multi Agency Risk Framework and Tool (2019) 'for those who do not access services.'

It is recommended that all Safeguarding Agency Partners and relevant voluntary organisations within the Local Authority area concerned in the safeguarding adults review, assure Slough Safeguarding Partnership that their agency and organisation will ensure all staff concerned in providing care and support within the community; are aware of Local and National available procedures and guidance concerning neglect including self-neglect and hoarding which should be disseminated to inform professional practice**.**

Finding 3 – Communication, Sharing Information and Record Keeping

What are the issues? There were communication and sharing information concerns identified at the practitioner event and within the agency submissions to the SAR. Communication and sharing information was inconsistent and requires to be clarified. Agencies did not communicate well initially with concern from the GP and Housing finding contact with ASC. After the concerns for Mr B were escalated by the GP who was pivotal, HRS, SCAS, TVP and RBFR by their referrals to ASC did act and took appropriate action. Also, information was obtained by his GP and his HR officer from Mr B who were all unaware ASC had closed their case on him due to his apparent rudeness to staff in June 2018. There needs to be clear communication and sharing of information. ASC subsequently question whether the case was closed to ASC? It was apparently the creative support service who closed Mr B's case in April 2018. They supported him for several months to try to address the 'belongings' in his property but withdrew due to his language and because he declined to be involved in the process. The fact that the GP and Housing say ASC informed them the case to Mr B was closed is evidenced within the narrative and agency reports. The issue is not whether the case was closed but the need of communicating to Mr B and interested parties such as his GP and other relevant practitioners, as Mr B was reporting to the GP and his Housing Officer, he was not seeing his SW. A joint visit with ASC and Housing was arranged for 25th June 2018 but ASC are unsure whether this occurred from their records.

What should be considered? The concern was contacting and communicating with ASC according to some agencies to the SAR. ASC should ensure there is an efficient process in place for ease of contact with and response from ASC. Furthermore, it was not known by key practitioners supporting Mr B that ASC had closed their case (see above comments) on him. He did not know and was questioning his Housing officer why he had not seen or received a visit from a SW. His GP Practice was also unaware of this. ASC should communicate to all interested parties including Mr B in order to share and update relevant information. It is confirmed by the GP and Housing that SW staff were spoken to when raising safeguarding concerns for Mr B and were informed Mr B's case was closed as evidenced in the narrative in Chapter 3.

It is not recorded whether the GP informed ASC regarding contact with the CMHT about a possible MCA. Mr B was assessed to have capacity by practitioners, but the GP may have considered a referral to the Community Matron who confirmed at the Practitioners Event they would have been able to support Mr B's situation. The GP's outcome of the consideration of a possible MCA to be conducted for Mr B has not been provided to this review. Housing Regulation Service in March 2017 had concerns about Mr B's hoarding, but it is not known if this information was shared. Agency records need to be accurate and comprehensive to ensure the correct information is available. It is therefore recommended: -

Slough Safeguarding Adults Board Overview Report Recommendation (4) for Slough Adult Social Care, Mr B's GP Practice and Housing Regulation Service

It is recommended Slough Adult Social Care, Mr B's GP Practice and the Housing Regulation Services reassure the Slough Safeguarding Partnership their communication, information sharing and record keeping processes, are effective, efficient to ensure they and all interested parties in a safeguarding case are kept updated and informed on relevant developments and outcomes recorded**.**

4.1 Key Line of Enquiries

4.2 The following Key questions from the terms of reference were of asked agencies to consider in their submissions to the SAR process: -

4.3 ***Was Mr B's mental health or a Mental Capacity Act (MCA) assessment ever sufficiently considered?*** There were three agencies who suggested Mr B should be subject to an MCA; the GP practice and SCAS both during the scoping period and after his admission to Salt Hill Care Centre raised the concern although outside the TOR. After he discharged himself, against advice back into the community to his home, no MCA was completed before he left. Completing an MCA, however, is still open to agencies if he was to return to his previous self-neglect and hoarding behaviour again. Practitioners working with him in their interaction with him assessed he had capacity to make his own decisions, which is obvious from the narrative and within the conclusions where his voice is captured for this SAR.

4.4 When other agencies were unable to engage with Mr B, the GP visited him to check on his welfare and carried out capacity assessments which were well documented and when he would not take medical advice, the GP took the appropriate actions based on his assessment that Mr B had capacity at the time he saw him. It is not known whether the risk of pressure sores were assessed by the GP as a concern for Mr B's health and wellbeing and but the GP's attempts to get him into hospital was apparent.

4.5 Is there a possibility there could be a reoccurrence of his concerns? There were no MCA's conducted for Mr B as stated above but, this remains an option if circumstances repeat themselves. Actions taken after the practitioner's event by operational staff were proactive to ensure there was no reoccurrence. He left the care home of his own accord. ACS with the HRS and RBFRS were mindful of the condition of his property and carried out an inspection; his ASW is working closely with him and other service providers and carers within the home, and he now has regular contact with the Community Matron**.** Furthermore, representatives from Slough BC as a result of the practitioner's event, committed to visit him, ensure his needs were being met and the reasons explained to him of the purpose of the

SAR and why safeguarding action was taken. (See summary of the SAR visit with him under Conclusions in Chapter 5).

4.6 *Are practitioners aware of the Slough Risk Assessment Tool for managing of risk outside of safeguarding*? Agency responses to the SAR did not particularly refer to the new Multi-agency Risk Framework Tool (MART). Furthermore, all Practitioners involved in the SAR, have recognised the need to utilise this tool. This ensures that practitioners are given the necessary support, in understanding all aspects of neglect in carrying out their roles and duties and assessing potential risk. Although relevant to this SAR a recommendation to implement it has been made in Slough SAR for another SAR 2019 and is not repeated at this juncture but is referred to in the Finding and Recommendation 2 above.

4.7 Would this (the MART) have helped dealing with him and his self-neglect in the circumstances? Agencies from July 2018 recognised the self-neglect and environmental issues for Mr B and effectively took action which, ultimately, protected him. Berkshire Safeguarding Policies & Procedures Group is updating guidance during 2020. This will ensure all practitioners have the knowledge and awareness with the necessary guidance to recognise and address neglect and local practitioners apply the MART.

4.8 The following additional questions were asked of agencies to the process to address:

4.9 Did agencies communicate with each other? If not, why not? This has been addressed in Finding 3 and Recommendation 4 above.

4.10 Were Mr B's views established, clearly understood and acted upon? If not, why not? There is clear evidence within the narrative of this review which describes his interaction with professionals and Mr B's views were captured. He was also seen for the purposes of this SAR and a meeting held with him after he returned to his home. Although his views were established, there was an issue of his reluctance to take the necessary advice for his health and welfare. His reluctance may have had a negative impact on his health and relationships with organisations offering the help to him. Practitioners had the task of duty of care but also balancing his rights and choice. By developing a multi-agency pathway as discussed in the findings above will support practitioners to be able to consider all the options to be taken in order to identify the most appropriate action to be taken.

4.11 Were there examples of good practice in relation to partnership working? There is good practice and appropriate referrals made by the GP Practice, his Housing officer, RBFRS, SCAS and TVP. ASC revisited their decision to close his case. There are differing views whether the case was closed or not as discussed and addressed above however, after receiving the referrals ASC expedited action for Mr B's health and wellbeing and the ASW intervention and action resulted in Mr B's sores and wounds being identified at SHCC and ASC supported managing his housing and recovery.

Individual Agency Recommendations

4.12 A SAB Action Plan will follow this SAR, incorporating the Overview Report and Agency Recommendations for dissemination and implementation for learning.

Chapter 5 – Conclusions

5.1 This SAR Overview Report for Mr B is the Slough SAB's response to prioritise and implement positive changes to ensure lessons are learnt for future cases.

5.2 Predictability and Preventability;

5.3 In 2016, TVP made a police referral to ASC regarding welfare concerns for Mr B who was seen in a dirty and dishevelled state in an uninhabitable home, the same situation which remained in August 2018 when he was admitted to Salt Hill Care Centre. The TVP MASH for Adult referrals at the time did not proceed with the referral stating it did not meet the threshold, Mr B had not agreed, and he had capacity. The decision is discussed within the narrative and findings in Chapters 3 and 4.

5.4 As events heightened in July 2018, with referrals and concerns for Mr B reported to ASC from his GP, SCAS, TVP, RBFRS and the HRS, ASC to their credit, reopened his case (ASC subsequently say closure was by a care agency contrary to information supplied by other practitioners to the review). There is no issue whether the case was closed or not. The issue was around communication which has been addressed. ASC, when receiving the subsequent referrals, took appropriate action to meet his needs, as outlined in Chapter 3.

5.5 Mr B's presentation and behaviour, in the circumstances from the initial 2016 referral, and the current concerns identified in July 2018 can be said to be predictable. To suggest it was preventable however relies on a robust multi-agency assessment and for practitioners to be able to communicate and work with an adult who could be challenging as Mr B. It must be stressed, agencies worked together once the extent of his self-neglect, environment and hoarding was evident and action taken. It is not always straight forward for practitioners trying to work with a person who was intent on making his own decisions and was not fully compliant to the help and support offered.

5.6 Practitioners, particularly his SW, encouraged Mr B to be admitted into a care home for appropriate care when the need for treatment became apparent. If agencies worked together and if the suggested learning from this review is implemented in future cases, future similar situations could be prevented. There are new integrated care structures which will support multi-agency working where individuals present with challenging situations. This includes the development of Cluster Meetings. In the circumstances of Mr B's case, it is hard to quantify if it was preventable due to the reluctance of him not always allowing contact and not disclosing his medical condition that had been developing to his lower body. This was clearly self-neglect and could have had a more tragic outcome with a possible risk of deterioration and amputation due to his vascular disease which, the agencies protecting him helped to avoid due to practitioner's intervention.

5.7 Voice of Mr B and his future health and wellbeing.

5.8 Mr B's voice is captured throughout the narrative of this review. It was identified at a practitioner's event held for him, he left SHCC to return home against professional advice in April 2019. The Independent Author facilitating the meeting requested practitioners to conduct a multi-agency meeting to be called for all necessary participants to the SAR process to reassess the risk to ensure the reasons why this SAR was commissioned was not repeating itself and to ensure his health and wellbeing. When Mr B discharged himself from

SHCC, ASC were ensuring his home was safe and were communicating with RBFRS and his health and well-being was being cared for.

5.9 Furthermore, it was agreed the SBC Risk & Exploitation Co-ordinator would visit Mr B with his current ASW to speak to him regarding the reason for conducting the SAR. Mr B was seen at home on the 7th August 2019. It was explained to him that the SAR is looking at what happened to him in order to see if there is anything professionals can do better in the future. There was no suggestion that Mr B lacked any capacity to make his own 'best interest' decisions.

5.11 He did not remember all the details of what happened in the run up to him going to SHCC stating the SW at the time was "the only one doing anything", which seems to be related to bringing him food, cigarettes and alcohol, all of which were, and still are, very important to him.

5.12 Mr B does not want to go to hospital under any circumstances, because "People go into hospital and they don't come out". If someone visited and found him unwell his opinion was to call his GP and if the GP felt that he was so unwell and hospital was the only option, he said "Then I would have to think about that very hard."

5.13 Mr B was upset with RBFRS because he blames them for the exit of his SW at that time (the reason for this comment is not clarified). They provided fire resistant bedding but that was for a single bed, when he has a double bed. He confirmed however, he never smokes in bed. (He has a fire-resistant sheet over his armchair, where he mainly smokes).

5.14 He was also upset because the police had forced entry to his home, and he felt the property was insecure. Mr B did not offer any alternative for police to have gained entry, especially given he had been laying on the floor for some time and the lock was later repaired as arranged by HRS.

5.15 In relation to the SHCC, he got fed up because they treated him "Like everyone else in there" by which he meant he does not have dementia which, his mother had died from the previous year. He felt ASC were trying to keep him there against his will, until the point where he decided he had had enough and left. It was suggested to him this was because those involved were worried about his safety at home; he derided the comment but did not completely refute this as an idea.

5.16 It was reported at the Practitioners Event Mr B was attempting to be registered with his previous GP Practice who this review believes was very supportive of him. At the time of the meeting with him he was still under the SHCC GP. This is being progressed, but he is frustrated that to transfer back to his original GP involves a fasting blood test, (a persistent theme for Mr B of his reluctance to have blood tests taken). He did not want to see his existing SHCC GP.

5.17 It was explained to him that the challenge faced by all agencies to try to help someone to be safe and healthy when there are lots of concerns about them, while not taking away their choice. Mr B was very clear about the support he wanted and did not want, and the practitioners felt his demands were not unreasonable. He does not see the amount of items in his flat as "hoarding", they are just his personal possessions. It was positive the home was not in the same state it was during the scoping period of the review, with all rancid

waste removed which at the time, he was unable to walk and therefore not able to remove the waste. He also does not feel he should have to pay for services and has issues about paying out money in other areas too.

5.18 He identified at least two carers who he particularly likes, and who he feels do the job "properly". It was felt advisable to use carers with whom he does have a good relationship to introduce others. It was also noted he had windows and the back door open in order to let smoke out of the property (something which has been an issue for all professionals entering the property previously). The issues with his property was a concern since his return home and a professional from HRS had discussions with RBFRS to check the property and it is believed the outcome of the discussion was the property was deemed safe.

5.19 Mr B appeared to have a good relationship with his current ASW. Mr B was able to say about the things he has in place now to keep safe in the home (including Careline and a falls monitor). He previously stated he requested Careline which is not referred to in the information supplied to this review, but he did have a reasonable amount of contact with OT services.

5.20 Mr B's current position appears more stable but there will be a constant need to reassess his health and wellbeing to ensure his self-neglect and his environment does not return to the serious concerns that this SAR had to act upon and address.

5.21 Safeguarding Policies and Procedures and Guidance

5.22 Berkshire Multi-Agency Adult Safeguarding Policies and Procedures, June 2016 have adopted the Association of Directors of Adult Social Services (ADASS) Pan London Multi-Agency Policy and Procedures, which outlines guidance for self-neglect and hoarding cases and should be followed. (See Finding and Recommendation in Chapter 5 which outlines other guidance available and previous related SAR's). Slough now have the Berkshire procedures on line for access and information. They are currently working on a Neglect and Hoarding Policy at Berkshire Level and Procedure at each council level.

5.23 In Conclusion

5.24 It must be acknowledged that working with vulnerable adults, often with additional complex health needs, can be a difficult process and challenging for practitioners to contend with. It is clear, every practitioner concerned in this review wished only the best for Mr B, but he could be particularly challenging. Action taken to resolve his personal care, health and environment have been made but there must be regular reassessment to ensure the factors which resulted in this SAR being commissioned for Mr B and lessons learnt will help Mr B and similar cases from occurring again.

5.25 Submission of the Overview Report

5.26 This SAR Overview Report for Mr B is submitted to the Slough Safeguarding Partnership to consider the findings and recommendations and to promulgate necessary learning through a SAR Action Plan that will accompany this report.