Safeguarding Adults Review for Anne

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Contents

1. Summary of events leading to the SAR referral

A Safeguarding Adults Review (SAR) referral was received by the Essex Safeguarding Adults Board (ESAB) on 29 November 2022 from Essex Police. The reason for the referral was that Anne[1] had been found deceased at home. It was reported that she had been living in a bedroom alone, with very poor eating habits, surrounded by her own urine and faeces and the room was covered in flies, maggots and other insects. The mattress she was using was brown and rotted to the springs. Her hair was severely matted. She had chemical dermatitis, across both her chest and her back, which the pathologist believed was caused by urine and/or faeces.

2. SAR Decision Making

The SAR referral was considered by the ESAB SAR Committee on 28 February 2023. The Committee concluded that Anne's experience met the criteria for a mandatory SAR under s44 of the Care Act 2014 where:

An adult has died 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.

And/or

There was evidence of a risk of significant harm to an adult at risk that was: not recognised by agencies or professionals in contact with the adult or perpetrator; OR not shared with others, OR not acted upon appropriately.

And/or

The case indicates that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case.

And/or

The case suggests that the SAB may need to change its local policy, protocols or practice guidance, or that protocols and guidance are not adequately being disseminated, understood or acted upon.

The SAR Committee expects the SAR to identify ways to strengthen current self-neglect and hoarding guidance, with a view to further promotion.

3. Methodology

A systems approach was applied to consider the findings from the Review and identify wider learning to be taken forward by the ESAB and its partners.

This was undertaken by an independent reviewer with support from a panel comprising representatives from the following agencies:

[1] 'Anne' is a pseudonym chosen by the SAR panel in the absence of family involvement

- Essex Adult Social Care (ASC)
- Essex Police
- Essex County Fire and Rescue Service
- Suffolk and North East Essex (SNEE) Integrated Care Board (ICB – focus on Primary Care)
- GP Practice
- Essex Partnership University NHS Trust (EPUT)
- Tendring District Council

Agencies were requested to provide summaries of their involvement with Anne and a timeline of key events. An interim findings report was completed, based on the information provided within the agency summaries. This was shared with the Coroner in readiness for the Inquest.

In April 2024, a practitioner event was held with those who had direct experience of working with Anne. Additionally, there were representatives from services that are usually involved with individuals who have care and support needs and neglect themselves. The reviewer used this event to explore the initial findings in more detail and consider to what extent Anne's experiences provided a window to wider practice in Essex.

4. Scope of Review

The specific period covered, for analysis of practice by the review, was set as **01 May 2022 – 17 November 2022. This reflected the period during which Anne was known to services. In addition, agencies were asked to review any key decisions in their work with Anne from 2011 onwards.**

The aim of the SAR has been to attempt to establish why, in 2022, an adult with care and support needs could be living in such dire circumstances, in the knowledge of agencies.

5. Key Lines of Enquiry

- Consider the responses and decision-making of the agencies involved with Anne when she declined support or treatment, to include: the application of legal frameworks; the use of welfare checks; the powers of entry to a property including to specific rooms; making referrals to other agencies, and the use of the self-neglect protocol.
- Discuss how professionals apply the Mental Capacity Act when there are clear signs of self-neglect, and the impact of this on safeguarding the individual.
- Evaluate the decision making by health agencies in stopping involvement with Anne in 2011.
- Explore how agencies sought to understand Anne's lived experience and what she wanted to happen.

6. Standard Terms of Reference

a. Did protected characteristics (codified by the Equality Act 2010) impact on Anne's care management and if so how?

b. Identify whether agencies complied with:
   i. the Southend, Essex and Thurrock (SET) Safeguarding Adult Multi-Agency Procedures, particularly relation to raising safeguarding concerns;
   ii. locally agreed information sharing protocols;
   iii. agency risk assessment and management policies, and
   iv. agency review policies.

c. To identify findings, set out the analysis, and consider: lessons learned and examples of good practice, along with a set of firm, achievable recommendations and accompanying actions, for relevant agencies involved, implementation of which will be monitored by ESAB.

7. Parallel investigations

Anne was found deceased in her room and her partner Peter[2] was originally arrested, until the post-mortem concluded there was no third-party involvement in her death. An inquest is awaited and will take place in 2024.

8. Family Engagement

Efforts have been made to communicate with Peter and invite him to speak to the reviewer. However, Peter has not responded. If he wishes to speak about Anne at a later point, the reviewer and SAB will be willing to accommodate this and add his views to the report.

9. Practitioner Engagement

The reviewer would like to thank the practitioners who had direct involvement with Anne for their honest reflections at the practitioner event held in April 2024. The focus of the event was to gain an understanding of why workers responded in the way they did. By using this method, the risk of hindsight bias was reduced and enabled the reviewer to see the situation from the worker's perspective and any wider issues in their work in 2022.

Participants at the event were from:

- Essex County Council Adult Social Care
- Essex County Fire and Rescue Service

[2] 'Peter' is a pseudonym chosen by the SAR panel in the absence of family involvement

- Essex Partnership University NHS Trust
- GP Practice

The event focused on the key episodes (section 11) and the following questions were explored:

1. Why was Anne not actually seen?
    - How was this considered within supervision?
    - Was this an unusual situation?

2. Why was there no formal mental capacity assessment undertaken?
    - What would be the usual practice when there is a person with care and support needs who refuses to let workers see them?

3. Why was there no joint working between ASC and the GP Practice?
    - What could have been done differently?

4. Why were there such different views of the state of the property?
    - What weight was given to the reports from neighbours and the landlord?
    - How were the differences in the appearance of the property evaluated by ASC?

The findings from the practitioner event are included in the analysis section of this report.

10. What was known about Anne?

10.1 Anne was a 68-year-old female who lived with her partner Peter in a privately rented home. There was limited information found by agencies regarding Anne, prior to May 2022.

10.2 The ASC workers who spoke to her described her as

'a lovely lady to speak to'

10.3 Primary care provided some historical information for 2010-12. In 2010 Anne was noted to be suffering night sweats and requested a repeat prescription for Temazepam 20mg (to treat sleep problems) which she said had been provided by her previous GP, when she took one tablet 2-3 times monthly and a repeat prescription for 28 tablets had lasted 6 months. In 2011 there was a medication review. At this point, the GP noted that Anne said that Temazepam was not helping the night sweats and a change of medication to Zopiclone was made (also used to treat sleep problems), however Anne did not want a change of

medication, and this was recorded as her last engagement with the GP and the last time she had a prescription.

10.4 In 2012 Anne called Police, accusing Peter of domestic abuse. Following a visit by a paramedic and a subsequent call from Anne, Police visited and were satisfied there was no evidence to support the accusations she had initially made. At this time, officers and the paramedic believed Anne to be possibly experiencing a psychotic episode. However, other than this record there is nothing to suggest domestic abuse in the relationship, and information demonstrated that Anne was known to the mental health crisis team at this time. The GP records noted that there had been a call from the mental health duty desk to ask for Anne's details and to advise that Police requested a call out to Anne from the crisis team, owing to concerns about Anne's mental health. There was no follow up by the GP and no other information has been received regarding any knowledge of her, from mental health services.[3] This would indicate that Anne was not known to any service in relation to any mental health problems, after the 2012 episode.

10.5 There seems to be no knowledge of Anne to services again until, in May 2022 a gas engineer attended to complete a yearly check and raised concerns with the landlord regarding the state of the property, which they perceived to have deteriorated from previous years.

11. Key Episodes between May 2022 and November 2022

Key Episode 1: 26-30 May 2022: Safeguarding Concerns Raised
On 26 May 2022 the landlord visited the property for the first time in over 12 years and subsequently raised a safeguarding concern with Essex ASC, reporting concerns about Peter and Anne's living situation. The landlord reported: *"100's of flies,' filth, faeces incrusted on the carpets, hoarding issues, rusted appliances, could see only a bunch of bananas as food in the property, toilet blocked and overflowing, and a general state of disrepair. (Peter) presented unclean, long greasy hair, bushy beard, dirty clothes".* The landlord's main concern was for Anne as when he opened the bedroom door, there was *'complete darkness and the door would only open 6 inches, with objects falling like a barricade behind the door*.' He believed there was risk that Anne was unable to care for herself, given no toilet access, no access to food, and being trapped in a dark bedroom.

[3] Regarding the absence of information by mental health services - EPUT was not in existence in 2012. At that time it had been two different Trusts and so records are not available.

Police attended and spoke to Anne through the door, noting concerns she was self-neglecting, and Peter could not help her. Police raised a safeguarding concern with Essex ASC which was combined with the concern raised by the landlord. Police also determined Anne was not open to EPUT services and made a referral to the GP surgery and a further referral to the Essex County Fire and Rescue Service (ECFRS) Community Builders regarding the clutter/debris causing a fire risk and risk to safe exit.

Essex ASC recorded that Police noted Anne spoke coherently and did not appear to be under any duress – they spoke to her away from Peter and she did not disclose anything of concern. Police also spoke to Peter who reported that Anne did not leave her room and he was unable to get her to go out.

Key Episode 2: 31 May – June 2022: Unannounced visits to home

An unannounced visit was made by two social care support workers as part of the information gathering by Essex ASC. Peter told the workers he was very unhappy with the landlord. The workers reported that they told Peter they were there to check in to help the couple and so Peter welcomed them into the home.

On the same day, an ECFRS officer visited and advised that the property was not cluttered. He reported that Anne agreed to a smoke alarm and fire-resistant bedding being supplied, as Anne smoked in bed.

The ECFRS officer reported an extensive conversation with Peter. In this conversation Peter explained that he was Anne's carer and that Anne did not leave her room. Anne did not like Peter being out of the house for long. Peter reported that Anne '*ate well'* and was *'content in her room, being an avid reader and of strong character'.*

It was interpreted from the visits by the ECFRS and ASC that action had been taken regarding the state of the property since the landlord and Police had visited. There was no evidence of hoarding, and the house was not cluttered. Anne had been unwilling to come downstairs; but she was offered a Care Act assessment which she declined. Peter was offered a Carer's Assessment, and he declined; the two ASC workers making the visit had no cause for concern regarding either Anne or Peter's mental capacity to make their own decisions. It was recorded that Anne had had negative experiences with medical professionals and chose not to engage with any medical support.

Following the visits, the safeguarding concern was ultimately concluded, though signposting was given to the landlord relating to their concerns about a gas safety certificate.

Key Episode 3: June – July 2022: Primary Care attempt to contact Anne

The GP surgery had attempted to speak to Anne and/or Peter to no avail, and a letter was sent on 10 June 2022 asking that Anne book an appointment to see a GP. The surgery planned a health visit for 11 July to make contact and offer Anne support, but there is no record of the visit taking place. The GP records however do note attempts to contact Anne and Peter, without success.

Key Episode 4: September – November 2022: Neighbour raises concerns

In September 2022, Essex ASC noted a contact from a concerned neighbour on Peter's record. Peter had asked a neighbour for some help cleaning and the neighbour and a friend, had visited the property, and reported that the state of the property was so poor, that it was too much of a health hazard for them to clean it. An attempt was made to gather further information from the neighbour with no reply, and the GP surgery was contacted and asked to do a home visit. By 04 November, no further information had been received from the neighbour or GP surgery, and ASC Tendring East Neighbourhood Team were tasked with completing a Care Act assessment. The case was discussed at the Supporting Independence Discussion[4] meeting.

On 07 November 2022, two members of the Tendring team made an unannounced visit as Anne and Peter were not answering the phone. The workers explained that ASC had received a call saying that Peter may need some help with cleaning, however the property was noted to be clear and clean, with a decorator present, painting rooms. Peter advised that he was getting everything finished, as the landlord would be calling again in two-weeks' time to check the property. Peter declined further support with the property and or with care for Anne and declined a Carer's Assessment.

At the visit ASC also noted that Anne refused to see the workers – one of whom who had previously visited in May. Anne was willing to speak and reported having a cold and wanting to get back to bed. Anne recalled the worker from their previous visit, but declined a Care Act assessment and the workers recorded there was no reason to doubt Anne's or Peter's mental capacity.

[4] Supporting Independence Discussions are internal meetings for Essex ASC to discuss individuals with complex needs to consider what solutions are available to support them.

Subsequently, at the Supporting Independence Discussion on 09 November 2022, it was planned to revisit after Anne had recovered from her cold. The meeting scoped some questions to work on, including what fear was stopping Anne's engagement; her mental health history; what needed to happen, to help her to open the door and if she would she agree to having a hairdresser or chiropodist visit.
Key Episode 5: 17 November 2022: Primary Care Paramedics visit home
On 17 November 2022, two paramedics from the GP surgery attended the address following a request from ASC, two days earlier. Peter was reported to have been agitated and would not let them in to examine Anne. It was reported that Peter believed Anne may have passed away, and his account of when he last spoke to her kept changing. Police were called, accessed Anne's room, and established she had died. They arrested Peter due to suspicious circumstances around the death, but he was later released without charge, when the forensic postmortem showed no signs of third-party involvement. The clinical cause of death was recorded as hypothermia and ketoacidosis.

12. Analysis of Practice

12.1 Agency responses when Anne declined support.

12.1.1 ASC responded immediately to the concerns raised in May 2022. At the practitioner event, the ASC workers reported that they talked about the information from the police and landlord prior to the visit. When they reached the home, what they saw did not align with the perception they had gathered from the information reported. There was nicotine dirt present, and flies, but no food left out. There were no concerning smells around the house and no flies upstairs. Peter reported that the flies were from the stagnant pond in the garden. The workers reported that everything was in its place, the cat litter tray was clean, and there was nothing out of the ordinary.

12.1.2 The ASC workers informed the practitioner event that Peter explained why Anne did not want to be seen. This was due to Anne having been in the armed forces. She was proud of her appearance but was now embarrassed of the way she looked. The workers reported that it was unusual not to see an individual at all. As the case was managed under the ASC duty function, the workers were unable to discuss it, in a formal supervision session, yet they undertook the appropriate assessments and discussions with Anne. ASC viewed her as being able to decline support, however, it would have been helpful to have explored her history and reasons for not trusting medical professionals, particularly as the GP was asked to follow up. Anne reported that she had a bad experience with the GP and hospital when she had problems due to flashing lights. She reported

that the GP did not listen to her, and she did not like the hospital. There should have been more consideration of why Anne wanted to live in her bedroom and not go out at all, which should also have raised questions with regard to Anne's mental health.

12.1.3 When ASC informed the GP of the concerns raised in May 2022, there were multiple attempts to contact Anne without success. There was a visit planned for 11 July 2022 which did not take place and it is not clear whether this was due to no response from Anne or Peter. The GP practice responded to requests for information from ASC. However, due to the way that ASC worked at the time, the ASC workers could not see the outcome of the GP activity on their records system. If a similar issue happened now, it would be clear on the system if there had been a response from the GP, which would enable ASC workers to maintain contact with GPs. At the practitioner event, the consensus was that, had the case progressed to a S42 enquiry, then there would have been a stronger multi-disciplinary team approach.

12.1.4 ECFRS undertook an immediate cold call. At the practitioner event, the officer confirmed that Peter was very willing to let him into the home and to chat to him. The officer reported that the fire and rescue service is a trusted agency, and so individuals are usually happy for visits. The officer was able to put up smoke alarms without any objection from Peter.

12.1.5 At the practitioner event the ASC and ECFRS workers reflected on their approach to Peter. They explained that he was very angry with the landlord. They listened to him, and he invited them to sit down, but explained that they would not be able to see Anne as she does not see anyone. The ASC workers reported that Peter facilitated the opportunity for them to speak to Anne through the door. They were able to have a good conversation with Anne who made it clear that she did not want any help. It is recognised that sometimes individuals will decline support. At the point of that first visit, the workers were not over concerned as they had been let into the home, were able to speak to Anne, the environment was no longer as described by the landlord and police, and the workers could see that Anne had access to the bathroom. The ASC workers informed their managers and there was the decision to ask the GP to follow up.

12.1.6 EPUT found no evidence of any historical involvement with Anne or Peter. From the Police and GP records, it looked as if there had been mental health service involvement in 2012. EPUT as an entity was not in existence at that time but interrogation of the records systems has not elicited any contact with Anne. Whereas the Police records note an incident in 2012, in which Anne was deemed to have a mental health episode which resulted in a referral to the local mental health duty team. No information has been found regarding the outcome of the referral. The views of the mental health services representatives at the SAR

panel and at the practitioner event were that Anne had not been known to secondary mental health services, and any crisis intervention was as a single event and did not lead to follow up work. It was also confirmed that no agency made a referral to mental health services after 2012.

12.2 How professionals apply the Mental Capacity Act when there are clear signs of self-neglect, and the impact of this in safeguarding the individual.

12.2.1 The ASC and ECFRS workers who visited on 31 May 2022 spoke to both Anne and Peter and concluded, through the conversations, that they both had the capacity to choose to live in the way that they did. It was recorded that both adults engaged verbally and gave expressions of their wishes and views.

12.2.2 Had the property been viewed as in a poor state, then there could have been consideration of whether the individuals did both actually have the mental capacity to make the decisions about the risks of their living conditions to their health and wellbeing. However, ASC workers and ECFRS did not witness the conditions that the landlord had seen just days previously. However, the landlord had reported, in particular, the state of Anne's bedroom. The workers who subsequently visited, viewed the rest of the home, perceived Anne as being able to exit her room to access the bathroom, and accepted her decision not to let them into her room. They had no permission to access the area the landlord had raised concerns about.

12.2.3 All of those workers who visited in May and November 2022, had considerable experience of visiting homes, and those where there might be vermin or hoarding. In November 2022, there was evidence of painting and cleaning of all parts of the home, apart from Anne's bedroom, as she would not allow it. There was evidence of fly traps which had caused a concern for the neighbour due to their location.

12.2.4 At the practitioner event, there were reflections that any attempt to push Peter into letting the workers into Anne's room would have led to Peter telling them to leave. Peter was described as coming across as authoritative, due to his career in the armed forces. In the view of the workers, there were no signs of significant hoarding or self-neglect, and both Anne and Peter were able to express their views clearly. The ASC workers reported, at the practitioner event, that they heard Anne moving around upstairs, when they were downstairs, and believe that was her exiting the bedroom.

12.2.5 Nevertheless, there should have been a direct conversation with the landlord and gas engineer to establish what they had seen. This could have been used as part of the safeguarding assessment by ASC on 31 May. However, as there were no signs of hoarding at that visit, it was difficult for the workers to delve

deeper. Had they been able to go into Anne's room, they might have reached a different conclusion, but they were not faced with any signs, apart from the flies, of anything untoward. The couple were both offered support to make the decisions about their living arrangements and care. ASC noted that Anne, although not seen in person, spoke through the door and was clear on her views and wishes.

12.2.6 The ECFRS Officer reported a lengthy conversation with Peter and Anne, in May 2022.

'Whilst the property/situation is perhaps not as we would wish to live in, (Anne) was adamant that she required no further support, accepted my fire safety advice. I (sic) certainly seems that (Anne) and (Peter) are happy with their situation, I cannot see any further help we can offer'

The Officer noted that there was clear evidence that Anne was able to leave her room due to there being a *'well-trodden path between the bedroom and bathroom'.*

12.2.7 When there were further concerns raised in September 2022, this should have prompted a multi-agency strategy discussion, as per the SET guidance[5] to consider what further support could be offered to Anne and Peter. This could have included the consideration of whether there was enough information to question the mental capacity of either Anne or Peter, including any mental or physical health issues which could lead to fluctuating capacity for Anne.

12.2.8 At the practitioner event in April 2024, the ASC workers reflected that they had no reason to doubt Anne's mental capacity. They assessed this through her responses to questions, the tone of her voice. However, it was reported that now, there would be consideration of executive functioning and support workers would discuss their experiences with a qualified social worker, to consider what questions to ask to try to gain access, e.g., '*why would you not be able to open the door a little for me?'*

12.2.9 A further reflection at the practitioner event, was that usually there would be a family member sharing concerns about an individual's mental health, if refusing to come out of their bedroom. Yet, for Anne, Peter was not raising any concerns and there were no indicators of mental health problems, Anne was open to talk, just not to be seen. The workers did offer a mental health referral, but Anne definitively declined her consent to this and so there were no opportunities to make a referral.

[5] Southend Safeguarding Adults Board, Essex Safeguarding Adults Board, Thurrock Safeguarding Adults Board (December 2021) *Hoarding Guidance*. https://www.essexsab.org.uk/guidance-policies-and-protocols

12.3 The decision to stop proactive health service involvement with Anne in 2011.

12.3.1 There is limited information as to why Anne ceased engagement with the GP in 2011 and it appears the GP changed, when the couple moved. The new GP reviewed Anne's medication and suggested a change but Anne declined this, wanting to continue to take Temazepam, (the GP noting this as being infrequently used). There was no follow up by the GP. The reviewer has concluded, in consultation with the SAR panel and practitioners, that something must have happened in Anne's life prior to 2011 to cause her to react to the GP's assessment in the way that she did. However, the absence of the historical information does not impact on how this review considers the agency responses in 2022, apart from the fact that agencies should have considered why Anne was so opposed to health services.

12.3.2 After this period, Anne does not appear to have sought any medical attention. In May 2022, she was reported to have informed ASC workers that both she and Peter, mistrusted medical professionals and that she felt let down by the GP surgery. Had there been more knowledge of her medical history at the time of the visits to her in 2022, then this might have enabled a conversation to gain an understanding of why she felt this way, or to ascertain her health issues, and to check what she wanted for her health and wellbeing. When the GP was informed about Anne, in May 2022, there were considerable efforts made to contact her. Nevertheless, it would have been helpful for ASC and the GP to have discussed the way Anne felt about health services and in what ways the agencies could work together to gain Anne's trust to enable them to see her.

12.4 How agencies sought to understand Anne's lived experience and what she wanted to happen.

12.4.1 When ASC workers visited in May and November 2022, they reported that they established a rapport with Anne and there were efforts made to hear her voice. At the practitioner event there were clear descriptions of how the workers had conversations with Anne. When she declined support, this was accepted because she came across as articulate and clear on her wishes. The ASC worker discussed the outcome of the November visit with the ASC team in a Supporting Independence Discussion, which is part of the ASC normal process. It was agreed to plan a re-visit when Anne's cold was better. The GP was asked to contact Anne but knowing her views on medical professionals, this could have been predicted to be unsuccessful. It would have been useful if there had been consideration of joint working with the GP in the plan agreed at the Supporting Independence Discussion.

12.4.2 Peter would ask neighbours for help, and they were among those who raised concerns and it would have been helpful for professionals to have engaged with those neighbours who had raised concerns. However, this would have needed Anne's consent to be able to undertake this.

12.5 Impact of protected characteristics on Anne's care management.

12.5.1 In the information provided there was no indication that the protected characteristics of the Equality Act had any impact on how agencies responded to Anne. Her age did not seem to be included specifically in any assessment and she was not known to have a disability. Information provided suggested that Anne and Peter moved in together as a couple but did not marry. In the contacts with Anne there seemed to be acknowledgement that Peter was her carer, confirmed by both Anne and Peter. There was no indication of any discrimination in relation to Anne's ethnicity, religion, gender or sexual orientation.

12.6 Compliance with policies and procedures.

12.6.1 The Essex Safeguarding Adults Board published Hoarding Guidance in 2021[6]. This guidance sets out the types of hoarding and behaviours.

12.6.2 Agencies demonstrated appropriate responses when they received the landlord's concerns. This was aligned with the Hoarding Guidance. Appropriately there was a fire safety check arranged with Essex County Fire and Rescue Service, and liaison with the referrer and other agencies, such as the GP, for follow up with Anne and Peter. This was in line with the hoarding guidance, but the fact that the GP was unsuccessful in contacting Anne, and Peter was not used to reassess the situation. The guidance solely states to refer to the GP, not follow up. For more serious concerns there is advice to hold a multi-agency meeting, in which the GP information would be shared. It would be of benefit for the hoarding guidance to include the need for follow up and a review of the assessment if onward referrals are unsuccessful.

12.6.3 There were concerns regarding Anne self-neglecting and in the SET Safeguarding Adult Guidelines[7], a Self-Neglect flowchart *(Figure 1 – see Page 20)* is in place. Considering the information received regarding professional responses to the concerns regarding Anne, there is evidence that the chart was followed in undertaking a visit and ascertaining the views of the adult. It was viewed that both Anne and Peter had the mental capacity to make the decision as to whether they wanted more support. However, the flow chart notes the need to consider capacity and an assessment of the risks, which would lead to a multi-agency meeting and a management plan, to be shared with the adult at risk. This means, that if the home had been considered to be in an inhabitable state, then

[6] Southend Safeguarding Adults Board, Essex Safeguarding Adults Board, Thurrock Safeguarding Adults Board (December 2021) *Hoarding Guidance*. https://www.essexsab.org.uk/guidance-policies-and-protocols

[7] Southend, Essex & Thurrock (SET) (2023) *Safeguarding Adults Guidelines* Version 9.

the risks could have been shared with Anne and Peter. Given the description of the home by the landlord, and the view of Anne's room by the police who found her dead, it is very difficult to understand how the workers who visited did not do more. This was addressed at the practitioner event with the ASC and ECFRS workers. They were all experienced in visiting homes where there were poor conditions. They reported that the home was not an environmental risk when they visited. They acknowledged that they did not go into Anne's room, and there were no grounds to consider how they could enforce a visit into the room. However, they did reflect that they could have questioned why Anne would not come out of her room or let them in to see her. There were no concerns that she was not using the rest of the home, as they saw evidence of a well-used carpet between the bedroom and bathroom.

The reviewer concludes that the workers undertook an appropriate assessment of the home when they visited. However, there was a gap in the way agencies approached Anne on 31 May 2022 as there should have been more exploration of what the underlying issues were that had led to Anne choosing to live in her bedroom. The focus of any self-neglect was limited to the hoarding and environmental issues, rather than considering the fact that Anne would not allow anyone to see her. The ASC support workers shared the information with the centralised ASC safeguarding team, but this did not progress to a multi-agency meeting to discuss the risks. At the practitioner event, the workers and managers reflected that, at the time, referrals were dealt with across local and centralised teams. This meant that there was a disjointed approach to concerns. They reflected that the initial referrer (landlord) should have been spoken to prior to the workers visiting the home in May 2022, and that on the second visit in November there should have been more curiosity about why Anne was refusing to see the workers. At the practitioner event it was reported that the system has since changed and so there is a more streamlined approach through the centralised team.

12.6.4 A Care Act assessment and a Carer's Assessment were offered to Anne and Peter. This was reported to be fully explained by the ASC support workers but both adults declined. The support workers reported that they had no reason to doubt either adult's mental capacity as both Anne and Peter engaged verbally and gave an expression of wishes and views. At the practitioner event, the workers gave a description of a couple who were happy to converse and were articulate in sharing their views. The gap here was that it was not clear why Anne needed Peter to be her carer, and why there had been no contact with health services by the couple. There was a referral to the GP, but, as previously noted, as the couple had indicated that they had no time for health services, it should have been assessed that there would need to be a joint plan in how to support Anne to seek medical attention.

12.6.5 The self-neglect flow chart states the identification of a lead worker is needed when a safeguarding adult concern is raised to undertake a home visit. In Anne's case, the lead workers were support workers, albeit highly experienced, they were not qualified social workers. This was deemed to be appropriate at the time. However, ASC have reflected that, for individuals not previously known, it would be more appropriate for a qualified lead worker to take the responsibility for the assessment and decision making. The centralised safeguarding team were informed after the visit, but this did not appear to lead to a social worker assessment. This has been acknowledged by ASC and recognised that there is a need to strengthen training and oversight by registered professionals when working with people with care and support needs who are not previously known by ASC, when there are safeguarding concerns raised by the Police. The system has been streamlined since 2022, to ensure that there is one team managing concerns.

12.6.6 The safeguarding guidelines[8] set out the definitions of self-neglect as:

> "There is no single operational definition of self-neglect however, the Care Act makes clear it comes within the statutory definition of abuse or neglect, if the adult concerned has care and support needs and is unable to protect him or herself. The Department of Health (2016) defines self-neglect as, *'… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.*
>
> The Care Act 2014 defines self-neglect as '*…. covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour'.*
> Self-neglect is when an adult neglects to attend to their basic needs or keep their environment safe to carry out what is seen as usual activities of daily living. It can occur because of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment or through personal choice. Self-neglect is an issue that affects people from all backgrounds."[9]

12.6.7 In May 2022, there was action taken in a timely way by Police, ASC and ECFRS. There was some liaison between services and Anne's views were sought and acknowledged. In this respect, the guidelines appear to have been followed and, from the reports made by the social care team, there seemed to

[8] Southend, Essex & Thurrock (SET) (2023) *Safeguarding Adults Guidelines* Version 9.
[9] Southend, Essex & Thurrock (SET) (2023) *Safeguarding Adults Guidelines* Version 9.

be no reason to progress the concerns to a section 42 enquiry. This was the conclusion due to Anne being spoken to by the workers. However, this missed the opportunity to link back to the serious concerns raised by the landlord, gas engineer and the Police. Once the environment had been viewed as not being as bad as described, there was no questioning of why an individual was living such an isolated life and refusing to be seen. This seems to be due to the way Anne was happy to talk to workers, just from behind the bedroom door. It was unusual for someone not to be seen, but Anne was so chatty to workers and was able to explain her reticence, that this reassured the workers.

12.6.8 There was information that the landlord remained concerned as the gas engineer had refused to work in the property. The safeguarding guidelines set out the use of multi-agency meetings to discuss concerns. In Anne's case, there was clear liaison with the landlord, but ASC deemed it not to be their role to communicate with the gas engineer. It would have been helpful for ASC to have had a direct conversation with the gas engineer as to why they could not work in the property. This might have elicited more information to support a risk assessment. At the practitioner event, it was suggested that the gas engineer had been into Anne's room. If this was the case, they would have had significant information not known to anyone else and should have been asked by ASC.

12.6.9 When ASC contacted the GP to inform them that the safeguarding case was being closed, it was noted that the GP had been trying to contact Anne and Peter. At this point ASC reported that:
'both (Peter and Anne) are anti medical people and that's why she hasn't made contact with surgery. (Anne) feels she has been neglected by the surgery and doesn't wish for any future engagement. She feels that her medical needs haven't been listened to in the past. Adult social care state that (Anne and Peter) have full capacity. (Anne) even told adult social care that she would never call an ambulance for her or (Peter) even if the situation was life-threatening.'

Therefore, this should have been considered when the GP was asked to follow up. The action should have been done jointly between the GP and ASC before the case was closed to safeguarding. Anne's views, although not unique, should have led to questions as to why she felt she had not been heard by medical staff. The comment that Anne would not call an ambulance in a life-threatening situation did seem an extreme view. There should have been a conversation with Peter to check his views and how he could keep himself safe in the event of a medical emergency for himself or for Anne.

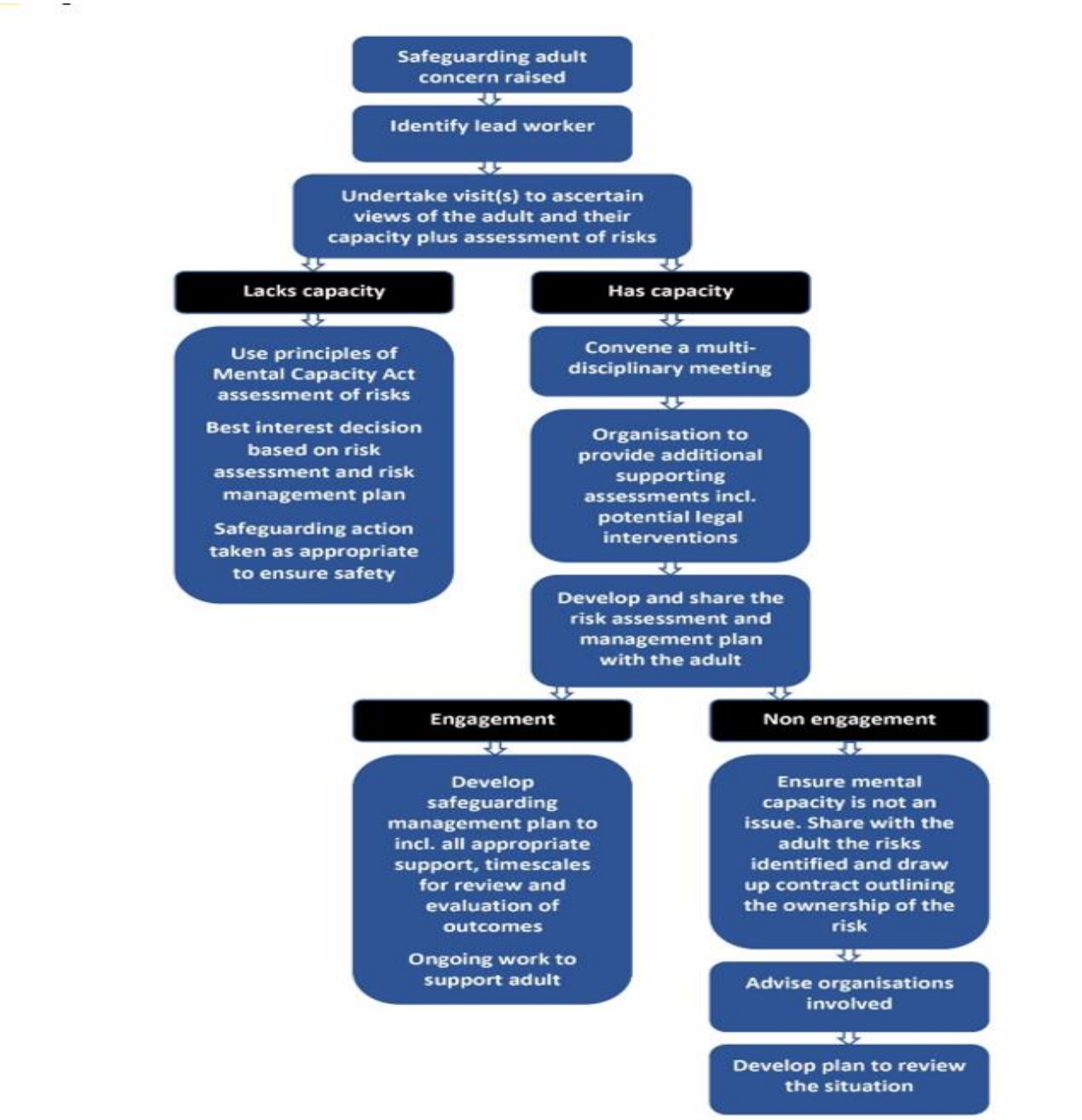
12.6.10 Given that by September 2022, neighbours were raising concerns about the '*inhumane conditions*' at the property, it would appear, that Anne and Peter chose to avoid professional involvement in their lives by masking the state of the property in May 2022. The report of the couple's mistrust of medical professionals

was not investigated. The GP surgery continued to try to contact but do not appear to have checked their records for any reasons for the ‘mistrust’.

12.6.11 In September 2022, a neighbour reported concerns to ASC that the property was a health hazard. This did not result in a timely visit by ASC as it does not appear to have been considered as a safeguarding concern. The report came in about Peter rather than Anne and this was not linked to the concerns raised in May 2022. Instead, the social care contact centre liaised with the GP to do a home visit. Of note, there is no record of this contact within the GP records provided for the review, presumably because the contact focused on Peter and not Anne. Due to there being no link to the safeguarding concerns raised just four months previously, and not yet fully closed by the central safeguarding adult team, there was no follow up of the concerns until November 2022, when ASC undertook a home visit.

12.6.12 When Anne was found dead in November 2022, agencies had been aware of potential self-neglect concerns for six months. Yet, despite visits to the home Anne had not been seen, only spoken to at the door of her room. This meant it was difficult to assess the extent to which Anne was neglecting herself, why she was behaving in such a way as to avoid the outside world, and whether a S42 enquiry was required to ensure she was safeguarded.

Figure 1: Self-neglect flowchart



13. Findings

13.1 Overview

13.1.1 Anne and Peter moved into their accommodation in 2012. The information provided to the review suggests that Anne was seen in the garden by a neighbour in 2012. It was reported that she was last seen by someone other than Peter in 2017. No concerns were raised until 2022.

13.1.2 SARs do not routinely include information from the community. Since Anne's death Peter has moved and time has moved on. Therefore, it has not been appropriate to seek to discuss someone's private life with neighbours.

13.1.3 Unfortunately, Peter has not responded to offers to speak to the reviewer. Without his insight of his experience, and his view of Anne's life, it is difficult to gain any real understanding of Anne's experience. Without this it is hard to identify the full learning for professionals. There was a period of nearly 10 years in which Anne was not known to any services. Once services were notified of the concerns about her, action was taken to attempt to engage both Anne and Peter, without success, and as the couple were deemed to have the capacity to decide whether they wanted professional help, no follow up was undertaken. Therefore, the only way professionals could have acted more incisively to safeguard Anne, was if they had assessed a lack of capacity or executive functioning in her decision to stay in her room. The workers needed to gain an understanding of why Anne was living in the way she did, or to ask more questions as to why an individual would spend their life in their bedroom.

13.1.4 Peter had been asking neighbours for help. He was offered a carer's assessment in May 2022, but declined. Had there been the opportunity to have further conversations with him about how he was coping with caring for Anne, he might have disclosed sufficient information to help professionals in their risk assessments and come to firm conclusions about whether there was self-neglect and what legal frameworks could be applied to safeguard Anne.

14. System learning and recommendations

14.1 'Invisible' people with care and support needs: proportionality of the professional response.

14.1.1 Anne's experience

At the practitioner event, it was clear that Anne was not considered 'invisible'. She was viewed as an independent person who was able to articulate her wishes. She just did not want to be seen by professionals. It was unclear what care and support needs she had but it was known that she had not been in contact with health services for a decade and expressed a distinct mistrust of medical services, indicating that she would not contact even in an emergency. It was not known why Anne had these views, bar a description of GPs not listening and an incident of flashing lights causing her concern in hospital.

The GP was asked, and made efforts, to contact Anne. However, these were unsuccessful, and the safeguarding concerns were seemingly resolved. When further concerns were raised, the Primary Care paramedics did manage to access the home, but this was too late to make a difference to the outcome for Anne.

It was reported that both Anne and Peter had been in the armed forces. They were reported to keenly watch a remembrance event on the television, with Anne calling for

the sound to be turned up so that she could hear the event. This could have been used as a way in to talk more about Anne's needs and to consider asking for support from a veteran charity.

14.1.2 Other reviews and learning within Essex

At the practitioner event, it was considered that Anne's situation was unusual. It was reported that there would usually be no one else in the home, or that family members would be raising concerns themselves about the individual.

Both Anne and Peter were armed forces veterans. The SAR Panel reported that there is now a lead clinician in the Primary Care Network covering Peter and Anne's GP practice, who is working on trying to identify veterans. It is perceived that not all veterans inform their GP of their experience. When veterans do inform the GP of their background, this is flagged on the system to support effective referrals to other services, where needed.

Across the East of England, EPUT deliver mental health services specifically for veterans.[10] Referrals in can be made by a GP or as a self-referral.

In respect of individuals who have had a long-term health condition but have not been seen by health professionals for a considerable period of time, changes have been made by the GP practice involved with Anne and Peter. There are now monthly meetings to discuss patients with long term conditions. Data reports can be presented to help to identify those who have stopped reaching out to their GP for support. There is then the opportunity to consider whether there should be follow up by the GP practice.

All local practices have been invited to sign up to become Veteran Friendly practices, but this is a voluntary process. The Royal College of General Practitioners has a toolkit and resources to train and support. Whilst GP Practices who have signed up reach out to their practice population it is reliant on the patients responding.

14.1.3 Wider research

There is increasing awareness that armed services veterans have specific needs that might not be seen within the wider population. Since 2019, there has been a scheme for GP practices to gain 'veteran friendly' accreditation. This helps GPs and practice staff to have a better understanding of the needs of veterans. Since September 2023, 77.5% of Primary Care Networks have at least one veteran aware GP practice in their area.[11]

[10] https://eput.nhs.uk/our-services/op-courage-the-veterans-mental-health-and-wellbeing-service/ https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/

[11] Armed Forces Covenant (2023) *The Armed Forces Covenant and Veterans Annual Report 2023*. Armed Forces Covenant: annual reports - GOV.UK (www.gov.uk)

For medical treatment, doctors have to respect that competent adults can refuse to consent to any treatment (unless authorised by mental health legislation). However, this needs to be considered separately for each aspect of treatment or care. Nevertheless, as long as the adult understands the impact of refusal of treatment on their long-term health, they do not need to justify their reason for refusal.[12]

Consent is not needed for medical personnel to act if a person is severely ill or infirm and living in unsanitary conditions when the person can be taken to a place of care without their consent.[13]

14.1.4 Recommendations

- When safeguarding concerns are raised about an individual who is not known to ASC but appears to have care and support needs, there should be a joint plan between ASC and Primary Care to enable an assessment to be undertaken. The safeguarding concern should not be closed until the individual has been seen by Primary Care. In the event of the individual declining health input, this should be reviewed jointly by ASC and Primary Care to reach a decision.

- There should be a review of the ESAB Self-Neglect Flow Chart and associated Self Neglect Guidance to incorporate fluctuating mental capacity, the consideration of physical health problems, and the need for Mental Capacity Act Assessments to be in place.

- ESAB should seek assurance that practitioners are competent in deploying Mental Capacity Act assessments, particularly in cases where fluctuating mental capacity might be the case, or where capacity may be affected by physical illness.

- This review should be shared with Primary Care to raise awareness of the need to review patients who have not been seen for years, when they were deemed to have a long-term health condition.

- There should be awareness raising for practitioners regarding how they can connect with armed forces veteran services. EPUT should be asked for guidance regarding this, through their work with veterans.

14.2 Involving the community in safeguarding: how do professionals listen to concerns raised by the local community?

14.2.1 Anne's experience

Anne was reportedly not seen by anyone in the community for several years. The safeguarding concern was raised by the gas engineer, but to the landlord rather than directly to ASC. The gas engineer would be used to visiting a wide range of homes. For them to refuse to work in a home, there would need to be something of

[12] BMA (2024) *Ethics Toolkit: Consent and Refusal by Adults with Decision-making Capacity*. p13. www.bma.org.uk
[13] Consent to treatment - NHS (www.nhs.uk)

considerable concern. However, the view of this worker was not gained directly by ASC, as the concern was raised by the landlord who had subsequently visited. It was reported at the practitioner event how the landlord was very annoyed at the state of the home they owned, whilst Peter was very angry about the landlord's attitude when visiting. Workers considered the information from the landlord and also listened to Peter's views about what happened. However, workers witnessed improvements in the home from what had been reported.

14.2.2 Other reviews and learning within Essex

At the practitioner event, there were reflections that, although the workers were all experienced in visiting homes, they would now ask more questions of why the home had been reported as being in a poor state, and how the improvements could be sustained. There was also a reflection by ASC that community workers such as gas engineers should be spoken to directly when it is known that they have raised safeguarding concerns.

The ESAB website includes some information about families and the community. This appears to focus on advising families if they are concerned about a loved one.

14.2.3 Wider research

The Independent report: Revisiting Safeguarding Practice[14] set out how local authorities need to work with communities to raise awareness of how to raise concerns and what to expect from agencies when a safeguarding concern is raised. Additionally, the report highlighted the need for access to community resources to reduce social and physical isolation.[15]

14.2.4 Recommendation

- ESAB should consider a safeguarding awareness programme to focus on how communities and workers who attend homes can understand how to raise safeguarding concerns and what happens when a concern is raised.

14.3 Strengthening assessments in relation to potential self-neglect and including historical information.

14.3.1 Anne's experience

Anne was not seen by workers until after her death. The state of her room and the condition of her body led to considerable concerns about her self-neglect. When alive, she openly spoke to workers but did not want to be seen. It was reported, at the practitioner event, that Peter had explained that Anne had previously taken pride in her appearance and was embarrassed by the way she looked. There should have been more questions asked, at that point, as to why she had not managed to maintain her appearance, particularly given that Anne could have been experiencing poor

[14] Revisiting safeguarding practice - GOV.UK (www.gov.uk)
[15] Revisiting safeguarding practice - GOV.UK (www.gov.uk)

physical health. By November 2022, some issues were being considered and there was an ASC plan to offer Anne access to a hairdresser.

At the practitioner event, there was a clear view that Anne had not been assessed as self-neglecting. This was concluded as she had spoken to workers and as she was not seen there was no opportunity for a self-neglect assessment. Meanwhile, the rest of the home, was not viewed as being an environmental concern. Both Peter and Anne had been willing for smoke alarms to be fitted and Peter asked the local community for help in decorating the home.

There was a sense that Peter was keen to respect Anne's wishes and would guard her against any outside interference. Peter was described as being authoritative with those visiting the home and that he would have told people to leave if they did not defer to him.

14.3.2 Other reviews and learning within Essex

At the practitioner event, participants reflected on how in potential self-neglect situations, there will be family members raising concerns that the individual is at risk, or that the individual is totally isolated from any social network.

There was also evidence of how services are considering executive functioning within mental capacity assessments. A learning and reflection session has been implemented in local practice meetings and has covered collaboration and multi-disciplinary team (MDT) working, learning from SARs, Domestic Homicide Reviews and inquests. Within the session three case studies were shared and one of which explored mental capacity and executive functioning. A second session has been completed and recorded which will be shared with the safeguard leads to support future learning across the rest of Essex County Council.

14.3.3 Wider research

Self-neglect is frequently considered within SARs nationally.[16] There is a need to gain a better understanding of the reasons for self-neglect and how to apply the Mental Capacity Act precisely to support practitioners to provide interventions and protect individuals where appropriate.

Individuals viewed as neglecting themselves can be perceived as having 'unconventional' lifestyles.[17] This diverts practitioners from undertaking mental capacity assessments, and physical health assessments, as the individual is assumed to have the capacity to make the decision as to how they live. What this misses is asking why an individual is living in the way they are, are there financial concerns, control from another person, physical or mental health issues affecting their ability to

[16] Preston-Shoot, M. et al (2024) Second National SAR Analysis: presentation 27 March 2024.
[17] Havering Safeguarding Adults Board GC: Safeguarding Adults Review (SAR) Executive Summary

maintain their home safely?[18] Practitioners need to have good access to supervision to be able to reflect on situations of potential self-neglect, and for clear escalation routes to enable services to come together to develop a joint plan.[19]

When services are declined by an individual who is perceived as needing support, there should be exploration of why they are declining, and checking whether the service is being totally refused, or that there are elements the individual will accept.[20]

14.3.4 Recommendations

- The Essex SAB should commission a learning and development programme on a reviewed version of the self-neglect guidance across the multi-agency network. This should include case studies to consider how practitioners identify and assess potential self-neglect and how they can use historical evidence to inform their assessments. There should also be mental and physical health views sought within assessments for potential self-neglect.

- The Essex SAB should commission a multi-agency audit of self-neglect cases to assess how the Mental Capacity Act 2005 and the associated statutory guidance has been applied and whether consideration of executive functioning or the individual's autonomy has been achieved.

[18] Havering Safeguarding Adults Board C: Safeguarding Adults Review (SAR) 7 minute briefing
[19] Waltham Forest SAB SAR HARRY July 2022
[20] Manchester Safeguarding Partnership/ Preston-Shoot, M. (2020) Homelessness Thematic Review.