Oxfordshire Safeguarding Adults Board

Safeguarding Adult Review in respect of Adult V

Author: Jo Taylor-Palmer

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OSAB
Oxfordshire Safeguarding Adults Board

Contents

Introduction

Safeguarding Adults Reviews (SAR) is defined under S44 of the Care Act 2014.

A referral for a Safeguarding Adult Review (SAR) may be appropriate where there are concerns about the circumstances of the death of an adult with support and care needs.

A SAR is concerned with ensuring learning and improvement in practice and is explicitly not about apportioning blame to any agency, service or individual.

Oxfordshire Safeguarding Adults Board (OSAB) will make the decision to instigate a SAR and a report will be produced to document findings and recommendations that are required to be undertaken.

Neither SARs nor Section 42 enquires are investigations into how an adult with support and care needs has died or who is culpable, that is a matter for the Coroner or Criminal Courts to determine.

S44 of the Care Act states:
Safeguarding adult reviews:

A SAB (Safeguarding Adults Board) must arrange for there to be a review of the case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) and there is concern that partner agencies could have worked together more effectively to protect the adult and Condition 1 or 2 is met.

Condition 1 is met if -

- The adult has died, and
- The death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if –

- The adult is still alive, and
- The SAB knows or suspects the adult experienced serious abuse or neglect.

The SAB can also undertake any review of any other case involving an adult with care and support needs in its area.

In 2020 Oxfordshire Safeguarding Adults Board, considered the case of V who died on the 8th April 2020

The Safeguarding Adults Review will use the case of V to provide insight into the operation of multi-agency working and safeguarding systems across Oxfordshire County Council.

This is so that lessons can be learned from the case and applied in practice to prevent similar harm occurring again.

Background to the case

It has been established from the details contained within the multi-agency chronology that V was a gentleman who had periods of time in his life when he struggled to maintain his health and well-being to an acceptable standard and was offered support on several occasions to achieve this.

He had not had any active ongoing involvement with services over this period of time and it is evident from the detail contained within the documentation that he did not to respond to professionals despite the numerous contacts they made via phone calls, letters and text messages, in respect of his health and well-being.

V stated to a professional on one occasion that he found it hard to keep "on top of things" and in October 2014 a referral to Adult Social Care highlighted areas of serious concern relating to self-neglect, which included his personal hygiene, his lack of food consumption and extremely poor living conditions.

There were occasions when V had to be prompted to pay his rent and the chronology verified that he was evicted on one occasion due to the condition of the property.

The period from 2014 to April 2020 highlights the general ongoing theme of professional concern for V regarding his general well-being which included his ability to attend to his basic needs, his health, and his ability to sustain a tenancy.

Methodology

Oxfordshire Safeguarding Adults Board commissioned a Safeguarding Adult Review. The review followed a blended approach incorporating elements of a traditional SAR methodology and an Appreciative Inquiry (AI) model.

This combines approaches rooted in action research, systematic thinking and organisational development, and is a strengths-based, collaborative approach for creating learning change while providing assurance of a thorough investigative process.

The process involves a professional's workshop, which was conducted using an Appreciative Inquiry mode. It aimed to create a safe, respectful and comfortable environment in which people look at the interventions that have successfully safeguarded; and share honestly about the things that, upon reflection, could have been done differently. It also looked at where, how and why events took place and used their hindsight wisdom to design practice improvements.

As a tool, an Appreciative Inquiry supports many of the principles now underpinned by the Care Act 2014 and those responsibilities placed on Local Safeguarding Adult Boards in:

- Promoting a culture of continuous learning and improvement
- Promoting good practice
- Involving service users in service improvement
- Reviewing a range of cases rather than just those where things have gone wrong
- Creating a safe, respectful, blame-free environment - enabling practitioners to share practice.

Principles

Safeguarding Adults Reviews must adhere to the six safeguarding principles outlined in Care and Support Guidance (Department of Health, 2018); these are Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

In addition to these, this Safeguarding Adults Review will be conducted in line with the following principles:

- Culture of continuous learning – incidents can provide the opportunity to learn and improve
- Independence and independent challenge
- Meaningful involvement of professionals without fear of blame for actions taken in good faith
- Involvement of family members and individuals affected by circumstances of the case
- Awareness of risks of hindsight bias and outcome bias
- Focus on system and teams functioning
- Not a re-investigation of incidents or performance.

About the Reviewer

This Safeguarding Adults Review has been led by Jo Taylor-Palmer who has no previous involvement with this case.

The contributors to the review were:

- Oxfordshire County Council – Adult Social Care
- Oxfordshire County Council – Social & Healthcare Team
- Primary Care, supported by the Oxfordshire Clinical Commissioning Group
- Cottsway Housing Association
- Thames Valley Police

Family Involvement

There was no family involvement in respect of the Safeguarding Review. From reading the chronology it is understood that Adult V had not been in touch with his family since 1980. There were no records available by any agency to identify family members.

Terms of reference (TOR)

Terms of reference for Safeguarding Adults Reviews are agreed by Safeguarding Adults Boards. The scope of the review covers the period from May 2014 until V's death on the 8th April 2020. The areas that the Oxfordshire Safeguarding Adults Board would like the review to consider are as follows:

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case? What are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any gaps in multi–agency working?

Summary of involvement of professionals based on the multi-agency chronology

One workshop took place in November 2020. It was led by the Reviewer and was well attended by multi-agency practitioners.

The workshop examined in detail the time under review, enabling a multi-agency perspective to be gained.

This exercise brought out the story of multi-agency involvement, helping to identify key periods of time that were significant and allowing the group to see how practice unfolded and how services were delivered from an interagency perspective.

Adult V came to the Cottsway property in 2015, moving from another property where he had been self-neglecting and hoarding rubbish. Concerns were raised to Adult Social Care and were sigposted to Connections Floating Support, who aided Adult V with his move from one property to the other.

From 2016 onwards, there were a number of auto-generated letters and texts sent on behalf of the GP practice that were not responded to. As these were auto-generated, there was no system in place for monitoring or reviewing the response rates to these communications.

Gas servicing was carried out annually by Cottsway. In 2019 a Gas Engineer visiting the property raised concerns to Cottsway about the state of the property. A visit was arranged but the Neighbourhood Housing Officer was unable to gain access to the property so a card was put through the letterbox. There are no further attempts to visit noted in the records, although Cottsway did make attempts to arrange stock condition inspections in early 2020, which were ignored by Adult V.

This resulted in Cottsway calling the Police with a welfare concern in early March 2020. The Police were also concerned by the state of the property and Adult V's inability to care for himself, which prompted a referral by Cottsway to Adult Social Care.

After multiple unsuccessful attempts to contact Adult V via the telephone, Social & Healthcare were able to speak directly to Adult V in mid-March, who advised them that his main need was around food. Details of local food banks were given and a formal request sent to the Adult Social Care Locality Team to conduct a care needs assessment.

On the last day of March, Cottsway contacted Adult Social Care to request an update and were informed Adult V was awaiting allocation for an assessment.
On 1st April two attempts were made to contact Adult V by the Adult Social Care duty worker. Neither were successful.

A week later another attempt was made by the duty worker. As this was also unsuccessful, the Police were contacted to conduct a welfare visit. Adult V's body was found him deceased.

A complete chronology is included as Appendix 1.

Findings

V was a gentleman with care and support needs who was known to services across Oxfordshire. The Oxfordshire Safeguarding Adults Board have determined that his case met criteria for a Safeguarding Adults Review.

The Safeguarding Adults Review will use V's case as an opportunity to learn about safeguarding practice in Oxfordshire. The findings of this review are presented

thematically, using the structure provided by the Terms of Reference set by the Safeguarding Adults Board.

The findings of this review are based upon the analysis of a detailed chronology of events and the involvement of professionals at an Appreciative Inquiry workshop, who were either involved in the case or had knowledge of the circumstances surrounding V's death.

What specific issues or questions does this case raise?

Professional curiosity

It is evident from the chronology that from May 2014 to April 2020 there were missed opportunities to explore with V his lifestyle choices, his lack of interaction with health services and why he occasionally needed intervention from agencies to either clean his home or offer support to ensure he maintained his health and well-being.

The chronology does tell a story of a man who appears not to have friends and family as a support network, with whom he engaged; that he had been in the RAF, acknowledged when asked that he struggled to maintain his home and accepted professional help when it reached crisis point.

V was not a person who reached out for help, but rather allowed the situation to become out of control. It is evident that practical tasks with him were undertaken such as arranging for services to help declutter his home, support and prompting in respect of paying his rent and questions asked regarding his food consumption.

This support is extremely beneficial in the short term; however, the evidence shows that V could not sustain this and therefore agency intervention was necessary again.
It is evident from the information provided that professional curiosity was not implemented by those agencies involved with V nor consideration given to any possible underlying reasons for why he chooses to live his life as described, which carried a level of risk to his health and well-being.

Lifestyle choice is often linked to risk and is a central defining feature and area of concern in providing services to adults.

This area of work is increasingly important as current policy advocates greater service user/patient choice and control through a range of self-directed support mechanisms and statutory duties and therefore, at times, professional boundaries will be challenged.

The need to be professionally curious is central to understanding the behaviours of those we work with, who are often not equipped to make the necessary changes in their lives without support from qualified practitioners.
For professionals working with V, he needed them to enquire deeper into the way in which he was living his life without judgement and using proactive questioning and respectful challenge, understanding one's own responsibility as a professional and knowing when to act, rather than making assumptions or taking things at face value. Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received.

- It means not taking a single source of information and accepting it at face value.
- It means testing out professional assumptions about a person's choice of lifestyle and whether, as in the case of V, there was a need to consider his capacity, linked to theory and research in respect of people who self-neglect.
- It means triangulating of information from different sources. In respect of V, professionals would have gained a better understanding of his functioning which, in turn, would have enabled them to make predictions about what may have been likely to happen in the future.
- It means seeing past the obvious which, in the case of V, was that he was struggling to manage his day-to-day life without professional help.

The learning from case reviews, both nationally and locally, is that responding to presenting issues in isolation and a lack of professional curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability or significant harm. We know that in the worst circumstances this has resulted in death or serious abuse.

Professional overreliance

The entries on the chronology from V's GP surgery between May 2015 and March 2020 demonstrate an over reliance on him reading the letters, administrative notes and text messages and choosing to respond. A quick calculation on the chronology shows 21 contacts that could have elicited a response (14 letters, 6 texts and 1 phone call).

This is a large town centre GP practice with over 19,000 registered patients and not a small rural practice with small numbers of registered patients. On the whole the 'contacts' mentioned would be administrative team tasks, and on occasion auto-generated. It is not practicable for GPs to check every patient record when a routine contact is made. It is generally assumed adult patients have capacity to make their own choices/decisions about whether they wish to respond to 'contacts'. When the concern was raised by Police the Practice acted quickly by sending a clinician for a home visit to assess patient.

The information known about V was that he did have a phone but it was not always charged and professionals struggled to contact him using this method of communication.

There was a professional assumption that he was receiving his letters in the post and that he was able to comprehend the information contained within the letters sent.

The information regarding V showed that he rarely used his phone to speak with professionals and therefore this mode of communication would not necessarily have been the best option. Whilst a large majority of the older generation use mobile phones there are many who find it intrusive, alongside needing at all times to remember to charge it in order to receive calls and messages. There is no information regarding V's view of this form of communication but there was merit in establishing with him his lack of response to its use and his reasons for not responding to professionals, as this would have saved valuable time and use of resources when there were high levels of concern.

If the lack of feedback from V had been discussed within the surgery, there may have been a different conversation regarding the most appropriate method of communicating with V who clearly would have been deemed as "hard to reach/engage ". However, this must be viewed in the context of the size of the practice and the practicality of reviewing every patient who does not respond to contacts. More information about what the practice is doing about this is contained in Appensix 2.

A critical point highlighted in the chronology was on the 10th March after a GP home visit, which was requested by Thames Valley Police to assess V's poor state of health. This GP visit resulted in a follow up phone call and text to check V's health, neither of which were responded to. With the benefit of hindsight and the knowledge about V's lack of engagement with his GP surgery, a different method of follow up would have perhaps yielded a better result and offered assurances regarding his compliance with completing his prescribed medication to alleviate his health concern.

There were 12 missed calls to V made by Adult Social Care and Cottsway which demonstrated a lack of joined up thinking and sharing of information regarding the most effective way to engage with him.

The theme of overreliance by professionals continued when professionals spoke with V over the phone after a referral was sent to Adult Social Care on the 10th March 2020. V had stated on the 18th March to a worker in Adult Social Care that his main concern was lack of food and it is evident and confirmed, that the information contained within the referral from Thames Valley Police was not discussed with him.

The overreliance and level of professional optimism regarding his feedback regarding his current situation resulted in him not receiving an immediate service.

If the information contained within the referral had been discussed in detail, there would have been an up to date assessment of his immediate needs, which would have included his living conditions, his health and well-being.

There were references to V not having eaten for a considerable period, having very little food in his home, living and sleeping on a mattress stained with faeces and urine in general squalor.

There is no evidence contained within the chronology of any action taken to address this. There was a discussion about obtaining food from a food bank but there was lack of clarity regarding whether V would be able to access this service.

If all the multi-agency information regarding V had been considered at this point, there may have been a professional judgement made that suggested that the food bank option would not be suitable and other plans made to address his current circumstances.

It is accepted that the referral to Adult Social Care was made just before a national lockdown and there would have been high volumes of activity to address immediate need and risk.

The unintended consequences of this was the delay in being able to meet with V face to face. The onset of the lockdown meant that assessments took place over the phone. However, for V this was not a reliable option, which is demonstrated in the chronology linked to the number of missed calls.

If a face-to-face discussion had been able to take place it would have been obvious that V's living conditions were not adequate and placed him at risk and that he needed support and interventions to address the self-neglect.

Face to face assessments capture people's non-verbal behaviour, which can reveal their underlying feelings, and this may be as important as what they say. It may even contradict what they say.

When people are less able to communicate verbally and/or directly such observations by practitioners are even more vital. Good observational skills are essential in order to understand non-verbal communication.

Are there any unusual factors in this case? What are they?

It is evident from the chronology completed by professionals who knew V that concerns were escalating regarding his health and well-being.
On the 10th March 2020 it is identified that V clearly was not coping. This is evidenced in the content of the Thames Valley Police report.

The information collated highlights that V would be deemed as a man who was self-neglecting and may benefit from formal intervention by statutory services.

A referral was made to Adult Social Care on the 11th March 2020 by Thames Valley Police and the process of assessment and allocation based on priority of need began. It was unfortunate that within 13 days of receipt of the referral the country went into a national lockdown due to the COVID pandemic.

This lockdown meant that all services needed to consider the duty of care to individuals who they would normally offer a service but also to staff delivering those services.

Impact of COVID

23rd March 2020. In a televised address, Boris Johnson announces new strict rules applicable to the entire United Kingdom with the aim to slow the spread of the disease, by reducing transmission of the disease between different households. The British public are instructed that they must ***stay at home****, except for certain "very limited purposes" – shopping for essential items (such as food and medicine); one form of outdoor exercise each day (such as running, walking or cycling), either alone or with others who live in the same household; for any medical need, or to provide care to a vulnerable person; and to travel to and from work where this is "absolutely necessary" and the work in question cannot be done from home.*

It is acknowledged that the national lockdown had an enormous impact upon the day to day delivery of services. The ability to undertake some face to face consultations and assessments was initially restricted or did not take place at all due to senior management decisions, and professionals became reliant upon feedback from people regarding their circumstances, which may not have been entirely accurate.

There were delays returning to a different form of "business as usual" and this was then based on a priority of need.

The lockdown produced an ethical and moral professional dilemma regarding when and how those in need of professional involvement from a variety of agencies would be able to receive the support they needed. The general duty of care to those with health and social care needs is a legal obligation and has been defined through common law. It applies to every person with the capacity to carry it out, in our society in any situation and not just when we are engaged in working in a caring profession.

Exercising the duty of care is about acting as any other reasonable person would in a responsible way towards others to keep them safe from immediate significant danger and protect them from being put at risk of significant harm.

The national lockdown came at a point in V's life when it had been identified that he was in urgent need of agency support and everyone involved had a "duty of care" to ensure that, despite the restriction on visiting, professional and personal responsibility and judgement on the facts of his case would engender a sense of urgent action and an agreed resolution with other professionals to ensure his safety.

His lack of self-care, his living conditions, health concerns and the evidence that he confirmed he had little food warranted an immediate response. There was an apparent lack of urgency to consider how best to address V's living conditions despite this being evidenced. At the very least it warranted escalation to discuss the possibility of a face to face visit with PPE or to consider using other agencies who may have been able to assist.

The COVID pandemic is unprecedented and the country had not experienced anything of this nature before. The ability to immediately put in place measures to protect vulnerable people and staff with the appropriate Personal Protective Equipment (PPE) for some services will have been delayed, which had unintended consequences in being able to provide vital services that would meet a person's individual needs.

As the pandemic has continued to disrupt the normal delivery of services to those in need of support, agencies have developed and refined structures and processes within their organisations to address this and have learnt lessons that will be embedded and continue to be implemented until there is no longer a risk from COVID.

Are there any failings that appear obvious at this stage?

Assumed Capacity

For most of V's involvement with services it was tacitly assumed that he had capacity to make the decisions, although on 18th March 2020 a professional from Adult Social Care noted that he seemed confused when they had a conversation with him.

This presumption of capacity reflects the first principle of the Mental Capacity Act 2005 (MCA). However, recorded references to V's lifestyle, living condition decisions, his lack of perceived awareness regarding risks to his health should have led a professional to question his mental capacity.

There was nothing within the chronology to demonstrate that this had been a consideration and in discussion with professionals there was an acceptance that this had not been explored but merely an assumption had been made, that V was choosing to live his life as described within the chronology in conditions that were at times of sufficient concern as to request Adult Social Care intervention . The information contained within the referral from Thames Valley Police identified that V was using a mattress that had faeces on it and used incontinence pads in the room. This information would normally lead a professional to consider two possible options: There was either a medical or a cognitive reason for such behaviour and it therefore warranted investigation.

It is acknowledged that there were challenges with being able to undertake a capacity assessment whilst in a national lockdown. However, collating information from other professionals and a conversation with V would have begun the process of establishing whether he had capacity.

The Mental Capacity Act 2005 (MCA) does provide the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make decisions for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act tells us that it must be assumed that an adult has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to decide for themselves at the time the decision needs to be made.

This is a key point regarding V as The Act does not suggest that professionals should not have explored with him the reason and purpose behind the choices that he made which may have led to a different conclusion.

The Act relies upon professionals to take a holistic approach, apply the principles but keep an open mind and not take on face value the view that people's choices are borne out of rational thinking but may be due to an underlying cognitive impairment.

Professional judgement

There were key moments in V's life when a professional judgement was made that initiated referrals being made for professional intervention. However, the information and professional judgement of each agency did not result in the ability to holistically share information that would have led to a different outcome for V.

The lack of multi-agency working and piecing the jigsaw together meant that the approach was fragmented and reactive. It led to assumptions being made regarding V's lifestyle choices; to not considering his mental capacity and being professionally

over optimistic about his ability to manage his life without key agency support.

It was important to draw together all the relevant knowledge that is used in the decision-making process, to be clear about the thinking and be able to demonstrate it to other professionals who knew V. This critical process is called informed decision-making and professional judgement.

Professionals across all agencies in the course of their everyday working life will be involved in decision-making that affects the lives of service users /patients. The process leading to a decision should be transparent so that it can be confidently and clearly explained. It is vital to be able to describe the evidence drawn upon and the critical thinking that has led to the decision. This information should be able to be satisfactorily demonstrated to all agencies involved with the individual.

Empowering service users by involving them in decision-making is fundamental to good practice and acknowledges them as experts in their own lives with the knowledge that they have the capacity. Informed decision making and professional judgement covers the following important areas:

- It is the gathering of facts and information that may be relevant to the decision.
- It is then making sense of or interpreting that information through critical analysis.
- It is utilising all relevant sources of information and experience. These will include:
- Law and Policy
- Service user/patient view
- Messages from research - reviewed and appraised
- Professional wisdom and experience
- Training and examples from best practice.
- It is exploring and using both explicit/formal and implicit/tacit knowledge.
- It is the best use of knowledge available at the time.

Self-neglect

There is clear evidence contained within the chronology to demonstrate that V had a history of self-neglecting that began in 2014 and needed intervention from services from time to time. Self-neglect is an extreme lack of self-care. It is sometimes associated with hoarding and may be a result of other issues such as addictions. Self-neglect indicators are as follows:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs

- Inability or unwillingness to manage one's personal affairs

Considering these indicators and understanding the way in which V lived his life demonstrates that he would be deemed a person who self-neglects.

The level of self-neglect escalated in March 2020 and the information gathered from professionals identified a high level of concern for V's well-being, his health and that he was living in squalor. This resulted in 4 referrals being made to Adult Social Care between 2014 and 2020.

The referrals made in 2020 were graphic, detailed and described a situation which was demonstrating that V was in urgent need of support.

There was a lack of identification by Adult Social Care staff that V was self-neglecting and used a professional judgement that he was choosing to live his life in this way.

It was acknowledged that the history in respect of V from the client file system had not been considered and the gathering of information from other professionals was not undertaken.

If this had taken place at the time of the 3rd referral initiated in March 2015 by West Oxfordshire Council a picture of V would have emerged which would have confirmed that this was a person who needed urgent attention regarding his health and social care needs.

Self-Neglect can present significant issues when considering intervention. It is apparent that V had lived his life since 2014 in a way that would be described from a professional perspective as self-neglecting. A person's lifestyle choices are often based on a judgement by an individual where they deem it to be acceptable to live in a specific way or they are unaware of the risk to themselves or others.

Assessing capacity for a person resistant to outside intervention will sometimes require an innovative approach. This particularly applies when there are no clear legal grounds to intervene and when the risk to the individual or others could be high and sometimes involve death.

It is important that practitioners seek to negotiate a common ground to understand the individual's own description of their lifestyle rather than making possible discriminatory value judgements or assumptions about how it can be defined.

Do there appear to be any gaps in multi–agency working?

The author of this report did not have access to any individual Independent

Management Review reports (IMR's) for the purpose of this Safeguarding Adult Review but the combined chronology demonstrates that multi-agency working was not evident in respect of V.

It was acknowledged that, in retrospect, the benefits of shared responsibility, problem solving and agreeing outcomes with V were not evident. There were repeated interventions with him when there was serious cause for concern that demonstrated the need for a multi-agency approach.

The complexity of his needs and multi-agency working would have reduced the need for reactive professional involvement.

Sharing of relevant information in respect of V's history would have been helpful in identifying patterns of behaviour that would have led to an overall picture of self-neglect and changed the approach to be taken by each agency in supporting him.

It was also noted that there was no evidence of agency responsibility for establishing outcomes and actions to be taken when referrals had been made to Adult Social Care and there was an overreliance on assuming that action was being taken, therefore abdicating any further need to clarify statutory involvement and any crucial role that that agency would undertake on an ongoing basis.

Working in collaboration is essential if individuals are to be offered the range of support they require in a timely manner.

Multi-agency working is about providing a seamless response to individuals with multiple and complex needs. This could be as part of a multi-disciplinary team or on a case-by-case basis.

Professionals need to be clear about their roles and responsibilities and understand the different structures and governance of colleagues from other sectors, including the private and voluntary sectors, micro and direct employers, service user led organisations and brokers assisting with support planning.

Working across these boundaries is critical to planning and providing appropriate support.

Effective multi-agency working can be a significant challenge in professionals day-to-day work. It is time-consuming and can lead to conflict.

However, putting together different parts of the jigsaw is essential. **Safeguarding adults: lessons from the murder of Steven Hoskin** (Social care TV) shows the tragic

consequences of poor multi-agency communication and collaboration.

Some studies focused on the perceived **benefits of multi-agency working**. The most commonly identified being improved/more effective services and joint problem solving. Although the ability to take a holistic approach and increased understanding and trust between **agencies** were also cited.

Challenges of interdisciplinary and multi-agency working

- Confidentiality: there may be concerns about what is confidential information.
- Location: the different professionals involved may work for different employers, are likely to work in different locations and have different line management.
- Staff availability can be a barrier to effective communication.

Improving communication

- Provide clear pathways for **inter-agency** communication.
- Include processes for sharing information at times of change.
- Establish a clear language around risk and vulnerability factors.

Learning Points & Recommendations

The aim of the Appreciative Inquiry was to look at where, how and why events took place and use professional hindsight and wisdom to design practice improvements.

The method of an Appreciative Inquiry uses a systemic methodology which refers to focussing on the interactions and relationships between professionals to help them address any interactions and to move on. It gives those involved with the process the chance to explore the circumstances and say what they think in a safe, non-judgmental environment.

Professionals at the workshop came to a consensus regarding the learning points to be endorsed by the Oxfordshire Safeguarding Adult Board for all agencies involved with V. Board members to ensure that frontline professionals are mindful of the following learning points from this review:

- **Professional curiosity** – remembering to explore with an individual what is happening in their life and challenging when necessary.
- **Professional overreliance** - from the individual without exploring the presenting information from professionals.
- **Professional judgment** - applying the knowledge, skills and experience of professionals to develop an opinion.
- **Multi-agency working** - revisiting the benefits of shared responsibility, improving outcomes, problem solving and working within a holistic framework.

- **Mental capacity** - the existence of capacity should not preclude further investigation into a person's circumstances and choices.
- **Self-neglect** - partnership knowledge of self-neglect needs improving through training to address the fundamental principles of this behaviour.
- **Understanding professional roles and responsibilities** - in respect of "duty of care". Who "owns" the case and who is taking the lead? Could a chronology be used to develop a wholistic picture of an adult's life?

Recommendations

The following recommendations have been made in regard to the case:

1. The Board should assure itself that the training offered to frontline workers includes the **fundamental principles of Self-neglecting behaviour and is clear and understood.**
2. The Board should consider producing a **7-minute briefing of the lessons** highlighted above for publication with the report.
3. The Board should consider a partnership audit that addresses the fundamental question of Mental Capacity and its application.
4. The Board should consider an audit to establish the level of partnership training that is offered to professionals.
5. The Board should assure itself that multi agency working is embedded across all services and is clear and understood.

These recommendations are deliberately broad as it is for the Board to agree on what actions it will take to progress

Appendix 1 – Complete Combined Chronology

20.05.2014 - TVP: Report made by landlord of a supported accommodation service regarding concerns about one of the residents, who was identified as V. The landlord went to V's room to carry out maintenance work and the room was extremely smelly and full of litter, he removed 25 bin bags full of rubbish from the room. V had admitted to the landlord that things have got on top of him and he could do with some help. The landlord provided some background information about V; he has resided at the address for seven years and used to be in the RAF. The landlord stated he had called Adult Social Care looking for some assistance and they had advised him to contact V's GP. The reason for contacting the Thames Valley Police was to try and get some assistance as he felt nobody was doing anything. Thames Valley Police created an Adult Protection referral to allow referrals to be made and the Neighbourhood Policing team was made aware.

October 2014 - ASC: V was referred to ASC by West Oxfordshire District Council (WODC) in October 2014 due to concerns that he was at risk of eviction and WODC would not be able to accept him if he had no social care needs. Concerns related to the condition of his accommodation. Concerns also expressed related to personal hygiene and not eating. Following an assessment of V, he was referred to Connections for support.

March 2015 - ASC: A further referral was made to ASC by West Oxfordshire District Council. Concerns related to risk of eviction. An assessment was completed in April. It was identified that V required support with basic housework, and he agreed that he would pay for someone to assist him with this. A member of staff was allocated to help provide support in identifying and arranging for an agency to help him keep his home in good condition.

25.06.2015 - Cottsway: Tenancy began. Connections Floating Support present at tenancy sign up. Assisted V with claiming housing benefit. Support was engaged for him following the pre-tenancy assessment. V's previous accommodation was ended because his landlord served him with a notice to leave due to the condition of the property.

02.09.2015 - Cottsway: New Tenant Welcome visit made the Neighbourhood Housing Officer. Reported property was clean and tidy; no issues with tenancy.
RAF had provided funds for V to purchase a mower to cut his grass, to keep the garden tidy.

22.04.2016 - Cottsway: Repair reported – no heating.

26.04.2016 - Cottsway: Asbestos survey inspection carried out.

18.05.2016 - GP: Letter sent from the GP Surgery. 1st recall letter to V requesting a Chronic Disease Management (CDM) appointment with a Health Care Assistant (HCA). CDM is a chronic health medical clinic for those on regular medications or requiring regular health checks. This was set up for V following a stroke in 2016 and linked to repeat prescriptions for aspirin and BP monitoring.

17.06.2016 - GP: Letter sent from GP Surgery. 2nd recall letter to V requesting a CDM appointment with HCA.

14.08.2016 - GP: Letter sent from GP Surgery. Letter to V as not collected prescriptions for aspirin, enclosing a new prescription and suggesting he ordered a repeat prescription.

29.09.2016 - GP: Letter sent from GP Surgery. 3rd recall letter to V requesting a CDM appointment with HCA.

16.01.2017 - GP: Administrative note sent from GP Surgery. Request to GP to record declined on V CDM record, as not replied to 3 requests to attend CDM clinic.

31.01.2017 - GP: Administrative note sent from GP Surgery. Excepted from stroke quality indicators: informed dissent X3 invites. GP decision not to continue to invite to these clinics due to 3 non-attendances.

29.04.2017 - GP: Administrative note sent from GP Surgery for blood test result.

18.05.2017 - Cottsway: Annual Gas Service carried out.

23.06.2017 - GP: Letter sent from GP Surgery. 1st recall letter to V requesting a CDM appointment with HCA.

06.10.2017 - GP: Invitation from GP surgery to participate in clinical trial.
13.11.2017 - GP: Text message from GP surgery to V for a smoking cessation clinic. 1st invitation.

15.11.2017 - GP: Letter sent from GP Surgery. 2nd recall letter to V requesting a CDM appointment with HCA.

08.03.2018 - GP: Letter from GP Surgery. 3rd recall letter to V requesting a CDM appointment with HCA.

09.05.2018 - Cottsway: Annual Gas Service carried out.

20.07.2018 – 06.11.2018 - GP: 7 Text Messages sent from GP Surgery (CDM, Flu Vaccine).

07.12.2018 - GP: Text Message sent from GP Surgery offering V a flu vaccination.

31.12.2018 - GP: Letter sent from GP Surgery informing V of change of named GP.

27.02.2019 - GP: Text message from GP surgery to V requesting consent to clinical SMS.

09.04.2019 - Cottsway: Gas Engineer raised a concern following a recent service regarding condition of property. Email sent to the Cottsway neighbourhood team to investigate.

10.04.2019 - Cottsway: Letter sent to V by Neighbourhood Housing Officer requesting a home visit. Date and time confirmed in letter.

27.04.2019 - GP: Administrative note from GP Surgery regarding bowel screening. Lab Result: BCS: FOB result.

08.05.2019 - Cottsway: Home visit by housing officer; V not at home, visual inspection. Unable to see inside property, no sign of tenant. Card left through letterbox asking to make contact. No response from V. No further attempts were made to contact him at this point. No repairs were reported by V or annual safety checks needed during 2019, to trigger any further visits by Cottsway staff.

02.07.2019 – 07.01.2020 - GP: 3 Text messages from GP Surgery – (shingles, flu vaccine)

09.01.2020 - Cottsway: Rent reminder letter sent

22.01.2020 - Cottsway: V phoned and paid his rent over the phone by debit card.

31.01.2020 - Cottsway: Attempt to contact V to book a stock condition survey. Voicemail left asked to make contact. Stock condition surveys are undertaken every 5 years. This involves a full inspection of the property.

13.02.2020 - Cottsway: Further attempt to book stock condition survey. Voicemail left asked to make contact.

10.03.2020 - Phone call received from neighbour to Cottsway Customer Services concerned hadn't seen V for a week. Customer Services request for Welfare Officer to make contact.

Phone call made to V by Community Welfare Officer, no response. Voicemail left asking for call back. Housing Management System interrogated for next of kin details. Details expired.

Cottsway visit to check on V. No response. Visual inspection-the curtains were closed at the front and back of the property and a large parcel outside the front door. There were also a lot of flies between the window and the closed curtains at the rear window. The kitchen was the only room that could be seen, which was visibly untidy.

Cottsway Housing called TVP to report a fear for welfare in respect of V as he had not paid his rent in respect of his accommodation and on attendance at the address, they found a parcel uncollected on the doorstep and no reply within.

On Police attendance, V was found safe inside in his bed. However, the property was in a poor state, rubbish over the floors, rotting food and extremely dirty.

Thames Valley Police contacted the GP and requested they carry out a house visit to check on his health. The Early Visiting Service (EVS) agreed to visit to assess his general health.

Discussion was also had with Cottsway Housing to identify possible actions to alleviate the obvious issues within the property.

Officers who attended the address graded the incident as "A" grade – imminent risk of significant harm due to the following reasons:

- Diet - not eating correctly, only eating prepared salad bowls from local supermarket.
- Alcohol consumption is significant.
- Home environment is a health hazard.

TVP reported "House is a 'health hazard'". TVP will make a referral to social care /adult safeguarding. They do not think he is unwell enough to need ambulance or admission but would like him checked over.

Thames Valley Police called Cottsway to confirm they had managed to gain access through an open window. V was alive, although quite unwell and that the property was in a 'bad' state.
Cottsway Officer visited V at home and was met by two Policemen. Spoke to V discussed accessing urgent medical attention, his living conditions, support and his finances.

Property littered with lots of Amazon boxes, living room was sparsely furnished, bedroom was worst affected area with used incontinence pads, faeces on the mattress and food waste on the floor. Kitchen didn't appear to be used much but lots of beer cans littered across the work top.

Offered to phone Ambulance but V refused. He told the housing officer that he hadn't been out for a week or more because he felt unwell. He normally went shopping daily and to the local pub.

Housing officer offered to make V a meal and although he said he wasn't hungry, they left him with a tin of soup and a bowl from his cupboard. V was walking around and made himself a drink before the housing officer left.

He was asked to keep his phone on charge/answer his phone so that the housing officer could keep in regular contact with him. Housing officer agreed to phone him over the next couple of days to check on his progress.

Cottsway held a Case discussion led by the Head of Housing & Welfare Team. Agreed Welfare Officer to follow up with Adult Services, engage support and begin steps to assist with property clean. V had showed his bank statements which suggested he had money in his account and may be able to pay for support. Further investigation needed.

Later the same day GP Home Visiting Team attended and assessed V. They found he had a chest infection and was prescribed antibiotics.

This visit was followed up with a phone call and text message to V from his named GP on 23.03.2020 but there are no records to say that he answered or returned the call.

The Police made the referral to the Multi Agency Safeguarding Hub (MASH), who in turn referred it to ASC on the 11th March 2020.

This information was also passed to the Neighbourhood Police Team. Police attended the following day at the address but got no reply.

From speaking to neighbours, they were informed that V won't come to the door, so a call back card was left.

11.03.2020 - GP: Administrative note sent from GP Surgery. Acute home visit report received from Early Intervention Service.

11.03.2020 - ASC: Thames Valley Police report received. V had not been seen for some time. He was in his bed; however, the house was in a very poor state with piles of empty, mouldy food cartons around his bed. The house was very dirty, and V stated that he had not eaten for over a week.

12.03.2020 - ASC: Call to V No response – voicemail left

17.03.2020 - Cottsway: Phone call to V no response. Voice message left. Due to the announcement of the national lockdown, Cottsway closed their offices and all face to face contact with customers ceased. Housing officer was unable to do a home visit as planned and instead tried to phone V

17.03.2020 11:37 - ASC: Call to V. No response – voicemail left

18.03.2020 10:38 - ASC: Call from V to Adult Social Care. He said his main needs were lack of food – he had a tin of soup left – and the condition of the property (there is rubbish everywhere, particularly in the bedroom). V agreed to referrals being made but worker reports that he seemed confused.

18.03.2020 - ASC: Call to V. No response – voicemail left with contact details for the local Food Bank and advised to try to see if friends were able to purchase food in the meantime. Confirmed that a Background Information & Contact Assessment (BICA) was in progress for support with cleaning the property and advised to call ASC if he has any further questions

18.03.2020 - ASC: Call from V and advice given as above.

18.03.2020 - ASC: BICA completed and sent to local Adult Social Care team, this was prioritised as: needs Care Needs Assessment – High Referral acknowledgment letter sent to V including details of food bank.

19.03.2020 - Cottsway: Phone call to Adult Social Care. Duty Officer confirmed they had received a referral and information from Thames Valley Police.
The case was awaiting assignment to a Social Worker.

23.03.2020 - GP: Administrative note sent from GP surgery. Attempted telephone consultation with V.

23.03.2020 - GP: Text message sent from GP surgery to V requesting he contact his GP at the surgery. GP asking how V was, following chest infection.

31.03.2020 - ASC: Received call from Housing Officer, Cottsway, requesting update. Informed Housing Officer that V still on waiting list to be allocated.
Housing officer advised that she couldn't get hold of V and due lockdown she is unable to visit. Concerns with the poor state of the property when she was last visited.

01.04.2020 - ASC: Duty worker called V no answer.

01.04.2020 - ASC: Duty worker made a phone call to the Housing Officer. Advised that V was on allocation list and that he had been given details of food bank.

01.04.2020 - ASC: Duty worker called V no answer. Message left to return call.

08.04.2020 - ASC: Social worker ASC West call to Housing Officer. Message left informing her that social worker would be undertaking a telephone assessment.

08.04.2020 - ASC: Duty worker ASC West call to V no answer.

08.04.2020 - ASC: Social worker discussion with Practice Supervisor. Agreed due lack of contact with V for some time a welfare check referral should be made to the Police.

08.04.2020 - ASC: Telephone call to Thames Valley Police to request a welfare visit to V.

08.04.2020 - TVP: ASC contacted Police as they were concerned about the welfare of V. They last had contact with him on the 18th March via the phone when he stated he only had one tin of food in the house to eat.

They had attempted to contact him on the phone but had failed and due to COVID they were unable to attend the address to carry out a welfare check.

Officers attended at the address and found the backdoor unlocked and on entering the living room they found V deceased with the suspicion that he had been for some time. The attending officer recorded concerns within the URN as they had initially been dispatched to the wrong address. It is thought that this information may have been provided by Social Care but would need further exploration.

08.04.2020 - Cottsway: Phone call from Out of Hours to Head of Housing to confirm that Thames Valley Police had accessed the property and V had passed away. Confirmed no active Next of Kin on the system. Property did not require making secure.

Appendix 2 – Changes as a result of the Review

All participants at the Appreciative Inquiry were asked to consider the changes that had been undertaken as a result of this Safeguarding Adult Review using these agreed headings:

Any national guidance which will have a positive impact on people who are hard to reach and engage?

Social and Health Care Team response:

All Professional Support in Social and Healthcare Team (SHCT) have attended training on Defensible Decisions and Evidencing them. This was to encourage more professional curiosity, to consider if all steps have reasonably been taken, to help prioritise cases based on this evidence and properly document them.

Cottsway Housing Association response:

There are no changes at present regarding national guidance

Primary Care (supported by Clinical Commissioning Group) response:

Quality and Outcomes Framework – new arrangements for GP's on proactive action with non-engaging patients. This will equate to extra funding and extra capacity. There are also Social Prescribers in place to support those who are deemed as needing extra support and help to address their health needs, which includes their emotional/mental health.

Adult Social Care response:

There are no changes at present regarding national guidance

Thames Valley Police response:

There are no changes at present regarding national guidance

Any changes in the use of patient/client file systems which allow greater transparency regarding people who are hard to reach and engage?

Social and Health Care Team response:

We are in the process of rolling out a new referral form/assessment tool that has the strengths-based approach more embedded in it.

Cottsway Housing Association response:

No. We have data sharing protocols in place which allows us to share data with other agencies

Primary Care (supported by Clinical Commissioning Group) response:

There are no changes at present

Adult Social Care response:

There are no changes at present

Thames Valley Police response:

There are no changes at present

Any policy/procedural changes within your organisation to reflect the need to change practice as a result of V's death?

Social and Health Care Team response:

SHCT have recruited new staff to help progress referrals/assessments to the Adult Social Care Teams (ASCT) more efficiently, and also free up more senior worker to manage the out of hours work (which included TVP reports, Ambulance reports). Seniors Social workers in SHCT have also met to discuss and implement how cases are triaged.

Cottsway Housing Association response:

Yes. Currently exploring technology to support internal processes to report immediate concerns by visiting Officers/Operatives. We will also be rolling out updated training next year to all customer facing roles. Potentially looking to host sessions within team meetings to discuss safeguarding at a local level.

Primary Care (supported by Clinical Commissioning Group) response:

The GP practice has been proactively following up patients who have chronic diseases and have had missed reviews. We are searching for those who have an underlying health condition and have not had a review in the last two years, although at the current time this number is higher than we would expect as many of these reviews have been put on hold due to COVID. Once we return to "normality" our GPs will be sent lists to review each month of those patients who have missed a review and will clinically assess what action to take. This may involve the GP contacting the patient by telephone or by letter but very rarely involve the GP making a home visit.

Adult Social Care response:

Guidance was sent around to the team and information was shared with them in a team meeting about the case to emphasise the need for professional curiosity, prioritisation of work and taking that step further to make sure we have made contact.

Thames Valley Police response:
There are no changes at present

Any referral pathways into your services that have been updated?

Social and Health Care Team response:
No other changes at present.

Cottsway Housing Association response:
Yes. We will always undertake our own referral even if another agency has agreed to do this.

Primary Care (supported by Clinical Commissioning Group) response:
There are no changes at present

Adult Social Care response:
Cases that have presented from the Social and Health Care Team and other agencies with similar situations have had clear management direction and timeframes for response and clear delegation of tasks across professions and agencies to reduce risks and maximise the opportunity for effective input.

Thames Valley Police response:
There are no changes at present

Any other change of practice?

Social and Health Care Team response:
The SHCT is in the process of fundamental change, modification and improvement. We are working with our ASCT colleagues to identify gaps and proposals to improve them in MIH (Making it Happen) groups. As well, the SHCT, as part of the overall Customer Service Centre project involving the PWC, are looking for efficiency gains, more robust decision making and leaner processes.

Cottsway Housing Association response:
No other changes at present

Adult Social Care response:
Managers have sought out information on Self-Neglect and will be looking for opportunities to share information with the team about how we work with these individuals. We will also be looking to pass on training opportunities to the team to allow them to add to their Personal Development Plans.

Primary Care (supported by Clinical Commissioning Group) response:

When patients have not attended more than 3 appointments, their records will be flagged denoting this. Although this is not a change in protocol, it has been highlighted in a recent all staff Safeguarding update regarding the importance of flagging any refusal of treatment or non-contact to other agencies. It has been highlighted regarding the importance of referrals to County Council safeguarding services where there are concerns.

Thames Valley Police response:

There are no changes at present