Safeguarding Adult Review

“Louise”

Overview Report

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The Report

1 INTRODUCTION

1.1 Scope of the review

1.1.1 The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory Safeguarding Adult Review (SAR) on 23rd March 2020 and this was agreed by the Southampton Safeguarding Adults Board (SSAB) in June 2020.

1.2 Terms of Reference

1.2.1 This SAR concerns the effectiveness of inter-agency practice in relation to engagement and care of an 87-year-old woman. The period covered by this review is from 1st January 2012 until the date of her death, on the 6th January 2020.

1.3 Key Lines of Enquiry (KLOE)

1.3.1 This review centres on the issues of partnership working and communication between agencies working with Louise specifically:

- What was known by agencies about the significant neglect Louise was suffering and whether there was ever a Section 42 Safeguarding enquiry and holistic assessment of Louise and her circumstances?
- To explore the self -neglect which was a contributory factor to Louise's death.
- Agencies understanding of self -neglect, neglect, and acts of omission offences and when these should be raised to the police.
- Relationship between Louise and her full time 'carer' – it is reported that he was finding it difficult to care for her, was reluctant to accept help, resistant to health services attending Louise's home, and at times failed to appreciate the severity of Louise's memory problems.
- Inconsistent record keeping.
- Timeliness of referral to services.
- Delay in Independent Mental Capacity Advocate (IMCA) allocation – referral confirmed as completed on 19th December 2019 therefore unclear why it was never allocated, and Louise was never seen.
- What evidence was recorded by the agencies that the Mental Capacity Act 2005, and its implications on practice and decision making were considered as part of their involvement with Louise?
- What evidence was held (or recorded) by the agencies regarding the Lasting Power of Attorney for health & welfare and whether it had been registered?

- Consideration whether a safeguarding concern should have been raised at any time when concerns were recorded by professionals.

- Professional involvement.

- Reasons/rationale for decisions made regarding engagement/referral /case closure.

- Understanding and practice in accordance with the Mental Capacity Act 2005 and the rights and responsibilities of the LPA.

- Understanding and practice in respect of involvement/referral to adult safeguarding.

1.4 Synopsis

1.4.1 Louise was an 87-year-old lady at the time of her death. She had lived in a supported housing scheme for 20 years. Louise was first noted to have cognitive problems in 2013, over the following 7 years her abilities declined, and a friend called Trevor supported her. Housing Officers visited annually and offered services and asked her to sign that she did not need them.

1.4.2 Louise would always say she did not need help even when observation suggested she was struggling. She came to the attention of Adult Social Care intermittently throughout this time and various agencies were involved in her care and support. Professionals raised three safeguarding concerns during the time frame, but all cases were closed without enquiry, as there was no evidence of intentional neglect.

1.4.3 In 2018 the GP called an ambulance as she had grossly overgrown toenails, that were digging into her skin. Trevor was frequently offered support and services, but he declined them, even when Louise appeared to be in need of extra care. Trevor was the attorney and registered the Lasting Power of Attorney (LPA) for both health and finance in 2017. Some professionals question the legality of these, but the Office of the Public Guardian (OPG) advised there was not enough evidence to demonstrate concern.

1.4.5 Professionals continued to try and engage with Trevor and provide care and support for Louise, but it was often rejected. In December 2019, Louise was admitted to hospital, severely malnourished and with significant pressure ulcers. She initially improved, but sadly deteriorated and died on 6th January 2021. Her cause of death was recorded as 1a. Malnourished,1b self-neglect,1c Dementia.

2 METHODOLOGY

2.1 Overview

2.1.1 The members of the Southampton Adult Safeguarding Board commissioned an independent nurse to carry out this review. The author, Lynne Phair, is an Independent Consultant Nurse and specialises in the care of frail older people and adult safeguarding.

2.1.2 The review was also supported by a panel from the SAB partner agencies. This brought a further level of expertise and scrutiny of the individual agencies' reports.

The panel was made of representatives from:

- Southampton City Clinical Commissioning Group CCG
- University Hospital Southampton
- Solent NHS Trust
- Southampton City Council Legal Services
- Southern Health NHS Foundation Trust
- Southampton City Council Adult Social Care
- Southampton City Council Housing Service
- Hampshire Constabulary

2.1.3 The methodology applied to this SAR combined management reviews from each agency. Each agency report included information from the records together with information following discussion with staff involved in the care of Louise. Louise did not have any family. She was supported by a man who will be called Trevor, who was her main carer. Trevor has been consulted as part of this report.

2.1.4 SARs should be conducted in a way that respects the person's dignity and the privacy of the person. A pseudonym has been used to refer to Louise. The male carer will be referred to as Trevor. Professionals and specific places are not named. Dates are deliberately generalised while retaining enough information to provide a context.

2.1.5 The report has been written for professionals and lay people (if published) to easily follow the story, consider, reflect, and assimilate the learning. The style has been developed over many years of writing court reports, whereby lengthy and convoluted reference-based theory content distracts from the importance of the purpose of the report.

2.2 Timeline

2.2.1 A timeline is set out in the appendix, taking the information from all the agencies who provided a management review.

2.3 Individual Management Reviews

2.3.1 The contents of each organisations individual management reviews have been considered alongside the timeline. Information from these documents is reflected in the analysis.

2.4 Meeting with carer / friend.

2.4.1 Louise did not have any family. She has a long-term friend (Trevor) who became her carer until she died. Trevor was invited to meet with the author, to share his experiences, but he was unable to do so. However, he did have a phone conversation with the Safeguarding Board Manager. He said that she was abandoned as a baby, and never knew her birth parents. She was married and used to work in Foyles's bookshop. Trevor's Aunt and Uncle knew Louise well. After Trevor's Aunt died and following the death of his own wife, Trevor helped his Uncle and got to know Louise. Trevor and Louise became friends, and they would have days out together, sharing their love of books.

2.4.2 It is noted that the records from various agencies involved in the care of Louise, recorded that Trevor told them he took over caring for her when his own uncle died. His uncle had been a friend of Louise.

3 LOUISE AND THE BACKGROUND FOR THIS REVIEW

3.0.1 Louise had been living in a local authority independent living supported housing flat for nearly 20 years. She showed signs of cognitive problems from 2013 and she lived with advanced dementia since 2018. Louise's full-time carer, Trevor, who lived with her, was also her attorney, as he had LPA for both health and welfare and finance. Concerns have been expressed about whether he always acted in Louise's best interest. Louise died in January 2020 in hospital, an inquest confirmed that the cause of death was malnutrition as a result of self-neglect and dementia.

3.1 Pen Picture of Louise

3.1.1 Very little is known about Louise's life before she became older and in need of support and services, apart from living in the supported housing flat for 20 years. There was no information in any of the IMRs giving, any history of her life, her personality and interests, family, beliefs, or evidence of her preferred approach to care.

3.2 Review of Care and Support between 2012 -December 2019

2012 -2013

3.2.1 Louise first showed an indication to the services, that she may be experiencing cognitive problems in May 2013, when there was report that milk had been left out all day. A support worker found her forgetful and informed the GP. The GP made a referral to Adult Social Care (ASC) who telephoned Louise. They found her confused but did not follow this up any further, writing to the GP to say Louise told them she did not have any support needs.

3.2.2 There was an annual supported housing review in September of 2013, but then no contact with any services for 9 months.

2014-2015

3.2.3 The supported housing service were called to the flat as the fire alarm was activated in May 2014.Thereafter there was no contact apart for a supported housing

review in August 2014, and a letter from her GP inviting her for a blood test, which she did not attend until the following August 2015, when there was the annual supported living review.

3.2.4 In October 2015 a phone message from the GP surgery was left inviting her for an over 75 check, but she did not respond.

2016- 2017

3.2.5 In August 2016, (11 months after last contact) that the GP went to see Louise as they were aware they had no contact with her. She was muddled and looked neglected. Trevor was in attendance and advised that he was supporting her.

3.2.6 The GP offered support and either the GP or practice nurse visited on three further occasions in August and September, but Louise refused any help. There was no referral to ASC.

3.2.7 Apart from a supported housing review in July 2017, when nothing is recorded apart from an attendance note, Louise was not seen by any services for another 15 months. In November 2017, her friend Trevor registered the Lasting Power of Attorney (LPA) for property and finance and registered the LPA for health and welfare in January 2018.

3.2.8 In December 2017, she was found walking about outside the flat. The GP referred her to the Memory Clinic and Older Peoples Mental Health Service (OPMH) and ASC. ASC telephoned but Trevor declined any help. Two more calls were made from ASC to offer help, but it was refused by Trevor.

2018

3.2.9 In early in the 2018, OPMH began visiting Louise, and referred her again to ASC for a care assessment. Louise was on the waiting list for ASC from February until May 2018. Around this time, the family friend, Trevor, began communicating with the services. He frequently cancelled or moved appointments, requiring OPMH to negotiate access to Louise with him. In May, neighbours expressed concern that she was walking with no purpose outside the flat. The GP attended and found her with severely overgrown toenails, frail, financial concerns, and Trevor very controlling. The GP referred her to the hospital. Trevor agreed to take her that night, but when it was found, the next day, that he had not done this, paramedics were called. They recorded that the flat was dishevelled, and she appeared neglected. The GP made a safeguarding referral to ASC.

3.2.10 Louise and Trevor attended the Emergency department, who advised them that this was not a service they provided and the GPs referral to Orthopaedics was also not activated. The hospital sourced a private podiatrist who attended Louise at home the following day. Her feet were very neglected, and she was very confused and restless. Her toenails were 5-8cm long, curled over and very thick and growing into her flesh. The chiropodist noted these were the most neglected feet seen in 25 years of practice

3.2.11 A referral was made (by the hospital) to The Urgent Response Service (URS), a 5-day service to prevent admission to hospital) in order to support her at home. A Social Worker also visited the home regarding the safeguarding concerns. Louise was unaware of her needs and showed signs of dementia. Louise was alert and chatty but unable to show any insight into Trevor's guarded and negative persona.

3.2.12 Louise was also asked about pain relief, but she said she did not need it and Trevor kept it in his pocket, despite the medical opinion being that her toenails would be causing significant pain and she was observed as in pain when mobilizing. Trevor strongly declined any support and only very reluctantly accepted the URS for 5 days.

3.2.13 Trevor was routinely reluctant to allow them into the home, and sometimes became aggressive, abusive, and suspicious and so staff attended in pairs. Although Trevor said the toenails had been cut, either Louise would not allow anyone to look at them or staff did not request to check them. During this intervention he stated he had been living with Louise for 15 years, however, on another occasion he stated he was living in Hampshire and travelled to see her.

3.2.14 Three days after the assessment, and despite the difficulties for the URS to attend to Louise, it was determined that there were no safeguarding concerns.

3.2.15 Although the notes record that the situation had settled, a referral was made to the Community Independence Service (CIS) due to safeguarding concerns noted during their involvement. A referral was also made to the Community Wellbeing Team (CWT - community nursing). The Nursing Service visited and assessed her health needs. She had a high MUST score (Malnutrition Universal Screening Tool), but Louise said she had always been slim as she used to be a ballet dancer.

3.2.16 The chiropodist attended in mid-June, noting the nails were no longer causing Louise any pain. No other appointments were made at that time.

3.2.17 During the month of June, Trevor refused access to CIS staff on all three of their visits. However, he did allow the GP in, and her feet appeared better. The GP also rereferred Louise to the OPMH service, as it was believed they had discharged Louise, however, this was not correct.

3.2.18 The safeguarding concern was reviewed by ASC, and a joint visit with OPMH and ASC occurred in early July. It was noted that Trevor had poor insight into Louise's needs. He did agree to the OPMH Occupational Therapist providing bathing equipment and to refer her to URS for a weekly bathing call. ASC determined that because the acts of omission by Trevor were not intentional, it was not a Safeguarding issue.

3.2.19 As part of their assessment process CIS contacted the Office of the Public Guardian to confirm the LPA status. It was confirmed that Trevor had both LPAs, a person who did not know Louise, was recorded as the alternative LPA and both had been registered.

3.2.20 In August ASC closed the safeguarding referral regarding the LPA, as they did not consider there was any evidence to challenge Trevor as they determined there

were no unmet needs. ASC advised OPMH and CIS that the LPA could be revoked if there was evidence of neglect.

3.2.21 CIS also discharged Louise and made a referral to the Social Wellbeing Service (long term adult social care support). It is noted that there is no further reference to this department, and no evidence that they became involved.

2019

3.2.22 Support continued throughout 2019 with unannounced visits from OPMH every few weeks. Sometimes Trevor would allow access and other times he would not. During the first few months of 2019, CWT, OPMH and ASC made attempts to visit Louise. Trevor regularly blocked entry declined to allow an appointment or deferred the appointment. He did allow an audiology appointment to be made, the GP took bloods and he wanted dietary advice. Louise was not always seen during visits, and some contact was by telephone. The GP diagnosed low Vitamin D and prescribed medication. The OPMH, remained concerned about the LPA and contacted the second name on the LPA, the second signatory of the LPA confirmed that he had never met Louise. OPMH advised the wellbeing nurse about their findings.

3.2.23 The chiropodist made a routine visit in February, and no concerns were noted.

3.2.24 By April, there was evidence that Trevor was struggling as Louise needed her hair washed and her weight was reducing. The CWT offered to help him, but he refused. Her hair remained unwashed becoming greasier over the next 2 months and it is unclear if it was ever washed. Louise was sleeping more, and professionals saw her less and less. OPMH have increasing concerns about Trevor and once again, raised these with ASC.

3.2.25 ASC contacted Trevor to arrange a visit, but he delayed this from May to July. When they did visit Trevor, he complained about OPMH always doing unannounced visits. In June and July Louise was not seen by health professionals and some visits were cancelled by Trevor. In June he admitted to CWT that he was struggling but refused help, refused a continence assessment, preferring to purchase pads privately and had still not washed her hair.

3.2.26 Supported housing visited on 18th June 2019 and Louise signed an individual agreement to say she was being supported. It is unclear how the housing officer determined that Louise had the capacity to sign this agreement.

3.2.27 No visits occurred in August, and Louise was next seen awake on 24th September. She had not been seen since 27th June. She had lost weight. Trevor was buying food shakes rather than using the prescribed ones and she had bruising under both eyes. Trevor said she had fallen. Trevor again refused a continence assessment or a package of care. Trevor also said he did not like 2 visits a week so it was agreed that OPMH would not visit that week. CWT advised ASC and OPMH about the concerns shared by CWT and the GP.

3.2.28 On 27th September Trevor was visited by a Social Worker who explained his responsibilities as an LPA, including that he could be removed from caring for Louise.

Trevor accepted he had been rejecting help at times and he agreed to cooperate with URS support if recommended by the GP or nurses.

3.2.29 The GP visited on the same day and Trevor did not recognise him and Louise was asleep in bed. Nutritional supplements were prescribed but referral to URS was not thought necessary. The GP did note a diagnosis of “severe dementia and possible dementia with carer”.

3.2.30 In October one visit was made by OPMH and Louise was in bed. Her hair was long and greasy, and the flat was more cluttered. A package of care was discussed but Trevor continued to refuse help.

3.2.31 A Social Worker called Trevor in October and told him that OPMH would only visit every three months.

3.2.32 CWT made telephone reviews and Louise’s decline was noted. Her weight was declining, and she was in bed. Trevor continued to decline continence assessments, preferring to buy them himself and also refused to use the prescribed supplements, again preferring to buy shakes. Trevor did call the CWT to seek advice about constipation, that they were both suffering from. Trevor was advised that Louise must be seen by CWT to monitor her.

3.2.33 In October OPMH made a referral to the Wellbeing team. In November, they tried to book an appointment to carry out a visit, but Trevor refused, and so Louise was discharged. OPMH continued to be concerned about Louise, and recorded incidents of Trevor refusing entry, refusing a package of care, refusing professional involvement, and raised another safeguarding concern.

3.2.34 A joint visit was booked with Trevor, which he agreed to reluctantly, although he tried to rearrange it. Louise looked well during the visit. Trevor answered for her, but she appeared relaxed in his company. The GP also visited and whilst there, noticed a possible diagnosis of dementia in respect of Trevor. Following the visit, the Social Worker emailed the GP asking if Louise was eligible for free podiatry and asked if a nurse could visit to advise on diet.

3.2.35 The Social Worker closed the Safeguarding Adults concern as there was “no evidence of intentional harm” and the OPG advised that there was not enough evidence to challenge the LPA legally. The case was also closed to the CIS and there were no unmet needs in terms of personal care or nutrition.

3.2.36 In November, OPMH made a referral to CWT to monitor her physical health. CWT contacted Trevor; however, he was reluctant to allow a visit and deferred it to the new year.

3.2.37 At the end of November, a Social Worker reviewed Louise’s case and concluded that the case would be closed as there was no role for ASC. The summary noted that in general Louise was settled in Trevor’s presence and he understood his responsibilities as the LPA and understood the consequences of not carrying out his duties. He was welcome of the interventions. Trevor confirmed that he would contact relevant services if Louise’s care changed.

3.2.38 This decision was communicated by email to OPMH, CWT and the GP. The OPMH would visit three monthly and the wellbeing team would visit and monitor health issues. There was no evidence that the Social Worker contacted the other professionals for a progress report since September or arrange a case conference.

3.2.39 Louise was only seen once by OPMH in October, and not at all in November. She was not seen by CWT, who were monitoring her physical health after 24th September, although telephone contact was made with Trevor 8 times and attempts were made to book visits. Trevor routinely either refused or changed the dates and there is no evidence they managed to see Louise after 24th September.

3.2.40 On 16th December Trevor contacted 111 reporting bed sores that were itching and bleeding. The URT attended. Louise was unresponsive except to pain and severely dehydrated (possibly suffering from dehydration and sepsis).

3.2.41 The paramedics noted that Louise was severely dehydrated and drank water and a protein shake from a gauze very quickly. She had very long nails, skeletal frame, hair not washed and appeared extremely malnourished, emaciated, incontinent and confused. The hospital recorded grade 3 pressure ulcers.

3.2.42 Despite attempts to treat Louise, and evidence of improvement around 23rd December, she deteriorated and died on 6th January 2020.

3.3 Review of the involvement of Trevor

3.3.1 It is not clear from the records how long Trevor was involved with Louise prior to 2017. He stated he took on the role as carer from his uncle when he died, on another occasion he said he had been cohabiting with Louise for 15 years and at other times he said he had his own home in another town.

3.3.2 Descriptions of Trevor suggest he was an older man, who occasionally admitted that he was struggling to care for Louise. However, almost as soon as he disclosed this, he denied it again. By 2018, Louise's GP was questioning whether Trevor also had dementia. Overtime the home became more cluttered and Louise looked more unkempt and was looking under nourished. The extremely poor condition of her toenails suggests she was not managing for a long time before they were discovered, but there is no evidence that Trevor called for advice.

3.3.3 From 2017, Trevor was offered help on numerous occasions of various types. The most fundamental of which was visits from professionals. However, he continuously and repeatedly refused access or changed appointments. He frequently delayed appointments meaning Louise was not seen and, on some occasions, delayed first assessments by new agencies.

3.3.4 Trevor was offered continence assessments and provision of incontinence products but declined regularly. He stated he was buying pads privately. There is no record that the type of pad was checked for suitability, or any enquiry made about how much he was spending (possibly Louise's money) on a product that was available free on the NHS.

3.3.5 He also refused to give Louise the prescribed nutritional supplements, preferring to purchase shakes. There is no record that the suitability of the purchased shakes was checked.

3.3.6 When professionals did visit, there were reports that his behaviour was aggressive, suspicious and defensive. Staff also reported visiting in pairs due to his aggressive stance.

3.3.7 The GP noted his controlling behaviour and expressed concern.

3.3.8 Trevor routinely spoke for Louise, even when she was able, to the point Louise looked to him to answer. This could have been because she trusted him and was content for him to answer, it could have been that she did not feel confident to answer or that she did not recall the answer, and this was a confabulatory action due to her dementia.

3.3.9 When a safeguarding concern was raised by OPMH, Trevor complained to the Social Worker that he did not like their unannounced visits, but there was no real reason given by him about why these were inconvenient, considering Louise did not go out and had been in the flat at least 4 years. After this complaint, ASC told him that OPMH would only visit 3 monthly, but there is no evidence to support that this decision had been made at a multi-agency review meeting.

3.3.10 In 2019, there was evidence that Trevor was not coping, and he was continuing to refuse or deflect engagement opportunities. He was seen by the Social Worker and his role as LPA explained; he committed to accepting help and then proceeded to refuse support of the CWT. Louise became gravely unwell, and it was only when she developed pressure ulcers, that Trevor called NHS111.Trevor had repeatedly refused visits for the 2 months preceding this.

3.4 Review of the Mental Capacity Act and Lasting Power of Attorney.

3.4.1 The Mental Capacity Act 2005 (MCA) requires the presumption of capacity unless proved otherwise. It is a legal duty of all professionals to consider mental capacity and undertake an assessment of capacity when engaging with a person who fulfils the Mental Capacity Act criteria. It is not the responsibility of any specific professional to do the Mental Capacity Assessment on behalf of another professional. The assessment does not always have to be recorded as this depends on the seriousness of the decision to be made.

3.4.2 If a Mental Capacity Assessment identifies that the person lacks capacity, actions must be taken in the persons best interest and the professional should ensure they weigh up the benefits and burdens of any action or decision. Skill is required by the practitioner to be able to assess the four tests for capacity, the ability to retain, understand, weigh up and communicate their decision.

3.4.3 To identify whether a person understands the decision to be made, requires an inquisitive approach, using open ended questions or rewording in alternative ways, to ensure suitable language and explanation is given. There is also a need to ensure another person does not answer on their behalf. A person can often present as understanding, by giving a confabulatory answer, that superficially appears correct.

3.4.4 Louise presented as a lady who was superficially able to give an answer, suggesting she understood, and often responded that Trevor helped her, or she did not need help. Yet numerous reports demonstrated that this answer was incongruous with visual facts or findings of other professionals. Furthermore, it is reported that she would allow Trevor to speak for her, or he did so of his own volition. Yet, there is no evidence that this was questioned in any way.

3.4.5 All organisations noted in their Independent Management Reviews (for this report) that there was poor record keeping of MCAs. Thus, it was generally not possible to establish how professionals established she had capacity to understand the risk and benefits of support that was offered. Housing Support Team have a policy of destroying written notes after 2 years. The electronic records are brief merely recording outcomes. This further complicated their ability to review the capacity assessment undertaken.

3.4.6 Professionals have a duty to understand the rights and responsibilities of an attorney who has registered a Lasting Power of Attorney. This duty includes understanding their professional responsibility to assess whether the LPA is acting in a person's best interest and what action to take if they do not believe the LPA is acting correctly.

3.4.7 That action should include holding a multi-agency best interest meeting with the LPA and, if necessary, referring the matter to the Court of Protection. If the dispute in care continues, or if there are repeated concerns, the Office of the Public Guardian should be consulted, as they have the authority to revoke an LPA. If the OPG believes the LPA cannot be revoked and there is a dispute about what care is in the person's best interest, there is a duty to refer the matter to the Court of Protection.

3.4.8 An attorney, has legal responsibilities that include:

- Acting in the donor's best interests and taking reasonable care when making decisions on their behalf.
- Acting in accordance with the terms of the LPA
- Helping the donor to make their own decisions where possible, rather than simply taking control.

3.4.9 Trevor registered the LPA for property and finance in November 2017, and LPA for Health and Welfare in January 2018. The forms had only been signed by Louise in September 2017 and November 2017. There is evidence in the records that Louise had significant cognitive impairment in 2016 and was forgetful in 2013. Additionally, the person who can act as LPA if Trevor cannot, did not even know Louise. This was discovered by a professional and reported to ASC. This was not investigated and did not appear to be relayed to the Office of the Public Guardian (OPG).

3.4.10 Trevor constantly refused support, denied access to professionals, refused NHS funded products, refused permission for her to have the Flu vaccine and refused support with personal care. All this was happening as Louise's condition was being recorded as deteriorating, and her cognition failing. In the final months, a

review of Trevor's understanding of his responsibilities by the Social Worker, concluded that he understood and was willing to cooperate. The case was closed, without a case conference despite Trevor continuing to refuse Louise access to services.

3.4.11 The safeguarding referrals were an indication that some professionals were considering whether Trevor was acting in Louise's best interests, but this did not appear to be considered when the safeguarding referral was assessed by ASC. These referrals were missed opportunities to hold a multi-disciplinary meeting and consider whether a referral to the Court of Protection was an option.

3.4.12 The records did not note how ASC concluded that Trevor was not intentionally denying or controlling Louise's opportunities for support. There was a note that he understood his role (in October 2019), but it had not been explored before this. However, there is no indication of how ASC established he understood his legal responsibilities and neither reason, justified his actions. Neglect (in accordance with the Care Act 2014) does not need to be intentional, to be considered as abuse.

3.4.13 There was no evidence of ASC questioning Louise's ability to understand and thus agree to the LPA in 2017, when it appears, she was significantly cognitively impaired. There was also no evidence to indicate that any agency explored whether Louise really knew who Trevor was and or that she was content that Trevor took over the role as carer when his uncle died. Indeed, there is no evidence that the involvement of the uncle was ever explored, to try and corroborate Trevor's story.

3.5 Review of Safeguarding referrals and action

3.5.1 There is evidence that contact with ASC and safeguarding referrals were being made regularly from 2013, by 4 different agencies.

Date	**Referral to**		**By whom**
	ASC	**Safeguarding Adult Referral**	
May 2013	✔		GP
May 2013	ASC telephones Louise. She was confused but no follow up required.		
December 2017	✔		Ambulance
December 2017	ASC call Louise but she declines help		
January 2018	ASC call Trevor. He declines help		
February 2018	✔		OPMH
	Outcome of this referral unclear.		
May 2018		✔	GP
June 2018	ASC outcome this is not a Safeguarding Adult Referral. No concerns as acts of omission are not deliberate.		
June 2018	✔		OPMH
August 2018	ASC close case. No evidence to challenge LPA, Refer to Social Wellbeing Service.		
November 2018		✔	OPMH

	ASC. No referral received by Social Well-being Service. Safeguarding Adult Referral closed no evidence of intentional harm.		
May 2019		✔	OPMH
September 2019	✔		CWT+GP
September 2019	ASC visit Trevor and explain responsibility of LPA		
November 2019	ASC close case stating Trevor is receptive and welcomes interventions.		

3.5.2 None of the safeguarding adult referrals appeared to be effectively investigated, and there was no evidence that a multi-agency best interest meeting, or a safeguarding planning meeting occurred. None of the referrals were investigated as a section 42 enquiry, and if they had been investigated thoroughly, it is likely it would have initiated consideration for the appointment of an IMCA to support Louise.

3.5.3 No one recorded what her wishes, thoughts or feelings were, or her understanding of who Trevor was, and whether she wanted him in her life. There were references to her looking content in his company, but there was no exploration if she was content with him as a person known to her, who would be responsible for all aspects of her life and personal affairs or a person who, at that time was a friendly face. This should have been a fundamental aspect of an enquiry and should have been supported by an Independent Mental Capacity Advocate (IMCA).

3.5.4 There was no reference at any time, that ASC consulted or engaged with housing professionals in any discussions about how Louise was managing. Indeed, housing appear to be totally isolated from all other statutory agency involvement. Perhaps, if housing had been more aware of what other professionals were concerned about, their annual reviews may have been carried out with a better understanding and consideration of her ability to sign forms.

3.5.5 The OPMH showed tenacity in continuing to raise concerns and investigated issues regarding the LPA, and correctly passed these onto ASC. The OPMH also continued to make unannounced visits; yet there was no consideration of whether there was any difference in Louise's presentation if Trevor knew he was to have a visit or not.

3.5.6 There is no evidence of a professionals meeting to discuss any issues or the complex care needs of Louise, which were created by Trevor's refusal to work with the services. It is noted that on two occasions ASC determined that there was no further action required as there was no evidence of intentional harm. Yet, there is no evidence of any multi-agency meeting to agree this.

3.5.7 The Care Act 2014 does not require neglect, harm or the risk of harm to be intentional, yet this seemed to be the overriding consideration of ASC.

3.5.8 Multi-agency professionals were repeatedly experiencing and reporting Trevor's refusal to allow Louise access to services that she required. This could have been because he was intentionally controlling Louise, or he had a "problem" with authority, or with a certain professional (as he stated). It could equally be that he thought he was

doing his best, trying his hardest and was too proud to accept help. The podiatrist reflected that she felt he was a genuinely caring man. His failure to work with services could have been because he was struggling physically or cognitively and could not recall the frequency of when he had refused care or denied access to professionals.

3.5.9 There is no evidence that the views of the professionals were sought, or Trevor having been given the opportunity to explain at the time ASC spoke to him about being the LPA and access to services.

3.5.10 The reasons why Trevor stopped Louise from receiving the correct care, is irrelevant in respect of determining whether she was being harmed or was at serious risk of harm or neglect. None of these possible reasons "justify" the harm or risk of harm, that Trevor exposed Louise to, but the reason may affect or mitigate the action taken against him by the OPG or the Police.

3.5.11 Regardless of whether it was intentional or accidental, Trevor was not (based on the evidence), fulfilling the role of the LPA. ASC did not carry out adequate information gathering to be able to provide the OPG with the relevant information for them to make a judgement regarding Trevor's suitability.

3.5.12 One of the 6 principles of safeguarding in the Care Act 2014 is Prevention. There did not appear to be any consideration by ASC that their involvement was required when repeated concerns were expressed by other professionals. Even if there was no evidence of neglect (which is disputed by the author of this report), there was evidence of a need for a prevention strategy under safeguarding. The question this raises, is "if the concerns raised about Louise had been made in the context of domestic violence, would this have changed the actions or plans by ASC?''

3.5.13 When Louise was admitted to hospital and sadly died, staff interchanged the terms neglect and self-neglect, and her death certificate records that her cause of death may be due to neglect/ self-neglect.

3.6 Interagency working and Professional Curiosity

3.6.1 Professionals for all backgrounds must undertake difficult assessments, often based on limited information. Louise always told professionals that she did not need any help, yet from 2014 she was identified as being confused and concerns were expressed that she was not managing.

3.6.2 There is evidence that health professionals made referrals to ASC, and these were responded to, yet there was no progression or follow up when Louise said she was fine. Housing undertook annual reviews, and accepted that she did not need any help, despite other professionals recording that there was obvious evidence that she was not coping well.

3.6.3 The housing officers may have made more detailed capacity assessments, but it is not possible to understand how they determined Louise had capacity to refuse help, as their written records are only retained for 2 years. Notwithstanding this, by 2019, all professionals were noting her severe confusion, yet a housing officer obtained her signature to say she didn't need any help.

3.6.4 Some agencies seemed to accept Trevor on face value while others were curious and concerned, but they appeared to not be heard by other agencies. This also applied to the LPA. Some agencies appeared suspicious, but there was no evidence that ASC, considered the mounting information, that on the balance of probability, Louise lacked capacity in 2017, to sign an LPA or that the replacement was a person who admitted not knowing Louise.

3.6.5 The OPG was approached, but as previously stated, it is unclear if they were given all the relevant facts. The evidence suggests that as ASC had not assimilated this information, it is unlikely they would have articulated it to the OPG.

3.6.6 The methodology of a SAR does not enable a review of how many professionals from one organisation were involved in a person's case. The nature of referrals, opening, and closing cases suggests that Louise may have had numerous ASC professionals looking at each referral, which may have contributed to the apparent lack of curiosity.

3.6.7 Professional curiosity and partnership work has been an emerging theme in safeguarding adult reviews for many years. The failure to use curiosity at both individual and direct practice levels and an organisational level led to failings to protect those in need of support/ assistance and protection (Braye and Preston-Shoot 2017).

3.6.8 The analysis of Safeguarding Adult Reviews (2019) by Michael Preston-Shoot et al identified that shortcomings in practice have an immediate and direct impact on the individual. A paper by Thacker, Anka and Penhale (2019) further analysed a significant number of Safeguarding Adult Reviews and highlighted that the law obliges local authorities to develop strong multi agency partnerships with other agencies and to take a coordinated approach to ensure better outcomes. There is also a requirement in law to address poor information sharing. The authors identify themes under the heading of professional curiosity.

3.6.9 Professional curiosity entails asking questions that give and solicit information without being intrusive or making the [service user] feel threatened. These should be open-ended and allow for additional probing. Professional curiosity relates to the capacity and communication skills needed to explore and understand what is happening with an individual or family. It is enquiring deeper and using proactive questioning and respectful challenge, understanding one's own responsibly and knowing when to act, rather than making assumptions or taking things on face value"

3.6.10 The authors identified three overarching themes (with sub-themes) from the literature, where professional curiosity could have improved the chances of a positive outcome for a service user. Case dynamics, professional issues, and organisational issues. There are key themes that relate to this SAR, and more broadly to some organisations (or professionals) involved which include:

Disguised compliance: where the care giver gives the appearance of co-operating with professionals, repeatedly disabling the safeguarding process and a lack of escalation by professionals. (in respect of ASC making further enquires).

Knowing but not knowing: having a sense that something is not right but not knowing exactly what it is.

Accumulating risk: professionals respond to each situation or new risk discretely, rather than assessing new information within the context of the whole person or the cumulative effect of a series of incidents and information.

Rule of optimism: professionals rationalise away new or escalating risks despite clear evidence to the contrary. The frequency of incidents and escalation is assessed separately rather than in the context of an overall escalating picture. There is a suggestion that professionals failed to spot accumulating risk because they optimistically believed the overall risk was low.

Normalisation: Ideas and actions come to be seen as "normal" and become taken for granted or viewed as "natural" in everyday life. As they are seen as normal, the ideas and actions are not questioned, and potential risk factors are not fully recognised or assessed.

Professional deference: professionals have a tendency to defer to the opinion of a higher status professional who has had limited contact with the person. In the case of Louise, matters were deferred to ASC, as the key agency, and their opinion appeared to be accepted, or professionals felt powerless to challenge it.

Confirmation bias: the practice of looking for evidence that supports or confirms one's pre-held views, ideas and values, and ignoring contrary information that refutes those views.

Lack of confidence in managing tension: The family undermine confidence as professionals are presented with concerns that are impossible to substantiate, which can bring about a temptation to ignore the concern.

Organisational issues

3.6.11 The nature of this SAR means that any organisation issues that might have impacted on professional curiosity cannot be examined. Thacker, Anka and Penhale note that inadequate supervision across agencies, changes in practitioner and pressure and complexity of work are all factors that can affect a professional's ability to demonstrate professional curiosity. They also highlight lack of professional curiosity at a strategic level as a common failing in SARs.

Multi agency working for prevention

3.6.12 As already stated, there is little evidence of multi-agency (including housing) working to enable information sharing, joint decision making and coordinated intervention. (Home Office 2014).

Neglect and self-neglect

3.6.13 When Louise was admitted to hospital there were refences in the records suggesting that Louise was suffering from self-neglect or possible neglect. The Care Act 2014, Statutory Guidance is helpful in defining both types of neglect (see appendix D). If a person is living alone, or every effort is made by the family and professionals to provide care, yet the person refuses, self-neglect could be a narrative used to describe their condition.

3.6.14 Louise had advanced dementia and was refusing help, when seen by professionals, however, her ability to understand (as set out above) was not explored.

She was also being cared for by Trevor, who was refusing help for her. Some community professionals were expressing concern that she was experiencing neglect and her toenails, weight loss and subsequent pressure ulcers supported this. On admission to hospital, understandably, the amount of information provided was limited, due to the urgent nature of the admission.

3.6.15 Despite numerous references in the hospital records to Trevor being unable to cope and Louise's presentation of being extremely malnourished, with reports of possible self-neglect and neglect by her carer, a safeguarding adults referral was not made. There was a referral to ASC noting concerns of neglect by the "unofficial carer", yet even this was not escalated to a s42 Safeguarding Adults Enquiry.

3.6.16 There was clear evidence that Louise was very unwell and had significant pressure ulcers and that this could have been caused by neglect (by others) or self-neglect (if she lived alone or adamantly refused to accept care). Her presentation could have also been caused by an overall deterioration, despite the best efforts of carers and professionals.

3.6.17 There was a review of the records, once she had been admitted and multi-agency involvement was noted, together with concerns raised about Trevor. It is also recorded that he asked for Louise to be returned to his care, yet this did not trigger a safeguarding referral or the professional curiosity to understand how she became so emaciated, whether he could care for her and whether it was in her best interests (the hospital described Trevor as her husband in one record). After a week in hospital, discharge plans were commenced and the involvement of ASC due to concerns about neglect was only considered the day before anticipated discharge date.

3.6.18 The hospital recorded the cause of death as 1a malnourished; 1b Self neglect 1c. Dementia. In my opinion, determining what was the most likely cause (i.e., neglect, self-neglect or consequence of frailty) of her presentation could only be achieved if a full enquiry was carried out.

3.6.19 The Coroner referred the death to the Police. The Police scoped the evidence and determined that there was no suspected offence, and no further action was taken.

3.7 Positive Aspects of the Care and Support Louise Received.

- There were several agencies involved in the Louise's care.
- Agencies frequently raised concerns with ASC about the lack of care of Louise.
- The OPMH and CIS showed tenacity and continued to visit, despite Trevor trying to stop them.
- OPMH and CIS demonstrated some professional curiosity and concern and made enquiries about the LPA.
- The community services responded well at critical times and showed tenacity with trying to gain entry.
- The hospital found a private podiatrist to treat her toenails urgently.

- A podiatrist responded quickly and managed to treat Louise.

The Working Relationship of the Professionals Involved and Missed Opportunities

1. There were several professional agencies were involved in the care and support of Louise. Some were for a short period of time and at some point, it was complicated to follow who was involved, and who was not. There was consistent evidence that the GP and the OPMH referred concerns to ASC, both for assessment and as safeguarding adult referrals. From 2018, OPMH was a consistent agency as others came and went.

2. There was evidence of communication and sharing information between professionals by email and telephone, but there was no evidence of multi-agency working, in the sense of consistent engagement by ASC as the coordinator of agency involvement. There was no record of a multi-agency best interest meeting, safeguarding adult review strategy meeting or meetings to discuss the implications of concerns regarding Trevor and the LPA.

3. The decision to close the case, in November 2019, was taken unilaterally by ASC with no reference back to the professionals to determine whether Trevor had improved. The note recorded that as the Social Worker had not heard any concerns, it was assumed “all was well”.

4. Whilst it is acknowledged that agencies had a responsibility to keep ASC informed, ASC also had a responsibility to communicate with other agencies. Over the 7 years, there were many examples where ASC had received information from professionals, undertook a limited enquiry and determined there were no concerns. The reality of this is that professionals may become weary of referring concerns, if they are constantly not listened to. It is also important to note that between the ASC visit to Trevor in September 2019 and the decision to close the case, there had been two visits by OPMH, one of which Trevor had refused to let OPMH see Louise, and the CWT had been refused visits and had communicated by phone. Added to this, ASC told Trevor that OPMH would only visit 3 monthly from November, yet no information could be found to note this was discussed and agreed at a multi-agency review and OPMH have no record of this decision.

5. The Supported Housing Service appeared to sit outside all of the other agencies. They undertook an annual review, and despite evidence of cognitive impairment, Louise was asked to sign an agreement in May 2019. In 2013, the support worker (who may have been from the housing department) contacted the GP as they were worried, but apart from this, there was no engagement by either Housing to ASC, or vice versa.

6. At the very least, supported Housing should have been informed that Trevor was living at the flat, as this may have affected Louise’s tenancy agreement.

7. Agencies were reporting the increasing dishevelled and cluttered flat, yet this was not reported by Housing. This calls into question how Supported Housing undertakes annual reviews, and how they assess whether the person needs referral to other agencies.

4 CONCLUSION

4.0.1 It is easy with the wisdom of hindsight to question whether if certain things had been in place, the outcome for Louise would have been different. Hindsight bias describes how an incident is viewed after the event, when it is easy to reflect and say, "*why didn't they just do this"* or "*why didn't they tell him to do that"*. Hindsight is a wonderful thing but should be considered with caution and with the reality check of how people live their lives with many difficulties.

4.0.2 Louise was a lady who was showing signs of increasing cognitive impairment for over 6 years and her difficulties were known by various agencies. She was able to present well superficially, even when there was evidence that she was clearly suffering and unable to manage, this was never challenged.

4.0.3 Trevor was seen by various agencies as a friend or carer, and when he became her LPA for both health and finances it was accepted without question. When some professionals showed curiosity, about the legality of this, the OPG said there was nothing to indicate concern. It is unclear whether they were given all the relevant information. Even when most professionals were concerned that Trevor was not allowing access or care services, and thus refusing care that was in her best interest, it appears that it was assumed that as he had the LPA, he had the legal right to do this.

4.0.4 The story of Louise and lessons to be learned, sadly reflects many of SARs already published and reviewed in the literature as referred to in the paper by Thacker and Penhale (2019), and the Analysis of Safeguarding Adult Reviews (April 2017 – March 2019) – findings for sector-led improvement, by Michael Preston Shoot et al.

4.0.5 Practical application of the Mental Capacity Act was a critical part of this story. There did not appear to be evidence of assessing understanding and using critical enquiry to ensure Louise was able to make the decision she was being asked to make. Knowledge of the legal duties of the LPA, how to challenge this, and role of the Court of Protection was lacking, together with cohesive multi-agency discussion.

4.0.6 Safeguarding referrals were made, and agencies tried to raise concerns, but they were closed without enquiry, and a reason, not set out in the Care Act 2014 or Care Act Statutory Guidance, of "neglect not being intentional", was not challenged by ASC senior managers.

4.0.7 There is some evidence of multi-agency communication by phone and email, but there is no evidence of "round table" professional meetings (albeit by video link). The Housing Support Team worked in isolation, despite having a central role in oversight of Louise and her changing needs. The evidence suggests that most communication was one way and decisions were made by ASC, without multi-agency involvement.

4.0.8 When admitted to hospital, there was no referral to adult safeguarding and Louise's death certificate listed the cause of death as 1a Malnourished; 1b Self neglect 1c. Dementia. The term "self-neglect" appeared to be used without any investigation (at that time) to establish if this was correct. A report-based Inquest confirmed self-neglect on the final death certificate.

4.0.9 The case has been reviewed by the Police as part of this SAR who have concluded that even with the information contained in this report, their opinion regarding the likelihood that a criminal offence had been committed was not identified. Notwithstanding this, all professionals would benefit from improved knowledge regarding what constitutes neglect and self-neglect alongside the criminal offence of coercion and control.

4.0.10 The care, support and protection of Louise should have been better. Professional curiosity, correct application of the Care Act 2014 and better understanding and practical application of the Mental Capacity Act 2005 and Lasting Power of Attorney could have improved her life and potentially changed the outcome.

5 RECOMMENDATIONS

The SSAB should seek assurance that:

1. All organisations ensure professionals understand the principles and importance of the practical application of the concept of professional curiosity.

2. All Mental Capacity Act training includes ensuring higher skills and competence in assessment of mental capacity, the role and legal responsibilities of the LPA and the role of the Court of Protection and when to make a referral.

3. Safeguarding training includes a better understanding of how to differentiate between neglect and self-neglect. Training should include environmental factors that need to be considered for example, clutter, fire safety risks, public health issues and housing safety issues.

4. Professionals are supported to develop skills and knowledge to respond to, overcome and manage barriers to engagement from informal carers and family members.

5. Organisations review the case load of staff who work with adults at risk and identify any risks caused because of organisational issues, such as inadequate supervision, frequent change of practitioners or pressure and complexity of the work. This could be carried out as part of routine supervision sessions and findings communicated through line manager reporting systems.

6. There is a review of ASC safeguarding pathway to ensure the requirements of the Care Act are embedded in safeguarding practice.

7. There is a review of how agencies identify safeguarding concerns and work together to implement early intervention and appropriate assessments. This should include consideration of the development of a MASH for adults.

8. All agencies ensure staff are aware of when and how to use the 4LSAB Multi-Agency Safeguarding Adults Escalation Protocol July 2018 and the SSAB should monitor its effectiveness.

9. All private and independent health & social care practitioners have access to free online training for safeguarding and the Mental Capacity Act.

10. The Housing Support Team should review their document retention policy and ensure it is within legal and best practice requirements.

The SSAB should ensure:

11. That HM Coroner is provided with a copy of this report and invited to consider its findings in respect of the Inquest outcome for Louise.

12. The identification of ways that learning from SARS nationally are determined and actioned.

13. A multi-agency education event is planned to develop multi-agency understanding of neglect, wilful neglect, and of the criminal offence of coercion and control in the context of domestic abuse.

6 APPENDICIES

Appendix A - Abbreviations

ASC	Adult Social Care
CIS	Community Independence Service (MD service-nurses, therapist).
CWT	Community Wellbeing Team
GP	General Practitioner/ Practice nurse
LPA	Lasting Powers of Attorney
OPMH	Older Peoples Mental Health
OPG	Office of the Public Guardian
URT	Urgent Response Team (part of CIS)

Appendix B - Timeline

Dates	Significant Information	Trevor's involvement	Louise seen by professional?
2012			
March	Repeatedly deferred appointments about a stair lift		
2013			
May	Housing support visit. All OK.		

	Support worker refers Louise to GP re: forgetfulness GP refers to ASC. Phone call-confused. No follow up		
September	Supported Housing Review all OK		
2014			
May	Housing support visit. Smoke alarm activated		
August	Supported Housing review		
December	GP letter inviting for blood tests. No reply		
2015			
October	GP leaves message for over 75 check		
2016			
August	GP visit- Holding furniture to walk Louise not left flat for 4 years. Unable to complete cognitive tests. Muddled Flat cluttered. Toenails long. Refused blood test	Trevor involved. Follow up visit, Trevor did not attend (said he would)	Yes
August	Supported Housing annual review. All OK.		
September	GP home visit. Refused entry & declined help		Yes
2017			
July	Supported Housing review.		
September	Louise signs LPA for finance and property		
November	LPA for property and finance registered 2 days later Louise signs LPA for health & welfare	Trevor is attorney. Named replacement in place	
December	Found outside the house by neighbours. GP referral to OPMH Ambulance referral to ASC -	Trevor reports burden of caring to GP Declines any help	Yes
2018			
January	LPA for health & welfare registered	Trevor is attorney.	

	ASC calls Trevor. No assessment carried out.	Named replacement remains Declines help from ASC	
February	OPMH do home visit. Trevor asks to be present. Referral to ASC for Care Act assessment	Trevor changes appointment with OPMH x2	
March		Trevor calls to move OPMH visit to April	
April		Trevor moves OPMH appointment again	
MAY	Louise walking outside alone. Neighbours concerned. OPMH assessment. Toenails very long. Taken to hospital. Ambulance concerned re neglect Podiatrist attends at home. Worst toenail neglect seen in 25 years and would have taken 5 years to get to this state. URT involved 5 days- visit in pairs due to behaviour of Trevor CIS involved. Send search of LPA to OPG GP makes Safeguarding Adult Referral	Trevor advises he holds the LPA. Trevor becomes uncooperative, hostile and agitated a number of times. Stops some visits by Rapid response. Refused entry of some visits. Did not take Louise to hospital when told to. Podiatrist describes Trover as genuinely caring.	Yes
June	GP reviewed. GP and CIS have SAR concerns OPMH refer to ASC- Trevor not meeting needs CIS +SW visit. X2	Refuses entry of CIS Denied access- Louise opened door, Trevor spoke from behind. Denied access on 2nd visit	Yes (GP)

			No-
July	ASC visit. 2nd visit with OPMH +ASC Supported housing review	Denied access Trevor lacks insight. Spends most nights at Louise's home	No Yes. Looks well
August	ASC close case. No evidence to challenge LPA CIS- transfers case to long term ASC- Social wellbeing service	Reluctant to allow OPMH visit to fit bath board	Yes. Tried bath board
October	OPMH unannounced visit. OPMH calls Well -being service who have not had a referral. No Safeguarding Adult Referral open	Refused entry	No
November	OPMH unannounced visit OPMH raise a Safeguarding Adult Referral, share concerns with GP +ASC SW- closes Safeguarding Adult Referral- No evidence of abuse or intentional harm Nurse to visit re diet. GP- give diagnosis. Probably dementia	Refused entry Trevor declined appointment with wellbeing team- so case closed. Refusing entry Refusing package of care Refusing any involvement Responding on Louise's behalf	Yes, seen at door - looks well Seen at on 6th attempt in the month
December	OPMH refer to CWT for physical wellbeing GP checks feet	Moved appointment for CWT to new year	Yes
2019			
January	CWT continence assessment Toenails long	Refuses to apply for benefits. Refuses NHS continence	Yes x2

	Blood all normal	products (prefers to buy) Rearranges visit by SW numerous times	
February	CWT visit. Audiology referral. SW did not visit as both unwell- buy CWL visited on same booked day- no reports of ill health. Low Vitamin D- prescribed medicine	SW visit rearranged	Yes x1
March	OPMH call alternative Attorney (LPA). He has not met Louise and concerned about Trevor. OPMH visit- Trevor speaks for Louise. OPMH advise Wellbeing nurse about LPA	Postpones SW visit to April.	No
April	CWT visits. Weight reducing. Hair needs washing. Chiropodist has been. Supervision notes monthly visit by OPMH and CWT.	Admits struggling. Refuses help, Trevor later denies he can't cope. Rearranges visit with SW.	Yes x1
May	CWT visit. Hair not washed. CWT phone call to Trevor OPMH unannounced visit x2 OPMH/CWT phone call. Refer to Dementia navigator OPMH email ASC re ongoing concerns. ASC book visit for July	Admits struggling. Refuses help Refused some visits Cancels dementia navigator Rearranges SW visit and complains about OPMH unannounced visits. Concerned about fluids	Yes x1 Not seen by OPMH

June	Supported housing review CWT visits. Trevor flustered. Hair not washed. SW rearranges visit to July	Cancels visit of CWT- rearranged Refuses help Refuses continence service	Yes x1
July	SW home visit. Trevor confirms named alternative remains on LPA	Trevor says Louise is asleep	No
August	No visits or information		
September	CWT visit. (1) Not seen. Trevor reports weight loss. Bruising under eyes. Fell GP visits -frail has dementia. SW visit. LPA duties explained. Trevor accepts he has rejected help and will cooperate.	Buying shakes not using GP prescribed supplements Refused entry of CWT (visit 2) Refusing help. Refused Flu Jab for Louise. Trevor does not like 2 visits in the same week so OPMH will not visit Still buying pads. Refusing NHS supplies	No x 2 Yes x2
October	OPMH unannounced visit.(1) OPMH visit.(2) Hair greasy. Needs help drinking. Falls detector to be fitted Telecare installed CWS phone call.	Refused entry (1) Refuses continence assessment Refuses help but says he is tired.	No (1) Yes (2)
November	No visits this month. SW. Case closed. Trevor is receptive and welcomes interventions. No new concerns raised by OPMH or CWS.	Calls CWS wanting advice on constipation and requesting a visit. Refusing continence service	No
December	OPMH get email for ASC closing case.	CWS Refused entry	No

	CWS visit. GP nurse attends- ungradable pressure ulcers, not alert on visit, responding to pain only. GP visit. Taken to hospital	Trevor calls 111 reporting bed sores	Yes (Nurse and GP)

Appendix C - Agencies involved in the support of Louise

- Southampton City Council Adult Social Care including Social Wellbeing Service and Hospital Discharge Team
- Primary Care/ GP
- University Hospitals Southampton Foundation Trust
- Solent NHS Trust including Community Nursing
- Southampton City Council Housing Services
- Southern Health Foundation Trust including Older Persons Mental Health (OPMH)
- Office of the Public Guardian
- Hampshire Constabulary
- Southern Central Ambulance Service

Appendix D - Facts on which the opinion is based.

Care Act 2014. Statutory guidance

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Neglect and acts of omission including:

- ignoring medical
- emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services

- the withholding of the necessities of life, such as medication, adequate nutrition and heating

Self-neglect

This 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. There may come a point when they are no longer able to do this, without external support.

Social Care Institute for Excellence SCIE: At a glance 71: Self-neglect Published: October 2018 (extract)

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. Practitioners in the community, from housing officers to social workers, police and health professionals can find working with people who self-neglect extremely challenging. The important thing is to try to engage with people, to offer all the support we are able to without causing distress, and to understand the limitations to our interventions if the person does not wish to engage.

What is self-neglect?

- 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

https://www.scie.org.uk/files/self-neglect/self-neglect-at-a-glance.pdf

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