Calderdale Safeguarding Adults Board

Safeguarding Adult Review
Mr. C

Contents

Introduction

This review will consider the events and circumstances leading to the death of an 81-year-old man who will be referred to as Mr C. He had lived in the Calderdale area since arriving in the UK at the age of 19, from Jamaica.

Prior to the review period, there are recorded concerns around his health and housing conditions and in early 2019, these conditions required immediate action. There was a fire soon after, caused by unsafe cooking which led to Mr C's attendance at A&E for smoke inhalation. The house was assessed to be unsafe and 20 chest freezers containing rotting food were removed, and rats were found in the property.

Emergency accommodation was found and, whilst it was anticipated this was a short-term measure, he ended up staying at care homes for nine months. This safe environment allowed an opportunity to make his home safe. During this period, further health concerns were identified, and he was given medication for alcohol dependence.

When Mr C returned to his home, professionals again identified concerns over safe cooking and electrical fittings and his poor vision compounded this.

In January 2020, his family raised concerns that Mr C was unable to care for himself and home conditions were again deteriorating. He was not engaging with health professionals and inconsistently attending health appointments. His family raised further concerns in June 2020 to Adult Social Care (ASC) and his GP. He moved to care homes to allow further cleaning of his home, and further concerns over alcohol misuse were identified.

In August Mr C returned to his home, at his request, despite the house being unsafe and the gas and electricity supply having been cut off. Family members and professionals identified a number of risks when visiting.

In September, a police investigation took place over possible crimes in relation to the withdrawal of Mr C's money (the investigations concluded that no crime had been committed). Living conditions within the house still presented risks both to himself and to others such as visiting professionals. Shortly afterwards there was a fire at his home, and Mr C was taken to A&E with smoke inhalation from a BBQ in the garden. Professionals described house as unsafe. In October it was reported that Mr C was using a lit oily rag as a torch.

On Friday the 30th October 2020 Mr C died at his home. The cause of his death was Ischaemic Heart Disease. A fire at his house also occurred at the time of his death, although it is recognised that Mr C did not die as a result of that fire. However Fire investigators did note a number of hazards in the property, the property was in a

state of disrepair, untidy and contained clutter. It also appeared that Mr C had in fact been living in one room in the house.

Throughout the review period professionals considered the mental capacity[1] of Mr C but only in general terms and assumed that he did have capacity as directed by principle 1 of the Mental Capacity Act. The issues of hoarding and self-neglect were central to the involvement of services, which was a challenge given the complexity of the environment that Mr C lived in and his difficulties in accessing services and engaging with professionals and his family.

Establishing the Safeguarding Adult Review

The purpose of the Safeguarding Adult Review (SAR) is

- To establish the facts.
- Establish whether there are lessons to be learnt from the circumstances of the cases about the way in which local professionals and agencies (or any other person involved in the care of an adult) work together to safeguard adults.
- Review the effectiveness of local procedures and guidance (both multi agency and those of individual organisations).
- Inform and improve local interagency practice and commissioning arrangements.
- Improve multi-agency response by acting on learning and developing best practice.
- Make use of relevant research and case evidence to inform the findings.

On 30th November 2020, the Chair of Calderdale Safeguarding Adults Board (SAB) determined that the circumstances of this case met the criteria for a SAR in accordance with Section 44 of the Care Act 20142. The cause of death was ascertained following this decision, it was initially assumed that Mr C had died from the impact of the house fire, subsequent information identified that the cause of death was due to Ischemic Heart Disease mean there was no longer a statutory requirement to undertake a SAR. After consideration however, the Panel and SAB Independent Chair of the SAB decided to continue with the review to identify multi-agency learning that was apparent in this case. The SAR process was under the discretionary criteria[3].

Mark Griffin was appointed as the Lead Reviewer and Author for the Review and was supported by Clare Hyde MBE.

Mark Griffin has experience within strategic partnerships that provide the framework for safeguarding children and vulnerable adults as a senior manager in the police and a Local Authority. This includes managing a Local Safeguarding Children Board,

[1] https://www.scie.org.uk/mca/introduction
[2] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[3] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

Safeguarding Adults Board, and latterly the new Safeguarding partnership arrangements. He has also authored and led on the production and progression of Serious Case Reviews, Child Safeguarding Practice Reviews and Safeguarding Adult Reviews. Prior to this he was the Head of Safeguarding in the Leeds District, West Yorkshire Police, responsible for one of the largest departments in the country as the Safeguarding lead. This involved both partnership and operational responsibilities. As a Safeguarding expert, he worked with and advised Her Majesty's Inspectorate of Constabulary (HMIC) undertaking inspections, at an operational and strategic level and within the partnership.

Clare Hyde was CEO of Calderdale Women Centre for 14 years and developed nationally acclaimed, high-quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody. Ms Hyde has led and authored numerous Domestic Homicide Reviews, Serious Case Review and Safeguarding Adult Reviews.

Neither has worked for any of the agencies who contributed to the review, during the period of the review, and they were considered to be independent to undertake the enquiry.

This review looked at the actions of the agencies who were supporting Mr C to identify if there were any gaps or actions that could have been taken to support him. The overall aim then being to identify learning for agencies for the future care and support of individuals with similar needs or in similar circumstances.

This SAR Panel agreed a time period between the 1st February 2019 to the 30th October 2020 but also to include any other significant events prior to that date, that would add context, inform learning and where relevant to the Terms of Reference. Whilst one agency records dated back to 1971 (CCG), other agency records began in 2014.

The Terms of Reference were ratified by the SAR Panel and are detailed at Appendix A. These terms were subsequently consolidated into four sections, which form the structure of this report.

This review will also consider other reviews and learning within Calderdale, in particular the Thematic Review – Burnt Bridges[4] (2020) and a learning review involving a fire related death in 2019. Analysis of practice will consider wider research.

[4] https://safeguarding.calderdale.gov.uk/wp-content/uploads/2021/06/burnt-bridges.pdf

Chronology of key practice events

1.2.19	Practice nurse reviewed leg ulcer due to Mr C not keeping appointments and not wanting ulcers to be bandaged. In light of diabetes diagnosis, urgent referral made to podiatry.
8.2.19	Joint visit completed between ASC and Environmental Health (EH). Home observed has been extremely cluttered, considering health and safety implications. An Emergency Remedial Action Order[5] was served shortly afterwards.
21.2.19	Mr C was admitted to hospital Calderdale and Huddersfield NHS Foundation Trust (CHFT) following a fire at his home, where he presented with no burns but had inhaled thick smoke. Professionals described the house as uninhabitable.
21.2.19	EH attended and most of the hoarding cleared; 20 chest freezers were removed from the property – they contained rotting food. Rats were also found in the property.
22.2.19	Emergency accommodation was secured at a homelessness accommodation (Care home 1), but staff quickly recognised Mr C was struggling to settle.
23.2.19	Mr C prescribed Pabrinex[6] as an inpatient. There were no safety alerts/flags on the discharge summary from CHFT to GP other than "known to social care." CHFT did provide additional information to the GP around treatment provided and further B12 injection requirements.
25.2.19	Concerns recorded whilst at care home 1. Mr C found wandering and soiled himself in communal areas and tried to bring alcohol into the building breaching the rules.
25.2.19	Legal notices were served to prevent Mr C entering his home and to enable cleaning of house.
26.2.19	Mr C moved to care home 2 as a temporary measure as care home 1 could not meet his needs. He was distressed that his home had been cleaned and things had been thrown away and wanted to return home. No formal mental capacity assessment undertaken around Mr C's understanding of this decision to move care homes.

[5] Housing Act 2004 - A local authority has an immediate right of access if it decides to take emergency action.
[6] Pabrinex - high dose of vitamins used to prevent a form of neurotoxicity that can occur in alcohol dependent people when they withdraw from alcohol

28.2.19 GP's records indicate Mr C was suffering from acute back pain and urinary incontinence. There is no mention of concerns about self-neglect in the Mr C's medical records held by his GP There was no query regarding his mental capacity or signs of memory issues/dementia.

29.3.19 Care act assessment completed by ASC. Mr C expressed he needs support when returning home. Identified needs includes occupational therapist assessment for mobility, support with personal cares, maintaining home environment, unable to manage financial affairs.

30.3.19 999 call received from family reporting that neighbours had made contact that Mr C was breaking into his own house. He was returned to the care home, and there was not a referral or report made to ASC by WYP.

27.6.19 EH spoke with Mr C's family as an intermediary. Discussion around several matters however the main issue was to obtain permission in writing to begin works in default. Maggots found in his room at the care home suggesting continued habits in storing food[7].

25.9.19 Joint visit to the property by ASC and EH with Mr C. Concerns identified suggested that Mr C wouldn't manage without support.

27.9.19 ASC records indicate an intended referral for mental health, but this was not completed, despite Mr C consenting. No evidence of a referral sent or joint working.

18.10.19 Social Worker (SW) conducted home visit. Concerns identified around cooking, storing foods safely, fire risk from a fuse box. Cooker rings on due to poor vision and Mr C cannot see how to turn them off. SW suggested to marker pen the hobs.

1.11.19 Home visit by SW. Mr C had attempted to clean his property. Dials on the cooker were turned on and heat coming from the oven as he was unable to see dials. Mr C reluctant to go for an eye test. SW advised to move lino off top of the stairs as trip hazard.

21.11.19 ASC records - Mr C left care home and returned to his home address, without an assessment.

4.12.19. West Yorkshire Fire and Rescue Service (WYFRS). False alarm – Mr C was cooking and filled the house with smoke – Safe & Well visit

[7] Family subsequently obtained written permission from Mr C for work to commence

carried out – risk factors triggered a visit from High-Risk team (WYFRS).

8.1.20 Community District Nursing team (DN) contacted the GP advising since his discharge home in December 2019 that they have struggled to gain access to Mr C's property to provide leg dressings. The DN team asked the surgery to make future appointments at the surgery.

27.1.20 Family raised concerns how Mr C was managing his daily needs and home conditions deteriorating rapidly. ASC records indicate planned case closure due to non-engagement and recommended that the family raise concerns to EH and refer to gateway to care.

4.2.20 GP received a task from the DN team (Entry 8.1.20) advising that Mr C will be discharged from their care due numerous 'no access' visits to the property. Records indicate that "he is not housebound and has full capacity".

13.2.20 GP records - Mr C did not attend chronic disease review with senior practice nurse, there is no evidence in his records of subsequent actions taken by the GP in response to this issue.

31.3.20. ASC. Covid Hub – Screening referral. Mr C would not engage with phone call. Concerns regarding access to food due to Covid 19 restrictions. SW spoke to Mr C the following day and he had access to food and didn't require support from ASC.

9.6.20 Referral from Mr C's family to ASC with concerns about his poor memory, clutter in the home, concerns that he was taking too much medication, fire hazards in the home. However the family had not sought consent from Mr C before the referral and therefore the referral was not processed. Mr C's Family advised to speak to GP and EH, previous SW informed.

15.6.20 GP. Family rang GP with concerns regarding Mr C poor coping skills, hoarding type behaviours and living conditions being unsustainable. The GP referred directly to Gateway for Care requesting for Support and Independence Team input. The GP acknowledged on the referral that Mr C "may need social care input – and possibly EH and needs a place of safety for himself and assessment of his social situation".

15.6.20 ASC. Safeguarding concern raised by previous social worker around Mr C self-neglecting - home rapidly declined; electric keeps tripping, keeping mouldy foods in the house. Liaison is through family who have attempted to visit Mr C, but he will not allow access.

26.6.20 GP documented a conversation with the practices pharmacist who stated that Mr C “was not looking after himself, not eating properly and asking for fortisips as supplements”. This information was shared with ASC as part of the referral.

7.7.20 British Gas engineer contacts WYP after he visited house and was appalled at the state and is very concerned for Mr C. House has no gas and no electricity, both doors are insecure, conditions inside are filthy and squalid and there was a major fire risk due to the build-up of belongings. Mr C crawled to the door to answer it and had to be assisted back to his bed which is downstairs. Concern for safety log and referral made to ASC, family attended and were speaking with ASC, but struggling to care for Mr C, who refuses any help.

7.7.20 ASC. Allocated worker contacted EH who agreed to visit the property. Mr C spoken to by phone and accepted he needed support and consented into going into 24-hour care if needed. Joint visit arranged for 16th July.

13.7.20 Referral to ASC for assessment via GP as per 15.6.20.

16.7.20 Joint visit by ASC and EH. Mr C and family member present. Concerns identified around the home environment, not paying bills so still had no electricity or gas. Mr C requires prompts and encouragement with personal care. Information that Mr C has a diagnosis of dementia and wants things to change (transpired he was not diagnosed with dementia). SW felt Mr C understood the risks and consented to go into a care environment while property was cleaned. No capacity assessment recorded.

17.7.20 CHFT/GP. Mr C attended A&E with a burn to the left side of the face, having dropped a cup of hot water. Information shared with GP, but no role identified for the GP.

17.7.20 ASC. Mr C moved to a hotel to allow cleaning of property.

28.7.20 ASC. Mr C moved from hotel to care home 3. Concerns identified around the amounts of alcohol Mr C is drinking, he admitted drinking for years. Discussion between ASC and GP advised referral to substance misuse service, no record of this taking place.

6.8.20 GP contacted by family, raising concerns that staff were supplying Mr C alcohol. Records do not indicate communication between temporary GP and previous GP. GP advised to make referral to substance misuse service.

17.8.20 ASC. Mr C returned home, at his request, and without support and before his property was habitable. No electricity in the property.

18.8.20 GP transfer back to original GP. There was no discharge summary from the care facility or notification around the outcome of the safeguarding concerns raised whilst he was in respite care.

18.8.20 ASC home visit by advanced practitioner. No electricity and Mr C using candles and acknowledged if they fall over, it will cause a fire. Mr C was assessed as having mental capacity but making unwise decisions, but no formal capacity assessment undertaken.

19.8.20 GP. DN team advising that after discussion with Clinical Manager it was agreed they would not be providing a service as due to previous safeguarding/hazardous living conditions, but an appointment made to be seen in clinic.

17.9.20 Mr C did not attend annual chronic disease review (for peripheral vascular disease) with senior practice nurse. Another appointment was made.

23.9.20 ASC visit with family member. Home very cluttered, Mr C admits he is not coping very well and still has no electricity. Mr C said he will accept help in the home. Recommendation to refer to the hoarding panel.

24.9.20 Police report of potential deception and with family member controlling finances,, matter allocated for further investigation, transpired there was authority to do so. Mr C cooking on a BBQ, Referral made to ASC. Police report notes that Mr C had capacity, but no capacity assessment completed around finances.

26.9.20 CHFT and WYFRS. Mr C attended A and E regarding smoke inhalation. YAS crew raised concerns about that he not eaten for three days was cooking chicken on a makeshift BBQ in a shopping trolley in the back garden. House described as uninhabitable and smoke filled, no electricity, mouldy food, combustible materials and vermin seen. Records states that he left the A&E department, transport was ordered and that he had capacity for medical discharge.

26.9.20 Discharge summary sent to GP. Third incident involving a burn/fire related admission. Discharge summary gave no detail regarding the reason for presentation, any action or investigations undertaken or further recommendations or follow up required. There were no safety alerts for safeguarding issues or risk of fire.

27.9. 20	WYFRS. Email from manager of fire prevention expressing concerns of fire safety to ASC. No visit was completed but intended conversation with Mr C around what support he would accept.
7.10.20.	ASC. Advice given from advanced practitioner for case to be closed to locality team and re referred back to community social work practice for support regarding hoarding and finances.
9.10.20	ASC Referral not accepted from community social work practice team.
18.10.20	WYFRS Mr C using an oily rag in the end of a wine bottle, lit as a torch to see around the house. Concerns shared with ASC.
21.10.20	ASC Case to remain with the locality team.
30.10 20	House fire at the home of Mr C. Cause of death was ischemic heart disease.

Analysis

What was life like for Mr C, was his voice heard?

Was there an understanding of his day-to-day life, conditions in the house and challenges he faced?

How well did agencies respond to requests of support and engage with Mr C and his family and involve them in assessments and planning?

Did the conditions within the house and non-engagement create barriers to working with Mr C?

What are the barriers to overcoming these, how can practitioners work with people with similar issues in the future?

Mr C lived alone in his terraced house, this was the first and only home he owned, purchased in 1961. He was a twin and had moved to England at the age of 19, by himself, but remained in touch with his culture. He had been married but his wife had passed away after their relationship had ended. A partner also died in difficult circumstances.

He was described as a proud man with two daughters and three sons, one who passed away as an adult. Practitioners highlighted that he would often wear a shirt and tie when he met with them. There were times during the review period when his relationship with his family broke down. His family noticed a difference in Mr C as he became older, becoming more stubborn and sometimes aggressive. At times the family felt able to talk and agree decisions, but this required sensitivity and patience.

The family of Mr C provided valuable background around Mr C's eating and cooking habits. Mr C would only eat Jamaican food and they recall that he would often cook food for his family when he returned home from work. In later life they thought he may have cooked out of boredom.

In the past, Mr C was a capable man, with a workshop in his cellar, and he developed an interest in car boot sales and purchasing items. Again, this may have stemmed from boredom. It was noticed that his house started to fill with items, and whilst the family were unable to provide an exact date, they felt it became a problem only in the last few years.

Professionals recorded concerns around conditions in the home as far back as 2014 and by 2017, these concerns included the storage of cooked food. It was noted that by 2018, there were unsanitary conditions in the house. His family had previously assisted in clearing the house but by February 2019, the conditions in the house had become so concerning that were recorded as high risk due to potential falls, risk of infection, infestation of flies and vermin, fire risks and electrical hazards. Mr C was served a notice to leave the property whilst it was cleaned and made safe. In February 2019, at the time of a fire, 20 chest freezers were removed from the property. The freezers contained rotting food, pigs' heads, and other animal parts, which can be used in Caribbean cooking. There is no reference to any explanations or exploration of Mr C's cultural heritage and records indicate a negative connotation to finding the animal parts. Mr C was reticent to let the freezers go, as he was hoping to send them to Jamaica. At the learning events the process of clearing a house in these circumstances was described as "brutal" and possibly embarrassing with affected personal possessions removed regardless of their value and potentially in public view. Added to this is that the occupant would be billed for the clearance, in this case, for £9000. The clearing process was under legal powers and did not need consent. Removing a person's possessions could be very upsetting for Mr C and he may have experienced this as a traumatic event. The impact of this would have been compounded by then receiving a bill to pay for the clearance.

Mr C experienced a number of health difficulties during and prior to the review period. Family members were aware of his medical conditions. GP records show that Mr C was flagged as at risk of dementia, and his family raised concerns around his memory. In 2019 the GP did conduct an assessment to see if Mr C had dementia, but this was not found, and no other action was required at the time.

In 2018 Mr C had a fall and broke bones in his leg in two places. He discharged himself early from hospital and was seen walking around despite being advised that he should not be weight bearing. He felt comfortable in his home and Mr C clearly communicated that he wanted to be at home.

Records show he had diabetes along with peripheral vascular disease and in 2018 podiatry professionals were treating Mr C. By 2019 mobility issues had been identified. In February 2019, he was being treated for leg ulcers, although he decided

that his legs should not be bandaged, despite the procedure being explained. This is not uncommon for patients, who choose not to use them, and other methods can be used. The wounds were reviewed, treated, and cleaned, and whilst not bandaged, they were covered. His eyesight was poor, and he refused an eyesight test, which made reading and cooking difficult and often dangerous. His movement would have been limited due to peripheral vascular disease and leg ulcers, and added to the conditions within the house, this posed the potential for increased risks to his health and an ability to live safely. He was also on anti-depressant medication.

Notwithstanding the conditions making movement difficult, the cleanliness, smell and infestations would have been extremely unpleasant and dangerous. It is reasonable to suggest that the unpleasant and unsafe living conditions within his house have impacted on people visiting him. It is of note though that despite the conditions ASC and EH did visit him regularly, and Health professionals also attended his house until 2020 to treat his leg ulcers. But there is evidence that concerns were identified about hygiene in the house, Mr C would also be out when health professionals attended his home for agreed appointments, which led to led to the appointments being held at surgery.

The family highlighted the period when the gas and electricity was cut off as an important and stressful time for Mr C. There was conflict with companies over the decision to cut off the supply which was due to non-payment of bills. In order to be able to maintain his wish to eat his own food Mr C started to cook food on a makeshift BBQ, and to minimise the time he needed to use the BBQ he cooked food in batches. At this time, he had memory problems and would forget which freezer the food was in, panic and start cooking more. This became a cyclical process in that he repeatedly used the BBQ and stored food in freezers without a power supply. The family feel that if the supply of gas and electricity had not been cut off, he may have continued to cook meals on a daily basis and could have been a solution to his approach of cooking in batches.

At the time of his death fire investigators found that Mr C had been living, sleeping, and dining on the ground floor, in one room, and there was a downstairs toilet. There was no gas or electricity and he used numerous candles for lighting but kept paraffin containers in this room. He used a shopping trolley as a makeshift BBQ to cook food. Of interest, the lounge and upstairs were by contrast, neat and tidy, without items stored, uncleanliness and unsafe conditions. Although he had been given advice about unsafe cooking during visits, no long-term solution was put in place.

At times, Mr C refused help, from services and his family and but there were also times when he asked for and accepted help. In 2018 he discharged himself from a care unit wearing a full cast on his broken leg and in August 2020 he made the decision to return to home despite it being unsafe. This decision suggests that Mr C had the intention to remain independent. He was clear that it would be at his pace,

when he agreed to de-clutter his house, this would only be in small sections at a time.

Records indicate that Mr C did not feel his living conditions or lifestyle posed a risk of fire. During the time Mr C spent time living in care homes, he experienced difficulties adjusting. Although the intention was that Mr C was only to reside in the care homes for a few weeks, this ended up being nine months. ASC did support Mr C by regularly taking him back to his home during the period. Practitioners recognised that he may have become dependent upon the 24-hour support, making a return to his home even more difficult. It is not clear if the reason for this extended stay was fully explained to Mr C.

He was also housed at a hotel for a period, which again may have caused him difficulties and anxiety. Given the collective issues including memory problems, hoarding tendencies; poor vision and lack of mobility such changes had the potential to have cumulatively impacted upon Mr C emotionally and physically.

Mr C had a constant fear, recognised by practitioners and in agency records, that he would lose his home, what might be done to his property or that he would be forced to leave his home. He had been twice removed from his home potentially making him frightened of this happening again when Social Workers and other professional called at his home. This fear may have been a significant factor in how Mr C engaged with services, often declining support, and not allowing access to his property. ASC did provide access to financial support around fees after legal notices were served but this may not have alleviated this fear.

It appears that managing finances presented a challenge for Mr C. In 2014 he experienced some financial difficulties over a loan secured on his home which required the support of a solicitor and repayment plan. A police investigation took place over Mr C's finances which concluded that a family member had authority to conduct his financial affairs and was acting in good faith. This highlights the confusion and anxiety that Mr C may have felt in his life. Added to this were the financial implications of EH activity and the costs of staying at care homes. ASC did support him with securing finance from a charity for the EH work and care home bills and sign posted him for overall financial management, but they did accept that financial matters caused significant anxiety.

The Burnt Bridges review and other learning recognises a mistrust of services and in this case, this could have been perceived by professionals as Mr C disengaging and making unwise decisions. This review has identified some good practice, care home 2 did develop a positive relationship with Mr C, their approach was to build independence and empowerment and staff supported him with tasks such as reading and paying bills and providing substantial meals. They attempted to prepare him for leaving the home and continued contact after he left. The family acknowledged that some services, such as the WYFRS were able to engage well with their father, but

other services adopted a more authoritarian approach, which led to conflict and dis-engagement.

The effectiveness of engagement by professionals varied between agencies. The practitioner event described this as “badge you wear”. The statutory nature and legal powers of certain agencies may have scared Mr C of the potential consequences of not being able to live or return to his home. Added to this was the financial implications resulting from action taken which he may not have wanted and was unable to influence. Practitioners did suggest that he felt let down by services and a lack of trust was a factor in engagement. This resulted in occasions when he would not let people in, became angry, declined support, and disagreed with actions. The wearing of masks, during the national pandemic, was also recognised as a potential barrier to communication.

At the learning events, agencies did highlight patience and persistence in attempting to maintain communication with Mr C and build relationships with his consent. One positive method of engagement was with the Community Social Work Practice Shop in Halifax. This was an informal location which allowed people to drop in and was a preventative approach and supported people and Mr C was often seen there. The shop helped Mr C in dealing with bills, as he struggled with reading and writing. Unfortunately, this facility changed its function and housing staff replaced ASC staff, based upon learning from the Burnt Bridges review and demands from the pandemic. The learning event recognised the value of a multi-agency community-based approach to break down barriers and provide a location for people to access support.

There are similarities in the complexity of this case and barriers to engagement found in the Burnt Bridges review. The Burnt Bridges review recognised the challenges in fitting people with multiple and complex needs into multiple disjointed services and any disruption to these services is not designed to cope with behaviour associated with trauma. Given the complexity and non-engagement that Mr C presented, the failures in providing adequate support and services to Mr C is comparable. Considering the findings of the Burnt Bridges review, Mr C was known and did receive care and support, but this was not joined up and coordinated and perceptions that he may have been “hard to reach” or another agency was leading may have added to this. There was information available, but it is not clear how well this was shared or explored in terms of the impact on Mr C or understanding how he lived his life. The agencies involved in this review reflected that this is a key element of the learning. Good practice requires positive engagement that demonstrates tenacity, consistent support, compassion and concern and liaison between the professionals involved. (Preston-Shoot, 2019)

Records show several occasions when family members approached services for support and ASC were in contact with a family member regularly. There was a mixed response to these requests, and the family felt they were not adequately supported

and advised in caring for and protecting their father. Repeated requests indicate the family were not satisfied with the response of services and discussions between the lead reviewer and the family established the same opinion. Equally, records do not indicate that they were actively involved in care planning and assessments despite one of his children regularly attending at the home, and an awareness of conditions and risks. A member of the family did make attempts to resolve the gas and electricity matters but was unable to do so. This was made more difficult as Mr C was financially able to pay the bills but chose not to. There was no multi-agency meeting during the review period despite a number of agencies identifying complex and escalating concerns. This is examined in more detail later.

Complex and cumulative factors.

There were a number of complex and cumulative factors that taken together increased the overall risk to Mr C. Were partners aware of these causal factors and able to recognise and respond to these risks?

How well were trauma and historical indicators known and considered in interventions and assessments?

Good assessment is an essential component of effective working and good risk assessments, and mental capacity assessments are particularly important for people who self-neglect and/ or hoard. (ADASS[8]).

Prior to the review period there was information to suggest self-neglect, alcohol abuse, hoarding behaviours and a number of health factors. The cause of death was Ischaemic Heart Disease (IHD). This is linked to peripheral vascular disease (PVD), which had affected Mr C's leg arteries and can affect the cardiac arteries.

The learning events discussed definitions linked to this case, such as "hoarder" and "habitable" and concluded that language and descriptions can be subjective, unhelpful and at times can create barriers to action. Simple terminology such as safe or unsafe living conditions and a recognition of collective complexity could simplify timely action for people with health and social care needs. Professionals at the learning events highlighted that any multi-agency response should look beyond specific terms which can be interpreted differently across agencies.

The Calderdale SAB produced guidance in October 2019 through the Multi-Agency Hoarding Framework[9]. The learning event considered if Mr C was a hoarder, and the conditions around February 2019 were discussed. It appears he had lived in these conditions for some time. Prior to this, in May 2018, there was a multi-disciplinary team meeting between the GP Surgery, ASC and DN team that identified concerns

[8] **Association of Directors** of **Adult Social Services** in England.
[9] https://safeguarding.calderdale.gov.uk/wp-content/uploads/2020/05/calderdale-hoarding-framework.pdf

around the cleanliness and safety of the property due hoarding type behaviours. Practitioners with operational expertise around hoarding did not consider that Mr C was a hoarder under the Calderdale SAB framework and national categories, but that he 'collected', and he exhibited hoarding behaviours. Although the hoarding policy was established during 2019, there was no referral to the panel despite the number of agencies involved, and discussions between agencies about the case. ASC did request the referral documentation in October 2020. The fact that EH were involved and had already undertaken activity may have been a factor but this was a missed opportunity to convene a multi-agency response or enable oversight of such a complex case through an established Calderdale SAB policy or group. The hoarding panel, as a result of this case, will be reviewing the threshold levels of this policy and considering widening the criteria for cases.

Hoarding is recognised as a mental health disorder and sometimes its origins can go back to childhood and there may be a triggering event or trauma[10]. This can lead to excessive emotional attachments. Blitz cleaning can distress the hoarder and doesn't address the cause.

Considering the impact of trauma, and the established links to self-neglect, the conditions that were evident in the latter end of the review period, suggest that Mr C may have been affected by trauma.

Records and the learning events have identified a number of incidents that would indicate Mr C had experienced trauma including a number of bereavements. The house was of emotional significance to him, and his cooking habits also appear to stem back to family traditions. Not all agencies were aware of these factors. A multi-agency approach to assessment and planning would have enabled a greater understanding and possibly a more sensitive approach, particularly around the removal of items.

Professionals attended at the home over a number of years and witnessed a decline in conditions. Following the decision in February 2019 to issue the Emergency Remedial Action Order, which led to the cleaning of the house, it appears that a risk assessment was not undertaken at this time.

The Calderdale SAB Self Neglect Policy[11] contains additional advice concerning when self-neglect, which includes hoarding and alcohol, chaotic lifestyle and risk-taking behaviour may escalate self-neglect. Given that the case did not reach the hoarding panel, agencies could have utilised this policy to coordinate a multi-agency response or convened a multi-agency meeting in line with wider partnership procedures. Care home 2 did recognise concerns around self-neglect, they describe

[10] https://www.mind.org.uk/information-support/types-of-mental-health-problems/hoarding/causes/
[11] https://safeguarding.calderdale.gov.uk/wp-content/uploads/2018/08/CSAB-Self-Neglect-policy-2018.pdf

that he arrived in an unkempt state and was unwell, and at the point of leaving had increased his weight by 10 kilograms and looked like a “new man”.

Following his death, the fire investigation concluded that the fire was caused by accidental ignition by Mr C. It was known that he used a naked flame to light candles, oily rags as improvised lanterns and cooking with unsafe items. It is possible that a naked flame ignited other combustibles in proximity within the room. Paraffin containers were also found in the room. Other professionals also recorded incidents of concern connected to cooking and use of naked flames.

During the review period Mr C attended CHFT Emergency Department on three occasions because of fires at his home. In January 2019 it was arranged for him to be discharged to temporary housing accommodation. ASC and EH were involved and CHFT made a referral to Locala. In July 2020 he was discharged from CHFT to the hotel accommodation arranged by ASC. In September 2020, Mr C informed staff that he was going home. The Doctor at the Emergency Department believed that he had capacity and was medically fit for discharge. He declined all offers of help. There was no safeguarding referral or consideration of a multi-agency risk meeting at the point of discharge. Insufficient discharge planning to mitigate the risks meant he was discharged back to an unsafe environment. Similarly, when he left the care home the discharge and subsequent care planning did not prevent the same situation re-occurring.

These incidents suggest that Mr C was making unwise decisions, but agencies did not mitigate this or recognise the escalation of risk and potential wider consequences. Whilst CHFT did liaise with other agencies, they did not deal with concerns through a safeguarding route, which was later identified as a missed opportunity. The learning events established that there were missed opportunities to have formal discussions around capacity and records evidencing decisions and discussions when risk taking behaviours are known. ASC did highlight that IT systems have changed with prompts to improve recording.

Mr C’s home was a terraced house and there were obvious risks to his neighbours from a fire. Records do not indicate that wider risk assessments were undertaken. Similar learning was highlighted in a separate learning review, in 2019, of a fatal house fire. The SAB has undertaken work to raise awareness from this review which also falls within the learning from the Burnt Bridges Review. It is recognised that this is a significant and transformational piece of work which will take time.

This review has established that Mr C was a frequent user of alcohol and at times this led to misuse. Practitioners did not witness inebriation or problems with functioning, communication and decision making and felt he had a tolerance to alcohol. There was no assessment of the scale or impact of alcohol use during the review period despite a care home raising a concern with ASC. Family members were aware of this misuse, (although Mr C did attempt to hide it) but it is not clear if

agencies assessed and supported Mr C to reduce his alcohol use, which would have impacted on the effectiveness of the anti-depressant medication.

Mr C was affected by numerous cumulative and complex factors which interlinked. Taken together they presented significant challenges for Mr C in being able to live comfortably and safely in his home and at times in other settings. Mr C was described as a hoarder, the conditions in the house evidenced this, but he was not supported through a multi-agency response. This learning echoes that from a previous learning review (fatal house fire), around the importance of a multi-agency approach in sharing information when undertaking assessments.

Fundamental problem solving and a holistic assessment through effective communication, including and involving his family may have enabled simple matters to be resolved at an early stage. Family members outlined that the gas and electricity supply was essential, and had it not been cut off, it may have reduced the need to batch cook and use of unsafe methods.

The actions of the agencies in removing his belongings, without his consent had the potential to cause significant trauma. Having been informed that he would have to meet these costs, he reluctantly moved to a care home for nine months. This process was repeated resulting in the same outcome, with Mr C adopting the same behaviours which resulted in the return to the previous living conditions. It is therefore considered that the impact of such trauma likely resulted in a reluctance to engage with services.

Mental Capacity

Was mental capacity understood, considered, applied appropriately by practitioners, particularly key events?

How well did practitioners assess capacity both formally and informally?

Was there an assumption of capacity without professional curiosity?

Were specific factors taken into consideration?

The Mental Capacity Act 2005 (MCA) provides a clear framework to support the assessment of capacity in relation to specific decisions. The assessment is a challenging piece of work, even more so in cases where the person's capacity presents a complex picture, where the risks are high and where significant decisions are being considered. Responding to the needs and rights of someone who has fluctuating capacity is in many ways more complicated.

Records show that on many occasions professionals considered and, on most occasions, assumed that Mr C had capacity under principle 1 of the MCA[12], but there

[12] A person must be assumed to have capacity unless it is established that he lacks capacity.

is no evidence that a formal assessment of capacity took place. ASC records imply that this assumption was influenced by previous decisions. Professionals did not recognise that there was reason to suspect his capacity given the unwise decisions he was making, and they should have considered a formal assessment of capacity There were missed opportunities and insufficient professional curiosity, questioning or challenge in testing these assumptions.

At the learning event practitioners highlighted that Mr C felt he was capable of looking after his home, but this contrasted with practitioners who felt he would need support when he left the care homes. When the conditions were discussed, Mr C did want to make changes and ASC determined that he was able to express awareness of the risks and fire hazards.

There were incidents during his stay at care homes which raised concerns, and whilst he said he was willing to stay for a few days, the overall length of time he did stay may have caused confusion. At the learning event ASC felt that he was able to understand information provided and make a decision. Understanding the information is only part of capacity assessment – being able to retain the information and crucially weigh and use the information to make a decision (as well as communicate the decision) is part of the capacity assessment. ASC records indicate the SW had no concerns with his capacity and although they secured funding to support his cleaning and care home bills and discussed what was happening, there were missed opportunities to clarify his level of understanding.

In February 2019, EH and ASC conducted a joint visit, and assumed that Mr C had capacity in understanding the concerns and risks relating to the conditions in the house. ASC later recognised that the conditions in the house should have prompted an assessment to ascertain if Mr C understood the identified risks. A few days after the house fire Mr C was seen in A&E when records show he was “speaking in long sentences” and gave an account of how the fire started. It appears that he was underestimating the situation, and this could have been explored further through an assessment, but this was not completed. There were no safety alerts on the discharge summary to the GP from CHFT to indicate that there were concerns with self-neglect or safeguarding issues.

The GP practice assumed that if there were concerns regarding mental capacity or safeguarding that these would be addressed at hospital. During transfers of Mr C’s care between GP’s, there was not a query regarding his mental capacity (for specific areas of decision making) or signs of memory issues/dementia. During a later visit, ASC records state Mr C had capacity, for him to continue not storing and cooking foods safely, but his understanding of the risks if he continued to do so were not recorded.

The learning events and agency records highlight a shared assumption between agencies. Some agencies followed the assumption of ASC’s assessment of capacity

without any challenge or escalation, despite having concerns. Agencies held individual information and concerns that collectively showed a picture that indicated a full and formal assessment of capacity was required. The family regularly raised concerns over their father's mental capacity. The assumption that he had capacity was generalised, based on previous decisions, and professionals did not differentiate between the specific factors such as daily living, cooking and financial matters. An assessment of each individual factor was necessary to assess Mr C's capacity to make decisions. These could vary between each area of his daily life and change quickly. At the learning events there was an acceptance that more could have been done around capacity assessments and there was a need to record capacity consistently. There was a lack of professional curiosity in testing these assumptions. Mr C was making unwise decisions and the fact that he was repeatedly making these decisions should have prompted further questioning and a more detailed assessment of capacity.

The theme of "executive capacity[13]" is particularly relevant when assessing an individual who has addictive or compulsive behaviours[14]. The importance of considering the ability of an individual to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity). Both these abilities need to be considered as part of the process of assessing mental capacity and if someone appears to have decisional capacity and then doesn't act on these decisions – further consideration is required. This may mean being unable to monitor and evaluate their own actions and less able to adapt to change. They may also struggle to act upon or execute a decision. ASC did identify that executive capacity was considered but it was applied informally. Simple tasks such as cleaning were identified and undertaken by Mr C, but he was very determined to live the life he chose and ASC had to be mindful of interventions before he said, "that's enough". Social workers felt that he remained a worry/concern.

In addition, the misuse of alcohol may result in fluctuating capacity and whilst it may be possible for people to have capacity to make significant decisions, they may lack capacity to make decisions about their daily safety needs. Professionals did recognise that alcohol misuse was a concern, but the consideration of potentially fluctuating ability to make decisions was not detailed in records, and a generalised approach seems to have been taken. There were also concerns raised by professionals and the family in how Mr C was misusing prescribed medication. There was no professional curiosity in exploring these concerns and the impact on capacity.

O' Brien et al (2000) have explored dilemmas faced by practitioners in cases of self-neglect, which can also apply to compulsive or addictive behaviours. This recognises

[13] Agencies within Calderdale also refer to this as executive functioning

[14] https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf Page 119

the need for an individual's autonomy and personal rights are prioritised over a more interventionist approach. A potential disadvantage of this approach can tend to prevent proactive professional intervention being taken at an early stage. This thinking is particularly relevant given the wider risk to neighbouring properties from fire. Decision-making capacity should be considered as a spectrum rather than a simple dichotomy, accepting that a decision will need to be made at specific points. An individual's independence does not and should not; mean disengaging from continued involvement with them. This case highlighted a respect for Mr C's autonomous and personal rights, but this needed to be balanced against the levels of risk and self-neglect. This again echoes the learning from the previous fatal house fire review which recognised the balance between capacity and safety and the need for a shared understanding of the MCA.

The MCA enshrines the rights of individuals to be actively supported to make their own decisions, and where they lack capacity to do so the Act ensures that their best interest (including their wishes) govern the outcome. Given the outcomes legally and ethically, a careful assessment of capacity is critical and particularly in cases where there is complex picture of capacity. Guidance recognises the role of the Court of Protection for particularly challenging and cases to make best interests decisions. It appears that this process was not progressed as no formal assessment was undertaken and on a number of occasions agencies assumed Mr C had capacity. Research of SARs[15] found instances where practitioners appeared unclear how to respond, for instance to hoarding, or neglected to seek legal advice and to initiate applications to the Court of Protection or the High Court for its inherent jurisdiction. It will also sometimes be necessary for a local authority to make an application to the High Court to ask the Court to exercise its inherent jurisdiction to protect an adult with mental capacity[16]. All legal options should be considered as part of assessment and care planning. (Preston-Shoot, 2019).

Primary and secondary legislation, central government guidance and judicial decisions provide essential frameworks for the commissioning and provision of adult social care. But legal rules must be interpreted and applied in complex situations requiring the use of professional judgement. This is often referred to as legal literacy and requires the ability to connect relevant legal rules with the professional priorities and objectives of ethical practice, with the exercise of professional discretion and evidencing decision making. (Preston-Shoot, 2021)

Throughout the period of this review there were key incidents that raised concerns over the capacity of Mr C, in that he was known to different agencies who were working with him in the community and when he attended A&E.

[15] Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice, England repository for SARs, available through the Social Care Institute for Excellence website
[16] https://www.scie.org.uk/safeguarding/adults/practice/gaining-access

Mr C was making extremely risky decisions, and because he was deemed as having capacity, further questioning about his capacity and / or inherent jurisdiction were not progressed. The learning events recognised that there were missed opportunities in sharing information which would have informed assessments or prompted a formal assessment. There was a recognition that a formal capacity assessment should have been undertaken and be time specific.

There is no record to suggest that a best interest meeting or the use of a IMCA (Independent Meal Capacity Advocate) was considered in the case of Mr C. This again may have been due to an assumption of capacity and insufficient professional curiosity.

Multi-agency working

How effectively did agencies work together, share information and respond in a coordinated way.

Was there any lead professional coordinating activity? Was there a care plan or multi-agency response?

How effective and timely was the response of agencies at key points when concerns were raised or near misses occurred? (To include periods where Mr C was not seen)

What factors informed decision making around case closure, withdrawal of services or providing services that were difficult to access for Mr C. (This will recognise the complexity of the case, non-engagement, Covid, safety considerations and the overall context in which professionals are working within Calderdale)

Were policies and procedures understood, applied and effective? (This will consider legal processes)

Are there examples of good practice to be highlighted?

How has learning from previous reviews and incidents improved multi-agency practice?

The Burnt Bridges review identified learning in how agencies should recognise and respond to people with multiple complex needs with persistence and through a multi-agency response including effective communication. The Calderdale SAB has since developed a strategy for implementing learning from the Burnt Bridges review, and work continues to embed learning into improved practice.

Both the hoarding framework and the self-neglect policy recognise and promote a multi-agency approach. Both provide guidance to alternative options that could have been considered in this case. The Care Act encompasses hoarding under self-

neglect, and whilst it may not fall under a Section 42 enquiry it does fall under Section 1 of the Act, around promoting wellbeing for individuals.

Mr C had been known to agencies for a number of years with ASC involved since 2017 and EH since January 2019. The case was closed to ASC in January 2020 due to non-engagement. At this time, it was evident that issues remained unresolved and family members were still raising concerns. ASC next visited Mr C in July 2020, after several concerns had been raised, most recently by the gas engineer. Capacity assessment at this time was focussed on financial matters and not the extreme conditions or, for example that Mr C was crawling about his home. In October 2020, the case was initially closed to the allocated SW, and although a transfer to the community SW team was intended, it was not accepted. The reason recorded, was that a formal package of care was not what Mr C needed or indeed wanted, but he needed support with finances and to maintain a safe home. There followed a two-week period before the decision was made for it to remain with the allocated SW.

On occasions agencies did work together and shared information, most notably the EH and WYFRS and EH with ASC. In May 2018, there was a multi-disciplinary team meeting between GP Surgery, ASC, and the District Nursing team. Throughout the review period, there was no effective oversight, coordination through a lead agency and no care plan. This resulted in some agencies being unaware of the complexities of the case, the conditions Mr C was living in and what action was being taken. Despite the numerous agencies working with Mr C, this was not joined up. The previous fatal fire review also established the importance of a multi-agency response in complex cases.

The learning events established that multi-agency meetings would have enabled the development and agreement of a plan. Multi-agency meetings are crucial to allow an opportunity to discuss differences of opinion between professionals, use adult safeguarding principles, evaluate preventive or risk mitigation options, and avoid defensive practice and it is a platform in considering the balance of autonomy and a duty of care. (Preston-Shoot, 2019). There are several established groups and policies that facilitate this approach including the hoarding panel, self-neglect and the newly formed pilot for complex cases. Health agencies also convene risk panels. The issues of definitions, criteria and thresholds appeared to be a barrier for entry, Mr C’s case would not have fallen within the hoarding or the newly formed complex case panel criteria but would have fit with the self-neglect policy and the Multi-agency Safeguarding Procedures.

There was, however, nothing preventing any agency from taking the lead and convening a multi-agency meeting. There appears to have been some confusion around lead agency. There was a sense that by default, that ASC were the lead agency but at times due to the statutory powers and pressing need to act, EH took the lead. There was an expectation that as ASC were involved, they would initiate multi-agency meetings, but a lack of professional curiosity and challenge led to

inertia. Similarly, there was no agreed and coordinated care plan, to enable agencies to compliment EH action and provide physical and emotional support to Mr C. This plan should have contained actions for when Mr C had and did not have capacity. CHFT identified that if some form of care plan had been in place, and shared, when Mr C attended at A&E, the response and referral route may have been different.

EH acknowledged that statutory action negated the need to use the hoarding panel, but the impact of such radical action should have involved wider agency involvement and oversight. Practitioners highlighted the importance of “aftercare” in undertaking this type of activity to prevent a recurrence. Plans may need to include practical solutions but also recognise the emotional impact of removing personal belongings and the anxiety this can bring.

A number of assessments identified that Mr C wouldn’t manage without support, and he was unable to maintain the improvements made when significant action had been taken to clean his home or when he lived in the care homes. Whilst there was a challenge in respecting Mr C’s independence, this case has not evidenced proactive interventions or a multi-agency response. As a result, Mr C’s living conditions repeatedly deteriorated, resulting in him living in one room in unsafe and unsanitary conditions. Simple things were missed for example he injured his back trying to carry new carpets into his house.

There were serious incidents, including three fires and false fire alarms. These were dealt with in isolation despite a road traffic accident and indicators of escalating risk. The family of Mr C contacted services at these times, highlighting their concerns. The circumstances at the time of and cause of Mr C’s death are unusual in that a fire started immediately after he died, and at the time of dying he may have accidentally ignited the fire. Nevertheless, the conditions in the house presented potentially fatal risks, and a fire could have started at any time. Agencies missed opportunities to work together to put in place additional preventative measures. A multi-agency safeguarding response and care plan would have allowed opportunities to share information, review the effectiveness of the plan and take additional measures. This may have included a formal capacity assessment.

GP records indicate that Mr C did not attend several appointments and medical reviews for dementia and peripheral vascular disease during and prior to the review period although the DN did conduct a full review in July 2020. The IHD would have evolved alongside the PVD from the same underlying causes (usually at least one of uncontrolled hypertension, hyperlipidaemia, smoking and/or diabetes). The recommended treatment (Cholesterol and blood pressure medication) was being prescribed by the GP practice and there was nothing to suggest an acute episode

was likely to occur. Whilst PVD is not immediately life-threatening, the process of atherosclerosis[17] that causes it can lead to serious and potentially fatal problems.[18]

Health professionals could have considered more creative methods of conducting health reviews and in particular there were missed opportunities for the annual health review when he attended at the weekly appointments for treatment to his leg ulcers.

In March 2019, the SW prompted the care home to make a referral to Care Home Liaison Team as Mr C had appeared anxious following recent events. It was decided that it was not appropriate to assess Mr C from secondary mental health services for symptoms of anxiety having not been first assessed by his GP. The criteria for referring service users for a primary care assessment did not include those in respite, only permanent residents. It is not clear if this decision was communicated to the GP for action or what action was taken to secure adequate support for Mr C.

At the time Mr C was due to leave the care home in September 2019, a further discussion took place between the SW and Mr C where the SW suggested to him that he may benefit from a referral to Mental Health services which he agreed with. There is no evidence on records within ASC or Mental Health services to confirm a referral was made or what the outcome was. Therefore, both incidents were missed opportunities in accessing support for Mr C.

On the 29th May 2019, a Care Act assessment was undertaken. Mr C expressed he needed support when returning home around mobility, support with personal care, maintaining home environment and that he was unable to manage financial affairs. It was expected that he would be in the care home for five weeks, but it transpired to be nine months, during which it is likely he became dependent upon the 24-hour care environment. It was predicable that he wouldn't manage at home without additional support. When he eventually left the care home there was no discharge plan including a re-assessment of the support required to maintain his home environment. Given the conditions that were found in his home, there was no evidence that he was able to prevent a recurrence of his happening. Care home 2 did work with Mr C in preparation for leaving the home and did visit him when he left.

The role of managers and supervision.

High-quality supervision has long been viewed as a fundamental 'cornerstone' (Laming, 2003: 211) and 'an integral element of social work practice' (DCSF, 2009: 29). Across the range of professional contexts in multi-agency practice the term 'supervision' can mean quite different things. Inadequate and inconsistent supervision is linked to detrimental effects on practitioners and has been highlighted as a significant factor in serious case reviews (Brandon et al, 2008; Laming, 2003).

[17] Atherosclerosis- The build-up of fats, cholesterol and other substances in and on artery walls
[18] https://www.nhs.uk/conditions/peripheral-arterial-disease-pad/

It is essential that practitioners and commissioned care staff are well supported by managers, with attention in cases of fluctuating capacity where there are high risks to the service user. Care plans should contain actions where the service user has and does not have capacity. The assumption that Mr C had capacity meant that the role of managers of applying this recognised practice was missed. In cases where the risks to the individual are high, greater supervisory oversight and assurance become even more important. It also seems that there was insufficient scrutiny by managers in questioning this assumption.

Supervision must monitor the approach being taken to a case and the decisions being made. It must correct poor practice, ensuring that risks are discussed, that practitioners have sufficient knowledge and/or skills for the complexities that they encounter, and understand safeguarding procedures, legal options and thresholds. Managers and senior leaders have particular responsibilities here; they must themselves have a high level of legal literacy, and also facilitate the legal literacy of staff within their organisation. (Preston-Shoot, 2019).

The use and value of reflective supervision was recognised at the learning events. ASC highlighted that supervision enabled some level of consistency but the transfer of case between staff could have been more effective. This was particularly important given that the case was allocated to a newly qualified social worker during the end of the period under review. There was no evidence to indicate if managers considered the appropriateness and decision to allocate this complex case to the SW. CHFT have the facility to increase supervision in more complex case, which is a practice that could be applied to other agencies. ASC also highlighted that a risk panel within ASC could have provided additional oversight, but this was stopped pre pandemic.

Given the complexity of this case, and that there was no oversight through any formal group or policy, the need for managerial oversight was even more critical.

Learning (Lessons identified)

Mr C was living with several health and social care needs some of which were unmet. Numerous complex factors and risks required the involvement of different agencies, but there was a lack of planning and outcome meetings, under the safeguarding procedures, involving relevant agencies to assess and mitigate risk. Additionally, there was no lead agency or coordinated multi-agency safeguarding response.

Agencies did not identify, assess, and respond to these opportunities to work with Mr C. to support. Assessments were not trauma informed, did not include wider information sources and there was a lack of understanding why Mr C behaved as he did. Whilst understanding and application of trauma informed approaches may have

been limited it would be reasonable to expect practitioners to take a holistic approach to understanding his behaviour. This information and factors would have informed intervention planning.

There were a number of key incidents which could have prompted practitioners to have considered if a formal and more detailed MCA assessment was required. Consideration could have been given to whether Mr C had fluctuating capacity or issues with executive capacity given the increasing identification of his alcohol usage. Further examination of Mr C's mental capacity and interventions were warranted when Mr C did not make the changes that were needed and there was evidence to suspect Mr C lacked capacity to make and carry out decisions to address the risks he faced.

There was an inconsistent and at times un-sustained approach which resulted in agencies withdrawing services and/ or providing services that were difficult for Mr C to access.

There was a lack of professional curiosity/responsibility by agencies in considering or exploring if Mr C did have mental capacity to make decisions about his safety needs and in not escalating the case into an effective and coordinated multi-agency safeguarding response.

The family and panel members concluded that agencies did not respond adequately to the requests for help and support from family members or involve them in planning and assessments.

There were occasions when agencies did not respond in a timely manner to concerns raised, assessments and involving other services. There were missed opportunities in providing adequate care and support when "near misses" occurred at times of escalating risk and following discharge from hospital / A&E when highly dangerous incidents had occurred.

The Calderdale SAB have commissioned other reviews which identified similar areas of learning to this review. This review has established similar learning to these reviews.

Good practice

The community-based ASC service in Halifax was effective in providing support to Mr C and enabling his engagement. This provided a known location that he could drop into, and the shop was a preventative resource. This service closed during the Covid 19 pandemic and Mr C was no longer able to use it.

District nurse teams maintained a good relationship with Mr C providing additional care and supporting Mr C, maintaining contact with his family, and showing persistence in attempting to keep in contact with Mr C.

A&E records were detailed when Mr C attended on a number of occasions.

Care home 2 developed a positive relationship with Mr C, effectively engaging with him and maintaining good contact.

Conclusions

This review has established that Mr C was a proud and independent man who maintained a strong determination to live his life as he chose. Over a period of time, his lifestyle and health led to the emergence of a number of complex factors that required the involvement of agencies. Unfortunately, this did not result in a coordinated and multi-agency response. Life for Mr C was generally difficult and at times unsafe.

Engagement was a challenge, despite patience and regular interactions. This was affected by the lack of trust that Mr C had in certain agencies and his fear of having to leave his home. Additionally, this case has identified that Mr C had experienced previous trauma and agencies have since highlighted that they didn't understand enough about Mr C. This trauma and subsequent re-trauma would have also affected his engagement and anxieties.

There was a great deal of information and opinion which suggested that Mr C was able to understand information and communicate his decisions but there were also risk-taking behaviours which raised concerns. Practitioners assumed he had mental capacity, but this was not formally assessed including specific factors and all potential legal routes were not explored.

There were a number of events, including three house fires, leading up Mr C's death indicating that a preventable tragedy may occur. Although Mr C's cause of death was a long-standing heath condition the risks to his own life and those of his neighbours from fire were not mitigated by multi-agency interventions. Assessments and care planning did not mitigate risks and prevent the recurrence of future similar events.

The learning from this review does have some similarities to other reviews within Calderdale. Transforming learning into improved practice is a challenge for many partnerships nationally against many organisational demands but must remain a priority in learning from the past.

Recommendations

1. The Calderdale SAB may wish to review existing and proposed arrangements, including previous learning, to ensure that complex cases including self-neglect are appropriately managed through existing policies and procedures. This should ensure that thresholds and definitions do not present barriers to accessing care and support in hoarding or complex case panels.

2. The Calderdale SAB may want to seek assurance from partners about how and when learning from this and previous reviews will be embedded into practice. Areas of key learning from this review are
    - Developing trusting relationships with people with complex needs through a trauma informed approach.
    - Risk assessments and planning in complex cases.
    - Identifying and responding to self-neglect.
    - Effective multi-agency safeguarding responses including information sharing
3. The Calderdale SAB may wish to improve agencies understanding and application of legal literacy – including the MCA and inherent jurisdiction. This should be extended to include training and learning around executive capacity (recognised locally as executive functioning).
4. The Calderdale SAB may wish to seek assurance that care planning in complex cases and/or self-neglect cases evidence multi-agency planning, effective coordination and communication and outcomes that "improve the wellbeing of the person and prevent serious injury and death of people who self-neglect."[19]
5. The Calderdale SAB may wish to seek clarification about the future of the "one stop shops" and similar hubs.
6. Agencies should look at innovative ways to provide accessible and assertive outreach services within the community to enable service users a known location to access support.
7. Professional curiosity, escalation and challenge processes should be understood and promoted across the partnership.
8. Agencies may wish to ensure that there are appropriate management oversight, audit and supervision processes in place for complex cases [20]. The role and involvement of managers in cases needs focus especially where there are high or escalating risks to the service user and/ or members of the public.

Glossary

A&E	Accident and Emergency Department.
ASC	Adult Social Care
CHFT	Calderdale and Huddersfield NHS Foundation Trust
DN	District Nursing Team
EH	Environmental Health

[19] CSAB – Self Neglect policy.
[20] Individual agencies may undertake supervision through agreed processes which may vary in methods

GP	General Practitioner
IHD	Ischaemic Heart Disease
MCA	Mental Capacity Act
PVD	Peripheral Vascular Disease
SAB	Safeguarding Adults Board
SW	Social Worker
WYFRS	West Yorkshire Fire and Rescue Service
WYP	West Yorkshire Police.

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Appendix

Appendix A - Terms of Reference

Specific areas to focus on and key areas to be analysed:

1. Was Mental Capacity considered and assessed appropriately when Mr C was making highly risky decisions?
2. Were relevant policies and procedures in place to support this specific situation clear, known by staff, used and effective?
3. How did services respond to safeguarding concerns if Mr C showed reluctance to engage?
4. How were risks and concerns identified, assessed, managed and responded to (including timeliness)?
5. How effectively did agencies work together to share information and respond in a coordinated way at key points?
6. What, if anything, prevented action being taken when concerns were identified?
7. Are there examples of good practice to be highlight?
8. Is there evidence the adult at risk remained the focus for professionals, were his views heard and views of the family?
9. Was there a clear understanding of Self-Neglect, Hoarding and Mental Capacity?
10. Were there any implications or impacts of Covid?
11. What is the impact of poverty in this case?
12. To what extent was previous trauma considered in assessments and interventions?
13. How has learning from previous reviews and incidents improved multi-agency practice?