REPORT FROM THE SAFEGUARDING ADULTS REVIEW IN RESPECT OF Mr D WHO DIED ON 21st MAY 2015 (EXECUTIVE SUMMARY)

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On behalf of the Lambeth Safeguarding Adults Board

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1. INTRODUCTION

1.1 This Executive Summary of the full SAR report covers the main findings and key recommendations of the Safeguarding Adults Review (SAR), undertaken on behalf of the Lambeth Safeguarding Adults Board (LSAB), and relating to a gentleman, referred to as Mr D throughout to maintain his confidentiality. The SAR also refers to a woman referred to as Ms E, who Mr. D lived with during the last 6 months of his life.

1.2 This summary is intended to give a brief overview of the SAR and the full report should be read for further details of both the process and outcome of this SAR.

1.3 The Safeguarding Adults Review is not intended to attribute blame but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Lambeth in the future.

1.4 The review was conducted in the light of the following legislation;

The Care Act 2014-Section 44 Safeguarding Adults Reviews

1.5 The Department of Health Statutory Guidance which accompanied the Care Act, has included Self-Neglect in their revised definition of abuse.

A number of agencies had concerns that Mr. D had suffered from significant self-neglect which contributed to his poor state of health and subsequent death. There was also concern that he may have been neglected by a woman whose house he lived in for the final 6 months of his life (referred to as Ms. E, to maintain her confidentiality). Therefore, the LSAB decided that the grounds for a statutory Safeguarding Adults Review were met.

2. BACKGROUND

2.1 Mr D was a 75-year-old man of white UK background who lived in Streatham prior to his admission to hospital, in May 2015. Mr D's parents married in 1935 and had 3 daughters and a son. There was limited information about his early life available to this review. He was known to have suffered a motorbike accident in 1960, which resulted in a compound fracture of his right leg. This injury continued to cause him pain and difficulties with his mobility, necessitating the use of a crutch in later life. He married in 1966 and had one son, who was born in 1974. He was separated from his wife, who passed away in 1996 and he had no on-going contact with his son. He also had no contact with his three sisters: one lives in Hampshire and one in Australia. His third sister passed away in February 2015.

2.2 Mr D had been a friend of Ms E and her family for 30 years. They both lived in Streatham and he was a regular visitor to the house of Ms E. Ms E had 2 sisters and a brother. Mr D had initially been a friend of Ms E's mother and her sister/brother in law. Her brother in law was very close to Mr D and regularly helped him out, until he too passed away in February 2015. Mr D previously had a personal relationship with Ms E, although they stayed in touch and remained friends long after this relationship concluded.

2.3 Ms E's mother had dementia and passed away in 2009. Ms E's sister, also had early onset dementia and she passed away in 2013. Ms E took over sole occupancy of her family home after her mother passed away. There had been some involvement by Lambeth Adult Services with both Ms E's mother (in 2008-9) and sister (in 2011-13). In both cases, concern was expressed about the condition of the family house. This was a Victorian terraced house, said to be in a state of disrepair and infestation. There had been no electricity supply to the property since 2009 and there was also said to be no effective running water supply either.

2.4 Despite the state of the property and lack of amenities, Mr D stayed regularly at the family house of Ms E and may have effectively moved in there from January 2015. After the death of her brother in law (in February 2015), Ms E seemed to have stayed at his property for some time, whilst Mr D stayed on in Ms E's property.

2.5 Ms E was in regular contact with Mr D from February 2015-May 2015. Also, Ms E's brother, who lived in Croydon, visited both Ms E and Mr D, approximately once a month. Although Mr D had his own tenancy, at a bedsit in Streatham, he did not spend much time there and appeared to stop staying there at all from approximately January 2015. Mr D used to get Housing Benefit to help pay his rent, but this was stopped in May 2014, resulting in rent arrears accumulating, which subsequently resulted in his flat being repossessed by the landlord, shortly before Mr D's death in May 2015.

2.6 Mr D stayed in Ms E's house, in a room on the ground floor and at some point his health deteriorated during the period of January-May 2015. He had no contact with either health or social services during this period and spent most of his time lying in a bed.

2.7 Ms E phoned the London Ambulance Service (LAS) on the evening of 15th May 2015, as she was concerned that Mr D was unconscious. At this time Ms E was in the property with her niece. The LAS sent both an ambulance car and ambulance to Ms E's property. Mr D was then conveyed and admitted to St George's hospital Acute Medical Unit in the early hours of the 16th May. The LAS crew who conveyed Mr D were concerned about his condition and raised these concerns as a potential safeguarding adults issue in line with LAS procedures.

2.8 Mr D was found to be emaciated and unkempt by St George's hospital staff. He was described as being covered in faeces, lice, scabies and maggots. He was breathing quickly, had a rapid heart rate with low body temperature and low oxygen levels. He had numerous pressure ulcers on the back of his head, down his spine, pelvis, sacrum, right hip and right shoulder. At the time of admission he had bandage dressings on both his legs. These dressings were soiled and malodorous and when they were removed in hospital they

exposed soft tissue, muscle and tendons on his right foot and broken skin with black toes on his left foot. He also had a deformed right knee in a flexed position with the head of the long thighbone protruding outwards. He was resuscitated, treated with intravenous fluids, antibiotics and cleaned up. He was dehydrated, malnourished and had a reduced level of consciousness.

2.9 A nurse on the ward immediately contacted the Metropolitan Police, due to the severity of Mr D's condition (as outlined above) and two officers attended the hospital. Ms E had accompanied Mr D and was also at the hospital. She was spoken to, although not formally interviewed by the officers on the 15th May. Hospital staff took 15 photos of Mr D on his admission and these were later supplied to the police. The Police thought that Ms E did not have a formal caring responsibility for Mr D at this time and so was not criminally liable for neglecting a duty of care to him.

2.10 Mr D was considered unlikely to survive and further police inquiries continued on the 16th May, with the case allocated to 2 Detectives. Ms E's property was visited by the police, with Ms E and her brother, along with a scene examiner who took photos of the property. There were lots of sealed storage boxes at the property, along with 3 dogs and 6 cats. There was no heating, lighting, or running water at the house. The condition of the house was said to be very dirty, with dust, cobwebs, flies and a stench of faeces and urine. Due to concerns about the animals' welfare police contacted the RSPCA, who subsequently visited and removed all the animals on the 19th May 2015. The Police undertook further enquiries in relation to Mr D's financial affairs, family and social circumstances. They requested statements from both Ms E and her brother, although these were not provided.

2.11 The nurses on the ward alerted the Safeguarding Adults Lead Nurse for St Georges Hospital to Mr D's case. He was in touch with both the Police and Lambeth Adult Services. An interim protection plan for Mr D was then agreed whereby he would only be allowed visits during hospital visiting hours and under supervision by hospital staff.

2.12 Mr D was spoken to by the police officers and assessed by Medical staff during his admission. He was treated with pain relief and antibiotics, whilst undergoing further medical assessment, including X-rays and blood tests. He was found to have septicaemia and a perforated bowel. He was put onto a palliative care pathway, to manage his symptoms, but not to actively treat his medical issues.

2.13 Although Mr D's condition improved slightly over the next 2 days, due to the care and treatment, which alleviated some of his symptoms, he became increasingly unwell during the night of the 20/21st May. Ms E and her brother were called at 3am on the 21st May to be informed of his deterioration and they attended the hospital. They stayed with Mr D until he passed away at 7am on the 21st May.

2.14 Mr D's case was subsequently referred to the Coroner and an inquest has been scheduled to be held at 12th July 2016.

3. SUMMARY OF KEY SECTIONS OF REPORT

The following sections of the full SAR report set out summaries of all agency involvement for each period of the chronologies. There is then a brief analysis of each period, with key learning identified. This Executive Summary is limited to the analysis and recommendations from each period of the SAR.

3.1. Analysis of First Period of the Chronology pre-November 2014

The first summary covers the significant recorded events for Mr D as summarised in health and social care records. Mr D had very limited contact with Health or Social Services for most of his life. The only agencies working with Mr D during this period were his GP and the local hospital (St Georges), due to his knee injury and subsequent complications. He clearly had long standing difficulties with his right leg, for which he had unsuccessful knee replacement surgery and which was then immobilised in a leg brace.

Physicians were so concerned about the condition of his right leg that amputation was repeatedly recommended but not accepted by Mr D. He had pain in his leg and took powerful painkillers, possibly through a repeat prescription via his GP. He also had later problems with his left leg, where leg ulcers developed. He seemed reluctant to engage with community health services and preferred to dress these himself.

He took an overdose of morphine, which may have been through taking too many painkillers, although no details of this are available to the review. It was not known whether this was a deliberate suicide attempt, or an accidental overdose. As he was not referred to any mental health services, there was no assessment of his mental health, which might have been helpful and appears to have been a possible oversight at the time. In fact Mr D was not known by mental health services at any stage and there were no records that he was ever referred for any assessment of his mental health needs.

3.1.1. Learning from review of significant events.

1. Any overdose, requiring hospital admission should automatically lead to a full mental health and risk assessment from liaison psychiatry, to be shared with primary care and if necessary with specialist mental health services.

2. Where doctors are repeatedly concerned about a patient's mobility to the degree that amputation of a limb is recommended and then refused, a referral to Adult Social Care for an overall assessment of care and needs should be made by the relevant physicians.

3.2. Analysis of Second Period of Chronology from November 2014- 14th May 2014

The second chronology covers the last 6-months of Mr D's life, up to his final week, which is covered in more detail in the final chronology.

Mr D had no contact whatsoever with his GP, the local hospital, Adult Social Care or Mental Health Services during this period and so very little information was known about this period. What information was available to the review has been drawn exclusively from the Police IMR. During the police investigation into the circumstances surrounding Mr D's death enquiries were made of his financial circumstances and living arrangements. Ms E and her brother were spoken to by police officers, as was Mr D himself, when he was in hospital.

His health went drastically downhill at some point over these 6 months and although the exact length of time that he stayed in bed is not known, he certainly seemed to have spent most of his time in one room and mainly laying in a bed.

He seemed to have a substantial and critical increase in his needs for care during this period. The person who had been helping him with personal care and food passed away in February 2014. After this point he would appear to have been largely confined to bed and became effectively reliant on Ms E to attend to his care needs. Mr D may have been physically unable to walk due to the problems with his right leg.

He was residing in Ms E's property, which had no heating, lighting, water, cooking or washing facilities. There were many domestic animals in the property and a poor physical environment. He had a high need for care and was living in an impoverished environment where it would certainly been challenging to meet these needs. Clearly Ms E was unable to cope with this situation. Judging by the extreme state of ill health he was found to be in when Ms E, finally called an ambulance for him on 15th May 2015, he was in need of urgent intervention by health services some considerable time prior to when they were finally alerted to his situation. What was not known is why Ms E did not alert any services prior to this date, by which time he was so unwell that little further could be done for him.

It was also not known why Mr D did not seek to contact any services himself at any point during the final 6 months of his life. He did not withdraw any money from his pension, or benefits after January 2015 and appeared to have essentially been destitute, despite payments accruing in his post office account. He was found to be so significantly malnourished to the extent that he

was judged to have not eaten sufficient food over some period of time. He clearly suffered from significant discomfort and pain during this period, but for reasons that remain unknown he did not seek any form of assistance, apart from that provided by his friend, Ms E.

3.2.1. Learning from Second Period of Chronology and review of significant events.

Mr D clearly needed assistance in this period of the Review, but only had the help of Ms E. He would have been eligible for intervention from Adult Social Care and could have been provided with a package of care to assist him. He also needed nursing and medical attention, but neither his GP, nor any District Nurses were notified of his condition. Only Ms E and her brother were aware of Mr D's circumstances, but did not share these with any health or social care services. Ms E has since stated that Mr D did not like doctors and did not want to see one.

Mr D became unwell but he also did not seek assistance from any services, the reason for this was not known. During the first part of the review there was evidence that he disengaged from health services over the treatment of his right knee and ulcers on his left leg. This disengagement continued throughout 2015, but the reason for this was not known.

Given that no agencies were informed about his situation, the only learning for services from this period of the chronology relates to provision of information for adults and their carers who are struggling to cope with their situation, to seek to proactively alert them to the availability of assistance from both health and adult social care services.

3.3. Analysis of Third Period of Chronology from 15th May 2015 to 21st May 2015

Mr D was clearly in a very serious physical condition when he was admitted to hospital on the 15th May 2015. This developed at some point over the course of the previous 6 months, since he had largely remained in bed in Ms E's house. Mr D was given a very thorough assessment and treatment during the course of his admission to St Georges Hospital. He had a number of specialist assessments from physicians, surgeons, dieticians, tissue viability and palliative care teams. He received good quality, thorough and compassionate care, but despite this his health was so poor that he died within a week of admission.

The Ambulance Crew, the nurses in A&E and in the Acute Medical Unit were all so concerned about the condition of Mr D when he was first seen that they

all separately raised these concerns under the Safeguarding Adults Policy & Procedures. Clearly he was found to have suffered from a significant period of self-neglect, prior to the time when he was admitted.

Also, the concern was additionally that if Mr D had received medical assessment and treatment earlier he could possibly have survived and the questions was raised as to why neither Mr D nor Ms E didn't call for assistance earlier. The police thoroughly investigated the circumstances of this case once they were contacted about these concerns. The officers attempted to interview Mr D, Ms E and her brother about his circumstances. Mr D was clearly quite unwell at the time of the interview, which limited the information he could give the officers. At no time when he was interviewed either by the police or health care staff were concerns of depression, or suicidal intention identified. He did not make any allegations, or complaints about Ms E to anyone at any time.

Given the concerns about Mr D's welfare, the decision not to allow him to have any unsupervised visitors appeared to be both proportionate and an appropriate response. This decision was taken together with the police and the safeguarding adults lead nurse for the hospital. Ms E and her brother objected to it, although they were not prevented from seeing Mr D. When he became very ill they were called at 3 a.m. and stayed with him until he died some 4 hours later.

Ms E did speak to police on several occasions, although neither she nor her brother agreed to give a formal statement, to the police. The financial affairs of Mr D were also investigated and it was noted that in April 2015 Ms E sought to be nominated to access Mr D's post office account. However, it was also discovered that she did not take any money from Mr D's account.

The officers sought advice from their seniors as to whether there was any criminal liability on the part of Ms E because she did not seek assistance for Mr D earlier. The view was that Ms E was not to be treated as a suspect of any crime, as she had no clear line of responsibility for Mr D's care and that she did alert services once she recognised he was unwell. The police were able to trace Mr D's surviving sibling and notified her of his death.

Lambeth Adult Services accepted responsibility for undertaking a Section 42 Enquiry, as required by the Care Act 2014 and associated statutory guidance (which included self-neglect as a safeguarding issue). However, the enquiries only amounted to collating information from the police and hospital staff. As Mr D died soon after Adult Services were notified there was a decision not to proceed with any further S42 enquiries. The case was kept open to Adult Services for 10 months, but this appeared to have been an administrative issue, rather than because there were any on-going actions being taken.

3.3.1. Learning from Third Period of Chronology and review of significant events

The LAS did respond well to Mr D, both conveying him to hospital and raising their additional concerns through the safeguarding procedures. The medical and nursing professionals at St George's hospital also responded well to his needs, managing his symptoms and treating him appropriately. They sought to maintain his welfare and managed any potential risk of visitors by supervising visits. The Police officers were thorough in their investigation and efficiently managed the gathering of evidence, with due consideration of both Mr D's and Ms E's circumstances and their relationship.

Communication between the above agencies was undertaken appropriately and led to shared decision-making.

Therefore, following a review of all available information during this period there were no recommendations, which identified any need for improvement in either a single agency, or multi agency response to situations, which could occur in future. Nothing could have been done differently during the period of his admission to hospital, which would have materially improved the outcome for him, or for the investigation as to whether he had been a victim of a crime, or of neglect as a safeguarding issue.

3.4. Analysis of Chronology for Ms E

There was involvement recorded by Lambeth Adult Social Care Services from 2008 with Ms E, in a connection with her caring role for her mother. Concerns were identified over Ms E's mother's condition upon admission to St George's Hospital. Ms E stated to a doctor that her mother had been in bed for 4 years prior to this admission. Ms E had not contacted her mother's GP, or any other services during this time.

During the work with her mother the records show, that there were concerns about Ms E's property already identified in 2008. There were some parallels with Ms E's mother's situation and that of Mr D. In both cases Ms E had been attempting to care for an older person in an impoverished environment. In both cases, the adult had been bed bound for some time prior to Ms E seeking medical attention and in both cases concerns were identified about Ms E's abilities to recognise how severe the care needs were. Ms E presented as someone who struggled to make headway with getting things done in support of her mother. She appeared to be overwhelmed by what may be to others quite

everyday matters. She also struggled to cope with her home situation, where utilities seem not to have been functioning since 2009.

Both Ms E's mother and sister had developed dementia, which ultimately led to them being placed in residential care services. Ms E has been diagnosed with small vessels disease, which can lead to dementia. However, when Ms E was seen in December 2015, there was no concern about her mental state, or decision-making ability.

In 2011, Adult Services received referrals about Ms E's sister, who was staying with a friend in an extra care sheltered accommodation. The contact with her regarding her sister did not appear to be informed by the earlier involvement with Ms E during the contacts with her about her mother. Evidence of this was that the records for Ms E and for her sister were not linked on the Lambeth Adult Services database (Frameworki system) until October 2012, and the two episodes of work were done by different teams.

So those working with her in relation to her sister would have been unaware of the earlier contact with her in relation to her mother. Perhaps if they had been aware, they may not have assumed that she would take forward dealing with the financial and tenancy issues and the deputyship application may have been made earlier.

Therefore, even if Mr D had been referred to Adult Services, it would have been unlikely that the previous concerns about Ms E's abilities as a carer would have been identified through the records, as links to Ms E's mother and sister would not have been made on the IT client records system (Frameworki).

3.4.1. Learning from Ms E's Chronology and review of significant events

Given the above there could be learning that some formal recognition of Ms E's effectiveness as a carer should have been formally noted by Adult Social Care and also Health Services. This should be clearly recorded on the IT system if she was known to also be a carer for another adult.

Although the fact that she was attempting to care for Mr D was not known before his admission, was this to have been known then some warning flag to notify agencies that he was being accommodated and looked after by Ms E would have been helpful. Given she had a history of struggling to meet caring roles for her mother and sister, this information may be of benefit in assessing the risk of her caring in any future, similar cases.

4. RECOMMENDED ACTION PLAN FOR LAMBETH SAFEGUARDING ADULTS BOARD FOLLOWING THIS SAFEGUARDING ADULTS REVIEW

4.1 Recommendation 1.

a) That LSAB seeks assurance that all Health Trusts in its area have robust processes in place to respond to adults presenting with serious self-harm or suicide attempts, in line with NICE guidelines. This should include evidence of appropriate risk assessments and referral pathways for psychiatric assessments, where appropriate.

b) That LSAB shares this learning with Wandsworth SAB and St George's University Hospitals NHS Foundation Trust.

4.2 Recommendation 2.

a) That LSAB recommends to Hospital Trusts in its area that they always offer adults who have a serious limb, or joint injury requiring amputation a referral to Adult Care Services for a full assessment of their care and support needs.

b) That LSAB issues guidance that a referral to Adult Social Care always be made, where medical/surgical advice is both refused and there are also concerns of significant self-neglect by the adult, and

c) That LSAB shares this learning with Wandsworth SAB and St George's University Hospitals NHS Foundation Trust.

4.3 Recommendation 3

That the LSAB seek assurance from both Health and Adult Social Care services that they have promoted the entitlement for all adults and their carers to have an assessment under the Care Act 2014, where there is an appearance of need and specifically for people either deemed to be at risk of, or caring for, adults who self-neglect.

4.4 Recommendation 4

That the LSAB are able to ensure that where a S42 Enquiry is undertaken in response to concerns about a carer's ability to monitor and manage risks of self-neglect for another adult that an alert will be recorded on the carer's electronic

records. Furthermore that the LSAB can demonstrate that this will prompt a further multi agency S 42 safeguarding enquiry, if the carer is known to be seeking or attempting to look after another adult at risk.

4.5 Recommendation 5

That where the LSAB decides to initiate a S44 SAR in future this can be clearly recorded on a new dedicated episode of the Adult Social Care Mosaic records for the adult and if necessary for their carer, where all relevant information can be recorded on both the process and outcome of the SAR.

4.6 Timescale for LSAB to ensure completion of recommendations

The LSAB in October 2016 will be provided with an update on the progress of implementing the SAR recommendations.

All recommendations to be completed with evidence submitted for approval to the LSAB in January 2017.

5. SUMMARY AND OBSERVATIONS BY THE INDEPENDENT AUTHOR

5.1 Despite the thorough collation of information about Mr D by all relevant health and care services, very little was known about him before he was admitted to hospital in May 2015, as a 74 year old man. Although very unwell at the time of his admission there was no clear explanation given by him about why he did not seek help earlier. Given that he was not known by any service to be in need then no agency can be found to be at fault for not preventing his deterioration and death.

5.2 Once his needs were known then he was given good care in hospital. He had no known mental disorder, or intellectual impairment, which might account for why he did not seek assistance from services. He did not have a known substance misuse issue and no known reason not to seek outside help. He appeared to have capacity to make this decision not to have help and so it may not have been possible to force him to accept help, even if his needs were to have been made known to services.

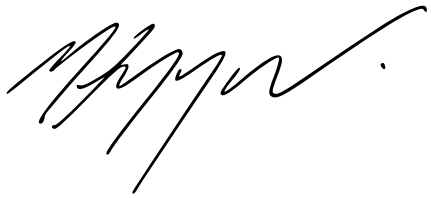
5.3 The question also remains unanswered as to why his friend Ms E did not try to get any help for Mr D any earlier during the 6 months that he lived with her. She had lived in the same home all her life and the condition of the property had been known to be a concern when services worked with her mother. She cared for her mother in the same environment and so may not have felt anything was untoward in the conditions she was living in when Mr D moved into the house. Both her mother and sister developed dementia and Ms E has small vessels disease, which also puts her at risk of developing this condition. The LAS and police did have concerns about her decision-making when they had contact with her, although when Adult Services offered her an assessment she was thought to be able to make the decision to refuse this service.

5.4 As Ms E did not participate in the SAR her own explanation for why she did not seek help for Mr D before May 2015 was not known. It can only be speculated that she was respecting his wishes not to see doctors or social workers before he became so obviously ill on 15th May, although it also appears she did not realise he was so ill, before he lost consciousness.

5.5 This case illustrates the difficulties, which arise when older adults lose mobility and become bedbound in the community. This is especially so where they live in a poor physical environment and are cared for by others who may not realise the impact of the circumstances on their health.

5.6 In terms of learning from this tragic case there needs to be some formal recognition by the LSAB that other people could be potentially in a similar situation and that help can be proactively made available for them. This should be jointly promoted across Lambeth, with people encouraged to share concerns about any isolated and vulnerable individuals that they are aware of, who may be suffering from self-neglect.

5.7 Although, in this case Mr D may have initially refused intervention it is possible that services would have been able to offer him help, were his needs made known. Other carers in a similar position to Ms E may be reluctant to come forward, so both they and the people that know them need to be encouraged to do so. The Care Act 2014 makes it a duty to assess the needs of both adults and their carers and this should be widely advertised across the borough in ways that reach hard to engage adults.



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On behalf of the Lambeth SAB