Hampshire Safeguarding Adult Board

Safeguarding Adult Review regarding 'Elizabeth'

6 Step Briefing

The Background

Elizabeth was known to a number of different agencies since the early 2000s.

Hampshire Constabulary had infrequent contact with Elizabeth at her home since 2009 when the property was described as 'derelict' following a reported attempted burglary. In 2010 Elizabeth was referred by the Police to Hampshire Adult Services specifying concerns about self-neglect following a reported theft from the address, which was found to be in a 'very bad condition'. In 2016 Elizabeth reported youths playing in her garden – it was thought that they assumed that the house was empty. Police again referred the situation to Adult Services advising that Elizabeth appeared vulnerable due to mental health issues; and that the house was in a poor state of repair. The police considered that she would struggle to improve living conditions. A further referral was submitted in 2016. Responding to a request for a welfare check, police were attempting to force an entry before Elizabeth came to the door. Officers saw that the house was full of clutter with the front door being barely able to be opened. There was a strong smell of damp and there was a hole in the hall floor where the floorboards appeared to have rotted. Two further similar reports were submitted by police in 2017 and one more in 2018 when a fire risk was identified.

Primary Care reported that they had not seen Elizabeth since 2012. She had been written to regarding routine screening but there had been no response. Concerns were expressed through Adult Services to the GP surgery in 2017 and 2018 but letters sent were not responded to and attempted phone calls found that the number recorded for Elizabeth was unobtainable.

Adult Services had records going back to 2004 when they contacted her but received no reply. Similar action in 2010 followed similar reports – but there was no reply to a letter and a visit received no response at the door. In 2011 Adult Services conducted a joint visit with Environmental Health but received no reply. They were informed by Elizabeth's GP that she was considered to have mental capacity, however this was not specific in terms of decisions to be made. In 2017 Adult Services conducted a joint visit to Elizabeth with a district nurse but they were refused entry. In 2018, following a police referral, Adult Services attempted to telephone Elizabeth without success and a further letter received no response from her.

Hampshire Fire and Rescue Service **(**HFRS) visited Elizabeth at home in 2018 but were refused entry and assistance which was offered was declined by her.

Environmental Health (EH) had contact with DR between 2001 and 2013, initially at her request for pest control advice. In 2011 they spoke with Elizabeth outside of her property but she declined any assistance.

Elizabeth's surviving older sibling stated that she was a recluse from the family for many years and always resisted family contact or offers of assistance. Elizabeth had resorted to a solicitor's letter on one occasion to discourage further contact.

Safeguarding Concerns

Elizabeth had come to the notice of a number of agencies over many years.

On most engagements with agencies the professionals involved identified either Elizabeth's isolation or self-neglect or both, and on occasions either attempted to provide support to her and/or made referrals to other agencies who were thought to be better placed to do so.

These attempts at providing support always met with strong resistance and a lack of engagement from Elizabeth.

On the occasions that her mental capacity was assessed she was considered to have capacity to take those decisions.

Upon a review into Elizabeth's circumstances in order to decide whether to hold a safeguarding adult review, it was noted by the Hampshire Safeguarding Adults Board that there was a lack of any co-ordinated multi-agency approach to the challenges posed.

Additional concerns were also raised around the recognition and management of self-neglect and hoarding, and the response to disengagement in complex cases.

The Incident

Elizabeth was sadly found deceased at her home in 2019. The last confirmed sighting of her was around six weeks previously.

A post-mortem examination was inconclusive as to the cause of her death and an open verdict was returned at the Inquest.

The house where Elizabeth had lived alone for the last thirty plus years, was found to be derelict and subject to an extreme level of hoarding.

The garden was completely overgrown with mature trees stopping the house being seen from the roadside.

The house was full, floor to ceiling, with hoarded bags and apparent clutter that prevented free movement. Tunnels in the hoarded material had allowed Elizabeth a degree of access around part of the house presumably by crawling from room to room. There was no running water, it was impossible to access any toilet, sink or cooking equipment, and there was evidence of rat infestation.

The house had extensive areas of damp and the chimney was found to be on the point of collapse.

Enquiries made after Elizabeth's death confirmed agency records that she had been a recluse for many years and had gone to extreme lengths to keep everybody away from her home.

The Review

The HSAB commissioned a discretionary Safeguarding Adults Review facilitated by two members of the Board's Learning and Review Sub-group in the form of Health and the Police.

The review was in three parts – consideration by the facilitators of the scoping returns from agencies involved in the case, engagement by the facilitators with Elizabeth's family members and a practitioners' workshop event to discuss the key issues and terms of reference which were set by the HSAB as below;

A discretionary Safeguarding Adult Review to consider:

- The levels of vulnerability and risks known
- Evidence that a Multi-Agency approach is Elizabeth embedded in practice
- Consideration of the legal frameworks available
- Application of the Mental Capacity Act (2005) in practice
- Recognition and management of self-neglect and hoarding
- Processes in place for managing disengagement and seeking expert advice and support when managing complex cases

The one-day workshop was attended by professionals from Police, Fire and Rescue, Southern Health, Clinical Commissioning Groups, Hampshire Adult Services, Environmental Health, Radian Housing and HSAB. It focussed on the terms of reference and allowed for partner agencies to share relevant information, highlighting key themes and to identify key learning.

The Findings

A number of key learning points were identified in terms of system learning, as well as for individual agencies involved.

Multi-Agency;

Agencies making safeguarding referrals to the local authority neither sought nor received feedback of action taken by the local authority. This meant that agencies involved with Elizabeth were unaware of what steps, if any, had been taken in response to the referrals. This issue has been identified in a number of other statutory reviews by the board and may reflect that capacity and workload within the Hampshire multi-agency safeguarding hub prohibits the flow of such information

No agency considered whether or not there were any other individuals living within the home that may have been impacted by the circumstances

There were gaps in knowledge of legal frameworks available to agencies to allow them to respond appropriately

Agencies did not appear to have sought specialist safeguarding advice in relation to hoarding and self-neglect.

Experts from Housing advised of the need to learn from previous cases including the need to think creatively about methods of engagement with individuals away from the home.

There was no structured approach, across the agencies, in managing disengagement.

There were missed opportunities to refer the case to the local Partnership Action Groups (PAG) for consideration of a coordinated response – possibly by utilising the Multi-Agency Risk Management (MARM) process.

Gaps were evident in relation to embedding the Mental Capacity Act as everyday practice.

There appeared to be an absence of professional curiosity when attempting to converse with Elizabeth to explore the underlying reasons for her disengagement and reluctance to resistance to contact.

Elizabeth's family expressed that they wished they had been contacted by agencies as her situation deteriorated so they could have had an opportunity to reach out to her to offer support. It is recognised however, that this can be a difficult area for professionals to navigate when the adult has chosen to maintain a distance from family.

Police; There was an identified need for more detailed information sharing with partner agencies but also internally with different teams within the force

Pathways to identify cases which needed to be escalated to Partnership Action Groups (PAG) were not always clear

Southern Health; It was unclear what processes were in place for escalating cases to GPs when a patient, for whom there were concerns, had disengaged had not been seen for routine health appointments.

Primary Care; The need for a process to be in place to identify and proactively engage with 'ghost' patients i.e. those who disengage

Adult Services; Good practice was highlighted in conducting joint agency visits with Health and Environmental Health

Adult Services had no record of considerations in relation to mounting S.42 investigations or MARM processes

Useful links for good practice

4LSAB Guidance on Responding to Self-Neglect and Persistent Welfare Concerns 2020

4LSAB Multi-Agency Hoarding Guidance 2019

4LSAB Multi-Agency Information-Sharing Guidance 2020

Mental Capacity Act 2005 Code of Practice

Hampshire Mental Capacity Toolkit Part A September 2018

Hampshire Mental Capacity Toolkit Part B September 2018