



REPORT TO GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW REPORT

“Ted”

**Found Deceased February 2016
Aged 72**

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Independent Author**

Final 10/1/17

1. Foreword by the Author

I was appointed by the Gloucestershire Safeguarding Adults Board (GSAB) in July 2016 to assist them in the preparation of this Safeguarding Adult Review (SAR) report. I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. I have also held senior Board level positions in the NHS and the voluntary housing association sector.

At the outset, I wish to record my thanks to all those who have assisted with and provided information for the review including the authors of the Individual Management Review (IMR) and other reports provided by key agencies. Particular thanks go to the members of the GSAB Business Team at Gloucestershire County Council who have provided unstinting and outstanding professional and administrative support.

The purpose of a SAR is to gain, as far as is possible, a common understanding of the events that led to death, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. A SAR is about learning not blaming and aims to improve future practice.

The Terms of Reference for this Review are given at Appendix 1. It will be noted that the SAR was to concentrate on the period from Ted's admission to hospital in late August 2015 to the date on which he was found deceased, at home, in late February 2016.

2. Introduction and Summary Chronology of Key Events

2.1 Ted was aged 72 at the time of his death. (Note: the name "Ted" is used throughout this report in the interests of anonymity – it is standard practice not to give identifying details in a SAR report. This principle extends to not naming the local agencies involved.)

2.2 While there are reports that Ted suffered from some mental ill-health some years ago, it should be noted that throughout the period under review, Ted was regarded as having mental capacity as defined by the Mental Capacity Act 2005.

2.3 Ted was originally from London and had worked as an engineer. It is believed that he may have had relatives in London but there is no record of any contact with them. It is not known when Ted moved to Gloucestershire but he was certainly in the County by 2003. He was reportedly “very deaf”. At the time of his death and since 2007, Ted lived alone (apart from his dog) on the second floor of a small block of flats, this being social housing provided by an Arms Length Management Organisation (ALMO) a not for profit company, set up to manage and maintain the local Borough Council's housing stock. The flat in which he lived was regarded as “sheltered housing” – this is referred to in more detail within the body of the report.

2.4 In late August 2015, Ted activated the alarm system within his flat and, as a result, the police and ambulance services attended and Ted was admitted to the local hospital with suspected kidney problems. Serious concerns of self-neglect were noted during the admission process. It also proved necessary for Ted's dog to be accommodated in a local animal shelter.

2.5 Ted received appropriate and effective clinical care from the hospital both on admission and over the ensuing 4 weeks, including a physiotherapy assessment. He cooperated fully with clinical and nursing staff being described as “chatty and bright” once medically stable.

2.6 A move to a ground floor flat was discussed with Ted while he was in hospital but he was adamant that he wished to stay in his current accommodation and have his dog returned to him.

2.7 By late September 2015 Ted was medically fit for discharge and ‘safely able to mobilise’. However, it was considered that a “deep clean” of his property was required before he could return home and therefore Ted was admitted to a local Intermediate Care Centre while that deep clean was completed.

2.8 At the time of his discharge from hospital, Ted had a urinary catheter.

2.9 At the very start of October 2015, Ted returned home with a reablement package. This meant that he received a visit each morning, at breakfast time, for 30 - 45 minutes, from staff employed by the County Council to enable him to become re-established at home. His dog was also reunited with him at home.

2.10 At the end of October 2015 the reablement service withdrew as Ted no longer required their services. He was managing self-care and medication independently.

2.11 Over the coming weeks, Ted was seen “out and about” on a number of occasions – he visited the scheme site office in early October and in mid-December the RSPCA visited Ted and tried to persuade him, unsuccessfully, to surrender his dog to them. The last recorded sighting of Ted was in early/mid-January 2016. At about the same time, the alarm was activated in Ted’s flat but when contact was made with him by the Alarm Call Centre, Ted responded that the alarm had been activated by mistake.

2.12 Some seven weeks later, concerns were raised, by a neighbour, about Ted’s safety. The police made a forced entry and both Ted and his dog were found dead. No known cause has been adduced because of the state of decomposition of Ted’s body – in June 2016 the Coroner recorded an open verdict: “No ascertainable cause of death”.

3. Consideration of Key Issues

3.1 As part of the Review process (and in addition to four individual interviews between myself and key agency personnel) a “Challenge Event” was held involving members of the GSAB SAR Committee and IMR authors at which the various IMRs and other agency reports were considered in detail. Arising from the discussions which ensued four key issues were identified:

- The nature of Ted’s “sheltered” accommodation: the general understanding of the term “sheltered housing” is at variance with current practice;
- The absence of any formal Safeguarding Concern at the time of Ted’s admission to hospital
- Catheter care
- Post-reablement support

3.2 Ted’s Accommodation

(i) The housing provider concerned delivers an Independent Living Service (ILS) in housing designated for older people. The ILS provides access to

needs based support and contact to enable older people to live independently and enjoy a quality of life. This includes the provision of a hard wired and pendant personal alarm. The service is delivered through an agreed personal support plan and through the provision of additional services and activities in local “community hubs”. Residents choose the support plan actions, contact with housing support team and frequency of review (linked to need). Support plans are reviewed every 12 months as a minimum although the frequency of review is determined by need and the resident’s wishes. This is, however, a person centred service and the rights of older people to live independently and choose the level of support and contact they wish to receive are respected.

(ii) The service is delivered within the scope of a Gloucestershire County Council (GCC) Supporting People Older People’s Service Contract. The GCC Commissioner of this service was fully involved in this SAR.

(iii) Throughout the first five years of his tenancy, Ted engaged with the support plan and contact processes, as delivered by the housing support team, and communicated his wishes to the team very clearly. Evidence suggests that he was living independently.

(iv) It is reported that this engagement changed soon after Ted got a dog. The housing provider worked with Ted to address the management issues that arose out of his lack of appropriate care for the dog and the impact these issues had for the neighbours and for his living conditions. At no stage was formal enforcement action taken – the housing provider (in my view, correctly) considered that a support approach was the right one. Along with other agencies (including the RSPCA), the housing provider tried several supportive interventions to try to encourage Ted to take better care of the dog and improve his and the dog’s living conditions. It is apparent that Ted resented these interventions: in March 2012, he ended the daily visits from support staff and changed his contact with them: he would call in at the local support base when he chose. (There is evidence that he did so, albeit not frequently.) As far as can be ascertained, at no stage was Ted ‘signposted’ to other support agencies such as Age UK.

(v) It was the triggering of the personal alarm in Ted’s flat that led to the attendance of the emergency services in August 2015 which, in turn, led to his admission to hospital.

(vi) Ted's support plan was again reviewed with him on his discharge from hospital (normally reviewed on an annual basis) – he made it clear that he wished the arrangements whereby he would call in at the scheme office when he chose to continue; he wanted no other contact.

[Note: The housing provider had not been notified by any other agency of Ted's admission to hospital and neither was the provider notified of his discharge home nor of the reablement team's involvement.]

3.3 Safeguarding concerns at the time of Ted's admission to hospital

(i) The GSAB's interagency procedures require all member agencies to raise a formal Safeguarding Concern when self-neglect of this magnitude is identified.

(ii) At the time of Ted's admission to hospital in August 2015, it was noted in the hospital record that the ambulance service reported that they had found "squalid living conditions, unkempt and dog faeces all over...patient was in bed on dirty sheets and mattress - no food in house". The ambulance service reported this to the Emergency Duty Team at Gloucestershire County Council.

(iii) Hospital staff at Gloucester Royal followed their usual process of referring Ted to the Hospital Social Work Team for support, on two occasions, two days apart. Although they mentioned "severe self-neglect" in the second referral, this did not result in a formal safeguarding concern being raised by the hospital social work team. Instead, Ted was assessed by a member of the hospital social work team; he agreed to a clean up of his property and Reablement support was arranged on his discharge home.

(iv) I am advised that, had a formal safeguarding concern been raised by either the Emergency Duty Team or the Hospital Social Work Team, the matter would have been screened and triaged and, in all probability, referred back to the social worker dealing with Ted. The anticipated actions that would have been required of the social worker would have been in line with what the social worker actually did. Therefore, it is unlikely that the outcome would have been different for Ted.

3.4 Catheter Care

(i) As part of Ted's clinical care, a urinary catheter was fitted. On discharge to the Intermediate Care Centre, the catheter was in place although no mention was made of this in the hospital discharge letter that was sent to Ted's GP.

(ii) On discharging Ted home, the Intermediate Care Centre left a message for the District Nursing Service requesting a call back as the hospital had requested a trial without catheter 'in coming months'.

(iii) At about the same time, a community pharmacist received a request originating from the hospital continence nurse that a catheter be prescribed. This was passed to the GP who was able to establish from information supplied by the Intermediate Care Centre/the local Community Health Service that the catheter had already been provided. The GP was made aware that a message had been left for the District Nurses by the Intermediate Care Centre a few days earlier.

(iv) Some 12 days later, the Reablement Team left a further message on the District Nursing Service answerphone requesting more catheter bags. Four days later, a further message was left, again requesting more catheter bags.

(v) At some stage, soon after hospital discharge, a "Choose and Book" letter was sent to Ted by the hospital outpatients department asking him to contact them to make an appointment to be seen at the Urology Clinic. It is apparent that Ted did not follow this up – records in mid-November show that 'the episode was closed' because there had been no response to the letter(s).

(vi) There is no Community Health Service record of the three messages that were left on the District Nursing Service answerphone being actioned, although two are known to have been transcribed into a message book held by the service. It should also be noted that, in relation to the two messages left by the Reablement Coordinator, an Adult Social Care record suggests that there was an actual telephone conversation between the Reablement Coordinator and a District Nurse. The content of the conversations is not known but it would appear that, on both occasions, the topic was the apparent confusion as to who was to supply catheter bags for Ted.

(vii) At the time of writing this report, an investigation into these matters is being conducted by the Community Health Service provider. Suffice it to say here that it is known that, at the time in question, the District Nursing Service was in some turmoil – understaffed and being reorganised. I am told that the reorganisation is now largely complete. It is also important to note that as Ted was self-caring, able to get out and about and could make his own arrangements to see his GP, it is unlikely that he would have received District Nursing services. The Reablement Service records show that Ted stated that he did try to contact his GP on at least one occasion, in late October, to discuss his catheter care but there are no records of contact being successful.

The District Nursing Service is only commissioned to see the house-bound although, in practice, they do see others as there appears to be no other pathway for catheter care. Having said that, the Community Health Service advised that best practice would have been for a District Nurse to contact Ted to check if he was managing his catheter and if not, to visit him and support him.

(viii) When Ted was found deceased in late February 2016 there was no sign of his catheter.

3.5 Post-reablement support

(i) During the Challenge Session the question was raised as to whether Ted should have been supplied with on-going, albeit perhaps occasional, support once the Reablement Team withdrew?

(ii) From subsequent enquiries, it has been possible to establish that as Ted could self-care and had full mental capacity – he made it clear that he did not want further care services – any form of post-reablement support would not have been considered necessary or viable.

(iii) However, as the issue of catheter care was still not resolved at the time when the Reablement Team was withdrawn, some follow up should have occurred.

4. Evidence of Good Practice

There were several examples of good practice by the various agencies involved in Ted's care. These include:

- The housing provider respected Ted's privacy and his self-determination at all times while remaining ready to support him at any time;
- The timely actions of the personal alarm control centre when the alarm was triggered in August 2015 and they could get no response;
- The speed and effectiveness of the Ambulance Service response when the personal alarm call centre called for their help;
- The ambulance crew raising concerns about Ted's self-neglect with hospital staff and they, in turn, reporting these concerns to the social worker at the hospital;
- The hospital based social worker finding accommodation for Ted's dog;
- With the assistance of the housing provider, the hospital social worker(s) arranging for the deep clean of Ted's flat. (Ted met the cost of the deep clean);
- The provision of information to Ted in relation to services offered by the Deaf Association and by the Cinnamon Trust. [The Cinnamon Trust is "a national charity whose primary objective is to respect and preserve the treasured relationship between owners and their pets. To this end it works in partnership with owners to overcome any difficulties that might arise" including, in this case, a dog walking service.] Sadly, it appears that Ted accessed neither of these services;
- The provision of the Intermediate Care Service once Ted was medically fit for discharge, releasing a much needed hospital bed;
- The provision of reablement services in Ted's own home;
- The housing provider's person centred review of Ted's support plan, post hospital;
- The neighbour for raising concerns about Ted's welfare with the housing provider who, in turn, liaised with the GP who called the emergency services;
- The Police response to the GP's call on the day Ted was found deceased.

5. How Future Practice could be improved.

5.1 As stated at the beginning of this report, the main purpose of a SAR is to seek to determine what the relevant agencies and individuals involved in the case might have done differently which could have prevented harm or death. This is so that lessons can be learned from the case and to ensure that those lessons are applied in practice to prevent similar harm occurring again. A key component of this process is the IMRs/agency reports submitted to the Review. It is disappointing to have to note that, in this Review, the quality of the various IMRs/reports from agencies was of variable quality, albeit the chronologies of events for the review period were of a high and extremely helpful standard. A particular omission in the IMRs and the agency reports was the failure by all agencies to submit “Recommendations for Action and [a] Single Agency Action Plan”.

5.2 Having said that, the process which was followed – four individual one-to-one interviews and the Challenge Event - did make it possible to identify several ways in which future practice, by relevant agencies, could be improved.

5.3 Therefore, the **Recommendations** to the relevant Gloucestershire Safeguarding Adults Board’s member agencies are as follows:

- The ambulance service, the hospital and the hospital social work team should, in future, raise a formal Safeguarding Concern in circumstances of significant self-neglect;
- Discharge letters from hospital to GP should include more comprehensive information, i.e. full clinical details and an outline of any key social issues. (It is acknowledged that this matter has already been identified for action by the hospital);
- Consideration should be given to the Reablement Service providing GP’s with a report when the service ends;
- Where an individual is in independent living accommodation (designated for older people) consideration should be given to notifying the housing provider of a discharge from hospital with the agreement of the individual concerned. Where agreement is withheld, this should be noted in the hospital record.
- The Choose and Book system whereby a non-response, after a reminder letter has been sent, leads to ‘the episode being closed’ should be reconsidered – as a minimum, the individual’s GP should be notified of a nil response so that a primary care follow up can be

considered (it is understood that the whole Choose and Book scheme is currently under review – that is to be welcomed);

- Where a patient is in receipt of repeat prescriptions, GP surgeries should consider how they can identify those who have not accessed the system for some time and consider a follow up;
- Before a reablement service is withdrawn, consideration should be given to any outstanding issues of relevance to the individual's future wellbeing (in this case catheter care). Liaison with relevant agencies should be undertaken and completed;
- The process for making referrals to the District Nursing Service should not rely on an answerphone (as stated earlier, this is currently under review);
- The housing provider should consider undertaking follow up contact more frequently than annually where there is no known next of kin and/or where issues such as self-neglect, tenancy management issues are or have been present;
- The Clinical Commissioning Group, with other health professionals as appropriate, to review/initiate care pathways for catheter care.

5.4 If these recommendations are accepted by the GSAB then it will be necessary for each relevant agency to draw up action plans saying what will be done, by whom, by when and how the outcome for each action will be measured/demonstrated. The GSAB will wish to keep these action plans under review and will only sign them off when the Board is satisfied that the required actions are complete and that the required learning has been achieved.

5.5 There are five other recommendations I would wish to make to the Board itself:

- Arising from the earlier recommendation relating to Safeguarding Concerns, the Board should explore/audit practice in each and all partner agencies to satisfy itself that practice is as it should be, fit for purpose, consistently effective and in line with the agreed inter-agency procedures;
- That if IMRs are to be utilised in future SARs, preparatory training be provided to IMR authors;

- That the Board considers how it can ensure that all partner agencies are aware of each other's responsibilities and practices and what the limitations to these may be;
- That the Board explores ways in which appropriate voluntary organisations can play a greater role in adult safeguarding;
- That, difficult though it may be to achieve, the Board should explore ways in which neighbours and local communities can be enabled/empowered to safeguard each other without this becoming a "snooper's charter".

If these recommendations are accepted, the Board will wish to draw up action plans for implementation and keep these under review until complete.

6. Closing Remarks.

It has become clear that Ted was a very private, fiercely independent man with no known/declared next of kin. I have to conclude that, in all the circumstances and at the time, his death was neither predictable nor preventable.

However, that does not negate the fact that there are lessons to be learned from these sad events and these lessons are reflected in the recommendations made.

I commend this report and the recommendations to the Gloucestershire Safeguarding Adults Board.

Robert Lake
October 2016.

Terms of Reference – Safeguarding Adults Review – ‘Ted’

General:

- 1.1 To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- 1.2 To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- 1.3 To inform and improve local inter-agency practice.
- 1.4 To improve practice by acting on learning (developing best practice).
- 1.5 To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

Specific:

- 1.6 To examine how the circumstances leading up to the death of ‘Ted’ who was found deceased on the 26th February 2016 were handled and

whether the policies and procedures in place across various agencies during that time were followed.

- 1.7 To consider whether all opportunities to ensure 'Ted' had received appropriate care and support within the overall delivery system were identified up to the time his body was discovered.
- 1.8 To review the effectiveness of the commissioning, monitoring and inspection of services being provided to 'Ted'.
- 1.9 To review whether appropriate and timely assessments of 'Ted's' mental capacity to make decisions about his care and treatment were considered.

Reason for the Review.

2. This review was commissioned by Gloucestershire Safeguarding Adults Board (GSAB). The subject, 'Ted', lived in supported housing and was found at his home in February 2016, having been deceased for some time. 'Ted' was seen walking out regularly in the local area until early January. A neighbour raised a concern in late February and the Police and Ambulance service forced entry to the property where the service user and his dog were found deceased.
- 2.1 The time period covered by the review is 27/08/2015 to 26/02/16. The Terms of Reference set out the particular issues agencies are asked to consider.