Havering Safeguarding Adults Board

GC: Safeguarding Adults Review (SAR)

Executive Summary

Lead Reviewer and Report Author:

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Executive Summary prepared by

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1. LEGAL CONTEXT

1.1. In March 2016, GC died in a house fire. At the subsequent Inquest Hearing the cause of death was 'smoke inhalation and carbon monoxide poisoning'.

1.2. Following GC's death, the Service Manager for Integrated Services completed a 'Safeguarding Adults Review Request Form' in November 2016. The criteria for the review included:

1.2.2 Customer was known to Adult Community Team South and had a care package of two visits daily, which was funded by LBH. Customer had an un-conventional lifestyle, living in a unkempt and hazardous environment. He was deemed as having capacity regarding the life choices he made. Concerns had been raised previously regarding his use of a fan heater instead of an oil filled radiator that he had available.

1.3 Dr Paul Kingston, Safeguarding Concerns Ltd., was commissioned as the independent author of the report.

2. BRIEF BACKGROUND

2.1 GC was born in London in the 1920s. His occupation had been service in the Merchant Navy and Docker. GC was married until the death of his wife, CC, in 2015.

2.2 GC was described by most people that worked with him as 'a pleasant very independent gentleman that chose to live an unconventional lifestyle all his life'.

2.3 He would not waste money and was noted to be frugal. For example GC would not have lights or a TV on and heating was only utilised as a necessity. GC's children started to offer support once his wife had died and they realised he was becoming fragile.

2.4 GC was a reasonably active individual. He did not sit around the house and was often found at the Docks; frequently taking his main meal at the 'pie and mash' café, alternatively he would be found at Tesco. GC did not shop or watch TV, although he did like sport, and was considered very unconventional. It is reported that his house was only somewhere he slept. When one of the Social Workers first met him in his room at home he was under several duvets and virtually hidden; he literally just popped his head out to say that he was ok.

2.5 The house he occupied with his wife, until she entered nursing care, did not have central heating or hot water, although it appears that different rooms in the house (the room his wife occupied) were furnished and modified with heating. GC slept in a separate downstairs room from his wife, which a visiting Social Worker described as 'full of boxes and bedding and it appeared that he was living and sleeping in a box'.

2.6 Alongside this atypical lifestyle, GC cared for his wife prior to her entry into nursing care due to being bedbound. At times, GC's level of hygiene presented difficulties in terms of his wife's care, particularly around meal preparation. As a result, he was encouraged not to support her and to allow carers and their daughter to provide the support required.

3. CHRONOLOGY

3.1. GC was first known to Adult Social Care in July 2007, when his family requested a care package on discharge from hospital.

3.2. In October 2013, Adult Social Care received a safeguarding alert in respect of financial abuse. At the same period the social worker investigating the safeguarding alert discussed the home conditions with the allocated Social Worker for his wife (who was receiving four calls a day for personal care and Activities of Daily Living) and the family. The family explained that the unkempt appearance of GC had endured throughout his lifetime, with a reluctance to wash and change clothes.

3.3. In January 2014, concerns were again raised with Adult Social Care in relation to the home circumstances and GC's unhygienic lifestyle. Anxieties were further compounded in relation to CC's safety, which was discussed with the GP, following reports that GC had left the gas on in the home. GC once again declined any assistance.

3.4. In December 2014, the GP visited GC and was concerned that he might be experiencing carbon monoxide poisoning, although this was proved negative by paramedics. Eventually GC was persuaded to attend hospital. This admission to hospital then allowed GC's family to clean the property in his absence.

3.5. This admission to hospital is recorded as required for a primary diagnosis of 'dehydration and self-neglect'. This is the first occasion self-neglect is formally recognised.

3.6. From 26th January 2015, a care package assessment took place. The re-ablement package was stopped in February 2015 at the request of GC's daughter in February 2015, although she later agreed to continue the package due to GC being alone in the house after CC had been admitted to hospital. Following discharge from hospital on 27th March 2015, CC was placed in a nursing home.

3.7. On 21st May 2015, GC was reported missing to the Police by the homecare agency. He was later found at Victoria Train Station and Police reports indicate that he did not know how he arrived there. He was admitted to Queens Hospital due to increased confusion and discharged on the 28 May 2015 with the same care package he received prior to hospital admission.

3.8. GC's wife died on 22nd June 2015.

3.9. In November 2015, the homecare agency reported to the Emergency Duty Team that GC, who was known to use candles at home, was also burning tissue in a cup (there is no explanation why, or a note of any enquiries into this being made by the homecare agency). Adult Social Care enquired whether GC's home had a smoke alarm fitted, and whether this was functional. The homecare agency were not able to provide information related to a fire alarm at that time and were asked by Adult Social Care to check at the next visit. The homecare agency records indicate that GC was asked for permission to install but that he refused to allow fitting.

3.10. In January 2016, the homecare agency raised further fire risk concerns with Adult Social Care. The homecare agency reported that, in extreme cold weather, GC was using an electric fan heater, which was noted to be a fire hazard, even though he had an oil-filled radiator available for use, which was noted to be safer but considered by him to be more expensive than using electricity. The homecare agency also reported

that GC had been placing the electric fan heater exceptionally close to his quilt, upon which scorch marks had been noticed. The homecare agency described having proactively moved the electric fire away from his bedding materials, but that GC appeared to move it back again.

3.11. On 11th March 2016, GC died in the house fire.

4. CONCLUSION

4.1 This conclusion with analysis utilises the six safeguarding adults principles set out in Care and Support Statutory Guidance (2016).

4.2 **Empowerment: people being supported and encouraged to make their own decisions and informed consent.**

4.2.1 There is unequivocal evidence that all agencies were sensitive to GC's choice of an unconventional lifestyle. This was predominately based on the presumption that GC had 'mental capacity'. However, it is not clear from documentation if at any stage a test of GC's mental capacity was undertaken.

4.2.2 There is evidence that perhaps the balance between GC's autonomy and the risks he posed to himself and his wife whilst they shared accommodation was skewed towards GC's independence, allowing the risks posed to remain unchallenged.

4.2.3 For professionals seeking an adequate balance between respecting an individual's autonomy (even if decisions made appear unwise), and managing risks to that individual and others is significantly challenging and stressful.

4.2.4 There is evidence that Adult Social Care did not appear to understand GC's lifestyle choices. There is also recognition that further exploration of GC's life-biography may have highlighted previous experiences or traumas that may assist to explain GC's current lifestyle choice.

4.2.5 The Care Act Guidance also notes that, when working with situations of self-neglect, whilst a formal safeguarding enquiry may not be actioned, it may still be necessary to intervene in order to protect the individual at risk.

4.2.6 There were consistent misunderstandings related to self-neglect and mental capacity. Agencies were aware that GC was self-neglecting, however they also assumed that GC had mental capacity, and consequently (and erroneously) decided that an intervention was not possible. Such an inflexible approach to managing clients who are self-neglecting (with alleged capacity), runs counter to the Care Act Guidance that suggests individuals who are no longer able to protect themselves are still owed a duty of care.

4.3 **Prevention: it is better to take action before harm occurs.**

4.3.1 Notwithstanding the challenges outlined above in relation to autonomy versus risk and prevention it is noted that Social Workers, and perhaps other professionals, may have focused on GC's wishes to the detriment of focusing on the significant risks his lifestyle imposed on himself (hygiene, food

preparation, health neglect, leg and foot ulcers and infection), and his wife whilst bed bound and cared for a home (fire risk, food preparation).

4.3.2 Reducing the risk of fire was an urgent priority. However, despite numerous reported concerns from a variety of agencies, the risk remained.

4.3.3 At no point was a referral made to the London Fire Brigade for their assistance and advice.

4.4 **Proportionality: the least intrusive response appropriate to the risk presented.**

4.4.1 The section on Empowerment has already argued that insufficient effort was applied to challenge and discuss with GC the risks he was posing to himself and others.

4.4.2 It appears that all professionals working with GC assumed capacity and therefore accepted that he had the right to choose this abnormal lifestyle, which was perhaps essential in early contact to facilitate a therapeutic relationship which was non- judgemental.

4.4.3 However, taking a non-judgemental position does not negate the instigation of a therapeutic conversation that attempts to both understand and challenge the lifestyle chosen by GC.

4.5 **Protection: support and representation for those in greatest need.**

4.5.1 Considerable effort was exerted by all agencies to offer a therapeutic and person-centred care package, focused on GC's health care needs.

4.5.2 However, little attention to action was employed towards the risks posed to GC and his wife, especially fire risk.

4.5.3 It appears that each agency reported concerns, and the homecare agency moved the electric fire away from bedding regularly.

4.5.4 However, no agency or multiagency collaboration conducted a fire risk assessment or established an action plan to prevent the risk of fire.

4.5.5 Most importantly, the London Fire Brigade expertise was not exploited.

4.6 **Partnership: local solutions through services working with people, families and communities.**

4.6.1 Partnership working appeared totally absent.

4.7 **Accountability: accountability and transparency in practice.**

4.7.1 Each agency appeared to offer a person centred approach to GC.

4.7.2 However, it appears this approach was based on personal care needs health care needs, and therefore risks did not appear to be of sufficient concern to warrant an assessment and intervention strategy.

4.7.3 There are also differing views from agencies concerning the complexity or otherwise of GC's situation. Adult Social Care did not consider GC's situation as complex and did not see the need to escalate to a senior level in the management structure.

4.7.4 Conversely NELFT staff considered it necessary to place GC on a 'High Risk Register' to report to the NELFT Havering leadership team.

4.7.5 However, no multiagency meeting was arranged and, whilst agencies occasionally communicated, it is suggested there was not a multiagency strategy to address GC's risks, as well as his needs.

4.7.6 Therefore each agency appears accountable for their own practice, and no agency accountable for a multiagency strategy.

5. RECOMMENDATIONS

5.1 The SAB should ensure that the self-neglect policy has an automatic care pathway referral route to the London Fire Brigade.

5.2 The SAB should regularly audit the interagency co-operation and care plans for individuals recognised as self- neglecting.

5.3 The SAB should ensure that processes to recognise 'complex and high risk' cases have a common escalation process *utilised* by all local agencies.

5.4 The SAB should ensure that there is a common escalation process for 'complex and high risk' cases *across* agencies.

5.5 The new risk assessment form should be evaluated for its utility and consistent application.

5.6 The recommendation of a specific policy for 'risk assessment' should be evaluated.

5.7 The SAB should consider if further training is required related to self-neglect and mental capacity.

5.8 All agencies should reinforce the necessity for timely and accurate recording of interactions with clients.

5.9 The SAB might consider a working group to reflect on the range of legal approaches to self-neglect.

5.10 ASC and NELFT will identify the scale of self-neglect cases and then consider if a multi- agency team should be established to address this issue.