Camden Safeguarding Adults Partnership Board

"Safeguarding is everybody's business"

A Safeguarding Adults Review: Significant Event Analysis Report in respect of the case of Ms UU

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Significant Event Analysis Report for the case of the late Ms UU

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Contents

This report was written by Sarah Murphy who is currently a Joint Senior Strategic Safeguarding Adult Lead in Tower Hamlets Local Authority and the Clinical Commissioning Group. She has over twenty years' experience of working in social care and has been a qualified social worker for nineteen. Sarah previously worked for Camden Adult Social Care but did not have any direct involvement in this case.

Acknowledgements

Thank you to all those who took part in this Significant Event Analysis and for contributing openly to identify learning and future actions.

1. Executive Summary

This Safeguarding Adult Review was commissioned by the Camden Safeguarding Adults Partnership Board (CSAPB) in 2018. The review examines the events leading up to the death of UU, a 92 year old white, Jewish woman and resident of the London Borough of Camden.

UU lived alone and was socially isolated following the death of her parents some years earlier. She suffered from mental and physical health problems, and was first referred to statutory services in 2012 following a period of admission for a mental health episode. She had limited engagement with statutory services up until the point of her death in 2018.

UU came into contact with the London Ambulance Service, Mental Health services and the Adult Social Care team, due to concerns relating to her mental health difficulties, her living environment, her physical health condition and her social isolation. There were significant issues relating to her hoarding of belongings, poor home environment, self-neglect and a lack of meaningful engagement with services.

Despite a number of contacts throughout this period, no single agency or practitioner identified the underlying issues for UU, and this led to a lack of significant engagement or proactive action to manage the risks associated with UU's pattern of behaviour and need. Tragically, in February 2018, after a short period of no contact with any statutory services, UU was discovered in her own home, following a forced entry by the police. She was found unconscious in a severely neglected state and sadly died in hospital the following day.

A significant event analysis methodology was adopted to provide learning to all agencies. This methodology involved a learning event, which brought practitioners and agencies from across the partnership together to reflect on the events and issues and consider how a similar series of events might be avoided in the future. The recommendations in this report stem from the learning generated from the discussions.

There appeared to have been a number of missed opportunities to develop a broader understanding of the extent of UU's needs, and a clearer understanding of the various perspectives of the professionals who were trying to support her. Her case had been brought to the multi-agency High Risk Panel in October 2017, and the efforts to engage UU were discussed. Although the ASC and Mental Health service records suggest that the threshold to pursue a section 42 safeguarding enquiry of UU's needs had been reached, this was not an option considered by the panel. Additionally, an assessment of UU under the Mental Capacity Act 2005 was another approach that could have been explored by all agencies working with her.

It is important to note there were clear examples of agencies working positively to try and engage UU. However, the lack of a coherent response to UU's situation from a multi-agency perspective, inclusive of consideration of statutory powers, prevented agencies from implementing an effective response to her situation. This may have opened up options that agencies could have explored in a partnership approach to reduce some of the risks to UU.

Based on these findings, the following recommendations are made:

1. When a case is referred to the High Risk Panel the following key questions should be explicitly considered:
   - What are the identified risks in the case and how are they being managed?
   - What statutory obligations have been triggered?
   - Has the Mental Capacity Act 2005 been considered?
   - What safeguarding action has taken place on the case inclusive of the duty to enquire?

2. CSAPB to consider a multi-agency audit plan for monitoring practice and partnership working for cases involving people who self-neglect.

3. CSAPB to consider how agencies obtain multi-agency training for staff on the assessment of risk, mental capacity assessments and safeguarding adult procedures.

4. All agencies to have systems in place to provide feedback to referrals with a detailed account of where they have been able to offer support and where they have not been able to do so.

5. All agencies to consider whether cases as complex as UU's should be referred to the High Risk Panel for consideration prior to closure.

The author would like to thank all participants in the learning event, and recognise the level of reflection and openness throughout their contributions. There are valuable lessons to be learned from the tragic circumstances of UU's death, with a view to further improving the way agencies work together with the most vulnerable people across the borough.

2. Introduction

2.1 [1]UU was a 92 year old white, Jewish woman who died on 7 February 2018 after being found in a state of neglect which led to concerns about the way that local professionals and agencies work together to safeguard adults at risk in Camden.

3. The circumstances that led to a SAR being undertaken in this case

3.1 Following UU's death the CSAPB called for a review of the circumstances leading up to her death with a view to identifying any learning moving forward.

3.2 In accordance with the Care and Support Statutory Guidance 2018, the CASPB selected a relevant and proportionate methodology for the scale and complexity of the Safeguarding Adult Review (SAR) as outlined in the terms of reference and methodology section of this report. This SAR has been undertaken in line with the Care Act 2014, the London Multi-Agency Safeguarding Adults Policy and Procedures and CSAPB's SAR framework.

3.3 This SAR is not intended to reinvestigate the case or apportion blame, but rather to bring practitioners together for a learning event. The focus of the event was to identify any lessons to be learnt and make recommendations to improve practice, procedures, systems and ultimately improve the safeguarding of adults in the future.

3.4 The purpose of the SAR is to:

- Establish whether there are lessons to be learnt, including good practice
- Identify what those lessons are, how and when they will be acted on, and what is expected to change as the result
- Foster a culture of openness and reflective learning, not individual blame or self-criticism
- Promote continuous learning and an improvement culture
- Enable relationship building between services and the exchange of information

4. UU: the person

4.1 UU was a 92 year old white, Jewish woman from Berlin and of Jewish parents. She moved to London in 1938 with her parents who decided it was best to leave Germany due to the increasing persecution of Jewish people from the Nazi regime. UU's father had children from a previous relationship resulting in her having half brothers and sisters.

4.2 Aged 14, UU moved to a boarding school in Swanage but this arrangement came to an abrupt end when her father, aged 85, was killed by the war time bombings of London. After the war, UU learnt that her half brothers and sisters were killed as victims of the holocaust.

[1] UU is used throughout this report in respect of the female subject of the SEA. This is in order to preserve anonymity.

4.3 UU was single and did not have any children. She lived with her mother in Camden. In the 1960s they moved to the address where she went on to spend the rest of her days. UU was her mother's main carer as she had scoliosis, a condition where the spine twists and curves to the side[2], and needed her support.

4.4 UU worked in mainly clerical and administrative employment. Her longest period of employment lasted for 27 years in a bank where she worked mainly in accounts. Later in her life she worked in a hotel. UU identified as an historian who had a keen interest in gathering journal articles for other historians. She advised professionals that she had always collected items and some of the items she had collected over the years were what she called expensive carrier bags, boxes and newspapers clippings. UU enjoyed reading newspapers and cutting out articles about recycling and sustainable energy programmes. She advised that she also liked sending articles to friends by mail.

4.5 There was no family involvement in this SAR because Camden agencies are not aware of any living relatives. The CSAPB manager did contact UU's neighbour and an attempt was also made to contact the manager who supported her in a local café to advise them of action being taken via the SAR. It was agreed that feedback would be provided to the neighbour but attempts to make contact with the café manager were unsuccessful.

4.6 One of UU's neighbours described her as "delightful" but very difficult to help. He described her as intensely private and believed that none of her neighbours could claim to have known her well. He believed UU had a hoarding disorder. Whilst respecting the wishes for privacy on the part of UU, her behaviour raised questions for him regarding when it is appropriate to intervene and when that behaviour poses a risk to others, in this case, a substantial fire risk.

5. Terms of reference and methodology

5.1 The SAR commissioned by CSABP was a Significant Event Analysis (SEA) – a practitioner event agreed via the SAR subgroup decision making process. Following agreement to apply this methodology, the practitioner event on 13 May 2019 was independently chaired by this author. All key stakeholders involved in UU's life were invited to participate.

5.2 Prior to the event the Chair met with representatives from the SAR subgroup to agree the terms of reference. It was agreed that chronologies would be requested from all key agency partners in order to acquire a greater understanding of UU as a person. A copy of an assessment completed by Adult Social Care and mental health services were included as additional documents.

5.3 The practitioner event was well attended by all agencies who had provided information regarding their involvement in UU's life via the chronology. The chronologies and assessments enabled the author to obtain a greater sense of who UU was, develop an understanding of her networks and some of her expressed outcomes.

[2] https://www.nhs.uk/conditions/scoliosis/

5.4 Additional information regarding UU was obtained during the three hour event itself with attendees contributing to further discussion about their agency's involvement in her life.

5.5 The purpose of this approach was to include the views of a wide range of people and agencies who had been involved in supporting UU. This method also allowed for an analysis of the circumstances leading up to her death. The anticipated advantages of employing this methodology are that it is group led and provides an opportunity to identify good practice and areas where care or systems could be improved. This report will summarise the key findings.

5.6 The SEA practitioner event focused attention on exploring:

What was it like to work with UU?

- How did it feel?
- What worked well?
- What did not work well?

How do services work with concerned members of the public?

- Involvement of neighbour / community resources
- Referrer – friends or foes / help or hindrance?
- Scope and limitations

How was legislation, policy and guidance applied on this case?

- What guidance and legislation was used on this case?
- How did it assist the decision making?
- What would have assisted?

5.7 Contributors to the SEA event were:

- London Borough of Camden – Adult Social Care (ASC)
- University College London Hospital
- Camden SAPB Business Manager
- Metropolitan Police Service
- Camden and Islington Foundation Trust
- London Fire Brigade (Camden)
- London Ambulance Service
- Camden Clinical Commissioning Group
- London Borough of Camden – Environmental Health

5.8 This methodology was limited by the fact that the author of the report had access only to information from chronologies, the SAR referral and assessment reports, together with information shared by the SAR group and during the practitioner event itself.

6. Summary of UU's involvement with services

6.1 UU was known to Adult Social Care (ASC) and Mental Health Services in Camden. She first came to the attention of Mental Health Services in 2012 when she was admitted to hospital under Section 2 of Mental Health Act 1983[3] which allows detention for assessment. She was discharged from Mental Health Services in December 2012. UU was described at that time as a hoarder, she was confused and said that neighbours were taking things from her flat and had put spy cameras in her home to spy on her.

6.2 During this admission UU advised staff that had been sleeping on the street voluntarily. UU strongly objected to her detention in hospital and questioned the legality of it on several occasions. She considered her lifestyle to be judged and mocked by others. UU was of the view that she was wrongly detained describing her sleeping out at night as a choice she had made and found exciting. She advised that all her faculties were intact and she had the capacity to make decisions regarding sleeping on the street. UU told professionals that if she had known she would be sectioned she would not have slept rough.

6.3 At the time of the detainment UU was agreeable to working with ASC, for instance she was willing to be accompanied to her flat and make steps to clear some of her belongings. However, when her section was rescinded she objected to having ASC involvement and did not consent to follow up after care.

6.4 UU was known to Camden FOCUS Team, who offer outreach support services to homeless people, from December 2012 to February 2013 due to her being found sleeping on the street when she was admitted to hospital. Although discharged from hospital on 06/12/12 with no known mental disorder, Camden FOCUS Team continued to work with her until February 2013.

6.5 In 2015 ASC received a referral from UU's landlord and neighbour who had concerns about her property appearing very dirty and cluttered and were also concerned about her having possible mental health issues. ASC completed an assessment and then referred UU's case to Camden Services for Ageing Mental Health (SAMH) in April 2015. The ASC assessment described UU as articulate, intelligent, mild mannered and very polite, noting that even when it appeared that she was uncomfortable with the way the social worker asked questions, she always gave respectful answers. The social work assessment noted what they believed UU to have an "irrational attachment" to things in her flat including the apparent rubbish the social worker pointed out at her feet. UU explained that it was all important to her.

6.6 The ASC assessment further highlighted that UU's property appeared very dirty, untidy and seemed as though she was hoarding. UU admitted to feeling embarrassed and did not allow anyone access due to the state of her home. She advised that she was working through the issue by clearing items from her home. From the records and the practitioner discussion it was felt that UU understood the purpose of the social worker's visit being a result of contact from her landlord who

[3] http://www.legislation.gov.uk/ukpga/1983/20/section/2

was concerned that the state of the flat posed a risk to her and others in the block. Despite this she declined offers of help to make the flat a more "liveable and acceptable state" advising that she could manage. At that time the landlord advised ASC that other residents might initiate legal action if the issues within the flat were not addressed. He also advised that he wanted to avoid forcing UU in any way.

6.7 UU was not registered with a GP at the time of the ASC assessment and told the social worker that she saw no point in doing so. UU suffered from neck scoliosis and sometimes had difficulty making eye contact. She advised that she did not believe that she needed to register with a GP, was too busy to do so and liked being her own doctor. She advised that in the event of her becoming unwell she always went to the pharmacy in the first instance for advice.

6.8 Following completion of their assessment, a team manager from ASC referred UU to SAMH in April 2015. She was visited on 13/05/15 and the assessment took place in the hallway as it was noted that the flat was so heavily filled with belongings, there was no floor space to walk on in any of the rooms and no surfaces available. The bathroom was reported to be fully covered with articles and UU was unable to use the toilet or wash at home. The SAMH chronology notes state that there appeared to be very little change in the physical environment but what did appear to be new was UU's belief that a neighbour upstairs had placed a camera in her ceiling. UU reported that the neighbour wanted her out of her flat so her sister could move in. It is noted that although there appeared to be some new onset of symptoms, at that point the only risk posed was to herself, due to the deterioration in her mental state. They assessed that there had been no change in UU's behaviour or lifestyle and the assessor could not detect any indication of cognitive impairment. It was agreed by the visiting psychiatrist and nurse that they would continue to monitor and review UU over a period of time in order to ensure there was no deterioration in mental state and to have an opportunity to examine the flat and any risks it may pose. The assessment report notes that UU had a diagnosis of Delusional Disorder. The assessing psychiatrist further noted that UU did not want to take medications, did not want to engage with SAMH or the Home Treatment Team and certainly did not want to be admitted to hospital. On 18/05/15 a nursing entry advised that there was no fire risk in the flat. The plan was for nursing to try and engage with UU and the focus of the intervention was to be on engaging and registering with a GP or community mental health team to complete physical health checks.

6.9 On 28/05/15 the SAMH received an email from the London Fire Service via the Multi Agency Safeguarding Hub identifying UU's properties as one of a number identified at that time with hoarding issues. The query from the London Fire Service was whether or not UU's property was on their radar. UU's property scored level 9 on the clutter index[4] which is the highest hoarding rating on the scale. It was reported that "the flat was piled high with stuff and the only access is to crawl at ceiling level through the rooms". The request from the fire service was for mental health colleagues to look into this address and provide feedback on the result of their

[4] https://www.bing.com/search?q=clutter+index+scale+london+fire+brigade&qs=n&form=QBRE&sp=-1&pq=clutter+index+scale+l&sc=0-21&sk=&cvid=6D30F84D009743E8B648B7811A9FEB47

enquiries. The author could find no evidence of feedback being given within the chronology.

6.10 Over a month later, on 02/07/15, a mental health nurse attempted to visit UU again but got no reply so planned another visit. On 24/07/15 a joint home visit by two members of SAMH was planned but again they got no response from UU's property. On this occasion, they tried a local café where they observed a woman who matched UU's description. They waited outside for her and approached her on her exit shortly after. UU agreed to re-enter the café with them and was reported to be pleasant, warm and engaging. UU spoke of her neighbour taking things and advised that she did not want to report her to the Police, as she felt sorry for her. She advised at that time that she would prefer to be contacted by letter as she did not have a phone and did not like using phone boxes. SAMH staff agreed to meet UU monthly. A letter was sent to UU arranging a meeting on 21/08/15 at the café. UU did not attend and there was no answer from her flat. Staff confirmed with the café that they had seen her the day before. Another letter was sent offering UU an appointment in the café on 03/09/15. It would appear that SAMH sent a letter to UU on 02/10/15 apologising for missing the appointment on 03/09/15 and suggested a further meeting on 14/10/15. UU replied asking for the visit to be rearranged on another date.

6.11 UU met with SAMH staff as arranged on 14/10/15. On this occasion UU advised mental health staff that she was struggling to remove items from her flat as the paperwork reminded her of friends and family who had died. UU again confirmed that she did not want to see a GP and refused the idea of seeing an optician. She advised that she buys the strongest reading glasses and they work. She said she felt well and looked after herself advising that she had always been between 8 and 9 stone all her life. UU stated that she bought food at reduced cost in the supermarket and as a result experimented with new food stuffs which she sometimes liked and other times did not. UU advised that she liked avocados a lot and ate them often.

6.12 SAMH wrote to UU on 20/11/15 offering her another appointment on 25/11/15. Despite the short notice period UU managed to reply in writing asking if she could rearrange the appointment until after Christmas. She explained that there was due to be another conference on the Global Climate in a few weeks and she wanted to gather as much information as she could. The tone of the letter was very friendly. SAMH sent UU a letter offering her an appointment on 14/01/16. UU did not attend and the café reported that she had not been using the cafe but had been putting her head in the door looking inside the fridge and then leaving. SAMH staff visited UU's flat but got no response. UU's case was discussed on 26/01/16 in a Community Mental Health Team meeting and it was suggested that UU's landlord be contacted to gain access to UU's flat. A letter had been received from UU asking why she was being "targeted" and also queried why the "continued hounding" of her.

6.13 On 02/02/16 a retrospective entry was made by SAMH regarding a telephone call from the landlord and a discussion held regarding how best to engage UU and help her with her flat. The landlord advised that he had no right of access to the flat and although he wanted to help, he also wanted to preserve his own relationship with UU. A neighbour had also been in contact to say he would offer support if necessary.

Further discussions with the landlord on 03/02/16 revealed that he did not want to arrange a joint visit, as was done with a psychiatrist in the past, as he was concerned about his relationship with UU. It is documented that an email was sent to a neighbour to see if he was free on 11/02/16 but it is not clear what the response was.

6.14 SAMH wrote to UU thanking her for her letter and arranging a home visit on 11/02/16 with her neighbour. When the home visit took place UU was not there but was spotted close by. Upon sighting SAMH staff UU appeared to cover her face with her hands and tried to move away down another street. Staff greeted UU "cheerfully" and she spoke to them for approximately 20 minutes whilst holding on to a newsagent's magazine stand for support. UU was reported to be animated and initially a little hostile and defensive. She explained that she had hand delivered a letter to the SAMH office that morning cancelling the visit. SAMH staff repeatedly asked if they could see her flat and she refused advising that she would want to tidy up before she showed anyone in. By the end of the conversation UU was described as warm and smiling and even told staff that their meeting had been the "high point" of her day. UU again agreed to meet with mental health staff monthly. Two months later a letter was sent to UU making an appointment on 06/05/16 which made it closer to three months since she had been last seen.

6.15 UU did not attend on the 06/05/16 and SAMH staff asked the café if she had been seen. Staff in the café advised that she had not been seen that day and were not clear about when they had last seen her. Staff tried her home address and walked around the local area but there was no sign of UU. The case was discussed in the SAMH's team meeting on 23/05/16 and a decision was reached for the case to be closed. A letter was written to UU and the landlord was also informed of the closure with the duty telephone number being provided. The summary of the case advised that following discussion with the team it was decided to close UU's case. Although there was clear evidence of psychotic thoughts, she looked after herself, was eating and drinking regularly and was well known locally. She was believed to be resistant to changing her life and was happy with her occupation of cutting out and collecting various articles. The next time contact was made with SAMH regarding UU's case is to confirm that she had died and to request information from them as the case was being considered for a SAR.

6.16 UU was referred back to ASC in May 2017 due to concerns shared by London Ambulance Service regarding self-neglect and homelessness. It was reported that UU had slept outside overnight as she was unable to find her keys. The chronology advised that she was freezing cold and unable to walk. LAS raised a safeguarding concern and a hoarding referral was made in accordance to the Trust's policies and procedures. The case was allocated to an Access and Support Officer who made contact with UU's concerned neighbour in June 2017 and completed a home visit to her in July 2017. UU advised ASC that she did not want support. An occupational therapist visited and offered support and advice regarding aids that could be provided and additionally offered to refer UU to physiotherapy but she declined advising that she could manage. ASC made contact with a local café which UU went to frequently and asked them to contact if they had concerns. The café confirmed

that UU visited daily and either bought food or they gave her food. ASC provided their contact details should the café want to make any contact regarding concerns about UU.

6.17 It was agreed by ASC in supervision in August 2017 that the case would be referred to the High Risk Panel which is a multi-agency panel that considers some of the most high risk cases in the borough. The referral was completed in September 2017 and presented in Oct 2017. The panel advised that UU's landlord should be contacted for permission to install a handrail in the communal area outside her home as she was holding on to a drain pipe for support.

6.18 In November 2017 UU fell in a local café she frequented and declined ambulance attendance advising that she did not want to go to hospital. The café manager contacted ASC to advise them of the incident and ASC asked him to monitor if UU came in the following day. Café confirmed that she did arrive the following day. Further concerns were raised by UU's neighbour in December 2017raising his concerns of high risks of fire to all residents in the block. These concerns were escalated to the High Risk Panel who advised that ASC try to facilitate a fire safety home visit with the London Fire Service to ensure that there is a working fire alarm and complete a referral to the integrated health multi-disciplinary team. The handrail which was discussed at the High Risk Panel in October 2017 was installed on 4/12/17and it was believed by ASC to be a proportionate intervention in view of the risks.

6.19 A plan for a joint visit between ASC and Environmental Health was proposed for after Christmas 2017 and a supervision entry on 09/01/18 confirmed this plan. When contacted by the concerned neighbour, the access and response officer shared the advice provided by environmental health, which confirmed that "unless the property is filthy and verminous or there is evidence of a rodent infestation we have no legal powers to remove items that are 'hoarded' alone. The property has to be filthy and verminous within the scope of the Public Health Act 1936[5] or there is an active harbourage of rodents under the Prevention of Damage by Pest Act."[6] The recommendation was to pursue support from the integrated health multi-disciplinary team.

6.20 The London Fire Service attempted to visit on three occasions between May 2017 and January 2018 but was unsuccessful in gaining access. However, when they visited on 04/01/18 the Fire Service observed the hoarded items stacked up approximately two feet high with the assistance of UU's neighbour. The Fire Service advised that they would generate a report for a serious outstanding risk.

6.21 On 6 February 2018 the Police were called to UU's address by a concerned neighbour who had not seen UU for at least a week and could get no response from her flat which was in darkness. On arrival, the officers forced entry. UU's property was in darkness and very cold. The flat consisted of four rooms, each of which was full of old newspapers and other random items up to knee height. There was a

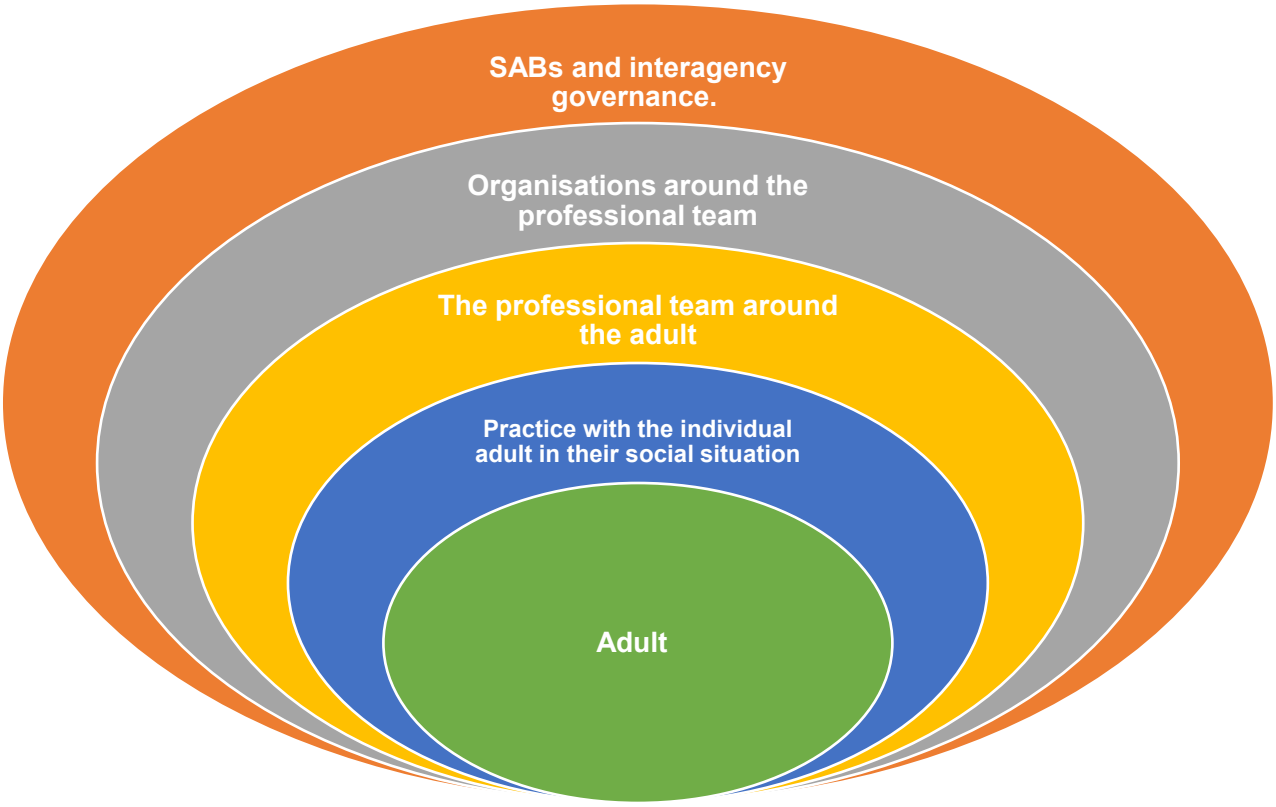
[5] http://www.legislation.gov.uk/ukpga/Geo5and1Edw8/26/49
[6] http://www.legislation.gov.uk/ukpga/Geo6/12-13-14/55/contents

general smell of decay and a lot of flies. It appeared as though UU had been attempting to defecate in a plastic bag. There was no access to the bathroom and no ability to cook or prepare food. UU was found severely emaciated and suffering from gangrene in both legs. She was admitted to Resuscitation with low Glasgow Coma Scale, hypothermia and cold sepsis. On 7 February 2018, she passed away in hospital.

7. Analysis of key events and conclusions

7.1 The purpose of this analysis is to identify the key learning from the circumstances surrounding the death of UU and to offer recommendations for the CSAPB. The information gathered from the practitioner learning event forms the basis of the analysis and findings in this report. The aim is to attempt to prevent similar events occurring in the future.

7.2 This report is supported by the influential research by Preston-Shoot (2019)[7] which draws on lessons learned from SARs featuring self-neglect. It highlights the fact that findings and recommendations from SARs involving self-neglect enable the construction of a good practice model against which policy and practice in specific cases can be compared. The model offered focuses on the following four domains which will be used as a framework for the findings and recommendations of this review consisting of:



[7] Preston-Shoot, M. (2019). Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice. *Journal of Adult Protection 21(4), 219-234.*

Building a relationship with UU

7.3 A person centred approach with a person like UU should foster a proactive rather than a reactive engagement. Good practice should involve a detailed exploration of her wishes, feelings, views, experiences, needs and desired outcomes as central to building a relationship with her. There are several references in the information provided about UU being a warm and friendly person, who clearly enjoyed some of her interactions with staff involved in her case. She showed potential to share some past life experiences inclusive of her time living in Germany and there was evidence of staff engaging with her on this aspect of her life. Preston-Shoot's research underlines the importance and challenges of skilled practice and interaction with individuals who are self-neglecting and emphasises the need for work to include skilled interviewing and authoritative but respectful challenge rooted in concerned curiosity.

7.4 It appeared that there were some clear parallels between UU's case and the ZZ SAR (2015)[8] in terms of the absence of open and honest discussions from professionals regarding how concerned they were and how difficult her situation could become. The London Ambulance Service fedback at the learning event was that they found the state of UU's property to be one of the worst they had seen.

7.5 A combination of concerned and authoritative curiosity is helpful in cases such as UU's when accompanied by gentle persuasion, skilled questioning, conveyed empathy and relationship-building skills[9]. When faced with service refusal from UU, there should have been a full exploration of this choice, with detailed consideration of what might lie behind her difficulty engaging in discussion regarding her flat and looking after herself. London Borough of Camden's Self-Neglect (including hoarding guidance) Guidance document 2017 highlights the fact that loss and trauma often lie behind someone's refusal to engage on these issues. It was known that UU had to flee Germany due to the increasing persecution of Jews by the Nazi regime, she had lost all of her siblings in the Holocaust and her parents during her life in London. Although there are a number of examples of staff meeting UU in her community which appeared to assist with her engagement, it does not appear that UU had an opportunity to explore loss in her life and there is no mention of any consideration of psychological support for UU and / or, those supporting her. Staff at the practitioner learning event reflected that they thought some engagement with the Jewish community could have helped understand UU on a deeper level.

7.6 Agencies shared at the learning event that they felt frustrated and upset that they could not arrange the help UU needed and although she was an articulate woman,

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[8] https://qa01.nonlive.camden.pfiks.com/documents/20142/0/Serious+case+review+ZZ+%281%29.pdf/5071e288-1135-d1cc-4514-d29c06eebe76

[9] Preston-Shoot, M. (2019). Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice. *Journal of Adult Protection 21(4), 219-234.*

she did not seem to understand the support she needed. Some shared their frustration about the difficulty they encountered contacting UU who did not have a phone and often did not answer the door. Despite these feelings of frustrations, agencies clearly showed evidence of adopting a flexible approach to working together with UU, for example, meeting in a café and establishing links with her community via their contact with staff in the café, her neighbour and landlord who helped monitor her welfare. The author considers these approaches to be good practice. Some agencies advised during the learning event that they were pleased to have an opportunity to discuss UU's case and reflect on the key issues with partner agencies.

Maintaining a link with UU

7.7 Preston-Shoot highlights the importance of contacts being about maintaining a clear link to the person so that trust can be built up over time. UU's case was closed by SAMH on 23/05/16 despite them agreeing with her on 11/02/16 to meet monthly following what appeared to be a particularly positive interaction inclusive of UU describing their meeting as the "high point" of her day. This would suggest that SAMH staff may well have been beginning to establish a rapport with UU.

7.8 Following contact with UU on 11/02/16, a letter was sent to her two months later offering her an appointment on 06/05/16 which was three months since their last contact. UU did not attend and checks with the local café confirmed that they had not seen her and could not be sure when they had last which was unusual. There is no reference to consideration of a welfare check and when UU's case is discussed at the SAMH meeting on 23/05/16 a decision is reached to close the case. The SAMH chronology confirmed that although there was clear evidence of psychotic thoughts, it was believed that UU looked after herself, was eating and drinking regularly and was well known locally. It is unclear to as to how this decision was reached in view of not having seen UU for approximately three months and the local café being unable to give an update on her well-being which was unusual. Although UU and her landlord were written to about the closure and contact details provided, ASC, the referrer of the case, were not informed of this decision. There is no record of which agency would continue to work with UU. The question remains as to whether cases as complex as UU's should be referred to the High Risk Panel for consideration prior to closure.

Use of the Mental Capacity Act 2005 in UU's case

7.9 A mental capacity assessment of UU in relation to accepting support from ASC was not carried out despite practitioners concerns about her abilities to use and weigh information about the risks of hoarding and the risks of not seeing a GP to manage her health. Such an assessment could have been helpful for agencies in terms of trying to gain a greater understanding of the vulnerabilities UU experienced. This could have provided further insight into her personal history inclusive of issues of loss and trauma in her life. The use of the Mental Capacity Act 2005 assessment did not seem to have been considered by any of the agencies involved. Perhaps this was because it was felt by agencies that UU had a right to make unwise decision as

enshrined in the legislation. However, the author could find no record of a multi-agency discussion about whether a capacity assessment was warranted. The absence or inappropriate application of a mental capacity assessment is a consistent theme in the findings from research into SARs[10][11]. Mental capacity in UU's case appears to have been assumed without professional curiosity into her decisions and without exploration of the concerns held by agencies regarding her decisions not to accept support.

7.10 Working with a person who displays hoarding behaviour is likely to raise questions as to whether the person lacks mental capacity to make particular decisions. This may particularly be the case when someone such as UU is reluctant or refusing to accept help for their hoarding, and practitioners may question whether the person has the capacity to refuse.

7.11 The first three principles of the Mental Capacity Act 2005[12], set out in section 1 of the act, support people's right to make decisions where they have the capacity to do so: The third principle states – a person is not to be treated as unable to make a decision merely because he makes an unwise decision - is perhaps particularly relevant to working with a person who hoards. Section 2(3) of the act also makes clear that a person's lack of capacity cannot be established simply by "an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity".

7.12 However, the Mental Capacity Act Code of Practice[13] states that one of the reasons why people may question a person's capacity to make a specific decision is "the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision" (4.35, MCA code of practice, p52). Arguably, extreme hoarding behaviour meets this standard and an assessment of capacity should take place.

7.13 Under section 2 of the MCA, a person lacks capacity to make a decision if they are unable to make the decision at the material time because of an impairment or disturbance in the functioning of the mind or brain. As set out above, this is likely to apply to someone like UU who hoards because it is often a symptom of a mental health condition or can be seen as a disorder in its own right[14].

7.14 Under section 3, a person is unable to make a decision if they are unable to:

- Understand the information relevant to the decision.
- Retain that information.
- Use or weigh that information as part of the process of making the decision.

[10] Preston-Shoot, M. (2018). Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change. *The Journal of Adult Protection*, *20*(2), 78-92.
[11] Manthorpe, J., & Martineau, S. (2009). Serious case reviews in adult safeguarding. *London, Social Care Workforce Research Unit, King's College London*.
[12] http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf
[13] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
[14] https://www.nhs.uk/conditions/hoarding-disorder/

- Communicate their decision, whether by talking, using sign language or other means.

7.15 The failure to conduct any capacity assessment was a significant omission in UU's case because without that assessment it is not possible to conclude whether UU fully understood the risks to her health and wellbeing.

Interagency work around UU

7.16 Inter-agency communication and collaboration, co-ordinated by a lead agency and key worker is essential in case work and helps build a team around the person. There were missed opportunities when ASC and SAMH did not respond to concerns raised by others in a more proactive way. Multi-agency meetings that pool information inclusive of mental capacity and assessments of risk, with clear risk management plans underpinned by legal frameworks, assist not only the adult at risk but those left with the often very difficult task of trying to support them. The referrals to the High Risk Panel clearly offered some support on this case. However, as discussed with agencies at the practitioner event, more could have been done by involving those directly working with UU had the case been pursued under the clear safeguarding pathway of section 42, Care Act 2014[15].

The duty to enquire

7.17 The use of the duty to enquire under Section 42 of Care Act 2014 would have assisted in coordinating the multi-agency effort. In view of the very early concerns held by agencies regarding UU's property, it is noteworthy that her case was not considered under the safeguarding process following the referral from the landlord and neighbour in April 2015. Had this case been considered under safeguarding it would have facilitated an early multi-agency assessment and a thorough assessment of risk. There would also have been an evaluation of the diverse legal options to assist with the case management of a case such as UU's. Staff fedback during the practitioner learning event that they believed that professionals needed to be more aware of self-neglect.

Information sharing

7.18 A comprehensive approach to information sharing would have enabled all agencies to consider the full picture of UU's case. There is no evidence available to suggest that the possibility of joint working between ASC and SAMH was considered, even in the early stages of transferring the case. For example, when the case is assessed by ASC and then referred on to SAMH, a joint visit does not appear to have been considered, nor any record of the possibilities of joint working. Additionally, when SAMH close UU's case there did not appear to be any direct communication with ASC, the agency that initially referred UU. It is not clear what consideration had been given to the future monitoring of UU's welfare.

7.19 As highlighted by Preston-Shoot (2019) balancing autonomy and duty of care remains a prominent theme in SARs. Multi-agency meetings are crucial in order to

[15] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

share essential information, discuss differences of opinion, consider use of safeguarding interventions, evaluate preventative or risk mitigation options and avoid defensive practice. It appears that agencies involved in UU's case were not working as part of a cohesive network, rather they were operating in separate 'silos'. Agencies appeared to be unaware of each other's interventions at various times and discussions did not take place about the implications of closing the case.

Policies, procedures and supervision

7.20 Staff use of policies and procedures to assist them in their work with UU was not apparent from the information gathered via chronologies or discussions held within the practitioner learning event. During the practitioner discussions at the learning event some staff appeared unfamiliar with London Borough of Camden's Self-Neglect (including hoarding guidance) Guidance and how this is consulted and utilised in cases such as UU's. Similarly, they were uncertain as to what support staff could expect from the High Risk Panel and what to expect from a referral there. Agencies fedback at the practitioner learning event that it would helpful if the terms of reference for the High Risk Panel could be revisited and reviewed as they were not clear.

7.21 Cases such as UU's raise complex issues for staff and often present a clear challenge in terms of day to day work. Supervision that promotes reflection and critical analysis can provide staff with the space to reflect on actions being taken and consider any alternative plans. Management oversight and consideration of how cases such as UU's are allocated is essential in ensuring that staff have sufficient knowledge, skills and support to take action as needed.

8. Recommendations

8.1 When a case is referred to the High Risk Panel the following key questions should be explicitly considered:

- What are the identified risks in the case and how are they being managed?
- What statutory obligations have been triggered?
- Has the Mental Capacity Act 2005 been considered?
- What safeguarding action has taken place on the case inclusive of the duty to enquire?

8.2 CSAPB to consider a multi-agency audit plan for monitoring practice and partnership working for cases involving people who self-neglect.

8.3 CSAPB to consider how agencies obtain multi-agency training for staff on the assessment of risk, mental capacity assessments and safeguarding adult procedures.

8.4 All agencies to have systems in place to provide feedback to referrals with a detailed account of where they have been able to offer support and where they have not been able to do so.

8.5 All agencies to consider whether cases as complex as UU's should be referred to the High Risk Panel for consideration prior to closure.

9. Conclusion

9.1 The SEA practitioner learning event and this report is the CSABP's response to the death of UU. The author hopes that the findings are useful and that the recommendations made assist to maintain and develop new and existing skills within the multi-agency safeguarding partnership.

9.2 Once again the author would like to thank all participants for their valuable contributions throughout this process and their willingness to work collectively to identify recommendations for improving future safeguarding work. UU's sad story provides agencies with an opportunity to engage collaboratively towards improving partnership work to help safeguard adults with care and support needs in Camden.