West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of MT

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1. Foreword

1.1. The West Sussex Safeguarding Adults Board (the Board) has published a Safeguarding Adults Review (SAR) in relation to MT.

1.2. The Board and the Independent Reviewer express their sincere condolences to the family and friends of MT. MT's daughter has contributed to this Review and with her agreement, MT's initials have been used. With consent from her daughter, the Reviewer has also included two of MT's neighbours to contribute to the Review.

1.3. MT was an 83-year-old woman who was described by her daughter as a mother who stayed strong in the face of challenges, in order to protect her. MT's neighbours also held her in high regard and described her as a very proud and independent person, and as a kind and lovely lady.

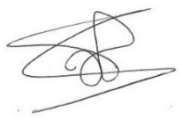
1.4. In June 2021 MT's General Practitioner (GP) raised a safeguarding concern due to hoarding and infestation of mice in her home. In the following months MT experienced increased dizziness and failing eyesight. Following intervention, there was improvement in the removal of belongings at a slow pace as led by MT. However, the infestation remained. A further safeguarding concern was raised by a friend in December 2021, due to a marked deterioration in her health and her home circumstances. Sadly, in January 2022, MT was found deceased in her home having collapsed or fallen.

1.5. The purpose of a Safeguarding Adults Review (SAR) is to identify how lessons can be learned, and services improved for those who use them, and for their families and carers. This Review looked at the circumstances prior to MT's death and the actions of agencies. Recommendations made will enable lessons to be learned and contribute to service development and improvement.

1.6. The Review identified key findings in relation to; safeguarding adults practice improvements, multi-agency needs assessment and risk management, and the Mental Capacity Act, service user and family voice. The Review made eight recommendations in relation to these key findings.

1.7. Agencies do not wait for the outcome of a SAR to consider their own learning and are fully engaged in taking forward the recommendations together. The Board will monitor progress on the implementation of recommendations. The purpose of this is to reduce risks and ensure the development of systems and procedures to improve practice.

1.8. The Board will ensure that learning from this Review is widely shared and that the outcomes of the learning will lead to improved services in West Sussex.



Annie Callanan
Independent Chair

2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards (SABs) must arrange a SAR when certain criteria are met. These are:

- when an adult in its area dies as a result of abuse or neglect, whether known or suspected, or has not died, but the SAB suspects that the adult has experienced serious abuse or neglect, and;
- there is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

2.3. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy to the person and support to family, friends, and practitioners.

2.4. There are clear Review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what), an analysis and findings (so what), recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations (now what).

2.5. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial panel meeting to agree the Review terms of reference; conducted research by critically analysing relevant records and interviewing family, neighbours, and representatives of agencies; culminating in a planned SAR outcome panel workshop and presentation to the West Sussex SAB.

2.6. The Independent Reviewer has conducted interviews with the following agencies' representatives, either by face-to-face or online meetings (unless otherwise stated):

- Southern Service Manager – West Sussex County Council (WSCC) Coastal Adult Operations
- Social Worker – WSCC Adult Services, Adur Community Team
- Private Sector Housing Officer – Adur and Worthing Councils
- Senior Environmental Health Officer – Adur and Worthing Councils
- Assistant Head of Safeguarding, Designated Nurse – NHS Commissioners (Integrated Care Systems (ICS), formerly Clinical Commissioning Group (CCG))
- Nurse Consultant for Safeguarding – South East Coast Ambulance (SECAmb) Service
- GP – Northbourne Medical Centre (information via email)
- Trust Senior Lead for Safeguarding Adults – University Hospitals Sussex NHS Foundation Trust (information via email)

3. Circumstances leading to the Review

3.1. A safeguarding adults concern in respect of MT was raised by her GP with Adult Social Care (ASC) in June 2021, due to hoarding and infestation of mice in her home. In the following months her physical health deteriorated, most significantly with increased dizziness and failing eyesight. Following the intervention of ASC, Clutter Queen and Private Sector Housing, there was some improvement in the removal of belongings, but this was at the slow pace accepted by MT and the infestation remained. A further safeguarding adults concern was raised by a friend in late December 2021, due to the combined risk of a marked deterioration in her health and the unresolved home circumstances. MT was 83 when she was found deceased in her home in early January 2022, having collapsed or fallen.

4. Key themes identified for the Review

4.1. Risk management decisions in circumstances bordering on or within self-neglect has emerged as an overriding theme in this Review, and practice learning from relevant national guidance and previous Reviews has contributed to the consideration of recommendations. The Care Act 2014 recognises self-neglect as a category of abuse and incorporates environmental concerns of hoarding and infestation. It places a duty of co-operation on all agencies to work together, to intervene early in order to minimise the risk of harm, and to apply the wellbeing principle. The Care and Support Statutory Guidance (2022) recognises that a formal safeguarding enquiry will not always be appropriate as a proportionate and personalised response to self-neglect. Whilst MT was engaging with agencies and services in addressing her physical health and environmental risks at an agreed pace, and therefore did not meet the threshold for self-neglect, the principles underlying this approach are very relevant and helpful in considering learning points.

4.2. The following key themes of the Review were agreed by agencies and shared with family at the outset, and form a thread through the analysis, findings, and recommendations in the report:

- Safeguarding Adults responses to concerns raised, including the use of self-neglect procedures;
- Multi-agency needs assessment and risk management, information-sharing, and communication; including any factors that may have impacted on service delivery, including COVID;
- Mental Capacity Act, service user and family voice;
- Compliance with statutory and procedural requirements;
- Environmental and resource considerations;
- Coroner findings and recommendations.

5. Pen picture of MT

5.1. MT was born in Bristol in 1938 and moved with her parents and older brother to the Southampton area. Her mother was a piano teacher and her father an aircraft engineer, entering carpentry after the war. They were a poor family, and her father had an alcohol misuse problem. MT left school at 15 to work in Boots chemist, trained in a secretarial college, worked for the Malaysian High Commission and then in other legal and secretarial positions. She was employed in a bank in Hong Kong for three years and then in an import and export company, enjoying an active social life. MT returned to England when her mother was living with dementia and she worked for a trade union, where she met her husband to be and married in 1975. They were posted to Australia and were divorced in 1981, due to her husband having affairs. Her mother had died the previous year and her father had contracted liver damage around the same time.

5.2. Her daughter recalls that MT stayed strong in the face of challenges, in order to protect her. She describes her mother as a demure woman who was not emotionally expressive. They both experienced health difficulties, and despite a strained relationship, remained in weekly phone contact for the remainder of MT's life, and daily in her final weeks. MT's neighbours clearly held her in high regard, and she is described as a very proud and independent person; 'such a kind and lovely lady.'

6. Engagement with family and neighbours

6.1. The Independent Reviewer met with MT's daughter online at the start of the Review to ensure that the family perspective is fully understood and incorporated within this report. She is very supportive of agencies' learning, in order to prevent the abuse and neglect of adults at risk.

6.2. MT's daughter explains that she was unaware of the extent of her mother's difficulties until her hospital admission in mid-December 2021, which was her first admission since 1976. Following MT's discharge home on 19/12/21, she spoke with her mother on a daily basis. Her mother fell on the stairs on one occasion, and she was also awaiting support due to her failing eyesight. She was aware that neighbours were providing support with shopping and cooking, but her mother and involved agencies did not share with her the difficulties she was experiencing. MT's daughter feels that both she and involved agencies failed her mother in some way.

6.3. The Independent Reviewer also had telephone conversations with two of many supportive neighbours. Their contributions add to the understanding of MT, her circumstances and her experience of agencies, and are represented within the report.

7. Key facts

7.1. June to November 2021

7.1.1. On 11/06/21, Adult Social Care (ASC) received a safeguarding adults concern from MT's GP surgery, following contact from the Fire Service. This described a worsening hoarding issue and infestation of mice in her home. The Safeguarding Adults Hub decided that there were insufficient grounds to progress as a safeguarding concern, as there were no apparent mental health needs, there was no previous contact with ASC and MT was not declining intervention. The concern was passed to the Adur Community Team as a wellbeing referral and was screened by Duty as requiring a non-urgent response within 14 days, aligned to an amber RAG rating. The decision was relayed to her GP on the same day.

7.1.2. An Adur Community Team Duty Worker rang MT on the same day. MT said that the house had 'got too much for her' after experiencing 'dizzy spells', which were being investigated. She agreed to a wellbeing conversation and was placed on the allocation list. The Duty Worker emailed Environmental Health on the same day and received confirmation three days later that MT was not known to them.

7.1.3. MT wrote to her GP on 16/06/21 to ask whether the Amlodipine medication (which treats high blood pressure) that she had been taking for some time could be causing her slow, shuffling walk, visual disturbance (flashing lights without pain for periods of around five minutes) and dizziness.

7.1.4. On 23/06/21, a newly allocated ASC Social Worker visited MT in her home. MT was managing her personal care and hygiene and did not present as dishevelled. The initial social work assessment provided an insight into the home circumstances. MT lived in a two-storey house. The garden was overgrown, with bushes protruding through downstairs windows; the hall had an accumulation of books; the lounge had a walkway through antiques and books; the dining area was cluttered with bags and was unused; the kitchen was slightly dirty but not cluttered; the bedroom she used upstairs had lots of clothing (also on the bannisters at the top of the stairs) but the bed was clear; the other two bedrooms were full of belongings; and the bathroom was clean and clear. Despite the amount of belongings and an infestation of mice, the house did not present as dirty.

7.1.5. The Social Worker gained an insight from MT about how the accumulation of possessions had occurred and how she felt about her home circumstances. She recalled significant life events. These included her father's alcohol misuse, moving to live with an aunt, the loss of her brother (an actor) and retaining some of his possessions, and a dog that had to be put down. MT said that 'this is why I like my things.' She added that in recent years the house had become too much for her, as she was experiencing physical health problems such as dizziness. MT said that she felt overwhelmed and embarrassed by the task of sorting the accumulation of belongings. She was able to articulate her needs and wishes and said that she would accept support in clearing belongings. MT expressed concern about her daughter, that she did not wish her to be contacted and made to feel anxious, and she would not clear her daughter's possessions from one of the two spare bedrooms until she had spoken with her. She received support from neighbours, including shopping and other practical tasks, but did not wish her neighbours and friends (including from church) to visit due to her circumstances.

7.1.6. MT agreed to the Social Worker arranging for a gardener and this service had started by early July 2021. She also accepted an arrangement for a further Social Work visit to discuss how to support her with removing belongings from her home, addressing the infestation of mice and planning long-term. She would not discuss her finances and declined any support beyond addressing her home circumstances. A neighbour recollects that MT had been arranging and paying for one or more companies to address the infestation, but that the problem had continued despite this effort.

7.1.7. The Social Worker discussed her planned intervention in supervision at this time and throughout her involvement. It was agreed that goals should be set with MT, at her pace and within a strengths-based approach. She was assessed as managing personal care tasks, despite deteriorating eyesight, dizzy spells and high blood pressure.

7.1.8. In a telephone consultation with MT on 28/06/21, her GP noted hypertension monitoring, ongoing dizziness and that there had not been any falls. MT returned phone messages from the Social Worker in late June 2021 by ringing her on 05/07/21. She relayed concerns about her health, that her GP had changed her medication due to high blood pressure, and she was awaiting an urgent eye hospital appointment due to a diagnosis of glaucoma.

7.1.9. The allocated Social Worker made a second visit to MT on 08/07/21. She assessed that there were eligible care needs, but MT still wished to focus on her home environment. The Social Worker therefore planned to start the wellbeing conversation and send information on meals delivery and the Clutter Queen service. Later in the same month, she sent the meals leaflet to MT and rang her. MT said that she had a telephone call from her GP on 22/07/21 and had received brain scans in hospital, which were inconclusive regarding Parkinson's. She was experiencing a tremor in one hand and felt dizzy at times but declined a pendant alarm. The Social Worker concluded that MT was "still willing to engage but is requiring support at her own pace" and the intervention priorities were to address the mice infestation; MT to ask her GP about whether mouse droppings may be contributing to her feeling unwell; and to consider multi-agency working with the GP and Environmental Health.

7.1.10. A friend contacted MT's GP on 09/08/21 to report that MT had been experiencing low mood for three to six months and had declined most help from ASC and the Fire Service with regard to clearing the infestation. MT had been attending appointments at Worthing Hospital eye clinic since June 2019. A letter from the clinic to her GP on 18/08/21 noted low mood and anxiety over the last few months, 'significant issues with hoarding', that her 'house is overrun with mice', and that a neighbour was assisting her in receiving Council support to clear the hoarding. MT's GP wrote to a Consultant Geriatrician on the same day, following a surgery appointment. The letter referred to possible Parkinson's and dizziness, with more recent complaints of reduced co-ordination and confidence in her walking and a stooped posture; a tremor in her left hand; and declining antidepressants but agreeing to consider talking therapy. The Consultant saw MT at his clinic on 06/09/21 and wrote to the GP surgery on the following day. He prescribed Sinemet (relieves symptoms of Parkinson's) and agreed to refer MT to a specialist, as he felt that her symptoms probably pointed to Idiopathic Parkinson's (unknown cause).

7.1.11. On 11/08/21, a Senior Social Prescriber at Adur and Worthing Councils emailed Private Sector Housing. MT was an owner-occupier and there had been no previous Housing involvement. The contact was to advise that the infestation had escalated and become a fire risk, combined with 'the incredible amount of clutter'; that electrical cables had been chewed through and she no longer had access to hot water or cooking. Following further phone contact, the Social Worker visited MT on the same day, leading to a phone message to Housing the following day to request disinfestation. At a joint visit with the Social Worker on 16/08/21, a Clutter Queen representative agreed to provide a quote for removing possessions from the property; whilst the Social Worker would seek charitable funding to cover the cost. A neighbour contributing to the Review recalls entering MT's hallway around August or September 2021. She noticed 'a lot of clothing' on a sofa and on the stairwell, as well as papers piled up on a telephone table.

7.1.12. The Social Worker contacted Private Sector Housing on 24/08/21, just after a Housing Officer had sent a letter to MT on the same date to notify of complaints regarding property conditions and requested sensitive handling. The officer visited MT on 02/09/21. She observed mice droppings, but did not consider the property to be dirty. There was no waste, but lots of furniture, clothing, linen and towels that had accumulated over many years. MT had access to all spaces that she was using in her home. The kitchen was a little cluttered, but surfaces were clean, and the bathroom was fine. The garden was partly cleared by this stage. MT was waiting on information from ASC about the cost of clearance, cleaning and pest control by Clutter Queen. Grant allocation was not suggested at this stage. She wished decluttering action to take place as she felt that the accumulation of belongings and infestation were impacting on her wellbeing. The officer emailed the Social Worker on 06/09/21 regarding the outcome, followed by a phone call a few days later. As MT was willing to engage with clearing belongings and addressing the mice infestation, enforcement action would not be taken. She advised that grant support may be available. The officer was not involved after 09/09/21.

7.1.13. Phone contact was maintained by the Social Worker with MT during September 2021. The Clutter Queen quote was received on 20/09/21 and backdated Attendance Allowance was received following Social Work support with the application, which MT intended to use towards the cost of clearing belongings.

7.1.14. An ASC line management decision was taken on 24/09/21 to close social work involvement, as it was considered that progress was being made with removing possessions and MT was accepting the support.

7.1.15. MT received a telephone consultation from her GP on 04/10/21 and it was noted that Sinemet medication had helped with her energy level and with lessening her tremors but had not reduced her dizziness.

7.2. November 2021 to January 2022

7.2.1. The Social Worker (who was no longer assigned) was contacted by Clutter Queen in late November 2021, to advise that significant progress had been made in clearing belongings, but that MT's funds were exhausted and there was outstanding work to be completed. The Social Worker visited MT, who expressed concern about her physical health. Around this time, the aforementioned neighbour entered the house again, when MT was feeling cold and had decided to leave her heat on constantly. This was the only time the neighbour saw the kitchen and living room and noticed 'stuff stacked up all over the place'; with many trip hazards, food all over kitchen counters and 'open stuff', mouse droppings, and medication on a stool. She felt that some belongings had been removed from the hallway since her previous visit. MT declined her offer to assist in 'going through stuff.' The neighbour feels that, despite the removal of some belongings, MT was not ready to clear sufficient items to make her home safe. The neighbour also feels that MT's health deteriorated markedly in her final months, including her poor eyesight and unsteady mobility, and recalls that another neighbour was warming up food for her.

7.2.2. On 26/11/21, Private Sector Housing responsibility was passed to an Environmental Health Officer, situated within the same team, to consider grant support with removing possessions and disinfestation. This was the initial involvement by Environmental Health, which is responsible for enforcement action and grants.

7.2.3. The Social Worker completed a joint home visit with the Environmental Health Officer to MT on 06/12/21, to consider available grants. It was agreed that he would make a referral to the in-house Home Improvement Agency for a 'Suitable, Safe and Warm' grant, as a high priority. The grant would be used to fund further removal of possessions, including those in the final two bedrooms. Pest Control were due to visit and lay poison in heavily infested areas. The officer recalls that the accumulation of belongings was 'not very bad' and that mice had chewed through electric wires, with a temporary power service set up by the electricity company. Clutter Queen had correctly targeted the kitchen first and had containerised food. A few days later, MT rang the Social Worker and mentioned feeling unwell but, despite not managing to get through to her GP on the phone as yet, would not accept support in making contact. The Home Improvement Agency visited MT on 22/12/21, completing the grant application and schedule of work for the surveyor to action.

7.2.4. MT was admitted to Worthing Hospital on 17/12/21, via an ambulance called by her GP. The GP had visited, following contact by MT to say that she was feeling generally unwell and unsteady on her feet, and on arrival found that she had fallen about five minutes beforehand. She had felt dizzy and, on falling, hit the back of her head on a radiator. MT was discharged on 19/12/21, with a discharge summary requesting a GP review. MT was considered to be independent at home without a care package and it was noted that she had support with decluttering and disinfestation. There was a note that a Social Worker and other agencies were involved. Contact was not made with ASC regarding her presentation in hospital. The aforementioned neighbour feels that MT's health noticeably deteriorated after her fall and recalls MT commenting that she had been sent home from hospital without follow-up support.

7.2.5. A friend of MT rang ASC Care Point on 23/12/21 to request a further assessment, as MT was not coping. The referral was passed to an Adur Duty Worker for an 'urgent care and support needs assessment'. The Duty Worker contacted the Social Worker, who rang MT on the same day, but did not receive a response.

7.2.6. MT's friend rang again on 31/12/21 to advise that friends and neighbours were supporting MT, whose circumstances were deteriorating. On the same day, another friend reported a safeguarding concern to ASC, as MT's health was poor, and she had tripped and fallen several times. The safeguarding threshold was considered to be met and the referral was passed to the Adur Community Team, leading to a Duty Worker ringing MT. In this call, MT said that she continued to feel dizzy following a course of antibiotics for a chest infection and would ring her GP if her health worsened. Meals delivery was agreed and started on 01/01/22. The Duty Worker made a follow-up phone call to MT on 05/01/22, as the allocated Social Worker was on leave, and it was agreed that a social work visit would be undertaken on 07/01/22, with a friend of MT in attendance.

7.2.7. MT's GP returned a phone call to her on 31/12/21. She advised her GP that meals delivery had been arranged due to her poor eyesight; she was experiencing difficulty in managing her eyedrops (for dry eyes) and her eyesight had recently been more cloudy; the Council were supporting her with decluttering to reduce the falls risk; she had fallen in December due to losing her balance and was admitted to hospital, as well as being pulled over by her dog on a couple of other occasions; and her appetite had reduced since hospital discharge. Her GP agreed to write to request an earlier annual glaucoma monitoring appointment and a letter was sent on the same day. MT contacted an Out of Hours GP on 01/01/22 due to concern about her eyesight, which she felt had deteriorated in recent months and significantly within the previous week, and that she had run out of eye drops. She was advised to contact her GP for an appointment. There was no further contact with her GP.

7.2.8. On 06/01/22, the 'Suitable, Safe and Warm' grant was approved and would have meant that the assigned work could have started in January; specifically, to address the electric wiring and central heating and to remove belongings and trip hazards via Clutter Queen. The Environmental Health Officer states that the long-term plan would then have been to pursue a Disabled Facilities Grant for further work and that MT would have been eligible for this.

7.2.9. An ambulance crew attended to MT on 06/01/22. A neighbour rang the Police on noticing through a window that MT was slumped in a chair. The Police alerted the ambulance service before also visiting, with MT rising and opening the door to them. Two paramedics arrived within 40 minutes and completed observations, with no concerning signs and she had not had a stroke. It was noted that MT was alert and in a low mood, was mobile but unsteady and was experiencing ongoing dizziness. She felt well enough to stay at home and assured the ambulance crew that ASC were visiting the following day. Therefore, MT was not transported to hospital and the ambulance service made a referral to the GP for a medical review. The GP surgery referred MT to the Falls Service on 06/01/22 for a further assessment. The letter noted her physical health conditions as Parkinson's; poor mobility; deteriorating eyesight due to glaucoma; repeated falls in the previous six months and now confined to home due to a fear of falling. It was noted that a Social Worker was assisting with decluttering. Whilst in hospital, Occupational Therapists (OTs) were not concerned about her mobilising. Her Amlodipine had been stopped in hospital and her blood pressure had been normal at home.

7.2.10. The aforementioned neighbour visited MT on the night of 06/01/22, providing food and supporting her with eating, which she was finding difficult. She supported MT in climbing the stairs to access the toilet. MT slept downstairs and had the use of a utensil as a temporary toilet. The neighbour noticed clothing 'stacked high' on the landing, two inaccessible rooms upstairs and clothing in the bedroom she was using. MT said that she had fallen out of bed within the previous week. The neighbour rang 'the Council' to prepare for the social work visit the following day and to say that she would visit in the morning. She had also attempted to support MT over the past week with removing food and other items, and with finding a safer place to store her medication. The neighbour returned on the morning of 07/01/22 and assisted MT with medication, which she was also finding difficult. MT presented as more alert and coherent than on the previous night.

7.2.11. A meals delivery person observed through the letter box, on the afternoon of 07/01/22, that MT was lying on the floor. Ambulance paramedics arrived ten minutes after an emergency call was received and pronounced that MT had died. They recorded that she had collapsed in the hallway, by the lounge door; had experienced an unwitnessed cardiac arrest; and there were no signs of injury. The crew awaited the arrival of the Police and, whilst in attendance, the neighbour, Social Worker and GP arrived.

8. Analysis of key facts

8.1. Overview

8.1.1. The agencies represented in this Review, along with family and neighbours, have been forthcoming in providing a searching and reflective review of learning. The Independent Reviewer acknowledges that intervening in the life of an independent and mentally capacitated person who is at risk is extremely challenging; particularly in balancing the principles of wellbeing and protection. MT had insight into her circumstances and engaged with the support that was offered to her. There were strengths in the intervention of agencies, including relationship-building and a commitment to address concerns in a personalised manner. The principal learning point for agencies centres on the need to have adopted a coordinated risk assessment and management approach, taking account of MT's dual physical health and environmental risks, to have engaged funding and services earlier, and to have offered a comprehensive and prioritised plan to sort through and dispose of possessions, alongside oversight of disinfestation.

8.2. Safeguarding Adults thresholds and decisions

8.2.1. The decision to progress the safeguarding concern in June 2021 as a wellbeing conversation, rather than as self-neglect and safeguarding, was appropriate. MT had insight into the factors that had led to her accumulation of belongings, recalling traumatic life events that meant her possessions held emotional value to her, and recognised the impact of physical health concerns on her ability to keep on top of household tasks. There was a clear assumption of mental capacity, specific to these areas of risk. Furthermore, MT requested support in addressing her medical needs, the accumulation of belongings and the infestation, stating that they were impacting on her wellbeing. In the following months, it is unclear whether MT would have accepted an earlier and quicker pace of removing possessions and of disinfestation, had this been discussed in the context of her deteriorating physical health. If she had declined, this may have presented grounds for self-neglect to be considered and consequently may have triggered a more formal risk management process (as covered later). However, a self-neglect approach would not have removed the necessity to progress at a pace that MT found acceptable.

8.2.2. The safeguarding threshold was considered to be met in late December 2021, when a friend and separately a neighbour reported to ASC that MT's physical health was deteriorating, and she had tripped and fallen several times. There did not appear to be grounds to suspect self-neglect, as MT was continuing to engage with support services at an agreed pace, albeit slow. It is not clear if suspected neglect was a consideration, as again MT may have accepted earlier comprehensive support at a quicker pace if it had been offered to her. This said, the decision to undertake a community care assessment was a proportionate safeguarding response. However, the assessment was not prioritised, despite the combination of deteriorating health concerns, partially resolved accumulation of belongings and unresolved infestation, and was due to take place on the day that MT died in early January 2022. It is unclear whether workload capacity to cover the social worker leave, or the Covid pandemic, were factors in this delay.

8.2.3. As the decision was taken to respond to safeguarding concerns by undertaking a wellbeing conversation and a community care assessment, the response to these concerns is addressed in the next section.

8.3. Multi-agency needs assessment and risk management

8.3.1. Social work involvement and risk assessment: Social work intervention was prompt, with two visits to MT undertaken at an early stage, alongside telephone contact. Relationship building is an important skill in responding to hoarding-type situations in a personalised and effective way. It is also important to dedicate time to this task and to progress at a pace that is acceptable to the person, balancing the risks to wellbeing of either removing items of emotional value or leaving hazards in place. These qualities were demonstrated in the social work interaction. A rapport was quickly established, as was MT's understanding of her circumstances and her commitment to change at her pace. In these ways, practice was personalised and strengths-based, with the support of reflective supervision. Furthermore, progress was made over the following six months in removing possessions. The Social Worker recalls that, when she last visited MT, the front garden, the kitchen, the lounge sofas and floor and the hall floor were all clear. Higher Rate Attendance Allowance had been obtained and MT had intended to use these funds to pay for a regular cleaner. The Environmental Health Officer adds that there was no actual rubbish or odour in the house when he visited in early December 2021. However, the pace of removing belongings was slow, alongside increasing risks presented by MT's deteriorating physical health, most significantly tripping and possible infection hazards. The remaining items presented a continuing risk, and the mice infestation was consequently not reduced. As referred to earlier, a neighbour gave her perspective that in November 2021, the conditions remained cluttered, unhygienic and with trip hazards present.

8.3.2. Social work closure: Social Work involvement was closed in late September 2021 and was re-opened when further concerns were raised in late November 2021. The rationale for closure, that 'all was working' and there were no funded services, is a not uncommon local authority outcome in circumstances of 'managed risk'. As a national issue, it is inevitably impacted on by increased demand and decreased resources, both staffing and services. However, a coordinated and robust plan was not in place, MT's environmental risks were only slowly and partially decreasing, and her physical health risks were increasing. Closure meant that relationship-building, assessment, planning, co-ordination, and oversight were not realistically possible for two months.

8.3.3. Practice-level multi-agency risk assessment and management: MT may have responded positively to a coordinated multi-agency approach from July or August 2021, along the lines of the Sussex Multi-Agency Procedures to Support Adults who Self-Neglect, which can be triggered by any agency; acknowledging that this is embedded within safeguarding procedures. The Social Worker had considered adopting a multi-agency focus in July 2021, but this was not progressed on closure and was discussed again in November 2021. A collaborative approach could have brought together MT (in a way that maintained her control and was comfortable to her), the Social Worker, the GP, Private Sector Housing and Environmental Health, and Clutter Queen, to undertake a joint risk assessment and develop a risk management plan; effectively a team around the person. The following three paragraphs consider the real and potential contributions of the key agencies.

8.3.4. GP involvement: There was frequent communication between the GP surgery and MT, with medication reviews and the active engagement of secondary health in assessing her declining eyesight and her Parkinson's symptoms. It is not within the scope of this Review to determine whether this intervention was timely. However, it is notable that there was no engagement either way between the GP and ASC, which would have enabled a more joined-up response. A combined risk assessment could have taken account of the physical health and environmental risks and the potential impact of these together on the likelihood and severity of harm. In turn, this could have informed a multi-agency risk management plan that was both proportionate and personalised. Whether this would have led to a more prompt removal of belongings and disinfestation is unclear. The development of a GP locality-based risk management forum, as exists in some areas nationally, would facilitate this engagement in a structured and accessible way for GPs and other agencies.

8.3.5. Clutter Queen involvement: The involvement of Clutter Queen, which was pivotal to progress with removing belongings, was discussed with MT in early July 2021. The service was invited to provide a quote on a visit in mid-August 2021 and commenced in late September 2021. This was a service that MT accepted from an early stage and engagement from July or August 2021 may have led to earlier removal of items at MT's pace. Also, the frequency of visits by the service was not monitored or incorporated within a coordinated plan.

8.3.6. Housing and Environmental Health involvement: A joint risk assessment and management plan may have prompted an earlier specialist assessment of the 'hoarding' risk by Environmental Health than December 2021; enabling earlier grant funding; and leading to a resourced and prioritised removal of belongings at MT's pace, and of support with arranging pest control. In terms of available grants, the local authority has access to a delegated deep clean grant; there is a Suitable, Safe and Warm grant, although means-tested and MT did not wish to discuss her finances; a Hospital Discharge grant of £3000, which could have been a consideration when MT left hospital in December 2021; and the main option, a Disabled Facilities Grant of £30,000 that is means-tested, requires an OT assessment and could have been used for work such as adaptations and decorating. Nationally, the provision of pest control is no longer a local authority function and MT contacted agencies privately, not as part of a coordinated plan and without success. An in-house service would be beneficial in terms of providing a coordinated response and, in the absence of this, involved agencies could have supported the commissioning of the service and have had more oversight of progress. There is a local arrangement with private pest control companies regarding pricing. A request for joint working with Environmental Health was not considered when contact was initiated in June 2021 to establish that there was no involvement. There was a possible opportunity for engagement by late August 2021, when Private Sector Housing was contacted, but Housing involvement ended in September 2021 and Environmental Health was not engaged until November 2021. At a joint visit by an Environmental Health Officer and the Social Worker in early December 2021, it was clarified that MT would be eligible for grant funding, to cover intensive clearing by Clutter Queen and the completion of electrical repairs.

8.3.7. Service-level multi-agency risk assessment and management: A Multi-Agency Risk Management (MARM) forum operates in West Sussex. The forum is a subgroup of the SAB and comprises statutory and voluntary representation. It was established 'to ensure that multi-agency communication and information-gathering takes place on a regular basis and to support professionals and their managers in managing the most challenging and concerning cases'. It is intended to be used when all other avenues have been explored and there continues to be a concern about the wellbeing and safety of the person. Referral to the forum involves the completion of a risk assessment form (alongside a needs assessment). The MARM would have been an appropriate vehicle to oversee a coordinated multi-agency response to MT's complex concerns; to ensure that the two arms of support, clearing belongings and disinfestation, were progressing to an agreed timescale, and were considered alongside the risks presented by her deteriorating physical health.

8.3.8. Hospital discharge and escalating concern: On discharge after two days in hospital in late December 2021, following a fall at home, a referral was appropriately made for a GP review. However, there also appear to have been grounds to have contacted ASC and to have triggered a community care assessment and risk management meeting, either before or immediately following discharge. MT's deteriorating physical health was by now causing considerable care needs, particularly concerning meals provision and medication administration. Also, her declining eyesight and continued dizziness were presenting ever greater risks in the context of her congested environment, alongside instances of her dog pulling her over in reacting to the presence of mice.

8.3.9. Escalating concern in the community: In late December 2021, four days after hospital discharge, a friend contacted ASC to report that MT's physical health had significantly deteriorated, and her environmental risks remained. Friends and neighbours were supporting her in managing practical care tasks at home. This was appropriately passed to the Community Team for an urgent community care assessment, but MT did not respond to a telephone call. The friend contacted ASC again at the end of the month and another friend raised the aforementioned safeguarding concern on the same day. The referral led to prompt duty contact with MT. However, the assessment was delayed, pending return of the Social Worker from leave, when a duty visit was warranted to meet urgent care needs. This would ideally have been undertaken jointly with a GP, as MT had contacted primary health care twice at the end of December 2021 and the start of January 2022 to discuss her deteriorating physical health; and possibly an OT in view of emerging difficulties in mobilising safely around her home. It may be that workload demands or the Covid pandemic had an impact on these decisions. The Independent Reviewer recognises that the intended intervention by agencies in January 2022 was likely to have been rigorous and coordinated, reflecting the increased level of concern.

8.3.10. Engagement with Police and ambulance services: The Police were called on the day preceding MT's death, when she was observed slumped in a chair, and contacted the ambulance service. Both services were proactive and visited promptly. Given the presenting circumstances and the expectation that ASC was visiting the following day, the response to request a GP review seems to have been both proportionate and personalised. However, the ambulance crew report did not mention the state of the property, and whilst this was known to other agencies, it is important that professional curiosity and a holistic assessment of circumstances is recorded. The SECAmb representative notes that safeguarding training to staff within the past year has incorporated a recognition of hoarding levels. Since September 2021, it has been the expected practice to escalate suspected self-neglect to the internal safeguarding team (with or without consent), electronically via an iPad, for referral to ASC.

8.4. Mental Capacity Act, service user and family voice

8.4.1. Mental Capacity: The Social Worker recorded that she did not have a concern about MT's mental capacity with regard to the accumulation of belongings, as she was aware of the circumstances and the impact, was engaging and was able to articulate her views. Private Sector Housing, including Environmental Health, also had no concerns about MT's decision-specific mental capacity. The GP surgery interacted with MT on the clear basis of having the mental capacity to make decisions about her medical needs, and indeed, MT demonstrated awareness and was proactive in engaging this support. The approach by all agencies to underpinning mental capacity was appropriate.

8.4.2. Engagement with MT: As referred to in the previous section, the Social Worker developed a close and trust-based relationship with MT, through home visits and regular phone contact. This enabled a personalised plan to address the accumulation of belongings and the infestation. She recalls that MT had a 'home full of memories' and that 'we were putting things in place that she was accepting'. By her second visit, the Social Worker had an understanding of the emotional significance of MT's belongings; including those of her deceased brother and of her daughter. She had offered to arrange deep clean funding earlier, but MT declined as this would have meant discarding belongings into a skip.

8.4.3. The role of Private Sector Housing, including Environmental Health, is primarily to enforce legal requirements and to prevent a risk to complainants and others. This should be conducted with respect and sensitivity, which was evident in the approach of the visiting officers. The involved Housing Officer has nevertheless changed her practice and now visits before sending a letter to people who may be hoarding, to explain and listen, and will share this practice with colleagues. The Environmental Health Officer, however, considers that a visit without notice may be as anxiety provoking to vulnerable adults. He confirms that the goal is to engage, demonstrating sensitivity to possible shame and fear of judgement. It may be that a review of the letter in terms of sensitivity may be helpful, alongside initial checks with ASC on possible involvement and background information, which the Officer would support.

8.4.4. As MT had the mental capacity to make decisions about her home environment, sharing information with her about available grants and the option of a resourced and prioritised plan at an earlier stage would have enabled her to make a more informed decision about addressing the risk factors.

8.4.5. It is understood from a neighbour who contributed to the review that MT was concerned about having returned home from hospital in December 2021 without a care package. It is therefore unclear if there was active engagement with MT in discharge planning, and if her requests for support directly and through calls by friends in the final two weeks were not acted upon with sufficient priority.

8.4.6. Non-disclosure to family: The Social Worker was asked by MT not to inform her daughter about the concerns and intervention, as she did not wish to cause her anxiety, and this was respected. Whilst this is often a difficult conversation, MT clearly had the mental capacity to make this decision and non-disclosure was correct practice in both legal and ethical terms. Her daughter became aware of concerns when MT was admitted to hospital in December 2021 and subsequently increased her contact. MT had not spoken to her daughter about her belongings in a bedroom upstairs and the Social Worker feels that she would have re-focused on this after November 2021, which would also have facilitated family awareness and support. Private Sector Housing had no contact with MT's daughter.

8.5. Compliance with statutory and procedural requirements

8.5.1. Whilst the Care Act 2014, section 42, safeguarding adults threshold decision-making was not consistently clear, the decision to address concerns by undertaking a wellbeing conversation (section 1) and an urgent community care assessment (section 9) was proportionate. The assessment should have taken place on hospital discharge and in response to referrals in late December 2021. It is unclear whether MT would have accepted a coordinated, resourced, and comprehensive intervention plan at an earlier stage and, if not, this may have triggered consideration of self-neglect and a safeguarding response. However, this would not have removed the legal and ethical requirement to progress at MT's pace.

8.5.2. The Human Rights Act 1998, Article 8, provides a qualified right to private and family life. This was respected by agencies in the commitment to recognise the emotional value of MT's possessions and to progress at her pace.

8.5.3. The Mental Capacity Act 2005, Section 1, requires that capacity is assumed, unless it is established that the person lacks capacity to make a particular decision. This core principle was evident in the judgement of agencies and there was no indication in MT's presentation of a need to assess capacity.

8.5.4. The Public Health (Control of Disease) Act 1984 (sections 31-32) gives a local authority the power to disinfect premises to prevent infectious diseases. Enforcement action was not taken in view of MT's engagement with services, which was a proportionate decision.

8.6. Environmental and resource considerations

8.6.1. The congested and infested home environment was the primary concern that was driving intervention by ASC and Private Sector Housing. Also, MT had a network of friends and neighbours who were on hand to support her with domestic tasks, as well as advocating on her behalf. Whilst Covid has not been highlighted by contributors to this Review as a contributory factor, the Review timeframe straddled a difficult period for statutory agencies in resourcing and undertaking home visits, which may have had an impact. There is also no suggestion by ASC and Private Sector Housing contributors that any decisions were resource-driven, although the reality of workload demands and diminishing resources is undoubtedly an underpinning pressure on statutory agencies.

9. Key findings

9.1. Overview

9.1.1. All agencies and staff involved with MT endeavoured to provide a proportionate and personalised response to her complex and intertwined physical health and environmental needs and risks. There is clear evidence of a respect and sensitivity towards MT and of assessment and measured interventions. Indeed, many of the learning points in national self-neglect reviews were addressed with MT; a person-centred approach, consideration of mental capacity, referral pathways, line management overview and supervision, and recording. However, there is particular learning in terms of multi-agency risk management, the timeliness of support offered and, to an extent, threshold decisions. Agencies should have worked together more collaboratively and offered MT the option of an earlier resourced and prioritised risk management plan. By December 2021, this should have been reprioritised to crisis intervention.

9.2. Safeguarding Adult practice improvements

9.2.1. The decisions to respond to the two safeguarding concerns in June and December 2021 by undertaking a wellbeing conversation and an urgent community care assessment were proportionate. It is unclear whether self-neglect would have been a necessary consideration, if a coordinated and resourced plan had been presented to MT at an earlier stage and possibly declined.

9.3. Multi-agency needs assessment and risk management

9.3.1. Whilst agencies were responsive and engaged with MT at her pace, a multi-agency risk management meeting and plan should have been triggered by August 2021. This should have brought together MT (meeting separately if she preferred this), ASC, the GP practice, Private Sector Housing and Environmental Health, and Clutter Queen. It is unclear whether an earlier, resourced, coordinated and timetabled plan for the removal of possessions and for disinfestation would have been acceptable to MT and, if not, this may have escalated the concern to consideration of self-neglect. The order of clearing belongings, starting with her living space, was sensible. The Sussex Multi-Agency Procedures to Support Adults who Self-Neglect (embedded within the Sussex Safeguarding Adults Policy and Procedures, edition 4) are clear and comprehensive, of equal relevance when self-neglect or safeguarding thresholds are not met and when a formal safeguarding enquiry is not proportionate.

9.3.2. The decision to close social work involvement in September 2021, whilst understandable in the context of 'managed risk' and of caseload pressures, was nevertheless premature. A comprehensive multi-agency plan was not in place and MT's physical health deterioration was an identifiable added and growing risk. This was a missed opportunity for the continuation of relationship-building and monitoring of risk reduction by agencies.

9.3.3. MT was discharged from hospital in December 2021 with a referral for a GP review; but without contact being made with ASC, a reassessment of her escalating care needs, or consideration of a risk management meeting.

9.3.4. The planned community care assessment at the end of December 2021 was recorded as urgent but was not undertaken with urgency, when MT was experiencing a marked deterioration in her physical health and functional ability. A joint ASC and GP assessment and care plan to meet the increased level of needs and risks would have been beneficial at this time.

9.4. Mental Capacity Act, service user and family voice

9.4.1. There was no doubt that MT had the mental capacity to make decisions about her physical health and environmental risks, and this was understood by all the involved agencies, correctly underpinning their practice.

9.4.2. Agencies engaged with MT in a respectful and personalised manner. However, she was not given the opportunity to consider an earlier, resourced and coordinated plan. It also seems that she felt unsupported by statutory agencies with her activities of daily living from the time of her hospital discharge in December 2021.

9.4.3. ASC and other agencies could not have informed MT's daughter about the dual environmental and physical health risks, as there was a legal and ethical duty to comply with MT's wishes in this regard. MT was also reluctant to invite friends and neighbours into her home, although she clearly formed community bonds and accepted support out of necessity. However, an earlier, resourced and coordinated plan may have provided an opportunity to explore ways of engaging with MT's daughter.

9.5. Coroner findings and recommendations

9.5.1. A Coroner's inquest was held in April 2022 and recorded a verdict of accidental death, without recommendations to involved agencies.

10. Recommendations

10.1. Safeguarding Adults practice improvements

10.1.1. Recommendation 1: SAB training subgroup to seek assurance from partner agencies that staff receive regular safeguarding adults training at an appropriate level of competency, and that this incorporates professional curiosity, thresholds, and self-neglect and hoarding response routes.

10.2. Multi-agency needs assessment and risk management

10.2.1. Recommendation 2: Private Sector Housing to consider a checklist on vulnerability and an arrangement with ASC to check if the person is known and receive relevant background information, before contacting vulnerable people, subject to urgency; with due regard to capacity and consent. Also, to review the content of letters sent to vulnerable adults, ensuring sensitivity, and to consider on a case-by-case basis whether to send the letter or to visit first.

10.2.2. Recommendation 3: Private Sector Housing to consider the feasibility of an in-house pest control service or, if this is not possible, a contact list and guidance for people in commissioning this service.

10.2.3. Recommendation 4: SAB to coordinate consideration of a multi-agency risk management framework, incorporating the existing practice-level risk management procedures for self-neglect and escalation to the existing MARM; with consideration of regular GP locality meetings and alternatives for practice-level risk management. The framework should include hoarding, with guidance on when to progress as a safeguarding response.

10.2.4. Recommendation 5: The multi-agency risk framework should be embedded in practice by partner agencies through training or briefings, commensurate with the agency role.

10.2.5. Recommendation 6: University Hospitals Sussex NHS Foundation Trust and ASC to audit a selection of discharge plans involving escalating care needs, for assurance that reassessment and care planning is undertaken before discharge. A hospital-based social worker is involved in discharge planning, handing on to the community, and this resource and practice had been suspended during the pandemic.

10.2.6. Recommendation 7: ASC to audit a selection of duty and community team referrals and closures; for assurance that community care assessments are undertaken with due urgency, joint with other agencies, when necessary, that robust risk management is in place, and that cases are not closed prematurely. Learning should inform strategic and team planning, reflective supervision, peer complex case discussions, and liaison with the ICS, GP surgeries and Housing.

10.3. **Mental Capacity Act, service user and family voice**

10.3.1. Recommendation 8: SAB training subgroup to be assured by partner agencies that personalisation and informed decision-making by vulnerable adults is embedded in staff training, at an appropriate level of competency.

11. References

Care Act, 2014, Sections 1, 9, 41
Care and Support Statutory Guidance, Dept. of Health & Social Care, 2022
Human Rights Act, 1998, Article 8
Mental Capacity Act, 2005, Section 1
Public Health (Control of Disease) Act, 1984, Sections 31-32.