London Borough of Richmond upon Thames

Safeguarding Adults Board

A Safeguarding Adult Review -

Mr. B.

February 2016

Safeguarding Adult Review panel chaired by J. Cassidy

Acknowledgements:
Thank you to all the people who have contributed to this report, including the agencies and professionals who have supported the Review Panel.

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INTRODUCTION

This Safeguarding Adult Review was commissioned by London Borough of Richmond upon Thames Safeguarding Adults Board in September 2015. It focuses on Mr. B. and the circumstances in which he was found at the time of his death on 9th July 2015.

The review was overseen by a specially convened Panel and led by an independent chair. Partner agencies provided panel members that were representatives of the agencies involved in either commissioning or providing direct services or had recent contact with Mr. B. at the time leading up to his death. The report has been prepared by the independent chair based upon information provided in Individual Management Reviews (IMRs) from:

- London Borough of Richmond Upon Thames – Adult & Community Services
- Richmond Housing Partnership
- General Practitioner

Information contained in the report below sets out the circumstances that resulted in a review being commissioned. The report provides analysis of the individual management reviews from the relevant agencies to determine any learning and identifies subsequent recommendations for the future.

All relevant agencies involved in the Review have confirmed their sign-off and acceptance of this Report.

1. THE CIRCUMSTANCES THAT LED TO THE REVIEW

1.1. On Thursday 5th March 2015 a Gas Operative, a sub-contractor for Richmond Housing Partnership ('RHP') visited Mr. B.'s home to undertake a gas repair. He noticed what appeared to be a 'head injury'[1] which he believed may have been sustained following a fall. The Gas Operative offered to call an ambulance but Mr. B. declined. After leaving the property, the Gas Operative contacted his office to advise them of his concerns, who in turn reported to RHP. An action was raised the same day for the Housing Officer (HO1) to report the concerns to Adult & Community Services (ACS) as per their internal protocols.

1.2. The following day On Friday 6th March 2015 the HO1 telephoned ACS Access Team to refer the concerns raised by the Gas Operative. This telephone referral was followed up with an email confirming the concerns, and advising that Mr. B. was elderly, had a 'cut' or 'head injury' assumed to be following a fall, was vulnerable and not coping at home and may be in need of support. The telephone referral suggests that Mr. B. was aware that the HO1 was going to make contact with ACS.

1.3. Mr. B. was not in receipt of services from ACS. The Social Care Assistant (SCA1) who took the initial referral sought advice from her manager, a senior social worker (SSW1).

1.4. On Monday 9th March 2015 the SSW1 passed the matter to another Senior Social Worker (SSW2) in the Access Team for follow up. The initial Senior Social Worker advised that further information gathering was needed and that Mr. B. should be contacted with a view to offering an assessment of his needs. The matter was passed to a second Social Care Assistant (SCA2) for action.

1.5. SCA2 contacted the HO1 to obtain more information, where it was clarified that Mr. B. was not coping with washing, cleaning or cooking and was in need of services. The HO1 believed the 'head injury' to be recent but was not able to advise what had caused him to fall, as the HO1 was following up on the call the Gas Operative had made to his office, who in turn had contacted RHP. The HO1 had therefore not spoken directly to the Gas Operative and, hence, had no direct knowledge/information to provide.

1.6. On Tuesday 10th March SCA2 contacted Mr. B. via a mobile telephone to follow up on the referral received. (It had proved difficult to reach him and as noted to RHP his mobile telephone was often switched off.) The officer spoke to both Mr. B. and his relative, both of whom advised that they did not need any assistance. Mr. B. confirming that his relative was looking after him and the relative confirming that they did not want a Carers Assessment.

1.7. SCA2 had asked if HO1 could help facilitate a visit. HO1 therefore visited the property that day and spoke to Mr. B.'s relative – on the doorstep (Mr. B. was out at

[1] For the purposes of this report 'head injury' is referred to – point of clarification: this was not a head injury but basal cell carcinoma of the scalp.

the time). Mr. B's relative reiterated that Mr. B. was fine and HO1 then reported back to SCA2 that 'all was well'.

1.8. Mr. B. had a range of serious health conditions, including basal cell carcinoma and squamous cell carcinoma and was under the care of his GP. In the past he had been referred for a biopsy and surgery but had declined both, and also declined to take his doctor's advice and be treated in hospital for the cancer. There was a history of general non-attendance for hospital appointments. (ACS and RHP would not have known of these health issues).

Mr. B. did however attend his GP practice, the last time being on 22nd May 2015 (during surgery hours) where he was seen by a locum GP.

1.9. On 2nd July 2015 the same Gas Operative had visited the property to undertake an annual safety inspection. (The Gas Operative had visited the property on a number of occasions over the years to undertake annual safety checks.) The Gas Operative advised RHP (as part of RHP's IMR process) that during this visit there was positive dialogue between Mr. B. and his relative and that the 'head injury' appeared better.

1.10. Mr. B. died at home on 9th July 2015. Mr. B.'s death was reported to the police on 10th July 2015.

1.11. The condition of Mr. B.'s home when he was found and the condition of Mr. B. himself prompted a more detailed police investigation and a Post Mortem to be undertaken. The police investigation was completed and satisfied that the death was not suspicious (July 2015).

1.12. Mr. B. himself was found to be in an unhygienic state at the time of his death with some evidence of not coping. Evidence suggests that Mr. B. was determined to remain independent and refused any help, however the circumstances in which Mr. B. was living, raised concerns that Mr. B. was not able to care for himself. Mr. B. did live with his relative who was his Carer.

1.13. It is understood that an interim Death Certificate was issued on 29th October 2015 however; the actual cause of death and the outcomes of the Coroner's report are not yet known.

1.14. The living conditions of Mr. B. and his relative were reported to be unhygienic (all rooms) – including unwashed kitchen utensils, with a toilet system that leaked and overflowed into the hallway.

1.15. Given the circumstances in which Mr. B. was found in regard to both his living conditions and health needs, it prompted a referral for a Safeguarding Adult Review

on the basis that agencies needed to review their interactions and interventions and determine singularly or collectively if they had acted appropriately, if they could have acted differently and what lessons are there to learn to improve singular and joint agency responses to a vulnerable person in a similar situation.

2. ABOUT THIS SAFEGUARDING ADULT REVIEW

2.1. It was noted that the referral from RHP to ACS was three weeks prior to the new Care Act implementation. The significance of this is that post April 2015 new statutory duties were placed upon the Council[2].

2.2. The circumstances in relation to Mr. B.'s death met the conditions outlined in the Care Act and a referral notice to the London Borough of Richmond upon Thames' Safeguarding Adults Board (SAB) was made on 22nd July 2015.

2.3. At the request of the SAB, the Safeguarding Adults Review Sub-Group (of the Board) met on 30th July in response to the referral notice received. In considering the Borough's SAR policy it was agreed by all that the concerns raised met the criteria and that this matter constituted a Safeguarding Adult Review.

2.4. This SAR was commissioned by LBRuT Safeguarding Adults Board (SAB) in September 2015. It was overseen by a panel and led by an independent chair. Partner agencies provided panel members that were representatives of the agencies involved in either commissioning or providing direct services or had recent contact with Mr. B. at the time leading up to his death. The report has been prepared by the independent chair based upon information provided in Individual Management Reviews (IMRs) from:

- London Borough of Richmond Upon Thames – Adult & Community Services
- Richmond Housing Partnership
- General Practitioner

2.5. The protocol followed was the London Borough of Richmond upon Thames Local Safeguarding Adult Review Protocol dated August 2015 which had been updated to reflect the Care Act 2014 requirements that came into force from April 2015.

The terms of reference and purpose of the independent Safeguarding Adult Review were:

- To establish the chronology of events in relation to Mr. B. leading up to his death in July 2015.

[2] Section 44 – Care Act 2014

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.

- Review the effectiveness of procedures (both multi-agency and those of individual organisations).

- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to prevent similar harm occurring again.

- Prepare an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations to the SAB for future action.

2.6. Those agencies required to complete IMRs utilised templates provided for this purpose within the updated LBRuT Local Safeguarding Adult Review protocol.

2.7. A number of attempts were made in contacting the relative, including a formal letter advising about the review and its purpose, with a view to engaging with them to facilitate an opportunity to seek their views and perspectives to inform the report. A meeting was arranged with them but was subsequently declined.

3. MR. B.

3.1. Mr. B. was a 94 year old man who lived in a three bedroom house (with his relative) for approximately 50 years, in accommodation provided by RHP.

3.2. Mr. B.'s relative was considered to be the main carer and was in receipt of Carers' Allowance.

3.3. Mr. B. was understood to be independent and continued to do his own shopping and walk to his local shops up until mid-June 2015. It is understood that Mr. B. declined any help from his relative/Carer in regards to personal care.

3.4. Mr. B. had been registered with the GP practice since 17th October 1997. He had a history of serious health conditions – Basal Cell Carcinoma, Ischaemic Heart disease, Hypertension, Atrial Fibrillation, Transient Ischaemic Attack (or mini-stroke) Benign Prostatic Hyperplasia, Angioplasty and Squamous Cell Carcinoma of the scalp. He was receiving medication for these conditions and regular blood tests as required.

3.5. Evidence indicates that Mr. B. generally did not attend most hospital appointments. Mr. B. was known to his local GP practice and would 'drop in' for occasional dressings (regular dressings were not required) and treatments but resisted any advice and recommendations to attend hospital for invasive treatments. On one

occasion when Mr. B. was advised to urgently attend hospital – the GP advised he ran out of the surgery.

3.6. The GP stated that Mr. B. was assessed in 2014 as having full mental capacity and capable of making his own decisions.

3.7. Although Mr. B. was a tenant of RHP this was the extent of their knowledge of him.

3.8. Mr. B. had been known to ACS in the past having attended a Day Centre from June 2001 to March 2002. There was again some contact with the service in August 2007 when Mr. B. had been referred to ACS by a charity worker expressing concerns regarding Mr. B. Contact was attempted at that time and again in October. In December a further conversation had taken place with the charity worker who continued to remain concerned about Mr. B. There are no records available to confirm whether this was followed up by ACS.

There had been no further contact with Mr. B. until March 2015 when ACS Access Team received the call from RHP.

3.9. Mr. B.'s relative was not known to ACS or as a Carer of Mr. B. Contact was made with Mr. B.'s relative in September 2015 by way of follow up support in relation to their loss. This was declined.

4. KEY EVENTS:

4.1. The details below are an amalgamation of the chronology sourced from the IMRs:

4.2. **Historical information:**

June 2001 - March 2002	Attendance at a Day Centre – no other records.
2004	Recurrence of Basal Cell Carcinoma to scalp with hospital referral made. Mr. B. did not attend appointment.
2007	
August	Mr. B. had been referred to ACS by a charity worker expressing concerns regarding Mr. B. Two attempts were made to contact Mr. B. but it appears no further action was taken.

October Mr. B. contacted again by ACS (same social worker) who was concerned about how well Mr. B. was coping with a view to undertaking an assessment regarding potential support. Mr. B. did not respond to approaches made by the social worker.

December ACS records indicate further conversation with the charity worker who remained concerned about Mr. B. whilst acknowledging Mr. B. was independent and may not be eligible for services from ACS at that point. It was agreed that ACS would contact Mr. B. No further records from this point until referral by RHP in March 2015.

2012 Hospital appointment which Mr. B. did attend. Operation proposed but Mr. B. declined the surgery and was removed from the operation waiting list as a result.

Mr. B. attended Stroke Clinic at a London Hospital. Records show that Mr. B. did not attend many of the appointments made.

2014

March Mr. B. attended surgery with wound on scalp and dressing was done.

September Urgent referral (under the 2 week rule for cancer) made by GP in relation to head wound. Mr. B. attended Dermatology Day Unit at a local hospital and was diagnosed with BCC. Mr. B. was advised to have a biopsy. After this Mr. B. declined to attend further appointments.

Mr. B. assessed as having full mental capacity by the GP.

4.3. **Sequence of events relating to SAR:**

2015

MARCH

Thursday 5th	Gas Operative attended Mr. B.'s house to assess heating problem. Gas Operative noted what appeared to be a 'head injury' and asked if Mr. B. wanted him to call an ambulance. Mr. B. declined. Gas Operative completed repair and after leaving the property reported his concerns to his office, who in turn reported to RHP - who put it on their CRM system. Action was raised for Housing Officer (HO1) to report concern to ACS.
Friday 6th	HO1 telephoned ACS and reported concerns to Social Care Advisor (SCA1), following up with an email – 6th March at 13.38 p.m. The email confirmed the following: • Mr. B. was vulnerable and in need of support • A gas operative had visited the property on 5th March and had reported that Mr. B. appeared to have had a previous fall with a 'head injury'. • The offer of an ambulance had been refused • That Mr. B. appeared not to be coping in his home and may need additional support.
13.20 p.m.	Telephone referral received by SCA1 from HO1 at RHP raising concerns regarding Mr. B. Reporting that a Gas Operative had visited Mr. B.'s home on 5th March and noticed that he appeared to have a 'cut on his head' - it was assumed by the Gas Operative that this was due to a previous fall. The Gas Operative had offered to call an ambulance but Mr. B. had declined and asked the Gas Operative to leave the property.
Email 13.38p.m.	HO1 followed up telephone referral with an email stating that Mr. B. was 94 years old, vulnerable, not coping at home and may need additional support. SCA1 auto reply to email – dated 6th March 2015 13.37. SCA1 advises HO1 that Mr. B. isn't a service user and they 'don't contact people out of the blue' and so management advice was needed first.
Email 13.29 p.m.	SCA1 passed details to a senior social worker (SSW1) for a decision regarding next steps.
Monday 9th 8.59 a.m.	SSW1 hands over matter to SSW2 via email. SSW2 advises further information needed to be gathered and then contact to be made with Mr. B. with a view to offering initial assessment of his needs. Allocation to SCA2.

	SCA2 telephoned HO1 to find out more about the concerns raised regarding Mr. B. ACS transcript of the call state that HO1 advised that Mr. B. was apparently not coping, with washing, cleaning or cooking and that he did not have any services. HO1 advised that the 'head injury' appeared to have been recent but could not say what may have caused him to fall. SCA2 also asked if Mr. B. was aware of the contact being made to ACS and whether he had agreed to it. ACS transcript of the call suggests that Mr. B. is aware that a referral was to be made to ACS. HO1 advised it was the first time Mr. B. had come to the attention of RHP – they had only become aware of his circumstances as a result of the gas repair. SCA2 advised she would speak to her manager about next steps and this might involve a visit to Mr. B.
Tuesday 10th	SCA2 contacted HO1 by email to ask if a member of RHP's team can help facilitate assessment of Mr. B. as he had no phone.
	SCA2 telephoned Mr. B. via mobile number supplied by RHP advising she was contacting about his fall and asked some preliminary questions. Mr. B. advised he was alright, although he was 94 and had a weak heart and other things but that he had a relative who lived with him and was doing everything for him. SCA2 asked to speak to the relative and asked the relative about Mr. B.'s apparent fall. The relative advised that he was fine and that they were looking after Mr. B. Offer of Carers' assessment declined – they are 'managing fine with Mr. B.'s care at the moment'. Contact details of the ACS Access Team given for future reference.
Email 12.44 p.m.	SCA2 emailed HO1 to advise that SCA2 had spoken to Mr. B. that his relative was living with him and that he had declined social services. SCA2 also confirmed the conversation with the relative.
	HO1 visited the property and spoke to the relative on the doorstep. The relative confirmed that ACS had been in touch but no help was required from ACS.
Case note 13.40 p.m.	NB – given the sequence of events relating to the referral from RHP the planned initial assessment was cancelled and no further action taken. No further contact with Mr. B.
Email 14.26 p.m.	HO1 reported back to the ACS, Access Team – 'satisfied that all was well'.
12th	Mr. B. telephoned RHP to say he'd be getting someone to collect his rent payment card from RHP office.
23rd	Record to say that HO1 hand-delivered rent payment card to Mr. B.

25th	Mr. B. referred to A&E immediately whilst he was attending GP surgery to see the nurse. Mr. B. declined to go to A&E by ambulance. The risks were explained to him but he left the surgery, declining to go to the hospital. Surgery staff contacted the relative and explained the risk as they were the main Carer. (The relative had confirmed to the GP this was Mr. B.'s choice.)
26th	Mr. B. telephoned RHP to say he had lost the rent payment card and would come to the office to collect another.

APRIL

2nd	RHP Rents team tried to call Mr. B. re housing matters – no reply.

MAY

21st	RHP Rents team tried to call Mr. B. – no answer. RHP sent a text asking Mr. B. to call RHP.
22nd	Mr. B. seen by a locum GP. This was the last review of Mr. B.
29th	Further contacts from RHP re Housing matters.

JUNE

18th	RHP Rents left a voicemail message for Mr. B.
22nd	RHP Rents left a further voicemail message

JULY

2nd	Same Gas Operative visited property to undertake annual service check. The Gas Operative subsequently reported to RHP (as part of their IMR review) that there was positive dialogue with Mr. B. and the relative and that the 'head injury' appeared better.
9th	Mr. B. died at home.
10th	Police notified of Mr B.'s death.
15th	Police notify the surgery that Mr. B. had died at home. Police contacted ACS, Access Team as part of their investigation in relation to Mr. B.'s death and confirmed he had died at home on 9th July 2015.

5. ANALYSIS OF THE INDIVIDUAL MANAGEMENT REVIEWS (IMRs)

IMRs contain detailed scrutiny of events and actions in an effort to better understand the circumstances leading up to Mr. B.'s death with a view to determining what may have been done differently by agencies or what lessons could be learnt. Additionally they can indicate what has happened that is positive.

5.1. Policy & Procedures

All three agencies involved have safeguarding policies and procedures in place. LBRuT operate within the 'London multi-agency policy and procedures to safeguard adults from abuse', and additionally have their local Safeguarding Adults Protocol. The local protocol was recently reviewed in light of the Care Act 2014. The Multi-Agency policy and procedures is also being updated and due for publication in January 2016.

RHP's safeguarding policy and procedure is reviewed every three years and was recently updated in light of the Care Act 2014, receiving Service Committee approval in June 2015.

Whilst the original referral from RHP was made just prior to the Care Act coming into force, all services should have been prepared for implementation at this point. Changes brought about by the new legislation embedded what had hitherto been good practice guidance into statutory requirements for adult services.

Both RHP and ACS confirmed they have specific protocols relating to response and management of issues related to self-neglect as part of their Safeguarding Policies and in light of new requirements within the Care Act. ACS protocols were not in place in March 2015.

5.2. Staff Knowledge and Awareness

5.2.1. The GP practice confirmed that all practice staff are aware of the safeguarding policies and sensitive to the needs of the vulnerable adult in their work.

5.2.2. RHP ensures that all front-line staff have completed safeguarding training via the LBRuT e-learning portal, SCIE e learning or attended RHP in house safeguarding training. They have also rolled-out a programme of safeguarding training to all caretakers and gas operatives to further raise awareness of safeguarding. This is particularly evident by the commendable response from the Gas Operative who raised concerns to RHP via his office on 5th March 2015 and further reinforced by RHP's response to refer onwards to ACS. RHP also confirmed that in such circumstances where there are concerns regarding the wellbeing of individuals, a protocol is in place which

prompts referrals to ACS. There is a long-standing, positive working relationship between ACS and RHP.

5.2.3. ACS ensures staff are trained in safeguarding adult procedures according to their level of seniority with access to the procedure documents for reference as needed. In this instance, staff involved in the initial referral on 6 March 2015 took appropriate steps in terms of taking some details, escalating to a SSW for a decision about next steps and identifying further information was needed, with a view to offering an assessment of needs.

ACS IMR highlights that the Access Team were working with reduced staffing levels for a variety of reasons. This, coupled with high volumes of incoming work, meant that the team was under considerable pressure. As a result SCA2 was undertaking this potentially complex initial exploratory work which would have normally been undertaken by a more senior member of staff. The IMR is reflective that had a social worker been undertaking the investigations, it is likely that they would have taken a more investigative approach and have been more knowledgeable about potential safeguarding indicators.

The other factor was that the SCA2 had not interrogated the Frameworki[3] system and therefore was not aware of the historical information regarding Mr. B. and earlier referrals of reported concerns. Had this been undertaken it may well have prompted greater consideration and linking of the presenting issues. The IMR further reflects that SCAs usually work under close supervision but on this occasion there was less scrutiny than would normally have been the case, again owing to the pressure the team was working under.

5.2.4. It is noted that the Access Team do receive many referrals regarding people who appear not to be able to look after themselves and the initial referral was not raised specifically as a safeguarding alert.

There is a protocol in place for referrals from RHP to ACS which was activated and it was appropriate for ACS to be aware of the range of concerns. RHP confirmed that the gas operative followed RHP process by offering help to call an ambulance and then referring to RHP to follow up with a referral to ACS. However, specifically in relation to the 'head injury' concerns, RHP advise that, unless there is a 999 emergency, the protocol is to refer to ACS as opposed to direct referral to the GP (given this was a health issue).

In this case, Mr. B. had been offered emergency services by the Gas Operative and had declined them. RHP therefore utilised the protocol they have in place with a direct referral to ACS, as not only were they not aware of Mr. B.'s GP, (help with this can be obtained by calling NHS 111 service) but it was their

[3] Frameworki is Adult & Community Services client records database

experience that a direct referral to a GP was not usually accepted where the customer did not want engagement from other services and capacity was assumed.

5.2.5. In this instance the information gathering and discussions with Mr. B. and his relative were taken on 'face value'. The conversations with Mr. B. and his relative on 10th March 2015 had confirmed that all was fine. Also the SCA2 was already aware that Mr. B. had been offered an ambulance and had refused it. Furthermore, SCA2 had further confirmation that 'all was well' from RHP's HO1 who had attempted to visit Mr. B.'s at his address on 10th March to find Mr B was not at home and his relative had advised that they had spoken to Social Services and didn't require any help or support. H01 was not given access to the home and conducted the discussion on the door step.

However, what needs to be noted is that the Gas Operative was sufficiently concerned that the 'head injury' (assumed to be from a fall) appeared to need immediate medical attention (hence the offer of calling an ambulance) and remained sufficiently concerned about Mr. B. to follow up those concerns with the referral via his office to RHP despite Mr. B. declining the offer of an ambulance.

Furthermore, the referral could have been considered as two main areas of concern – the most immediate being the apparent 'head injury' and the second being the concerns around coping at home.

5.2.6. Whilst it may not have been referred specifically as a safeguarding matter, it suggests that the Access Team risk assessment of the presenting issues was inadequate - in particular given an element of the referral related to a 'head injury' possibly from a fall. This, coupled with the historical information on the client database system, which, had it been researched, could well have triggered the referral into the safeguarding procedures/processes and as a result a different response from the one that took place. However, regardless as to whether this was a safeguarding matter, ACS have a duty of care towards vulnerable adults. In addition, it is questionable whether a formal safeguarding alert is required in order to trigger health input when there is a known medical need.

This has highlighted some learning for the Access Team in relation to the supervision of this type of referral for the future and some development needs of staff in relation to opportunities to provide support that were missed in this instance.

5.3. <u>Care and Support Planning</u>

5.3.1. Mr. B. was provided with regular care by the healthcare professionals, including regular blood tests as required – and was seen on the following dates:

28.3.2014 Mr. B. attended surgery with a wound on his scalp and dressing was done.

19.9.2014 Mr. B. was referred urgently under the 2 week rule (cancer referral) but he had full mental capacity and did not attend.

25.3.2015 Mr. B. was seen by the Health Care Assistant. He was referred urgently to hospital but refused to go.

22.5.2015 Mr. B. was seen by the locum GP. He was again found to have full mental capacity.

5.3.2. There was no care plan for Mr. B. - note he was not in receipt of any services from ACS and this was therefore appropriate. As part of the referral process this would have been an early stage of planning to gather information, offer support and an initial assessment of his needs. ACS was therefore not aware of Mr. B.'s GP.

5.3.3. The offer of support was not progressed as Mr. B. stated that his relative cared for him 24 hours a day. A Carer's assessment offered to Mr. B.'s relative was also declined. An initial needs assessment did not take place and no further interventions were considered necessary.

5.3.4. RHP was not involved in any support planning for Mr. B. as expected. Mr. B.'s GP was not aware of any concerns regarding how well Mr. B. was coping at home.

5.4. <u>Professional standards</u>

5.4.1. The GP practice had provided Mr. B. with both local medical support as well as appropriate referrals for specialist input from hospitals in relation to his health matters but, as noted from the chronology above, Mr. B. was reluctant to attend for hospital interventions.

5.4.2. RHP's sub-contracted Gas Operative had followed procedures to escalate any concerns to the RHP housing team via his office who in turn referred the matter to ACS in line with protocols in place. RHP's Rents Team were trying to contact Mr. B. without a response in relation to housing matters but there was no reason to suggest that they should have escalated this matter further.

5.4.3. ACS response was in part in accordance with the required standards of care. The referral did not immediately suggest to staff that an urgent response was

needed and follow up investigations took place on the following working day. (This is in accordance with timescales.) All the actions that took place were appropriate in themselves but insufficient. There were gaps in the interpretation/risk assessment and information gathering in relation to the initial referral which resulted in missed opportunities to take a different response.

5.4.4. It is noted that the initial concern raised by the Gas Operative was on Thursday 5th March and was not referred to ACS until Friday 6th March. Whilst it was clear that there were concerns in relation to Mr. B.'s wellbeing, there was nothing that suggested that an urgent response was needed. However, the referral was considered in its entirety, rather than considering the potentially immediate issue of the 'head injury'. As mentioned earlier, the Gas Operative was sufficiently concerned to not only offer an ambulance, but, when this was declined, continued to relay his concerns to RHP (via his office).

5.4.5. However, it is noted that the further information gathering about the details of the referral and telephone conversations with Mr. B. and his relative were not completed until Tuesday 10th March – six days in total. This potentially left Mr. B. at some risk, given the known 'head injury' – although it must be taken into account that Mr. B. had been offered the call of an ambulance and had refused it.

5.4.6. ACS IMR is reflective that when Mr. B. was contacted on 10th March and offered support which was refused, this was taken on face value. It was also noted that HO1 had on 10th March visited Mr. B. and had confirmed back to ACS that 'all was well' which affirmed to ACS that no further action was needed.

5.4.7. ACS has reviewed the events that took place and have acknowledged that some discussion with Mr. B.'s GP should have taken place. This was a critical gap in the process as had the GP been made aware of the concerns regarding the 'head injury', steps could have been taken to respond via the health professionals. As it was, the GP was unaware and, hence, Mr. B. potentially did not have treatment that he may have needed at that time (assuming he was willing to accept it).

(NB: Subsequent to the referral to ACS on 6th March, Mr. B. had attended his GP practice on 25th March and was referred urgently to hospital which he declined.)

5.4.8. Furthermore, it is acknowledged that a social worker should have arranged a visit to Mr. B. rather than placing reliance solely upon the information provided by the Housing Officer. Whilst accepting that a social worker should have arranged a visit, it is further accepted that Mr. B. may have rejected

such an offer or declined any further support, if it were offered. The absence of such a visit, however, did mean there was no opportunity to further explore how Mr. B. was coping.

5.4.9. It is noted that the initial enquiries were undertaken by an unqualified, albeit experienced SCA, who may not have asked all the right questions. Had the SSW looked more broadly at the referral and the information gathered it may well have led to more exploration of needs. However, it must also be taken into account that Mr. B. and his relative had both refused support that had been offered by the Gas Operative, RHP on the their visit on 10th March and in telephone conversations with SCA2 on 10th March.

5.4.10. Mental capacity was assumed in accordance with the Mental Capacity Act principles by ACS, although no assessment under the Mental Capacity Act had been undertaken.

5.5. Services provided

5.5.1. All the appropriate medical support was offered or provided:

- In 2004 Mr. B. had a recurrence of basal cell carcinoma of the scalp. Mr. B. had been referred to a plastic surgeon at a local Hospital in 2004 – however he did not attend the appointment.

- In 2012 Mr. B. was referred again and on this occasion attended the hospital and was advised that an operation was necessary. Mr. B. did not attend for the operation and was hence removed from the operation waiting list.

- In June 2012 Mr. B. did attend the Stroke Clinic at a London Hospital (he had lacunar infarct) but had a history of non-attendance for hospital appointments.

- In September 2014 Mr. B. was referred by his GP practice urgently under the two week cancer rule and was seen in the Dermatology Day Unit on 30th September at a local Hospital. Mr. B. was diagnosed to be suffering from Basal Cell Carcinoma and advised to have a biopsy. Following this Mr. B. refused to attend further appointments.

- On 25th March 2015, Mr. B. was referred to attend A&E immediately by his GP after being seen by the practice nurse. However, he declined to go despite the risks being explained to him. Mr B.'s relative, as the main carer, was also contacted and advised. Mr. B.'s relative confirmed it was Mr. B.'s choice.

5.5.2. Where individuals do not attend hospital appointments, the GP practice is informed and then follows up with patients – both by letter and also by discussion when they next *see* the individual.

5.5.3. Mr. B. did attend his GP practice on an informal basis for INR (management of warfarin therapy) and was known to the practice staff. This arrangement was by way of occasional 'dropping in' (he attended once in June 2015) and therefore no formal appointments. There is no 'safety net' process in place for then following up with people if they stop 'dropping in', when it is known that they would need some form of monitoring and possible dressing changes/treatment. It is noted that there was no need for regular dressings as the wound had healed and the GP advises that Mr. B. only attended on a few occasions.

5.5.4. Mr. B. was also in receipt of regular medication, with an arrangement for repeat prescriptions with the local pharmacy. The medication would have included pain relief. Mr. B. also had regular blood tests as required.

5.5.5. RHP would not necessarily be involved usually in the care assessment or support services to individual tenants but, as in this case, would report any concerns raised to them through the appropriate channels.

5.5.6. In terms of ACS, the aim was to gather further information and to offer support/assessment of Mr. B.'s needs. The support was offered on 10th March and declined and, therefore, no initial assessment took place. Hence the potential to determine what type of services might be needed was negated and no services were provided. No enquiries other than to RHP as the referring organisation and Mr. B. and his relative were made.

5.6. <u>Assessment and decision-making</u>

5.6.1. In relation to Mr. B.'s medical conditions, appropriate assessments and decisions were made via the GP practice.

5.6.2. As regards ACS, following the gathering of information regarding Mr. B.'s circumstances there was an opportunity to arrange an initial assessment. However, because Mr. B. had confirmed the support from his relative as his Carer, no assessment was provided. Similarly, a Carer's assessment was offered to Mr. B.'s relative, which was also declined. The messages from both Mr. B. and his relative were that 'everything was fine'.

5.6.3. Given the assumption of full mental capacity, and no indications to contrary regarding capacity, the decisions by Mr. B. and his relative were fully accepted.

5.7. <u>Specific Safeguarding Arrangements</u>

5.7.1. No safeguarding adults or care plans were in place as no safeguarding process had been indicated or initiated. However, regardless of whether the referral was raised as a safeguarding matter, ACS has a duty of care to a vulnerable adult. Had ACS undertaken a more rigorous risk assessment of the referral, and triaged against the Frameworki information it could well have determined this was a safeguarding matter and triggered instigation of safeguarding processes. It is also questionable as to whether there is a need for a formal safeguarding alert to trigger a medical response if there is a known medical concern.

5.8. Mental Capacity Act Assessment

5.8.1. The GP practice confirmed that a full mental capacity assessment had been undertaken in 2014. When Mr. B. visited the practice on 22nd May 2015, he was seen by a locum GP who also confirmed that Mr. B. had full mental capacity.

5.8.2. RHP was not aware of whether a mental capacity assessment had taken place.

5.8.3. ACS had not undertaken any assessment of mental capacity. There was no information at the time of referral that indicated that Mr. B. may lack capacity and, when SCA2 contacted Mr. B., it was not perceived that there was any cognitive impairment or confusion during their conversations. However, this was not explored and it was assumed that Mr. B. did have full mental capacity.

5.8.4. As a Social Care Advisor, SCA2 would not have been trained to carry out Mental Capacity Act assessments but was sufficiently experienced to know that had indicators emerged in the conversations, further advice would have been sought from the senior social worker. Mr. B.'s relative also did not indicate during the conversation that Mr. B. lacked capacity to make decisions. Hence there was no trigger to undertake such an assessment.

5.8.5. There was no Mental Capacity Act assessment undertaken.

5.9. Senior Oversight & Scrutiny

5.9.1. Appropriate levels of oversight were in place.

5.9.2. Upon attending the GP practice, whenever there were concerns regarding the health condition of Mr. B. beyond the services the practice could offer, Mr. B. was immediately referred to hospital but generally declined these interventions.

5.9.3. The escalation process was evident in relation to the Gas Operative contacting RHP Housing Team via his office in the first instance who then referred onward to ACS.

5.9.4. Senior managers within LBRuT were not involved in this matter, as this was a reasonably typical referral to the Access Team and managed within the Team systems and processes. There were no reasons as to why the matter should have been escalated further.

Within the Access Team itself, the Team Manager does not routinely have oversight of every activity. SCA2 had involved the SSW appropriately and had

advised the SSW of the information gathering and that support had been offered but declined. Based on the information presented to the SSW, the advice was to close the case and this decision did not need to be made by a Team Manager, as it appeared a straightforward matter. Equally, had a home visit been undertaken, unless exceptional issues emerged from such a visit, it would not necessarily have required escalation to more senior managers.

5.10. Process and actions

5.10.1. It is not yet known what was the actual cause of death; however, the care provided to Mr. B. to treat his known medical conditions via the GP practice was satisfactory. However, there was no contact made with the GP or other medical services (i.e. out of hours if this had been necessary) following the referral on 6th March 2015 to ACS. The GP was therefore unaware of the concerns regarding Mr. B.'s wellbeing and unaware of the issues regarding the conditions in which Mr. B. was living. ACS were unaware of the details in relation to the conditions in which Mr. B. was living other than the information received in the original referral and subsequent information gathering about how Mr. B. was coping and would not have been able to advise the GP of this. However ACS was aware of the concerns regarding the 'head injury'.

5.10.2. In terms of ACS, there was no care being provided, however, had a risk assessment been carried out, a quicker response would have taken place and was likely to have been managed by staff with appropriate levels of experience and knowledge.

5.10.3. Had an assessment visit been offered and accepted, it could have resulted in not only better clarity regarding Mr. B.'s circumstances but also a better outcome in terms of responses, particularly in terms of Mr. B.'s immediate medical needs, although issues relating to lifestyle and coping at home may well have taken longer to work through.

It does need to be borne in mind that Mr. B. declined to accept any kind of support or need for assistance. Individuals have a right to make lifestyle choices and, it is only when these choices pose a serious risk to themselves or others, where it would be considered appropriate to invoke steps under self-neglect protocols. Given that Mr. B. had almost no contact with statutory services, these types of interventions take time to build up trust.

5.10.4. It cannot be known whether the lack of assessment or interventions would have contributed to Mr. B.'s death four months later but Mr. B.'s serious health conditions and his age are factors to take into account. It is also noted that the Gas Operative visited Mr. B.'s property again on 2nd July (a week before Mr. B.'s death) and subsequently confirmed to RHP that there was a

positive dialogue between Mr. B. and his relative, and that Mr. B.'s 'head injury' looked better[4].

5.10.5. Had the GP been made aware of the concerns regarding the 'head injury' and been able to offer medical interventions, even if Mr. B. had refused, there may have been the opportunity to ensure that Mr. B. was at least medically comfortable at home at that time. Noting that Mr. B. had also received treatment on 25th March and was seen by the locum GP on 22nd May.

Patients generally do not return to their GP for follow-up reviews if their health has got better, and the high demand on primary care means capacity is limited so systems for monitoring patients who DNA is currently by letter or telephone.

There is no other system for primary care in regard to follow-up monitoring when there are 'informal drop ins' as opposed to fixed appointments and therefore in this case there was no tracking to determine why Mr. B. had not appeared at the practice and therefore to check on his wellbeing, although he did attend for INR in June 2015.

5.11. Equality and Cultural Sensitivity

5.11.1. All agencies have confirmed that they would have ensured sensitivity to Mr. B.'s cultural, racial, linguistic and religious identity. However, it is noted that contact with Mr. B. from both RHP and ACS was limited and therefore the racial, cultural, linguistic and religious identity of Mr. B. was not established but would have been explored and taken into account in all dealings with him with due regard to legislation, departmental policies and standards.

6. LESSONS

All the agencies generally work well together, including in relation to the safeguarding of vulnerable adults – for example, protocols are in place between RHP and ACS in relation to concerns regarding individual tenants *when they are known*. However, there is more that could be done for agencies to work together in cases of a complex nature – see recommendations below.

6.1. The GP practice was unaware of any of the concerns regarding Mr. B. other than the known medical conditions that they were already supporting. However, Mr. B. occasionally dropped into the practice to see the practice nurse for dressings (noting that regular dressing was not required) or INR checks, this was an informal arrangement and so there were no appointments made and therefore no triggers for

[4] The nature of skin cancers can mean occasional bleeds – this may have accounted for the concerns raised by the Gas Operative on 5th March, and the fact that the 'injury' looked better on 2nd July.

non-attendance. As a consequence, when latterly Mr. B. did not drop in, there was no process in place to follow this up by practice staff as there was effectively no 'DNA' recorded on the system and no 'safety net' in place for monitoring.

6.2. RHP had acted appropriately in terms of the referral to ACS, in accordance with existing protocols particularly, given that Mr. B. had declined the offer of an ambulance (i.e. emergency services), and there were wider concerns regarding how Mr. B. was coping at home.

The actions of the Gas Operative were an example of good practice.

ACS is the lead agency for safeguarding matters, however, there is a question as to whether the medical needs require a safeguarding alert in order to trigger health intervention via ACS, and whether, going forward there could be simultaneous referrals to both ACS and medical professionals in these circumstances.

There was an issue of 'boundaries' once the referral to ACS had been made. In an effort to work in partnership but also there was a perception by RHP that the need for a visit to Mr. B. had been "pushed back" to RHP (possibly from the email that asked if a visit could be facilitated – ACS advise that this was not the intention by the request but rather that as Mr. B. was difficult to contact RHP may have been more successful as they already had a connection, although this was not clear in the request). The HO1 took a greater responsibility at this stage and then subsequently advised that 'all was well'. RHP's IMR reflects on the learning and that they should not be involved in the care or assessment of Mr. B., and that a visit to Mr. B. to assess and check on his wellbeing should have been undertaken by ACS and not HO1.

The referral from RHP was reflecting the concerns raised by the Gas Operative. This meant that RHP had limited information to offer to ACS other than what they had been told by the Gas Operative's office.

6.3. In relation to ACS:

6.3.1. The initial referral was limited (a lack of clarity regarding the presenting issues and a lack of urgency regarding the reported 'head injury'); concerns as to how well Mr. B. was coping were indicated but not the severity. (RHP would not have known the details as they did not have access to the home)

This referral was provided by the RHP Housing Officer, who was in turn relaying what had been advised by the Gas Operative via his office. Some discussion between RHP and ACS about obtaining more information directly from the Gas Operative would have helped.

6.3.2. Had the client database been checked for historical information it would have provided some useful information to trigger more enquiries.

6.3.3. When it was determined that Mr. B.'s relative lived with Mr. B. there was no exploration as to whether the concerns reported were due to not coping or some other reason. This was not explored further.

6.3.4. There was no exploration of the medical support that might be needed and no referral made to the GP practice regarding what, on the face of it, appeared to be a 'head injury' that was of sufficient concern to the Gas Operative to warrant an offer of calling an ambulance. Such a referral to the GP practice or out of hours service, had this been necessary, would have resulted in a range of potential medical interventions (even if Mr. B. then subsequently refused them), e.g. community health referral for a home visit. Ultimately this would have enabled the GP to be made aware of the concerns and act accordingly and in a timelier way and, perhaps as a minimum, to ensure that Mr. B. was medically comfortable at home. Furthermore, the process took some six days from referral to case closure which was too long in relation to the apparent medical needs.

6.3.5. ACS did not determine that a visit to Mr. B.'s home was necessary and relied upon the 'referrer' (RHP's Housing Officer) who subsequently visited the house and had advised that 'all was well' (although they had not entered the property and this was indicated to them from the discussion with the relative on the doorstep as access was not granted).

6.3.6. The referral was not fully risk assessed so there were no considerations as to potential safeguarding and, hence, the safeguarding procedures were not instigated which may have resulted in a different process being adopted. (Note that ACS has a duty of care regardless of whether the referral was considered a safeguarding matter). Whilst the SCA2 is experienced in their role, this referral required more oversight by an experienced social worker.

There was insufficient follow up/action by ACS in relation to the concerns regarding how well Mr. B. was coping at home, in addition to the health issues.

Mr. B.'s relative had not indicated any concerns around Mr. B.'s capacity to make decisions, and hence no further exploration regarding mental capacity.

The Access Team would now (and would have at the time had resources allowed) allocate this type of referral immediately to a social worker (which may have an effect upon staffing resources within the team), and a more detailed focus would be taken to elicit and triangulate information, including clarification of mental capacity. The Safeguarding Adults procedure would be initiated to consider potential self-neglect issues.

The SCA was asked to gather information at a time when the team was under pressure in order for a wider decision to be made regarding potential for further intervention

6.3.7. In terms of good practice, SCA2 did explore a number of concerns with Mr. B. in relation to management of personal care and home environment and ensured that this information was checked with Mr. B. for accuracy. SCA2 had explored ways in which to engage with Mr. B. – including the possibility of a home visit. SCA2 did discuss this matter with her line manager. Importantly too, SCA2 not only spoke with Mr. B. but also did have a discussion with Mr. B.'s relative as the main carer and ensured a Carer's Assessment was offered. SCA2 also provided the Access Team contact details if further help was needed.

6.4. There was good liaison and communication between RHP and ACS throughout.

6.5. There appeared to be a lack of clarity in relation to the Information Sharing protocol[5] and obtaining Mr. B.'s consent prior to any consideration of referral to the GP.

6.6. The GP assessed Mr. B. as having full mental capacity but it is noted that no other mental capacity assessments were undertaken in line with the Mental Capacity Act.

7. CONCLUSIONS

7.1. Mr. B. was 94 years old and had multiple, serious medical problems. He suffered with cancer and was referred appropriately for secondary care. On many occasions Mr. B. did not attend appointments and did not want any operative procedures.

7.2. Mr. B. was receiving treatment via his local GP practice for his medical conditions, including dressings (when needed as there was no need for regular dressings) and medication, with a repeat prescription service. He was known to take his medication regularly and had a 6 month supply.

7.3. The GP assessed Mr. B. as having full mental capacity and capable of making his own decisions regarding his care. Mr. B. had also been liaising with RHP in relation to his rent payment card (12th and 26th March) – evidence that he had capacity in relation to managing his finances. Mr. B. was mobile and independent until around mid-June 2015.

7.4. Mr. B.'s relative was his main carer and was informed of Mr. B's conditions and the advice regarding the need for hospital treatment by the GP. Mr. B.'s relative had confirmed that it was Mr. B.'s choice.

[5] Information Sharing Protocol across agencies was revised in December 2014 (although available on the LBRuT website, it is not clear whether it has been fully signed off by all parties). Appendix B provides advice and guidance regarding the issue of consent.

7.5. The GP practice acted appropriately in relation to responding to his medical needs. However, the informal drop-in arrangement at the practice meant there was no tracking of Mr. B.'s attendance/non-attendance and as a consequence, there were no follow up actions when Mr. B. stopped attending and no monitoring of his continued wellbeing.

The GP practice was unaware of the concerns regarding Mr. B.'s living circumstances or the recent referral to ACS. No referrals or expressions of concern were received by the GP from other people who may have known Mr. B.

7.6. RHP acted appropriately and responsively to the concerns raised by the Gas Operative. RHP, as is usual with most tenancies, did not directly know of the details of Mr. B. other than that of being a tenant. They were therefore unaware of Mr. B.'s circumstances until the referral from the Gas Operative on 5th March 2015. There were no concerns reported by others. Furthermore, it is noted that the same Gas Operative visited Mr. B. on 2nd July (a week before Mr. B. died) and had subsequently advised RHP that Mr. B. had a positive rapport with his relative and the apparent 'head injury' looked better.

It is noted that neither RHP, nor ACS were aware of who Mr. B's GP was. ACS as the lead agency in safeguarding matters (Care Act 2014) has the responsibility for making these enquiries. However, staff do need guidance as to what to do if the GP is unknown i.e. this could have been determined with the help of the NHS advice service or by dialling 111.

7.7. The stages of the Access Team's involvement were appropriate but limited – a referral was received; further clarification sought; the individual contacted and offered support with the intention of providing an initial assessment of needs. However there was no evidence of risk assessment in response to the concerns regarding the 'head injury', the degree of seriousness relating to this and little background information, in addition to the issues regarding how well Mr. B. was coping at home. Thereby the risks were unknown. The length of time the process took was not an urgent response and the case was handled by a social care advisor and needed more scrutiny and support (as a minimum) from a Senior Social Worker.

8. RECOMMENDATIONS

The recommendations below have been developed from the information gathered and analysed that has been available. At the time of preparing the report, the actual cause of death remains unknown and whether, had it been known, it may have added further to the report and any consequential lessons or recommendations.

Recommendation 1 - Training

It is recommended that RHP continue to roll out safeguarding awareness training to its immediate partner contractor.

RHP has recognised the important role that Gas Operatives play as they will enter every one of RHP's homes at least once per year to undertake the annual safety checks. RHP has already implemented rolling out training to their partner contractor who carries out the gas safety inspections.

Recommendation 2 - RHP Protocol

It is recommended that consideration be given to reviewing RHP's current referral protocol to ACS.

To help ensure as much information as possible is provided when making a referral to ACS.

Recommendation 3 - Staff Guidance

It is recommended that guidance for staff to be produced that advises what steps to take when the GP is unknown.

Recommendation 4 - Service Development

It is recommended that consideration be given to the development of a Marac or other multi-agency approach to assist in situations of a complex nature.

This links to the same framework as Domestic Violence Maracs that already exist – a multi-agency problem solving meeting. Such a group could then discuss high risk, complex cases e.g. those involving vulnerability, disability, chaotic lifestyles, ASB, repeat victimisation, hate crime, etc. Having a multi-agency approach can help look at what can be done to expedite and assist cases where engagement with a person in need of help can be difficult but also help to clarify and manage risk, facilitating information sharing which is often of a confidential nature. It would also help to consider approaches to be taken when, on the face of it, the individual advises 'they are managing'.
This type of approach has been piloted elsewhere[6] and the benefits have been in having multi-agency resolution and joint ownership, together with harnessing creative solutions to problem solving with specialist inputs.

A Multi-Agency High Risk Panel is in the final stages of development by ACS along the above lines and will be mobilised during the early part of 2016.

Recommendation 5 - Staff Guidance and Protocols

[6] Community Marac first piloted in Ealing but now pilot schemes being developed in a number of London Boroughs including Kingston.

It is recommended that there is a review of protocols for staff around the issue of how the service should respond to issues of self-neglect.

It is recommended that where procedural guidance exists in relation to self-neglect, this needs to be rolled out to all agencies to provide support and guidance to staff.

Such a review should also consider how the protocols would link to a multi-disciplinary approach described above – that include the involvement of health professionals. People have the right to live a lifestyle of their choosing, however, good practice examples have helped define lifestyle levels in a way that is non-judgemental but provides a graded spectrum from 'untidy' through to what would be considered 'dangerous' and therefore harmful to the wellbeing of that individual. This helps determine what the intervention, if any, could be.

RHP has confirmed they are already working on a model with the Fire Brigade and this working group may need to be expanded to ensure representation from all appropriate bodies. The Care Act has placed a statutory duty on local authorities to change the way self-neglect issues are responded to – utilising safeguarding procedures.

Procedural guidance has been drawn up as an adjunct to the safeguarding procedures. This needs to be rolled out to all agencies to provide support and guidance to staff in cases where self-neglect is apparent.

Recommendation 6 - Information Sharing

It is recommended that Information Sharing Protocols are reviewed to ensure clarity about what can and what cannot be shared.

Clarity is particularly required to provide for those circumstances where the service user has not provided their consent to share but there are serious safeguarding concerns or concerns regarding wellbeing, taking note of 'duty of care'.

Recommendation 7 - Training

It is recommended that the Access Team staff, particularly Social Care Advisor roles, receive refresher/training in relation to risk assessments of referrals received.

It is recommended that the Social Care Advisor roles also receive further training/guidance in relation to information gathering to ensure that the full range of sources are considered.

In light of this particular incident, it is recommended that Access Team, particularly Social Care Advisor roles, receive refresher/ training to help them with 'risk assessing', particularly in relation to safeguarding vulnerable adults in relation to neglect. Some development needs were highlighted for the Social Care Advisor roles

appropriate to their level of responsibility in relation to gathering sufficient information from a range of sources to provide as full a picture as possible.

It is noted that an additional Social Worker post has been added to the staffing establishment in the Access Team and already recruited to which has been invaluable in strengthening the balance of qualified staff within the team and therefore the management of complex casework.

Recommendation 8 - System Development or Protocol

It is recommended that within GP practices there is exploration/development of a more robust trigger system or protocol for alerting the practice in relation to regular 'drop-in' patients who stop dropping in unexpectedly.

It is accepted that the GP practice involved in this review has more than 6,000 patients, and it is also acknowledged that the demands on primary care are such that to establish tracking systems for following up on informal 'drop-in' arrangements may be challenging to achieve. However, it is suggested that perhaps there could be some exploration of what may be possible (i.e. protocols) that would facilitate some kind of 'follow up alert' or trigger system when a patient who had previously been 'dropping in' for treatments does not appear.
It is suggested that letter writing is not necessarily adequate follow up for DNA's in the case of fixed appointments and the GP practice has confirmed that an email system is already being developed.

Recommendation 9 - Relative Engagement

It is recommended that the SAB determine post-report liaison with the relative regarding the outcomes of the Review.

It is proposed that such engagement to be prior to any publication of the findings as determined by the SAB.

Recommendation 10 - Staff Guidance

It is recommended that refresher guidance is provided to ACS, particularly the Access Team, in relation to the support available from Health partners such as 111 services.

The Access Team are aware of the support from Health Partners, such as 111 services. However, information about the 111 service could be included in the Access Teams guidance or protocol documents for further reference.

Recommendation 11 - Training

It is recommended that the CCG roll out updated training in relation to Mental Capacity Act Assessments for GP practices.

To ensure that all GP practices have the same level of expertise.

Appendix A: References – legislation, policy and guidance context

Care Act 2014

Section 44 of the Care Act puts a duty upon the Safeguarding Adults Board (SAB) to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) – specifically, Section 44 states:

1. *"An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*

   (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, ***and***

   (b) condition 1 or 2 is met.

2. *Condition 1 is met if:*

   (a) the adult has died, and

   (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

3. *Condition 2 is met if:*

   (a) the adult is still alive, and

   (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

4. *An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)."*

Under the Care Act each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

Appendix B: Serious Adult Review Panel Members

Julia Cassidy	Independent Chair
Janet Cole	Head of Early Intervention, Prevention & Rehabilitation – LBRuT
Caroline Hand	Head of Community Services – Richmond Housing Partnership
Dr Arun Kudra	GP
Julie Sobrattee	Chief Nurse for Safeguarding Adults - Richmond CCG
Kam Ubhi	Administrator/Minutes

Appendix C: Acronyms

SAR	Safeguarding Adult Review
SAB	Safeguarding Adults Board
ACS	Adult & Community Services
RHP	Richmond Housing Partnership
LBRuT	London Borough of Richmond upon Thames
HO	Housing Officer
SCA	Social Care Advisor (Access Team)
SSW	Senior Social Worker