MK Together Partnership

Safeguarding Adults Review - *Denise*

Overview Report

Concerning the care of *Denise*

Independent Reviewer

Pete Morgan BA, MA, MA & CQSW

Approved by MKT Review Board, January 2021

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1. Introduction

1.1 For the purposes of this review report and in order to protect the identities of those involved the subject will be known as Denise.

1.2 It is easy for Safeguarding Adults Reviews and Overview Reports to focus on events and the involvement and actions of a number of agencies; it is important that this Safeguarding Adults Review and this Report recognise that, at their centre, is a human being, who should be treated with respect, and likewise their family members.

1.3 Denise was born on the 1959 and was 59 years old and living on her own in a Housing Association flat in Milton Keynes at the time of her hospitalisation.

1.4 At the time of her death Denise was in contact with her mother and a brother, but no details of her birth family were available to the Review.

1.5 Denise had a son, Eric, who was born in November 1991, but he hadn't lived with her for some time before her death. The exact date he left home and his current whereabouts were not available to the Review.

1.6 In February 2019, there was a leak at Denise's flat resulting in her water being cut off. The Housing Association was unable to fix the leak due to the level of hoarding in the property. Denise was assessed as having capacity and did not agree to any of the contents of her home being removed. She lived with her animals in what was described as *'a cluttered and dirty home'* and following the leak lived without water for six months. The RSPCA removed a number of her pets, but no legal proceedings were initiated.

1.7 During the following six months, Adult Social Care (ASC) was involved with Denise, working with her to try to support her to clear and clean her flat to the point where the leak could be repaired and the supply of water reinstated.

1.8 On 16 August 2019, the Police were contacted by neighbours who hadn't seen Denise for several days; when they accessed the flat, they found her on the floor. Her physical presentation was described as emaciated and she did not have the energy to get up. An ambulance was called and she was admitted to hospital where she was treated for extreme emaciation and multiple pressure sores. While in hospital, Denise developed pneumonia and died on 5 September 2019.

1.9 The case was referred to the Case Review Panel for consideration for a Safeguarding Adults Review (SAR) by the Milton Keynes Council Adults Safeguarding Team Manager on 27 August 2019.

1.10 Information from agencies was gathered as part of the Rapid Review process and considered by the Case Review Panel. On 25 September 2019, the Case Review Panel made a recommendation to the Independent Scrutineer that the case met the criteria for a SAR.

1.11 On 30 September 2019, the Partnership's Independent Scrutineer confirmed that a SAR should be undertaken in accordance with the multi-agency Safeguarding Adults Review Procedure.

1.12 This Report was authored on behalf of the Partnership by Mr Pete Morgan, an Independent Consultant.

1.13 The administration and management of the Safeguarding Adults Review has been carried out by the MK Together Team.

1.14 This Review was commissioned under s44 of the Care Act 2014; its commissioning will be reported in the Partnership's Annual Report for 2019/20 and its findings and their implementation will be reported in the Annual Report for 2020/21, as required by the Act.

1.15 The Report was ratified by the MKT Review Board at the meeting held on 9 November 2020.

2. The Review Board

2.1 The Review Board acted as the SAR Panel for the Review on behalf of the MK Together Safeguarding Partners and comprised individuals across a range of statutory sector agencies as below:

Central and North West London NHS Foundation Trust
Milton Keynes CCG
Milton Keynes Council Adult Social Care
Milton Keynes Council Children's Social Care
Milton Keynes University Hospital Foundation Trust
Thames Valley Police

2.2 The business of the Panel was conducted in an open and thorough manner. The meetings sought to identify lessons and recommend appropriate actions to ensure that better outcomes for adults with care and support needs in similar circumstances are more likely to occur as a result of this Review having been undertaken.

3. The Safeguarding Adults Review's Terms of Reference

3.1 The meeting of the Review Board held in November 2019, agreed the Terms of Reference for the Review but agreed they would be regularly reviewed as the Review progressed to ensure they remained fit for purpose.

3.2 The finalised Terms of Reference can be found in Appendix A.

4. Scope of the Safeguarding Adults Review

4.1 The scope of the SAR was set as the period from 9 February 2016 until 5 September 2019.

4.2 The reason for this was that it would focus the Review on the period between the time Denise first came to the attention of services for hoarding to the date of her death.

4.3 Agencies were asked to include a summary of any earlier information about their involvement with Denise if they considered it to be of particular relevance to the Review.

5. Information Trawls

5.1 Information trawls were completed on Denise to identify which agencies had had relevant contact with her during the period of the Review.

5.2 These enabled appropriate Independent Management Reviews and chronologies to be requested to enable the Panel to ensure the Review was in possession of all relevant information about single and multi-agency support offered and received by Denise and her family.

5.3 The Panel considered at each of its meetings whether further Independent Management Reviews or other reports were required; in the event, the Panel decided that none were.

5.4 IMRs were requested from the following agencies regarding their involvement with Denise and her family:

- TVP
- SCAS
- MKC Adult Social Care
- MKUHFT
- Housing Association
- GP
- Bucks Fire and Rescue

5.5 Agencies were required to make recommendations within their IMRs as to how their own performance could be improved. These were accepted and adopted by the agencies concerned. The recommendations are supported by the Independent Reviewer.

5.6 Due to the Covid-19 Pandemic, it was not possible to hold a briefing session for the IMR authors. The original IMRs were of a mixed standard, reflecting the experience and expertise of their authors and their agencies of origin, but were revised where necessary.

5.7 A full and comprehensive review of the agencies' involvement and the lessons to be learnt was achieved.

6. Family liaison and involvement

6.1 Attempts were made to contact Denise's mother and brother by letter. They were offered the opportunity to meet or speak to the Independent Author and/or the MK Together Programme Manager.

6.2 They were advised they could change their mind about meeting either of the above at any time and that they would be given the opportunity to see and comment upon the findings and recommendations contained in the final draft of the Report before it was presented to the Review Board.

6.3 No reply was received so the review and this report were completed without the benefit of their views of the support and care offered and provided to Denise.

7. Liaison with the Police

7.1 There had been no prosecutions relating to this case and there were therefore no issues regarding disclosure at the commissioning of the review.

8. Independent Overview Report

8.1 The Terms of Reference for the Review require the Review Board to identify an Independent Author but does not provide any Job Description or Person Specification to assist in their identification or recruitment.

8.2 The Review Board appointed Mr Pete Morgan as the Independent Author from their pool of Independent Authors.

8.3 Mr Pete Morgan has previously chaired a number of a number of Safeguarding Adult Boards as Independent Chair, following his retirement as Head of Service, Safeguarding Adults at Birmingham City Council. The author has experience of commissioning and participating in statutory reviews. The author has previously completed one thematic review for the MK Together Partnership. He was a member of the Department of Health's Safeguarding Adults Advisory Group and is currently the Chair of the Board of Trustees for the Practitioner Alliance for Safeguarding Adults and the Independent Chair of the Safeguarding Panel for Advance, a charity that provides accommodation and support for adults with care and support needs.

8.4 The independent author had no involvement, directly or indirectly, with any member of the families concerned in this Review or the commissioning, delivery or management of any of the services that they either received or were eligible for prior to being commissioned to write this Report.

8.5 Mr Morgan also had no involvement, directly or indirectly, with any of the agencies contributing to this Review prior to being commissioned to write this Report.

9. Agency involvement prior to the review period

9.1 Agencies providing IMRs were able to include brief details of any particularly relevant involvement they had had with Denise prior to the review period.

9.2 In April 1997, the Housing Association allocated Denise the tenancy, where she remained the tenant until the date of her death. It would appear that she was the sole tenant, with her son Eric living with her.

9.3 In July 2003, Milton Keynes Council Adult Social Care (ASC) recorded their first contact with Denise when they were contacted by the Thames Valley Police (TVP); Denise would repeatedly contact the TVP on 999, saying she was having panic attacks and that she could hear noises. When the Police attended, they would find nothing to support these concerns, but Denise told officers she was lonely. The TVP advised ASC that they would not be attending in future unless there was more concrete evidence of an incident having occurred. The TVP also reported a child (Eric) living at the address. ASC advised Denise by letter that she should contact her GP, who was reported as prescribing medication but it is not recorded what or what for, regarding possible mental health issues and Children's Social Care (CSC) to explore what support could be available to her.

9.4 No further action was taken at this time by ASC; there is no record of TVP contacting CSC. As this event happened outside the review period, CSC was not asked to contribute to the review.

9.5 The above is not supported by TVP's records: these show that Denise was first known to them in August 2003, when she reported that a window in her tenancy had been smashed by a stone. No entry had been gained and the neighbourhood officer was made aware.

Finding 1:
Both TVP and ASC were aware that Eric was living with Denise and was potentially a Child in Need and a Young Carer but neither brought this to the attention of Children's Social Care but relied on Denise seeking support for both herself and Eric

9.6 The TVP records also show a verbal argument between Denise and Eric on his 13th birthday in 2004 and further domestic incidents between Denise and her partner between 2007 and 2009 when Eric was still living at home. Details of the outcome of these incidents is not known to the Review.

Finding 2:
TVP was aware that Eric was experiencing domestic abuse, whether as a victim, perpetrator or a witness is unclear, but did not refer this to CSC.

9.7 South Central Ambulance Service (SCAS) first became aware of Denise on 20 November 2011; the review is not aware of the reasons for or the outcome of this contact.

10. Key Events and Analysis

10.1 Buckinghamshire Fire and Rescue Service (BFRS) first became aware of Denise on 9 February 2016, when they were contacted by a Housing Association Neighbourhood Housing Officer (NHO1) with the requesting a joint Home Fire Risk Check (HFRC); this was carried out on 18 February 2016 by the BFRS1 and NHO1. This identified "high fire loading, restricted access, trip hazards and overloaded electrics", resulting in NHO1 referring Denise to Floating Support and BFRS1 making referrals to Telecare and to "the falls team" with osteo-arthritis given as the identified need.

Finding 3:
This is an example of good practice in that a referral was made to BFRS for a Home Fire Risk Check that identified clear areas of concern and some additional referrals were made for support services.

Finding 4:
Despite there being evidence of hoarding and possible self-neglect, no referrals were made to specialist self-neglect forums or to Adult Social Care for consideration under the Safeguarding Adults Procedures.

10.2 There is no reference to Eric or to any partner living with Denise at this time; the review is not aware of any record of any of the above referrals being received or of any outcome from them. This may be due to records not being kept of those people who decline having an alarm installed, the most common cause of which is its cost. It was recorded by BFRS when they visited on 3 April 2019 that there was no evidence of a telecare system in the property.

Finding 5:
Despite referrals to possible support services being recorded as being made there is no record of them being received or of any follow-up to establish the outcome of those referrals.

10.3 On 12 April 2017, TVP records show that Denise contacted them as she was concerned that she might not be in when workers called the next week because of problems with her hot water system and they might try to gain access to the property; she was concerned that it might be a scam. Practical advice was given including contacting Action Fraud if Denise was concerned. No other reference to this incident was brought to the Review's attention.

Finding 6:
This was good practice in that TVP provided Denise with appropriate practical advice

10.4 In July 2017, the GP Practice recorded that Denise attended an appointment due to acute exacerbation of her chronic back pain and was provided with appropriate analgesia.

10.5 On 5 February 2019, the Housing Association recorded a phone call from Denise, but its content and outcome are not known to the Review.

Finding 7:
This is one of numerous occasions where contact is made with an agency and there is no record of the content, purpose outcome of the contact; on occasions, the identity of who the contact is with is not clear – for example just a phone number is recorded

10.6 On 11 February 2019, the GP Practice recorded a prior arranged phone call to Denise but a message had to be left as she didn't answer; she later rang back to request a sick note until the end of the month when she had an Employment Seeker's Allowance (ESA) assessment. A sick note was issued from 5 - 28 February for chronic back pain.

10.7 On 11 February, BFRS recorded that a 999 call was received by Thames Valley Fire Control (TVFC) from Denise re "a drawer freezer defrosting and leaking water"; she was advised that this was not something BFRS could assist with, that no emergency response was required and "to ask for the assistance of a friend or neighbour to move the freezer outside and to contact the council to arrange disposal".

10.8 On 12 February 2019 the GP Practice recorded a request for a prescription for paracetamol for Denise's diagnosed osteoarthritis and Propranolol for her anxiety, which was issued.

10.9 On 12 February 2019, Denise rang the Housing Association, but the Review is not aware of the content or outcome of the call.

10.10 On 14 February 2019, the Housing Association recorded a call from Denise to report that her freezer is leaking; she was advised that the care of her white goods is her responsibility.

Finding 8:
The Housing Association had been aware of the condition of Denise's tenancy for at least three years – see 10.1 above – and therefore the potential for self-neglect, but she was offered no support to deal with the leaking freezer.

10.11 On 14 February 2019 at 17:30, TVFC recorded a 999 call from Denise to report internal flooding; BFRS attended the flat having completed an address check with TVP and been advised there were no warning markers of recent calls to the address. The BFRS crew were unable to identify its source and isolated the water supply at the roadway. The BFRS Watch Commander contacted the Housing Association to inform them of this and that the property was "inhabitable".

10.12 On 14 February 2019 at 19:00, the Housing Association recorded the contact from the Watch Commander with the additional information: hard floor but rugs and carpets are saturated; bathroom hasn't been used in 12 months – there was a bucket in the kitchen; second bedroom and bathroom impossible to enter; as an assessment had identified Denise as a Level 6 hoarder, BFRS had made a referral to ASC; they had contacted the RSPCA due to the number of animals in the property – the details are not recorded – and advised that the property was "uninhabitable" – see 10.11 above – but that Denise had gone to a friend's overnight. Denise had advised the BFRS Watch Commander that she had reported the leak to the Housing Association and had agreed to him making the above referrals. BRFS has no record of advising the housing association of any referral to ASC.

10.13 On 14 February 2019, BFRS recorded an email at 19:07 from the Watch Commander to BFRS1 and copied to the Station Commander, "detailing hoarding level 6, use of bucket for toileting, combination faeces and leaking water over floor coverings".

10.14 On 15 February 2019 at 7:44, the Housing Association recorded an email from the Neighbourhood Housing Manager (NHM1) to NHO2 asking them to complete a "safeguarding referral and advice and support to TSO (Tenancy Sustainment Officer*)*" and to arrange a home

visit with Denise and the relevant agencies. NHM1 queried if Milton Keynes Council (MKC) provide a deep-clean service via Environmental Health. They also emphasised that, while clearly vulnerable, Denise needed to understand the need to work with agencies to return “this property back to a reasonable condition”. Having been able to access and assess the property while Denise was out, it was necessary to get her and agencies to “sort out the property”. NHM1 told NHO2 that NHO1 knew the case and could advise her on previous contact with Denise.

10.15 On 15 February 2019 at 8:04, the Housing Association recorded an email from the Area Surveyor, Housing Association Response (HAR) to NHM1 advising that, given the known condition of the property, repairs could not be carried out until it had been cleaned due to the animal faeces and querying what toilet facilities Denise had been using for the past year. Repairs would also be difficult without the hoarding being addressed, but HAR would work together to carry out the repairs once this was possible.

10.16 On 15 February 2019 at 8:35, the Housing Association recorded an email from NHM1 to NHO2, copied to NHO1, advising that no repairs can be carried out until “the property is sorted”. She stressed the need to work together with Denise and the relevant agencies to resolve the situation and to ensure it doesn’t recur. She attached the relevant forms and policies to assist NHO2 and advised the risk assessment be completed to enable a decision to be made as to whether or not to consider a tenancy breach had occurred and act accordingly. In particular, she asked that MKC be contacted about a possible deep-clean of the property and that Denise be asked if she can continue to stay with her friend and what the RSPCA are doing about her pets, with a view to considering refusing her permission to keep pets in the future.

10.17 On 15 February 2019 at 10:52, the Housing Association recorded an email from NHO2 to TSO1 to refer Denise, giving the background details above about the state of the property, the referrals to MKC and the RSPCA and that she is staying with a friend as the property is uninhabitable.

10.18 On 15 February 2019, the Housing Association recorded that NHO1 had contacted their Caretaker to visit “and knock and card the property”, meaning to call, and if there is no answer, leave a calling card with their contact details asking the tenant to contact them; this they did, resulting in NHO1 talking to Denise on the phone. She had returned home at 3am that morning “as she wanted to be with her animals in the comfort of her own home”. She said she was happy in the property and had cleared up after the leak. NHO1 invited Denise to come to the office. NHO1 had spoken to a Customer Liaison Officer (CLO) at the Access Team MKC, who advised that they had had no referrals for Denise but that this would not be a safeguarding referral but an ASC referral which could be made on-line. After explaining the details of the situation, NHO1 was advised to contact the Urgent Care Mental Health Team and was given the appropriate phone number.

10.19 On 15 February 2019, ASC recorded receiving a referral via a CLO in the Access Team from NHO1 with the Housing Association; she was checking if BFRS had referred Denise due to hoarding issues; there was no record of such a referral being received by the Access Team.

10.20 ASC recorded NHO1 advising CLO that the Housing Association had been aware of and working with Denise for some time to try to support Denise regarding the poor state of her property and her hoarding issues. A contractor had visited the previous day and had been unable to carry out some repairs; Denise had been told she could not remain at the property and she had gone to a friend's but had returned to her flat as she wanted to be in her own home and that there is no water in the flat, that there is animal faeces and that Denise was 'in denial about her situation'. ASC advised they were not currently working with Denise and were asked to work with the Housing Association to support her.

10.21 NHO1 advised that there were animals in the property and that Denise had breached her tenancy agreement and was at risk of eviction, although this was a course of action the Housing Association did not want to pursue. ASC confirmed they did not consider this to be a safeguarding concern. They did agree a Community Support Worker (CSW) could visit with NHO1 to see if there were any needs they could assist with. NHO1 discussed this with Denise by phone, who agreed to the joint visit.

10.22 The ASC Deputy Manager Assessment Team contacted the Mental Health Social Care Team (MHSCT); SW1 advised that any concerns about Denise's mental capacity should be referred to the Urgent Care Team; this appears to conflict with advice from the same member of staff at MHSCT to staff at Access Team earlier that day to ask Urgent Care Team to respond and to seek an assessment under the Mental Health Act (1983) if they believed Denise was a risk to herself or others.

10.23 The ASC Deputy Team Manager advised the CLO that NHO1 could complete the mental capacity assessment and agreed the CSW would visit Denise on 20 February 2019.

10.24 On 15 February 2019 at 20:11, BFRS recorded an email from Watch Commander to BFRS1 advising that he has made an online referral to the RSPCA and will discuss a safeguarding referral with the Duty Officer the next day.

10.25 On 15 February 2019, the Housing Association recorded a contact from Watch Commander advising of the state of the property and detailing that there had been one dog, one cat, one kitten, two rabbits, two guinea pigs and one corn snake in the property, with little room and faecal material throughout the property. The RSPCA had been contacted. This contact is not timed, but Watch Commander understood Denise to be spending the night at a friend's so was presumably early in the day. This appears to a duplicate recording of 10.12.

Finding 9:
That BFRS should have raised a safeguarding concern regarding Denise's hoarding and the condition of her flat.

Finding 10:
That the Housing Association should have contacted the RSPCA with regard to the animals in Denise's flat.

Finding 11:
That the CLO should not have refused to accept a safeguarding concern and advised that an on-line referral to ASC should be made; the triaging of safeguarding concerns should be undertaken by a qualified social worker and ratified by a manager.

Finding 12:
That, on the one-stop-shop principle, the CLO should have transferred NHO1 to the Urgent Care Mental Health Team rather than merely providing her with a phone number to ring.

Finding 13:
That ASC should have treated the contact from the Housing Association as a safeguarding concern as there were concerns about self-neglect/hoarding and grounds for concern regarding Denise's mental health and potential eviction, certainly until after the Community Support Worker had visited.

Finding 14: That ASC should have involved Denise's GP and BFRS in a sharing of information to inform any decision about possible interventions to support Denise.

Finding 15: That the Housing Officer was not in a position to formally assess Denise's mental capacity without specialist advice as to whether or not she had 'an impairment of or disturbance in the functioning of the mind or brain'

Finding 16:
Despite the above, it was good practice that NHO1 tried to raise a safeguarding concern with ASC; when it wasn't accepted however, this should have been challenged and escalated within the Housing Association.

10.26 On 16 February 2019 at 17:07, TVFC recorded a 999-phone call from Denise requesting advice on remedial work required at her flat; this did not require attendance by BFRS, and she was advised to contact the housing association to discuss any remedial work required.

Finding 17:
Given their recent contact with Denise and knowing of the various agencies involved with her, it is surprising that TVFC did not advise BFRS of this contact, had they done so, a safeguarding concern should have been raised and accepted and a multi-agency response should have been put in place to coordinate involvement with Denise.

10.27 On 18 February 2019, the Housing Association recorded an email from NHM1 to NHO2 in which she states "that this is definitely a safeguarding issue … and needs a referral completing. She requests details of the animals Denise is keeping in the property and that she be advised that her permission to keep them could be revoked if she fails to keep the property in a reasonable condition, that she must allow access for inspections and work with the housing association to improve the property or action will be taken, that failing to do so is unacceptable and will be considered a breach of her tenancy and that repairs can't be carried out until the state of the property is improved.

10.28 On 20 February 2019, ASC recorded their first contact regarding Denise in the Review period, “a referral for an adult social care assessment from (Denise’s) housing provider”. There is no reference to the housing association wanting to raise “a safeguarding referral” or the contact with mental health services. The recorded issues of concern “included: hoarding, self-neglect and no water in the flat due to a leak. It was also noted that there were a number of pets in the flat. Case allocated to a Community Support Worker (CSW) on 20/02/19 with the intention of them visiting (Denise). An appointment was made to visit on 28/02/19.” This contradicts 10.17-22 above.

Finding 18:
It is of concern that the information recorded as being received by ASC from the Access Team was incomplete and that ASC’s records contradict themselves.

Finding 19:
It is of concern that a referral for an adult social care assessment – under s9 of the Care Act 2014 –is allocated to a CSW rather than a qualified social worker where self-neglect and hoarding are identified issues as they are indicators of a possible safeguarding situation

10.29 On 20 February 2019, the housing association recorded that the CSW, a member of the Access Team, met Denise and NHO2 at Civic Offices. NHO2 spoke to Denise about the state of her property and advised that she was in breach of her tenancy agreement. Denise agreed to work with the Housing Association and ASC to improve the state of the property and that she will clear those areas that the workmen need access to and then work on the rest of the property. Denise said she had the following pets: “one kitten, one cat, one corn snake, two female guinea pigs, one dog”. CSW advised that her role was to assess whether ASC can provide any further help, but that if Denise needs help cleaning the property she would have to pay for it herself; she also advised that Denise “has capacity and therefore is making a conscious choice to live in the way she is and because of this they would not offer any assistance.” It was arranged that NHO2 and the CSW would visit Denise on 28 February 2019.

Finding 20:
It is of concern that a CSW should state that Denise would have to pay for a service before an assessment of her care and support needs had been completed

Finding 21:
It is of concern that a CSW should undertake an assessment of Denise’s mental capacity, particularly on her first contact with her and without access to the relevant information to enable such an assessment to be completed.

Finding 22:
It is of concern that there is no statement as to which decision/s Denise’s mental capacity was being assessed in relation to.

10.30 On 20 February 2019, ASC recorded the meeting between Denise, CSW and NHO2. The CSW spoke to Denise while NHO2 was out of the office; Denise advised her that she hadn’t worked since she was 16, that she had sent a sick note to the DWP but they hadn’t received it

and so she had no money. She had requested another sicknote from her GP and had a medical assessment the following Monday. The record of the meeting with NHO2 present repeats the details recorded by the housing association but adds that Denise said she was being provided with water by her friends and a neighbour. She denied that she had a problem with hoarding but admitted "collecting things" and that her osteoarthritis stops her cleaning her home, but she "will clear it in her own time", as she had before and she didn't want any help to do so. Denise said she couldn't get in the bath because of her osteoarthritis but washed in the sink. The CSW said she could refer her for Occupational Therapy assessment once the flat is cleared. After Denise left, NHO2 said she thought there must be a mental health reason behind Denise's behaviour but was advised by the CSW that "there are many people who live in this condition and feel they do not have a problem and are happy to live like it" and that they have a right to do so and that they can only be supported with their agreement.

Findings 23: That a welfare visit due to issues of hoarding and the state of a property should involve visiting the property.

Finding 24:
That the CSW made assumptions about Denise's capacity and her care and support needs before any formal assessment of either had been completed.

10.31 On 20 February 2019 at 17:02, the Housing Association recorded an email from NHM1 to NHO2 expressing satisfaction with her work and the fact that Denise had agreed to work with them. While recognising that she has too many animals in the property due to the size of the property, NHM1 advises that the housing association won't require her to get rid of any of them at this time but might if the state of the property doesn't improve and she must not get any more. NHM1 accepts the statement that Denise has capacity and the importance of this should the housing association need to take action in the future. She also asked NHO2 to inform the Area Manager Repairs (AMR) of the current situation and that she will inform him when any repairs can be carried out.

Finding 25:
This is an example of good practice as the housing association is looking to work with Denise and other agencies to resolve the issues with her tenancy in a manner that is least disruptive to her life choices.

Finding 26:
It is of concern that the CSW's statement that Denise has capacity – for no stated decisions – is not challenged or at least clarification sought as to its basis.

10.32 On 21 February 2019 at 8:49, BFRS recorded an email from BFRS1 to Watch Commander regarding the safeguarding referral; he replied that 'it sounds like (Denise) is known to a number of different authorities already and he would try to call that day'. It is now known that call was not made.

10.33 On 28 February 2019, the housing association recorded that the home visit arranged for NHO2 and the CSW was cancelled by Denise; the reason given is not recorded.

10.34 On 28 February 2019, ASC recorded a phone call from NHO2 to SW1 advising her of the above and a phone call on 29 February 2019 – a date that doesn't exist – from NHO2 to the CSW to confirm the home visit has been rearranged for 8 March 2019.

10.35 On 1 March 2019 the housing association recorded an unsuccessful attempt to phone Denise – a message was left asking her to call back to arrange a meeting with the Tenancy Sustainment Officer (TSO).

10.36 On 5 March 2019, the housing association recorded a phone call from Denise; there is no record of any meeting with the TSO being discussed. Denise wanted to know what was happening about her water supply being turned back on. She suggested she knew what caused the leak but wasn't prepared to say what it was, despite being advised it would be of assistance if she did. She said she had an appointment with NHO2 on 8 March 2019.

10.37 On 5 March 2019, the GP Practice recorded a request for a sicknote through Reception – the GP advised a review is required before another sicknote can be issued so a review phone call was arranged - date and time not recorded.

Finding 27:
While it may be accepted practice to review sicknotes and medication by phone, had the safeguarding concern been processed correctly, the GP Practice should have been contacted and might have reviewed the request for a sicknote more rigorously; likewise, if the GP Practice had been contacted to inform an assessment of Denise's capacity.

10.38 On 6 March 2019, the housing association recorded a phone call from Denise, but its content, purpose and outcome are not recorded.

10.39 On 8 March 2019, the housing association recorded a home visit by NHO2 and the CSW – the records state incorrectly that the CSW was a Social Worker. When the front door was opened, flies flew out of the property and the smell was so strong that Denise had to spray some air freshener before they went in. NHO2 described the small hall as very cluttered with items hung on the walls and draped on the radiator, the living area/kitchen as having so many items in it to make cleaning very difficult. She saw no animals but heard the dog in the bedroom and concluded that no improvement in the state of the property had occurred since the initial report from BFRS on 15 February 2019. The Group Fire Safety Compliance Manager was also present and confirmed that the property was uninhabitable and that it was unacceptable that she lived as she did; it was also pointed out that she was not only in breach of her tenancy agreement and putting herself at risk of a fire but that the state of the flat posed a fire risk and hazard to her neighbours and the wider community. NHO2 agreed to visit the next week and Denise agreed to have cleaned the property by then and the CSW advised her of someone who could help tidy her front garden.

10.40 On 8 March 2019, ASC recorded a home visit by the CSW and NHO2; the records state that the front garden was "piled up with rubbish", the property smelt, the hall was cluttered with things hanging from the ceiling, wall all over the floor" and that there was a walkway

through the flat. The record refers to Denise having “a dog and various other caged animals and cats”. Denise said the leak was not coming from a pipe but from a broken washing machine which she can’t afford to have removed. The bathroom was accessible but smelt “unbearable” due to “a tray full of animal faeces” which Denise said she was going to get rid of. The CSW offered to contact a gardener to clean the front garden and Denise agreed to her phone number being given to the gardener.

Finding 28:
Despite the condition of Denise’s flat not having improved and it posing a health and fire risk to her and her neighbours, there is no consideration of either reviewing her capacity or of raising a safeguarding concern to provide a multi-agency structure for coordinating support for Denise.

10.41 On an unspecified date in March 2019, the GP Practice recorded that Denise did not attend an appointment to be assessed for her ongoing back pain and frequent requests for medical certificates; it was also recorded, again on an unspecified date, that Denise contacted the surgery to say she had “had to call an ambulance due to flooding in her flat had been advised to see her GP after she was assessed by the paramedics. Unfortunately, she did not attend this appointment either.”

Finding 29:
Despite Denise not attending two appointments, there is no record of any ‘Did Not Attend’ policy being implemented by the GP Practice or any record of her non-attendances being raised with her in subsequent phone contacts.

10.42 On 11 March 2019, the housing association recorded a phone call from Denise enquiring about the water being turned back on at her flat; the call was transferred to Housing Association Response (HAR). HAR recorded that a job had been raised with them to turn the water back on, having been turned off in February.

10.43 On 13 March 2019, the housing association recorded an email from the Contact Centre to NHO2 advising that Denise had made contact by phone as she was worried that she would lose her home through hoarding. She said she had “cleared the living room and most of the kitchen and is working on the hallway but she pulled a muscle in her back which is now preventing her from clearing the property quickly”. She was going to her GP to get a medical note. She wanted to work with housing association and understands she could lose the property if progress is not made. She said that NHO2 was due to visit the next day, but the Contact Centre member of staff couldn’t see the appointment in NHO2’s calendar.

10.44 On 13 March 2019, the GP Practice recorded a phone call from Denise requesting a sick note for chronic back pain; one was issued from 1 to 31 March 2019.

10.45 On 14 March 2019, ASC recorded the CSW contacting the gardener and giving him Denise’s contact details; he said he was willing to do the work and be paid later if Denise can’t pay him immediately.

10.46 On 14 March 2019, the housing association recorded an unsuccessful attempt (not known by whom) to contact Denise by phone; a message was left asking her to ring back to discuss the TSO service and to see if they can offer her any further advice and support. There is no record of Denise returning the call.

10.47 On 14 March 2019, the housing association recorded a home visit by NHO2; the property still smelt, the hallway was still cluttered making it difficult to enter, her dog was again shut in the bedroom where it was barking and scratching, the living area/kitchen was still extremely cluttered and it still wouldn't have been possible to carry out the repairs to the pipework. NHO2 advised Denise that, although some articles had been removed, unless she made dramatic changes the repairs could not go ahead, that there had been no improvement in the state of the property in the month since she became involved, that her tenancy was at risk as a result and that NHO2 would consult with her manager as to what action would be taken. Denise agreed to continue decluttering the property.

Finding 30:
Despite the above contradicting the information provided by the Contact Centre – see 10.43 above – no consideration was given to escalating the safeguarding concerns about Denise's self-neglect and hoarding or to seeking a review of her capacity on the basis of repeated Unwise Decisions – 2.11 of the MCA Code of Practice.

10.48 on 14 March 2019 at 17:26, TVFC recorded a 999 call from Denise wanting to speak to the BRFS crew who attended the flooding on 14 February 2019 - see 10.11 above, stating the housing association had refused to turn the water back on; this did not require BFRS to attend and TVFC advised her to contact the housing association.

10.49 On 19 March 2019 ASC recorded a home visit to Denise but no details of who visited; decluttering the flat was discussed and it was agreed that ASC would contact the gardener.

10.50 On 20 March 2019, the GP Practice recorded receiving a letter from the Department of Work and Pensions (DWP): "they claim the patient is able to do some work and we do not need to issue sick notes anymore".

10.51 On 20 March 2019, ASC recorded a phone call to the CSW from Denise; she had changed her phone number so the CSW and the gardener had been unable to contact her. ASC contacted the gardener who arranged to visit on 22 March 2019 to clear the front garden. Denise said she was slowly clearing the flat and that the water was being turned back on 29 March 2019 but the CSW did not check what progress had been made. The records do not state whether or not the CSW went into the flat.

Finding 31:
While this is an example of good practice in that the CSW supported Denise to contact the gardener, she did not check what progress had been made in clearing the flat and it is not clear if she entered the flat.

10.52 On 21 March 2019 the housing association recorded a phone call from Denise but not its purpose, content or outcome.

10.53 On 22 March 2019, BFRS recorded an email from NHO2 to cancel a joint home visit to Denise with BFRS1 due to another commitment.

10.54 On 22 March 2019, ASC recorded that the gardener cleared the front garden and helped Denise remove rubbish and wet carpet from the bathroom. Denise said she was clearing the lounge and hallway and the CSW arranged to visit the next week when more would have been cleared. The CSW recorded that Denise seemed to have a good rapport with her and "I am working well with her and hopefully get to the point where her flat is in a better condition." The records do not state whether the CSW visited Denise's flat or spoke to her on the phone.

Finding 32:
The CSW was unduly optimistic in her assessment of her relationship with Denise; at this stage she had seen no evidence of any improvement in the condition of Denise's flat.

10.55 On 25 March 2019, BFRS recorded that BFRS1 suggested some alternative dates for the joint visit with NHO2 – see 10.53 above – with the earliest being on 3 April 2019 due to NHO2's availability.

10.56 On 25 March 2019, ASC recorded a home visit by the CSW to Denise to check the progress with the clearing the flat and the garden. The CSW recorded very little progress in the lounge and that she "gave Denise some encouragement about the progress she has made and asked her to continue the good work as we do not want her evicted." Denise advised her that the DWP have stopped her benefit and asked her to apply for Universal Credit, which she was dealing with. Denise had sufficient food for now but the CSW said she would pick up some food from the Food Bank later in the week for her. Denise said she visits her mother who lends her money at times. The gardener hasn't been paid yet but is prepared to wait.

See Finding 32 above

10.57 On 28 March 2019, the GP Practice recorded that Denise requested a sick note for one more week; a sick note was issued for 1 - 7 April 2019 – see 10.50 above.

10.58 On 28 March 2019, ASC recorded a phone call from Denise to the CSW advising her that her benefits had stopped, and she had no food. The CSW collected and delivered some food from the Food Bank, noting further progress had been made on clearing the flat.

10.59 On 29 March 2019 at 17.00, Housing Association Response (HAR) recorded an email to the Area Manager Repairs (AMR), NHO2 and one other Housing Association member of staff advising of a home visit to Denise but it hadn't been possible to identify the source of the leak or carry out any repairs due to the state of the property "as there is a lot of stuff in there and it is extremely dirty. We cannot complete any repair to the kitchen pipework until it is cleared out and cleaned first, as we will need to remove units etc to get to the pipes."

See Finding 30 above

10.60 On 1 April 2019, the GP Practice recorded that a neighbour (Neighbour 1) collected Denise's sick note and that a prescription for Paracetamol and Propranolol was requested and issued.

10.61 On 3 April 2019, BFRS recorded a Fire and Wellness visit completed by BFRS1 and NHO2. As a result, an online referral was made by BFRS1 to the RSPCA for animal neglect and a safeguarding referral made to the Duty Group Commander at 16:29 "detailing faeces throughout, no access to running water and thin, unkempt state of (Denise)". Reference was made that "CSW has recently visited the premises." Receipt of the safeguarding referral was acknowledged by the automatic email system at 17:33.

Finding 33:
An example of good practice as a safeguarding concern was raised regarding both the condition of the flat and Denise's self-neglect and a referral made to the RSPCA for the neglect of her animals.

10.62 On 3 April 2019, the housing association also recorded the above home visit; NHO2 recorded, the very strong unbearable smell in the property, that the hallway was still cluttered, making it difficult to get in or out, and the floor was soggy. Denise said she had put her animals in the bedroom for the visit. BFRS1 said the property was at risk of fire and asked to enter the flat to confirm the smoke alarms were working as she needed to establish if Denise was safe. Denise said they were working but allowed her to enter. NHO2 advised that the state of the property hadn't improved sufficiently for any repairs to be carried out and the housing association would have no alternative but to take action for a breach of Denise's tenancy agreement. Denise agreed to continue to declutter her home.

See Finding 30 above

10.63 On 3 April 2019, the housing association recorded a phone call from Denise's mother to NHO2; she was shouting "Why have you been threatening my daughter?", "There is nothing wrong with her place" and "What have you got in it for her". She was asked to moderate her tone or NHO2 would hang up; she didn't and NHO2 ended the call.

Finding 34:
Throughout the review period, staff from the housing association and ASC have appeared to be reticent in initiating action in direct response to Denise's behaviour/compliance with agreed plans; the report author notes this could have been due to their being intimidated by her and there is no evidence of any management overview questioning this.

10.64 On 3 April 2019, ASC recorded receipt of a safeguarding referral from BFRS1, detailing the lack of water in the flat, the saturated floor coverings, the animal faeces, the lack of food or water for the numerous animals, the flies, the smell and that Denise was very thin and unkempt. BFRS1 had contacted the RSPCA about the animals. Denise was getting water from a neighbour to wash and for the toilet but there was a bucket in the kitchen containing urine.

BFRS1 described evidence of self-neglect and hoarding and fire risks through the use of electrics and hazards in the kitchen. Denise had been asked by the housing association to clear/clean the property, but she is unable to do so without support or access to hot water and is therefore at risk of losing her tenancy. BFRS1 has asked the housing association to write to Denise detailing the actions she needs to take with realistic timescales and expected outcomes.

10.65 On 4 April 2019 at 17:26, TVFC recorded a 999 call from Denise who believed one of her smoke alarms had stopped working following being tested the day before - see 10.64 above. After initially advising her to contact the person who had checked it, TVFC agreed to contact the local BFRS crew to complete a HFRC.

10.66 On 4 April 2019, ASC recorded the screening of the alert from BFRS regarding hoarding – see 10.61 above – by SW2 in the Safeguarding Adults Team. “This is an open case to a CSW from the ACCESS Team. The CSW advised SW2 that NHO2 is not helpful (not working with her). I advised that work is slow with her – she is making some progress with lots of encouragement. The water was turned on but started to leak so had to be switched off and will be dealt with next week. (Denise) is able to access the toilet at a neighbour’s who also gives her bottles of water to use. She also goes to her mum’s house. Work will continue with her with the CSW. No issues with capacity, able to make choices. Screening outcome dealt with via care management, screening letter sent to referrer.”

Finding 35:
There is no evidence that any contact was made with any other agency to inform the screening decision of the safeguarding concern and no consideration given to Denise’s capacity or the appropriateness of the case being held by a Community Support Worker.

10.67 On 4 April 2019, the housing association recorded a phone call from Denise’s neighbour (1) regarding the lack of running water in her flat; he was transferred to Housing Association Response.

10.68 On 5 April 2019, the housing association recorded that this case was transferred from NHO2 to NHO1; it also recorded an email from the Complaints Co-ordinator to NHO2, Area Manager Repairs (AMR) and NHM1 detailing the background to the situation and containing a complaint from Denise about NHO2’s manner towards her, that she has put a stop on the repairs to her property, the fact that her water has not been turned back on, claiming the housing association has a duty of care towards her, that her osteoarthritis has deteriorated during this period without water and threatening legal action and going to the media.

10.69 On 5 April 2019, the housing association recorded an email from the Area Manager Repairs at Housing Association Response (HAR) advising this case is “currently with housing, we did attend on 29th but the property is not fit to work in.” “Once the property is not a hazard to work in then Repairs can carry out whatever works need to be done.”

10.70 On 5 April 2019 at 17:03, the housing association recorded that NHM1 emailed the Complaints Co-ordinator advising that NHO2 would not have stopped any repairs to the

tenancy, that was a decision of HAR's. She outlined NHO2's involvement in the case and how she had tried to engage with Denise and to involve other agencies to support her, but that Denise had not co-operated or addressed the hoarding issues. She advised that the case had been open for a number of years, with NHO1 being involved previously but with no more success than NHO2. Denise is considered to have capacity to make decisions regarding her tenancy, but chooses to live as she does, making "all sorts of excuses" for her failing to address the state of the property. It has now come to the point where her behaviour will be treated as a breach of her tenancy as the state of the property is impacting on her neighbours. NHM1 supported the way NHO2 had conducted herself and reiterated the housing association's willingness to work with Denise if she agrees and improves the state of the property, then the repairs will be carried out.

10.71 On 5 April 2019 at 17:22, the housing association recorded an email from NHO2 to NHM1 expressing her thanks for her support and advising that she believes that Denise thinks NHO2 has a personal agenda and has given her mother NHO2's phone number, resulting in her receiving an abusive phone call – see 10.63 above.

Finding 36:
No evidence of the outcome of this complaint was brought to the attention of the Review.

10.72 On 8 April 2019, the GP Practice recorded a sick note being requested and issued for back pain from the 8 – 24 April 2019.

10.73 On 8 April 2019 at 10:50m BFRS recorded receiving the following response to the safeguarding referral made on 3 April 2019 – see 10.61 and 10.66 above "Safeguarding screener (SW1) has applied the current screening process to the alert and the decision is 'Dealt with via Care Management', the case is open to an ACCESS team support worker".

10.74 On 8 April 2019, ASC recorded a phone call from the CSW to Denise to check how cleaning the flat was progressing and to arrange a visit. Denise said that she hadn't done a lot as she had not been feeling well and that NHO2 had visited the previous week with BFRS1 who had checked her fire alarms. Denise said that she didn't want NHO2 visiting her again because of her approach and attitude, that a friend had made a complaint to the housing association about her and that NHO2 "is not working with her like I am, she does not mind me visiting; appointment arranged for tomorrow." There is no record of this visit.

Finding 37:
The CSW's recorded comment about a colleague is unprofessional and should have been addressed by her manager who should also have escalated the identified failure of joint working with the Housing Association.

10.75 On 9 April 2019, the GP Practice recorded that Denise collected the sick note (see 10.72 above) and requested and was issued with Paracetamol and Propranolol.

Finding 38:

It is not clear on what basis the GP Practice continued to issue sicknotes after the DWP advised that Denise had been assessed as able to undertake some work (see 10.50 above) but again raises a question about agencies being intimidated by Denise – see Finding 34.

10.76 On 9 April 2019, the housing association recorded an email from NHM1 to NHO2, Complaints Co-ordinator 1, AMR and Housing Association Response (HAR) suggesting a joint home visit to assess whether the state of the property is reasonable or not in order to decide if there has been any improvement and, if there has, to get HAR to mend the leak.

10.77 On 9 April 2019, the housing association recorded receipt of an email confirming receipt of their Safeguarding Alert by what appears to be a computer-generated email. It did not state which Safeguarding Alert this related to.

10.78 On 9 April 2019, ASC recorded receipt of a safeguarding referral from NHO2 in which she described visiting Denise who appeared "to be a hoarder and is living in squalid conditions and from the strong smell that emanates from her and her home this is evident that she is not keeping herself or her animals clean. She is breaching her tenancy agreement and could become homeless if she does not receive professional help. The second bedroom and bathroom impossible to enter. The bathroom has not been used in 12 months and there is a bucket in the kitchen. (BFRS) referred customer to RSPCA due to the number of animals, their condition and faecal matter across property."

10.79 On 10 April 2019, ASC recorded a home visit by the CSW; the record also refers to another home visit on 23 April 2019 and "a joint visit with housing on 26/04/2019 – some small improvements were noted with regard to the state of flat. It was noted that the leak could not be fixed due to hoarding issues."

10.80 On 16 April 2019, ASC recorded SW3, Safeguarding Adults Team, screening an "Alert" from the housing association; "There is already a support worker involved. She is best placed to deal with the concerns raised. She will take any action she feels is appropriate. Safeguarding will take no further action at this point".

Finding 39:
It would appear that it took over a week for the safeguarding referral/alert/concern raised by the housing association (see 10.77 and 10.78) to be screened.

10.81 On 17 April 2019, the housing association recorded receipt of an email from the ASC Team Manager, Adult Safeguarding Team to NHO2 advising that, regarding a Safeguarding Adults Alert received on 16/04/2019 the "Safeguarding screener has applied the current screening process to the alert and the following decision has been reached: Dealt with via Care Management. There is already a worker involved. She is best placed to deal with the concerns raised. Therefore, safeguarding will take no further action at this point"

Finding 40:
As elsewhere in the Review, there is inconsistency in the use of language and terminology between agencies in the implementation of the multi-agency safeguarding procedures.

Finding 41:
There is no reference to previous safeguarding concerns raised with ASC which would have enabled the identification of a pattern and revealed the failure of the CSW's involvement to have any significant impact on Denise's behaviour, self-neglect or hoarding.

10.82 On 17 April 2019, the housing association recorded raising a job with HAR who noted that two units needed to be removed in the kitchen in order to trace and remedy a leak and that (Denise) "has removed and cleaned items which made the units inaccessible in the past. Social Worker (named) approved". An appointment was agreed with Denise for 22 April 2019.

Finding 42:
The CSW is again incorrectly identified as a social worker; this may be indicative of a number of things, but particularly a lack of clarity in respective roles in multi-agency working that should not have arisen if a multi-agency procedure such as the Safeguarding Adults Procedure or the VARM (Vulnerable Adult Risk Management) had been initiated.

10.83 On 22 April 2019, the housing association recorded that NHO1 and a Housing Association Response Operative (HARO1) visited as arranged and found that the property was in a worse condition than when HARO1 visited previously. "I have got animal excrement all over my boots and trouser legs from inside the kitchen. I turned the stop tap on outside in the street and there is definitely a leak behind the kitchen cupboards, but we have no way of accessing this until the kitchen is cleared of all the contents and cleaned." Photos of the property were sent to AMR. Denise was unhappy that HARO1 unable to do repairs due to her not clearing the units, claiming that NHO1 hadn't told her she needed to, or that a HARO would be attending; it was pointed out that she had been told of the appointment on 7 May 2019 which Denise accepted but said she intended getting a solicitor involved.

Finding 43:
Despite the flat being described as being in a worse condition than previously, there is no evidence that the housing association escalated their concerns to ASC.

10.84 On 23 April 2019, ASC recorded a home visit by the CSW who recorded that Denise is making some progress in tidying her flat but that it "is a very slow process". Denise advised her that NHO1 was visiting on 26 April 2019 and the CSW agreed to be present. Denise said she had been offered an appointment to have the water turned back on but she didn't feel ready to have any workmen in the flat in case they said they couldn't do the work because of its state - there is still a lot to do in the kitchen. The CSW pointed out the state of the animals' cages which were in urgent need of cleaning and "filled with faeces". Denise had offered the gardener £10 towards the £25 she owed him, but he said he would wait until she could pay hm in full.

10.85 On 26 April 2019, the housing association recorded a phone call to Denise to arrange an appointment with a TSO; Denise asked them to ring back as a Social Worker (was this the CSW?) and NHO1 were with her. There is no record of Denise being called back.

10.86 On 26 April 2019, the housing association recorded a home visit by NHO1, NHO2 and CSW. NHO2 noted that Denise would not let her into the flat in case she said something rude. NHO1 and CSW did enter the flat and could see that Denise had made some alterations, but it continued to be in an unfit state for any repairs to be carried out; it was agreed that CSW would continue to support Denise in trying to clean the property.

10.87 NHO1 recorded that there were flies in the flat and that, from the smell, Denise "was not clearing up after her pets. Denise had rabbits and guinea pigs in cages/hutches inside the home. CSW explained how it had been much worse, and that Denise had emptied/cleaned the hutches since her last visit (23 April). Denise spoke about an abusive relationship "from around 20 years ago, how it had affected her and how fearful she was of losing all her property". It was explained that no repairs would take place until the state of the property improved; NHO1 suggested she put some things out to go to a charity shop, which Denise agreed to do and she also agreed to move the hutches outside. NHO1 and CSW agreed that there was a lot of work to do before the repairs could start and photos were taken to show there was "not much improvement".

Finding 44:
For the first time, Denise disclosed a possible causation for her self-neglect and hoarding behaviour; this is not acknowledged or picked up for exploration at a later date despite research showing that much self-neglect and hoarding behaviour is linked to past loss and bereavement.

10.88 On 29 April 2019, the housing association recorded a phone call from Denise but not its content, purpose or outcome.

10.89 On 2 May 2019, Adult Social Care recorded a home visit by CSW, NHO1 and NHO2; this appears to be the same visit as that recorded by the housing association as taking place on 26 April 2019 – see 10.86 above. The only additional detail is that Denise had moved her animals indoors as their cages were damaged. NHO1 advised Denise to speak to the estate caretaker who might be able to help. Denise later rang CSW to say the caretaker was going to help her.

Finding 45:
This is just one example of agencies differing about the date on which events happened, there are others elsewhere in the review, which raises concerns about the efficiency of multi-agency working.

10.90 On 3 May 2019, the housing association recorded an email from NHO2 to 'Indexing' (Indexing is the recording of information on the Housing Association computer system. Items are sent through an indexing email and the customer support team then ensures that the right teams deliver the right actions to resolve the issue raised) copied to NHM1 requesting that breach proceedings be started regarding Denise's tenancy. The background details to the case were provided, as well as the comment that "the progress is very slow" and the property is not fit for contractors to work in. It was noted that Denise was aware that she is in breach of her tenancy agreement.

10.91 On 9 May 2019, the housing association recorded an email from NHO2 to NHM1 to advise that she has spoken to another tenant, Neighbour 2, who lived opposite Denise who advised "that she has been suffering with the smell for 8 years and she said she was unable to use the communal hallway due to the smell and dirt when the block has not been cleaned. She informed me that she is looking to take legal advice." NHM1 asked that NHO2 forward the information to Indexing (see 10.90 above) for inclusion in the tenancy breach process.

Finding 46:
There is no evidence that the decision to commence breach proceedings regarding Denise's tenancy was communicated to ASC, despite the two agencies supposedly working together to support Denise or that Denise herself was informed at this stage.

10.92 On 14 May 2019, the housing association recorded an email from NHM1 to NHO2 asking her to check if any action has commenced on the breach process.

10.93 On 20 May 2019, the housing association recorded a phone call from Denise, asking to speak to NHO1 about her last visit. Denise wanted to let her know she had put out the rubbish she had been asked to.

10.94 On 21 May 2019, the housing association recorded NHO1 phoning Denise; she said she had "done a lot of work and moved the rabbit hutches out of the flat and has a carrier bag of cuddly toys for charity". NHO1 reminded Denise that the repairs can't happen until the flat "reaches a particular standard" which it hadn't done when she last visited. It was agreed that NHO1 would visit again on 31 May 2019 to reinspect the flat.

10.95 On 23 May 2019, ASC recorded a phone call from the local MP's case worker, who had been contacted by Denise. The CSW explained why the workmen could not complete the repairs to turn the water back on. The MP's case worker advised CSW she would contact the housing association.

10.96 On 24 May 2019, the housing association recorded a phone call from Denise but not its purpose, content or outcome.

10.97 On 24 May 2019, ASC recorded a phone call from Denise to the CSW advising that workman had called that morning to look at the water, but she hadn't let them in as she had not finished clearing the kitchen. She was unhappy as she wasn't expecting the workmen but CSW pointed out that, had she cleared the kitchen as she had said she would, the work could have been done, the situation resolved, and she would be left alone.

Finding 47:
This is good practice on the part of the CSW, being supportive of Denise but pointing out the need for her to cooperate with any agreed plans.

10.98 On 24 May 2019 at 19:21, SCAS recorded receiving a 999 call from Denise; she had fallen that afternoon, bruising her knee and grazing her thumb. She has arthritis in both thumbs and

numbness in a wrist. A clinician rang her back, completed a clinical assessment, advised she take paracetamol and gave 'worsening advice.'

10.99 On 24 May 2019 at 22:55, SCAS recorded receiving a 999 call from Denise asking if she could take more paracetamol; a clinician spoke to her and "the disposition reached was home management". (This means the patient was deemed to have symptoms that could be safely managed at home, and therefore advice was given either by a call handler or a clinician that the patient could carry out, at home, without the need for medical intervention.)

Finding 48:
There is no record of the GP Practice being advised of either of these two contacts.

10.100 On 28 May 2019, the housing association recorded a phone call from Denise about her appointment on 31 May 2019 which was transferred to NHO1.

10.101 On 29 May 2019 at 10:49, BFRS recorded attending Denise's address following a 999 call in which she stated she was locked out of her flat and needed access to her medication. TVP recorded a request for an address check from BFRS re Denise's flat and were advised there were no warning markers of recent calls to the address. Access was enabled and "Previous safeguarding noted Watch Commander would carry out further local referral" by which he meant he would speak to BFRS1.

10.102 On 29 May 2019 at 17:02, BFRS recorded an email sent by the Safeguarding Manager (SM1) to the CSW (recorded as being a Social Worker) advising of their attendance earlier that day and that (Denise) "had previously been referred for safeguarding on 03.04.2019".

Finding 49:
This is an example of good practice by BFRS, recognising previous safeguarding concerns about Denise and advising CSW of the contact; again, there is confusion regarding CSW's status – Social Worker is a protected title – which would have been prevented had an appropriate multi-agency procedure been initiated – see Finding 42 above.

10.103 On 31 May 2019, the housing association recorded that NHO1 completed a home visit to Denise as previously arranged (see 10.100). She was joined by the local MP's Case Worker. NHO1 recorded a strong smell of ammonia remained in the flat, possibly from the animal faeces and urine. Denise had moved one rabbit outside but one dog, two cats, one rabbit, two guinea pigs and one snake remained in the flat – the only animal Denise had permission to keep was thought to be the dog. Denise said she had removed 4-5 black bin bags since the previous visit and had filled a carrier bag with cuddly toys for a charity shop. There were a number of rugs on the floor that were water-damaged and could have caused the smell in the flat. "The flies were pretty bad and lots of daddy long legs crawling up the walls amongst cobwebs etc." NHO1 and local MP's Case Worker advised Denise that the property did not meet an acceptable standard and workmen cannot be expected to enter to undertake any repairs. NHO1 also advised that the housing association was preparing a court case to seek an injunction which could lead to a possession order being sought and that she was breaching her tenancy agreement by allowing the flat to deteriorate as it has. NHO1 expressed her concern

at “how skinny” Denise was but she assured her that she was eating every day, NHO1 agreed to visit again in two weeks, when she expected all the rugs to have been removed and all the caged animals that can live outside to have been moved out of the flat. The local MP’s Case Worker agreed to visit on 7 June 2019 to assist Denise. Denise asked about moving but was advised that this would not be considered until the flat was in a better condition. The local MP’s Case Worker also said that, from the background checks she had carried out, Denise had a learning disability, which NHO1 had no knowledge or awareness of.

Finding 50:
Despite the local MP’s Case Worker raising the possibility that Denise had a learning disability, and therefore potentially meeting the first stage of the 2-stage test for capacity, no consideration was given to reviewing the assessment of her capacity.

10.104 On 31 May 2019 ASC recorded a home visit by the CSW after Denise had locked herself out of her flat and needed assistance from BFRS to gain access – see 10.101 above. Denise advised the CSW that her dog had shut her out by jumping at the door while she was outside.

10.105 On 5 June 2019, ASC recorded the local MP’s Case Worker contacting a Team Manager at ACCESS. The local MP’s Case Worker outlined the background to her involvement and that CSW had been visiting almost weekly to try to engage Denise with clearing her flat but concerns were escalating – she described Denise as ‘emaciated’ and weighing approximately six stone. She also thought Denise might have a slight learning difficulty. It was agreed that the ACCESS Team Manager would request an “Adult Social Care Assessment” which she discussed with the Deputy Team Manager in the Assessment Team.

10.106 On 7 June 2019, the Housing Association recorded a phone call from the local MP’s Case Worker to NHO1; the Case Worker had spoken to Denise who said she cannot move all the flooring as agreed on 31 May 2019, that it is unfair to expect Denise to do so and she will only move the ones that are damp. The MP’s Case Worker said that, according to the information she has received from the DWP, Denise has a learning difficulty, that she is concerned Denise is not eating properly which may be a mental health issue they are not aware of. She has spoken to “the team leader for social care team as Denise’s worker is currently on leave and expressed her concerns. As a result they are now going to complete a full care assessment as they feel she is suffering from self-neglect based on mine and the MP’s Case Worker observations and ….. we need to establish if she has capacity. The MP’s case worker thought this would be done next week by Lynn, Denise’s case worker.” NHO1 notes the option of referring Denise to TSO1 for additional support, both because of the possible benefit to Denise but also to strengthen any future court case against her.

Finding 51:
The above raises the question of what assessment was being undertaken, though not yet completed, by CSW (see 10.28 above) as well as what has changed to require Denise’s capacity to be assessed and for her self-neglect to be acknowledged.

10.107 On 10 June 2019, the Housing Association recorded “RSPCA – confirm animals removed”.

10.108 On 10 June 2019, the Housing Association recorded raising a job with their Response Team to repair the patio door lock.

10.109 On 10 June 2019 at 22:49, SCAS recorded a 999 call from Denise, describing "anxiety and heaviness in her chest"; an ambulance was despatched, arriving at 23:03. Against the crew's advice, Denise refused transport to hospital. The crew noted that the house was very cluttered with a variety of animals living there, including a dog, two guinea pigs, a corn snake and a rabbit, and a strong smell of damp. They highlighted that the increased stress and poor living conditions would leave Denise susceptible to illness. With her agreement, they completed a safeguarding referral. Denise remained at home when the crew left.

Finding 52:
While the MCA requires an assumption of capacity to be the default position, it is of concern that there is no reference to Denise's capacity to make the decision not to go to hospital against the crew's advice.

10.110 On 10 June 2019, the GP Practice recorded receipt of the report from SCAS.

10.111 On 11 June 2019, the Housing Association recorded that the patio door has been completed. No reference to state of the property.

10.112 On 11 June 2019, ASC recorded receipt of a "report of concern", not "a safeguarding referral" from SCAS as a result of their visit on 10 June 2019. No screening or outcome is recorded.

Finding 53:
Given the previous safeguarding concerns received by ASC regarding Denise, it is of concern that there is no evidence of any screening of or outcome for the safeguarding referral raised by SCAS, though this may be due to confusion in terminology – was it a "safeguarding referral" or a "report of concern"?

10.113 On 11 June 2019, the GP Practice recorded receipt of an "OOH (Out of Hours) report" of phone not face-to-face contact with Denise. No details of purpose, content or outcome of contact recorded, but phone contact was made with Denise by the Practice who advised she had been checked by the paramedics after she rang 999 because of anxiety and dyspepsia and there were no cardiac problems. She had tried Gaviscon which helped a bit. A prescription for Lansoprazole was issued and Denise advised to see a GP on Friday if no better but to call 999 if she has any acute chest pain or shortness of breath.

10.114 On 13 June 2019 the housing association recorded a phone call from NHO1 to Denise to confirm the appointment tomorrow. Denise told NHO1 she had been unwell during the past few days and would have to put clearing her flat on hold. She was advised this wasn't possible, but NHO1 agreed to delay her visit to 24 June 2019. Denise said the RSPCA had visited the day before and removed one rabbit, two guinea pigs, one hamster one gerbil and two cats. Denise said the RSPCA Inspector had agreed she could keep one dog, one snake and two kittens. NHO2 had contacted the RSPCA for an update on their involvement. NHO1 asked Denise if she

was receiving any help for her mental health and she replied that she is being treated by her "GP and the paramedics". NHO1 contacted the local MP's Case Worker to advise her of the above and to check if she had information about Denise's social care assessment – she hadn't but agreed to chase.

10.115 On 13 June 2019, the housing association recorded an internal email from NHO2 to a colleague, copied to NHM1 and NHO1 advising that she had spoken to the RSPCA Inspector and the animals still with Denise are one dog, one gerbil, two rabbits, two kittens, one gecko, one corn snake and one outside cat. The RSPCA Inspector was visiting the next day and on 17 June 2019 asked for confirmation of how many animals Denise is allowed to have "without compromising" her tenancy agreement. NHO2 sought advice as to what to tell her.

Finding 54:
This appears to be the first time the RSPCA had attended the flat despite being first contacted in February 2019 (see 10.12,10.24, 10.28, 10.61, 10.64 and 10.78)**. The response of the RSPCA Inspector in balancing the needs of the animals with those of Denise is an example of good practice.**

10.116 On 13 June 2019, ASC recorded that the case is allocated to SW5*,* in the Assessment Team, for the completion of a "joint adult social care assessment on 20 June 2019 with (CSW)". On 14 June 2019, SW1 emailed CSW to request a pre-assessment meeting.

Finding 55
This is an example of good practice by maximising the likely quality of the joint assessment by SW5 and CSW; however, best practice would have included liaising with her GP, the housing provider and BFRS staff who had prior knowledge of Denise and her situation.

10.117 On 14 June 219, the GP Practice recorded receipt of an "NHS 111 report" but not its content or source. The Practice recorded a telephone conversation between a GP and Denise – it is unclear who phoned who - Denise confirmed that the Lansoprazole was working well but that she was having problems with her flat, the water having been turned off by BFRS. She said she had contacted a solicitor and will call back if she needs a letter from the Practice in support as the Practice had offered.

10.118 On 14 June 2019, the housing association recorded an email from a Customer Support Administrator to NHO2 advising that the animals allowed at Denise's tenancy are one dog, one cat and two small caged animals (the latter would include gerbil, rabbits, gecko, corn snake). Denise had not sought permission for any of the animals and a condition of having animals is being able to look after them appropriately. If the RSPCA believe the animals are being neglected, the Administrator suggested Denise should not be allowed to keep any animals.

10.119 On 17 June 2019, ASC recorded a case discussion between SW5 and CSW; due to other work commitments and the need for CSW to attend, the home visit to Denise was rearranged to 1 July 2019. CSW advised that Denise was happy for the date to be changed and that she would provide the contact details of NHO1.

10.120 On 18 June 2019, the GP Practice recorded a request by phone from Denise for a repeat prescription for Propranolol and Lansoprazole which was issued by the GP***.***

10.121 On 19 June 2019, the housing association recorded a phone call from TSO1, the initial assessment had been completed by phone and an email had been received requesting the water be turned back on in the property. TSO1 advised that Denise had said she wanted to remain in the property, that she knew she had to pay the "bedroom tax" on the vacant bedroom, but she was unaware she had £1653 rent arrears and that no payments had been paid since she moved to UC as she thought UC paid the housing association direct. She thought she had no Council Tax arrears. TSO1 offered assistance with this, but Denise declined, saying she was confident dealing with official forms and paperwork. She said the water could be turned back on as there was no leak from the pipes but from the washing machine. She said she had been diagnosed with arthritis, anxiety and depression and is being treated by her GP but did not have a learning disability. Her medication is helping but she struggles to eat solid food. She had applied unsuccessfully for a Personal Independence Payment and didn't want to apply again. She said she had been allocated a Social Worker who was visiting her on 20 June 2019 to help her sort out her flat, but she wished to be independent and do it herself. The RSPCA had "seized a lot of her pets as they think she can't look after them, but she can, and they are wrong". She only agreed they could take some of them as they threatened to involve the Police. She reluctantly agreed to work with TSO1 but only around the Council Tax and rent arrears and to get her water turned back on. TSO1 emailed NHO1, copied to her Team Leader, to update her on the outcome of the assessment and to ask if the repair issues can be resolved so the water can be turned back on.

10.122 On 20 June 2019, the housing association recorded an email from NHO1 to the Area Manager Response and a housing association worker, copied to NHO2 and NHM1 referring to TSO1's email – see 10.121 above. It briefly outlined the case and that a case is being put together to seek an injunction – it does not say with what purpose - but makes the point that a court is likely to look unfavourably on the housing association leaving Denise without water for so long but insisting she cleans the property without water. She also points out that Denise has said the leak was from a now-disconnected washing machine not the pipes so turning the water on should not cause further leaks or require workmen to enter the property and asks if this can be arranged.

10.123 On 21 and 24 June 2019, the housing association recorded phone calls from Denise but not their purpose, content or outcome.

10.124 On 25 June 2019 the housing association recorded an email from the Area Manager Repairs to several Housing Association workers, including NHO1, copied to NHO2 advising that he is not prepared to turn the water back on without the floor being cleared and cleaned as the leak would have to be identified and fixed at the same time and this will require moving the washing machine and accessing the rear of the units.

10.125 On 26 June 2019, the housing association recorded a Tenancy Sustainment Officer requesting a copy of the Person Centred Fire Risk Assessment that had been completed by the

Fire Safety Manager; they also contacted BFRS asking “for further details of their findings when they attended” Denise’s flat. BFRS has no record of receiving the request.

10.126 On 26 June 2019, ASC recorded an exchange of emails between SW5 and the local MP’s Case Worker in which the Case Worker expressed her concern as Denise is not eating and “the removal of all her animals apart from the dog and the gecko has … hit her quite hard”. She also asked whether the assessment had taken place on 20 June 2019 as arranged. SW5 advised that “The assessment did not take place on 20 June as I understand it was the client who requested another date” – see 10.119 above. She also stated that CSW has “informed me that (Denise) has capacity” and “that things have improved with (Denise).” The MP’s Case Worker replied that “There has definitely not been any positive progress; (Denise’s) housing officer has known her for a number of years. She is concerned with the deterioration in (Denise’s) appearance.” A meeting she had arranged with her was also cancelled by Denise and the MP’s Case Worker was concerned that was indicative of a further deterioration and asked to be kept updated of SW5’s progress as “this is an urgent matter.”

10.127 On 26 June 2019, ASC recorded an email exchange between SW5 and CSW: SW5 asked if CSW had any concerns about Denise not eating and whether she thought the GP should be involved. CSW replied that she had spoken to Denise several times about her eating but had been advised that she had never been “a big eater” and had “always been very slim” and that she eats when she wants. Although Denise has no concerns it could be suggested that she sees her GP.

10.128 On 28 June 2019, the housing association recorded a hand-delivered letter from NHO2 to Denise: “I am writing to inform you that NHO1 will be carrying out a visit to your home on Wednesday 3 July 2019 at 10am. It is vital that you provide us access to your home. Please note that failure to allow access to your property to undertake this visit could result in court action being taken against you for failure to provide access. If you have issues, please do not hesitate to contact NHO1 on 0300 100 0303”.

10.129 On 28 June 2019, ASC recorded that their only contact with Denise that month was a phone call from Denise to her support worker CSW on 28 June 2019 to inform her that the RSPCA had removed some of Denise’s animals.

Finding 56:
That the level of direct contact with Denise during June 2019, despite there being continuing and escalating concerns sufficient for her to be allocated a social worker, was insufficient to appropriately support and monitor her care and support needs

10.130 On 30 June 2019 at 21:04, SCAS recorded a 999 call from Denise saying she had breathing difficulties; she was advised to contact a Primary Care service within six hours. The Milton Keynes Out of Hours provider was advised electronically to make contact with her.

10.131 On 1 July 2019, the GP Practice recorded receipt of an Out Of Hours report of a phone contact with Denise but no detail of its content or outcome.

10.132 On 1 July 2019, ASC recorded a supervision session between SW5 and a Deputy Team Manager Assessment Team (DTMA2) in which the case was "briefly discussed. Mostly housing issues does, not appear to have other needs, MP involved, support worker involved, animals removed, no water in property and house will likely need a deep clean."

Finding 57:
At this stage, SW5 had not met Denise, no assessment of her care and support needs or capacity had been completed and there had been several safeguarding concerns raised by other agencies; given the length of time CSW had been involved with little change achieved both SW5 and DTMA2 should have shown greater professional curiosity in Denise's situation and its possible causation.

10.133 On 2 July 2019, the housing association recorded receipt of an email from TSO1 asking "who is dealing with this patch – email back"

10.134 On 3 July 2019, the housing association recorded a home visit by NHO1 with HAR1 at 9am (see 10.128). Denise did not open the door, but her dog could be heard barking. NHO1 rang her to ask to be let in; Denise said the appointment was for the next day. NHO1 noted that Denise had rung the office on 1 July 2019 to try to postpone the appointment but had been persuaded to go ahead with it on the basis that they were trying to get her water turned back on and someone from Housing Association Response (HAR) would also be attending. Denise continued to refuse to open her door as she wasn't dressed, hadn't had her breakfast, hadn't had the chance to clear up, the house was a mess etc. When NHO1 offered to return later that day, this was also refused. The earliest day that NHO1 and HAR1 could call back was the next Wednesday; they decided to write offering an appointment later the next week. NHO1 also spoke to Neighbour 3 who said that Denise had been allowed to keep her outdoor cat but wasn't feeding it; the neighbour had spoken to the RSPCA and NHO2 who said it was being dealt with but she remained concerned for the cat. NHO1 agreed to follow this up. Neighbour 3 said she was no longer providing Denise with any water, so it was unclear how Denise was washing, flushing the toilet or drinking. NHO1 had been in contact with the local MP's Case Worker about the social care assessment, but noted "there seems to be some kind of hold up over this"; as a result, she was concerned for Denise's mental health and was going to make a safeguarding referral. Neighbour 3 did say that a man came every day to Denise and provides her with food, Neighbour 1, causing NHO1 to question her capacity if she is relying on others to eat.

10.135 On 4 July 2019, ASC recorded the first visit by SW5, Denise's allocated social worker, accompanied by CSW to complete the social care assessment. It was noted that there was what appeared to be animal faeces smeared in the corridor leading to Denise's flat and that "there was an overwhelming malodorous smell" that could be smelt from outside the flat. SW5 considered that Denise had "full capacity and there are no physical limitations to prevent her from maintaining her property. Her hinderance is having no water in the property which exacerbates the smell and poor hygiene." Denise advised that the water was being fixed on 19 July 2019 and a blitz clean was discussed though she "may not be eligible for a care service." Denise said she had a gastro infection that limited her wish to eat, but that this was improving; she was advised to see her GP. Denise said all her animals had been removed except for her

dog. The assessment was only partially completed "as the smell from the property was too toxic" and it was arranged for Denise to go to "the Civic" on 16 July 2019 to complete it. It was recorded that Denise would not let either SW5 or CSW into the property and that she stood in the doorway blocking access and visibility. It was agreed to get a quote for a blitz clean service once water was back on in the flat.

Finding 58:
As Denise would not let either SW5 or CSW into her flat, it is not clear how SW5 was able to effectively assess her capacity or her care and support needs.

10.136 On 4 July 2019, ASC record a discussion between SW5 and NHO1, followed up by an email from SW5 confirming its content: NHO1 had advised that Denise had been informed of the visit on 3 July 2019 (see 10.134), though they had arrived earlier than Denise had been told, which may have caused her some additional anxiety. NHO agreed to check if a repair call was booked for 19 July 2019 as Denise had stated though she was due to call on 11 July 2019 with workmen to try to repair the water leak; NHO1 also understood that Denise visits a friend Neighbour 1 and frequently stays there; SW5 asked what the basis of NHO1's safeguarding referral was and was advised it was Denise's failure to keep the flat clean and her weight loss, to which SW5 replied that it wasn't a safeguarding issue as she couldn't clean her flat with no water and the first priority should be getting water into the flat. NHO1 responded that because of the animal excrement in the flat, the water couldn't be turned back on until the flat was cleaned; if NHO1 thought it was a safeguarding issue, she should make a safeguarding alert; SW5 said that they had advised Denise to contact her GP "to check her weight, BMI and, with their advice, to follow a meal plan or even obtain supplements if need be"; NHO1 agreed to contact Environmental Health to see if they could provide any support or advice; SW5 advised that Denise seemed keen to consider a blitz clean but that her fear of eviction and her personal attachment to the hoarded items would need sensitive handling which could be hindered by discussions of eviction or breaches of her tenancy.

10.137 On 4 July 2019, the housing association recorded the above phone call to SW2 by NHO1; SW5 advised that Denise has capacity and that she is making a lifestyle choice as to how she lives; she requested that the housing association do not make a safeguarding referral as she is already working with Denise and making progress.

Finding 59:
The basis for SW5's assessment that Denise's situation wasn't a safeguarding issue is hard to understand: Denise's self-neglect and hoarding were evidenced as was her neglect of her animals. It is also hard to understand the basis of SW5's claim that she is making progress with Denise – she had met her once when she wasn't allowed access to the flat. Like CSW, SW5 is unduly optimistic in her assessment of her impact on Denise's situation

10.138 On 4 July 2019, the housing association recorded an email from TSO1 to NHO1, copied to NHM1 in which she advised that she had visited Denise that morning, reiterating her tenancy conditions and addressing her refusing access to the property the previous day. She said a workman had visited this morning and she had told him the appointment had been rearranged for the next week, when she has said she will allow access. She said she had been

visited by two social workers this morning, she had let them into the flat and she will be meeting them at their office on 16 July 2019 to complete the care assessment. Denise agreed that TSO1 could contact the DWP on her behalf to apply for a Discretionary Housing Payment (DHP) and confirmed she had received and signed the consent forms which she will ask a friend to post this afternoon. The friend is a man and is doing her shopping and bringing her food and water. TSO1 described Denise as "very fixated" on her weight and what she can and can't eat; she declined any support with this. TSO1 made the referral for the DHP and sought information on Denise's rent arrears from the Accounts Department.

Finding 60:
Had ASC and the housing association been working together effectively, NH01 would have been aware that Denise refused access to SW5 and CSW, an example of Denise being less than honest in her contacts with professionals.

10.139 On 4 July 2019, the housing association recorded receipt of an email from a social worker with ASC for confirmation of the repairs to Denise's water supply being booked for 19 July 2019 and clarification of "the roles and responsibilities of Environmental Health."

10.140 On 5 July 2019, ASC recorded a phone conversation between SW5 and the MP's Case Worker: they discussed SW5's conversation with NHO 1 (see 10.136 and 7) and that there was a plan to work with Denise; SW5 considered the flat was not "ideal to live in", that this was due to the lack of water and that this be resolved but that Denise "shouldn't be penalised for not keeping her property clean when she has not had any water and the MP's Case Worker agreed." SW5 said that Denise "had no presenting care and support needs" but that she was seeing Denise on 16 July 2019 to complete her assessment of need "to be certain and plan for further advice and support." The MP's Case Worker said she was "much better reassured with the support planned and offered to provide any assistance to help (Denise).'"

Finding 61:
At this stage, having been denied access to her flat, SW5 cannot be considered to have started her assessment of Denise's care and support needs; how she was able to state that she "had no presenting care and support needs" given the previous safeguarding concerns, the state of the flat and her deteriorating physical presentation is unclear.

10.141 On 8 July 2019, the housing association recorded receipt by NHO1 of an email from Ecolution, the contractor, that there was a hold on all works on Denise's property due to its condition. There was a service outstanding on her hot water cylinder but nothing else.

10.142 On 9 July 2019, the GP Practice recorded a phone call from Denise to a GP saying the Lansoprazole was finished but she thought she may have had a reaction to it – blistered lips – and would like something else for her dyspepsia. A prescription for Ranitidine was issued.

10.143 On 9 July 2019, ASC recorded a phone call from Denise to CSW asking for assistance to remove three bags from her flat as she was unable to put them out. She agreed to ask a friend to put them out. She said she had spoken to NHO1 the day before about workmen coming the next day to fix her water; CSW asked if she had cleared the kitchen so the work could be done

and Denise replied that she had done what she could and she opened the window every day to air the flat. CSW pointed out that when she visited with SW5, they had been unable to enter the flat because of the smell – see 10.135 above which shows that Denise would not let them enter the flat. As CSW was about to go on leave, she agreed to visit the next week. There is no record of this visit taking place.

10.144 On 10 July 2019, the housing association recorded a home visit by NHO1 and CRO1; the property was significantly worse than when they previously visited. The floor coverings had not been removed as had been requested on the last visit on 31 May 2019, there were "unusually high amount of cobwebs etc", a kitten that Denise said the RSPCA had returned to her as they couldn't rehome it and five black bin bags of rubbish – one apparently "full of rabbit hutch waste" – that NHO1 and CRO1 removed to the bin store as Denise couldn't carry them. CRO1 turned on the water and there was a definite leak, but he was unable to access it to fix it. Denise was advised that she would have to clear the whole of the kitchen for any work to be done. Denise advised that she was using bottled water to flush the toilet. Both NHO1 and CRO1 left the property with animal faeces on them.

10.145 On 10 July 2019, the housing association recorded an internal email from CRO1 to NHO1, AMR, and others confirming he and NHO1 had visited Denise that morning, that the state of the property had worsened since their last visit and that it is not possible to carry out any repairs due to its condition. He had turned the water on and there was a leak behind the kitchen cupboards, but it is inaccessible until the kitchen is cleared of all its contents and cleaned. He had left the property with "animal excrement all over my boots and trouser legs from inside the kitchen".

10.146 On 10 July 2019, the housing association recorded an email from NHO1 to NHM1 and NHO2 confirming the content of CRO1's email but added that she thought she might have flea bites as well. She asked NHO2 to check with the RSPCA about the kitten being returned. She repeated that the property was in no state for repairs to be carried out and that she doubted Denise was well enough to clean it to an acceptable level. She repeated the content of her phone call with SW5 on 4 July 2019 – see 10.137 above – regarding Denise having capacity and her making a lifestyle choice meaning it is unlikely they will be able to provide any support and that Denise has an appointment with SW5 on 16 July 2019 for "a full care assessment" but that NHO1 can't be there as she is on leave. Although SW5 had asked her not to do so, and she had delayed doing so, NHO1 was going to submit a safeguarding referral after today's home visit. NHO1 was concerned that, should Denise's situation deteriorate to the point where she died, would the housing association be held liable in any way; she felt, as did the resource planner for the Housing Association Response team (repairs and maintenance team) and AMR, that they should "decant" her from the flat so it could be "environmentally" cleaned. NHO1 made a safeguarding referral due to "concerns of self-neglect and acts of omission".

10.147 On 11 July 2019, ASC recorded receipt of a "safeguarding alert"; the record acknowledges the presence of animal faeces, and urine and fleas, the hoarding and the lack of running water. The alert was screened by SW4, Assessment Team, who recorded that "Since the alert had been received I am aware of the substantive actions completed by colleagues in ASC to support (Denise). I refer specifically Case Note recorded of 04/07/19 by (SW5)". The

outcome of the screening is not recorded but appears to be that the alert was to be dealt with by care management.

Finding 62:
It is unclear just what the "substantive actions completed by colleagues" were; SW5 had visited once, CSW once since the beginning of July 2019. A further example of professional optimism by ASC staff. It is also of concern that the outcome of the screening process is not recorded.

10.148 On 12 July 2019, the housing association recorded a warning letter/final inspection notification from NHO1 was sent by 2nd Class letter to Denise; this detailed the key events since February 2019 and advised that "Social Services have confirmed you have the capacity to clean your home and that this is your life style choice to live in your home in this way". As the state of the property had deteriorated over time, NHO1 would visit again on 24 July 2019, and if the kitchen area and cupboards had not been cleared and all the floor covering removed, the housing association would have no choice but to commence legal proceedings for an injunction requiring her to bring the property to an acceptable standard and to meet court costs of £308.00. Denise was advised that this was a formal warning and that she should seek independent legal advice on the matter.

Finding 63:
While it is understandable that the housing association was obliged to instigate legal proceedings, it is of concern that this course of action does not appear to have been part of a coordinated multi-agency plan to support and monitor Denise's care and support needs.

10.149 On 12 July 2019, the HA recorded an email from NHO1 to SW5 advising her of the events of her visit to Denise on 10 July 2019 – see 10.144 above -, the warning letter - see 10.148 above – and the return visit arranged for 24 July 2019. She said she was contacting the RSPCA about the kitten Denise claimed had been returned to her, that no repair had been arranged for 19 July 2019 – see 10.135 above – and that she would speak to Environmental Health on her return from leave on 22 July 2019.

10.150 On 15 July 2019, the HA recorded a phone call from TSO1 to Denise; Denise stated she would not be attending her appointment with SW5 the next day as her legs were "wobbly" and she neither needs or wants help with her flat and she can deal with it herself. She said all but 1 of the rugs had been removed and she would remove the last one that week. Despite TSO1's best efforts, Denise would not change her mind but asked TSO to let SW5 know she would not be attending her appointment. TSO1 rang SW5 on her mobile and was asked to ring her at the office and send an email; SW5 then terminated the call. TSO1 rang the office and left a message for SW5 and sent an email; she also contacted CSW, who was with a client and said she would ring back; neither call back happened. SW5 did respond to advise that the assessment would be rearranged and a multi-agency meeting arranged with NHO1 when she returned from leave. TSO1 chased the Housing Association Welfare Benefits team for support applying for a Discretionary Housing Payment, contacted MKC for details of Denise's Housing Benefit and Council Tax claims. She also emailed NHM1 and NHO1 to update them on developments.

10.151 On 15 July 2019, ASC recorded an email from SW5 to NHO1 and TSO1, copying in CSW and the local MP's Case Worker in which she proposes a case discussion meeting is held, that, in the light of NHO1's safeguarding referral, it should happen the following week – no specific date is mentioned - and asks if the housing association could host it as their office is closer to Denise's flat. It is unclear which safeguarding referral this relates to – possibly 10.146 and 10.147 above. She and CSW would meet Denise at 12:00 and all five of them meet at 13:00. She also asked NHO 1 for an update from Environmental Health.

10.152 On 15 July 2019, ASC recorded a phone call from Denise to SW5 apologising for having to cancel their appointment the next day but she felt too weak in her legs". She said she hadn't spoken to her GP but would do so. She confirmed that the water had been turned back on but then was turned off again because there was a leak – she said "there is no leak and she is fed up with housing delaying water supply. (Denise) confirmed there is no limit to access." SW5 advised Denise that, from the concerns expressed by the MP's Case Worker, the completion of her assessment was crucial in order to assess her needs and that, if she cancelled again, she would not be able to support or reassure her. Denise "promised" not to cancel the next appointment and said she was willing to meet at the office.

10.153 On 16 July 2019, the housing association recorded receipt of being advised that their safeguarding referral – it is unclear which safeguarding referral see 10.146 and 10.147 above – had been referred to the care management team and to refer to SW5 for further information.

10.154 On 16 July 2019, the GP Practice recorded a phone call from Denise; she spoke to a GP about her dyspepsia. The Ranitidine had brought some improvement, but she still needed to take Rennies. As this combination was working well, GP suggested "TCI for r/v – to come in for review - at some point in next few weeks".

10.155 On 17 July 2019, the housing association recorded a discussion between NHO1 and TSO1 about a referral to P3 (a charity organisation commissioned to support people to become integrated into society and meet their full potential) or Connections for further support for Denise with "her needs and for assistance with her property condition". TSO1 agreed to discuss with Denise as her agreement would be required for any referral.

Finding 64:
This is an example of good practice as NHO1 and TSO1 seek to identify alternative possible sources of support for Denise to ASC; again, this would have been better managed through a multi-agency procedure such as the multi-agency Safeguarding Adults Procedure or the Vulnerable Adults Risk Management (VARM).

10.156 On 18 July 2019, the housing association recorded a phone call from NHO2 to RSPCA1, who advised they had not given Denise permission to have a kitten and did not know where she had got it from.

10.157 On 22 July 2019, the housing association recorded receipt by NHO1 of written confirmation from Team Manager Assessment Team*,* of the outcome of the safeguarding

referral – see 10.132 and 10.146 above: “Dealt with via Care Management. Thank you for your alert. I understand my colleague, (SW5), is now working with (Denise). Please continue to keep the situation under review and revert to her in the first instance.”

Finding 65:
Given the number of previous safeguarding referrals made and the lack of progress in resolving the issues with Denise’s flat, the housing association should have escalated their concerns within ASC.

10.158 On 22 July 2019, ASC recorded an email from SW5 to the MP’s Case Worker, TSO1 and NHO1, copied to CSW, cancelling the meeting arranged for the next day with Denise as she had not been able to confirm a venue. She asked NHO1 to suggest some alternative dates and times when a room would be available at the housing association. SW5 rang Denise to advise her of the above and that she would let her know the revised time and date; Denise said she was feeling a lot stronger.

10.159 On 23 July 2019, ASC recorded that the case discussion meeting was rearranged for 1 August 2019 at the housing association offices.

10.160 On 24 July 2019, the housing association recorded a home visit by NHO1 as previously agreed with Denise; Denise said she had been up all night and the appointment was rescheduled to 26 July 2019. Denise asked if NHO1 could visit Neighbour1 to ask him to call round to do some shopping for her. She did so, and Neighbour1 said how concerned he was about Denise, as she hasn’t left her flat for five weeks and that he had contacted her brother – the outcome of this contact is not known.

10.161 On 25 July 2019, the housing association recorded that TSO1 rang and left a message for Denise letting her know of a change of time and officer for a phone appointment with the Tenancy Sustainment Service.

10.162 On 25 July 2019, the housing association recorded a phone contact between SW5 and NHO1 in which SW5 advised that Denise is unlikely to meet the care needs eligibility criteria and that a meeting has been arranged for 1 August 2019 (see 10.159).

10.163 On 26 July 2019, the housing association recorded a home visit by NHO1. Denise said she had been unwell and so unable to clear or clean the flat. She said she wasn’t eating well and felt weak. She asked NHO1 to carry a 5l bottle of water into the flat as she was unable to do so. NHO1 advised her that the state of the flat had deteriorated during the time she had been involved and Denise hadn’t removed any of the flooring despite being asked to do so. The water could not be turned back on until Denise had cleared and cleaned the kitchen and removed the flooring. Denise insisted she was getting better and would deal with everything herself and didn’t need any help. Although she hadn’t been out for five weeks for fear of falling, she was going to her mother’s that weekend and would attend the meeting on 1 August 2019. NHO1 felt “her health had deteriorated drastically since I first started working with her 26.04.19 and do not see the situation improving.”

Finding 66:
Although a multi-agency meeting was arranged for 1 August 2019, this was a missed opportunity for the housing association to escalate their ongoing concerns for Denise, given the deterioration of the state of the flat and her physical if not mental health during their involvement with her.

10.164 On 29 July 2019, the housing association recorded that an advisor from the association's welfare benefits team left a message on Denise's answer phone asking her to call back to discuss her Housing Benefit***.***

10.165 On 1 August 2019, ASC recorded that the Case Discussion meeting took place, attended by SW5, CSW and NHO1 but not Denise or TSO1. Denise was contacted by phone and she said that her legs were swollen, and her GP had advised she rest – the GP Practice has no record of any such contact. SW5 reminded her of the agreement to attend and the implications of her not doing so and she agreed to completing her assessment by phone the next day. The meeting confirmed the position regarding Denise's animals – the RSPCA had not returned a kitten to her, her dog had been removed as she was too weak to walk him and nobody knew where or how Denise got the two kittens and the gecko. There was a leak in the kitchen and this could not be fixed until the kitchen was cleaned and cleared. Denise had made some attempts to clear and clean but won't accept any help; she didn't believe there was a leak and believed that the water just needed to be turned on. There had been a deterioration in the state of the flat in the past month. The housing association had organised the paperwork for legal action to require Denise to clear and clean the flat but not to seek its possession; SW5 and CSW thought Denise didn't understand the distinction. The possible options regarding a blitz clean were considered, including their impact on Denise. NHO2 advised that the housing association would not pay for a blitz clean and this would be a social care need – a complication as Denise was assessed as having no social care needs. NHO2 advised that Denise was in breach of her tenancy agreement. NHO2 had been advised by her manager that she could not contact Environmental Health as previously agreed – see 10.136 above. The housing association had received several complaints from one of Denise's neighbours about the smell from her flat. SW5 agreed to speak to Denise the next day about their concerns about her health and possibly suggest she contact the GP. It was agreed that: SW5 would complete the Adult Social Care Assessment the next day; that NHO1 would provide new images of the flat; NHO1 would send Denise a simplified letter explaining the possible court proceedings; an update would be sought from TSO1 as to their support to Denise; SW5 and TSO1 to contact Environmental Health regarding what support they can offer; SW5 to speak to Denise regarding the health concerns and seeing her GP and SW5 to ascertain what will motivate Denise to clear and clean the flat so the water can be turned back on and what support Denise wants.

10.166 On 1 August 2019, the housing association recorded that NHO1 met with SW1 and CSW, but that Denise didn't attend, "saying her legs are wobbly". SW5 advised that the care assessment would be completed via a phone appointment on 2 August 2019 and that Denise has informed them she does not have a mental health diagnosis or a learning disability and "there are no medical records on their files to suggest this either." SW5 is unable to determine whether Denise has capacity until the re-assessment is completed though "their

instinct is that (Denise) does have capacity". She agreed to confirm the outcome of the care assessment as soon as it is completed. NHO1 expressed her concerns about Denise's deteriorating health and that she thought "something awful was likely to happen if social services didn't intervene." When asked to be more specific, she referred to Denise's lack of drinking water and the risk of dehydration. SW5 and CSW confirmed that Denise had told them there is no leak in the flat and that he housing association are lying; SW5 felt the housing association should take responsibility for cleaning the property so the repairs can take place and asked why they wouldn't do so. It was explained that it was due to ASC stating Denise had capacity and that living as she did was a lifestyle decision. Denise was in breach of her tenancy agreement by doing so, but she had insisted that she wanted no assistance and would clear and clean the flat herself. SW5 asked for the contact details of NHO1's manager so that her manager could contact her. NHO1 confirmed that housing association was preparing to take legal action to seek an injunction requiring Denise to clean and clear the flat and only if she failed to do so, might possession be sought. It was suggested that Denise should be written to explaining this, but it was pointed out that this had already happened in NHO1's letter of 12 July 2019 – see 10.134 above. At ASC's request, NHO1 agreed reluctantly to send another letter explaining the content of the earlier letter. NHO1 explained that, if Denise is assessed as having capacity, they would proceed down the legal route; if not, the housing association expected ASC to arrange and pay for a specialist clean of the property. ASC asked that the housing association defer any application to the court until after the care assessment is completed and Denise has one last chance to clear the kitchen area. A timescale of 14 days was proposed by NHO1.

Finding 67:
There is a confusion as to whether or not SW5 has completed her assessment of Denise's care and support needs; it is stated that the assessment is still to be completed but also that she has been assessed as having no support needs.

Finding 68:
Given that Denise's physical and possible mental health has been questioned, input from her GP should have been sought to inform the meeting and any decision making.

Finding 69:
At this stage SW5 has not had access to Denise's flat; it is questionable how she could complete her assessment of her care and support needs without doing so.

10.167 On 2 August 2019, HA recorded a series of emails between NHO1, NHM1, the Head of Housing, the Customer Service Manager and others in the Customer Services team. These outline the events and attempted interventions since February 2019 and the basis for any application to the courts for an injunction, including confirming that Denise has rent arrears of £2261.72. Concerns are raised about a possible public health issue due to the insanitary conditions in Denise's flat compounded by her hoarding behaviour and her insistence that she doesn't want any assistance in clearing and cleaning the flat.

10.168 On 2 August 2019, ASC recorded the receipt of two emails from NHO1 advising SW5 that TSO1 has made the relevant referrals for welfare advice for Denise and advised her of

what is likely to happen. She also pointed out that it is part of the housing association's procedures to apply for possession of the flat due to the size of the rent arrears (see 10.167 above) unless a payment plan is put in place and asking if this could be addressed in the care assessment which can address issues of benefit eligibility as no payments of Housing Benefit have been received since April. In the meantime, the housing association will proceed with their procedure on rent arrears.

10.169 On 2 August 2019, ASC recorded three unsuccessful attempts to contact Denise by phone. The reason for the calls is not recorded but presumably was to complete the care assessment (see 10.165).

10.170 On 2 August 2019, the housing association recorded a phone call from the tenant, in response to a text message from the NHO asking Denise to call her.

10.171 On 6 August 2019, the housing association recorded a phone call to Denise to arrange a phone appointment on 9 August 2019 with TSO2 to discuss possible advice and support.

10.172 On 8 August 2019, the GP Practice recorded receipt of an OOH report of a phone contact with Denise but no details are noted of date, purpose, content or outcome.

10.173 On 9 August 2019, ASC recorded the completion of the care assessment over the phone; SW5 determined "(Denise) does not have eligible care and support needs as assessed under the Care Act 2014 …. does not wish for support to help her achieve maintaining or cleaning of the property, nor does she feel the need for other support … (her) daily functioning is not impacting her holistic well-being sufficiently and she is meeting all of her own care needs.. it is recommended that (Denise) be supported to complete the bulk of her cleaning with the aid of a Blitz Clean service – but she has firmly declined this … She is content in her home environment and has shown she is engaging with her (TSO) … (she) reports no other diagnosis other than Osteoarthritis … (she) is advised to work with (NHO1) and (TSO1) to ensure she adheres to her tenancy agreement (which NHO1) reports that (she) is in breach of… (Denise) is likely to continue with (CSW) however support worker role is more short term." There is no reference to any capacity assessment.

Finding 70:
There is no assessment of Denise's capacity to make decisions about her care and support needs, the basis of the statement that her "daily functioning is not impacting her holistic wellbeing sufficiently and she is meeting all of her own care needs" is not clear given the state of her flat and her noted physical deterioration.

Finding 71:
While SW5 had access to information from the housing association to inform her assessment, there is no record of her contacting either Denise's GP or BFRS for information, despite both agencies having had extensive contact with Denise over the previous six months.

10.174 On 10 August 2019, the GP Practice recorded receipt of an OOH report of "made excellent progress with aiding (Denise) to engage historically" outcome.

10.175 On 13 August 2019, ASC recorded an email from SW5 to "all involved" having been agreed with Deputy Team Manager Assessment2 advising that Denise contacted her on 9 August 2019 to complete her adult social care assessment. This took place "using the Care Act 2019 eligibility criteria". Denise did "not have eligible care needs and she has declined any further input" including a one-off blitz clean service; SW5 felt Denise might benefit from long term support and this can be continued by TSO1 and/or CSW, the latter having "made excellent progress with aiding (Denise) to engage historically" but questioned whether her continued involvement was appropriate "when the issue is really for (housing association) to try to and get the water on" is for her manager to decide. She continued that a simpler letter to Denise explaining "what the 'legal notice involves" is "highly likely to resolve the issue". SW5 also provided advice to the housing association on how to meet their responsibilities as landlords. The email ends stating that SW5's assessment is awaiting "manager authorisation" when her "involvement will end".

Finding 72:
The quality of SW5's assessment of Denise's care and support needs is highly questionable – see Findings 66 – 68 above – which should have been picked up and addressed by her manager before it was signed off.

Finding 73:
It is unprofessional for SW5 to have advised the housing association on how to meet their responsibilities as landlords; this should have been picked up and addressed by her manager before the email was sent.

Finding 74:
The citing of CSW having "made excellent progress with aiding (Denise) to engage historically" is a further example of professional optimism and does not accurately reflect the reality of ASC's involvement with Denise.

10.176 On 13 August 2019, the housing association recorded the receipt of the above email from SW5 to NHO1, two tenancy support workers, the MP's case worker, and the ASC CSW and confirming its contents.

Finding 75:
That, given their divergence from the housing association's experience and knowledge of Denise and her situation, the housing association should have challenged the quality of SW5's assessment and its conclusions with ASC.

10.177 On 13 August 2019, the housing association recorded that the Head of Housing had agreed to pay for a Blitz Clean.

10.178 On 13 August 2019, the housing association recorded an email from NHO1 to NHM1 and a Customer Support Administrator referring to the letter to Denise from Customer

Support. NHO1 thought it had been agreed that legal action would be taken as Denise had had a warning letter – see 10.148 above – which had had no effect. NHO1 considered that "Social Services are failing to take any responsibility" and she had "very real concerns about how frail (Denise) had become". She asked to be advised what action will be taken assuming Denise does nothing to improve the condition of her flat, as she has failed to do over the past six months.

10.179 On 14 August 2019 at 22:53, SCAS recorded a 999 call from Denise who had slipped and was unable to get up; an ambulance attended and the crew recorded that there was no electricity as the smart meter card had run out and there was no water. One of the crew had attended Denise before and noted she was more emaciated than before. The flat was described as damp and smelling of mould, with plates, cups, rubbish and animals and "not safe long term and not fit for purpose". Denise was too weak to sit herself up but was stated to have mental capacity and all observations were within the normal range. She refused any other medical treatment and did not agree that the flat was unclean. She said that the housing association had asked her to clear the clutter in the flat but had not offered any assistance to do so. She did agree that the crew remove some rubbish to create a pathway in the flat and to them raising a safeguarding referral.

10.180 On 14 August 2019, the GP Practice recorded receipt of an ambulance report.

10. 181 On 15 August 2019 at 08:01, SCAS recorded a 999 call from Denise; she had fallen again but had no injuries. An ambulance was despatched and arrived at 08:16. The crew had to access the flat via the patio door as Denise unable to get up. They had to move items in the living room to access Denise. The flat was described as "extremely cluttered, dirty – appears to have been like this for some time. Cobwebs over doorways which shows they haven't been used for some time. (Denise) sleeps on the sofa. The whole ground floor smells strongly of urine." Although Denise "caused the crew great concern, refused hospital attendance, has capacity." She agreed to the crew raising a safeguarding referral and contacting her GP having completed a falls referral. The crew considered the flat a fire risk due to trailing wires and the clutter and that Denise would not be able to leave the flat if a fire occurred. The crew also spoke to CSW to make her aware of the situation.

10.182 On 15 August 2019, the GP Practice recorded the receipt of an ambulance report and a phone call from a paramedic to the GP to make the Practice aware that Denise "not engaging … and multiple agencies involved and emaciated and RSPCA taken pets away and not attending Social Services meeting and has capacity and have referred safeguarding and all agencies made aware … - no action needed".

10.183 On 15 August 2019 ASC recorded the receipt of two safeguarding alerts from SCAS – see 10.179 and 10.181 above. Denise was described as having the capacity to refuse hospital attendance. Crews had attended on both occasions after Denise called via 999 having fallen off the sofa while asleep and been unable to get up. In addition to the information in 10.178 and 180 above, the crews reported that Denise told them a friend brings her shopping and they noted tinned food and cuppa soups in the flat. Contact had been made with CSW who advised contacting SW5 as Denise's case was going to be closed, which they did before the

second safeguarding alert was raised. SW5 spoke with NB, BFRS and asked if the GP had been informed; she was advised that they had and that they had advised that Denise had capacity and that she understood the consequences of refusing medical treatment. SW5 said she could add nothing to what the GP had said. NB, BFRS also referred to the high fire risk due to Denise being unable to get out of the flat; SW5 advised that she had assessed these risks and that Denise had said she would leave the flat if necessary. SW5 recorded that NB, BFRS "became agitated and raised her voice" asking what ASC were doing; SW5 explained the content of the email of 13 August 2019 – see 10.175 above – and that while risks remain, Denise has capacity and chooses to live as she does and that the GP needs to either consider an urgent health assessment or a Mental Health Assessment if Denise is putting herself at risk.

Finding 76:
That SW5's statements about assessing risks in Denise's flat cannot be based on direct evidence as she had never had access to the flat.

Finding 77:
That the GP was in a position to comment on Denise's capacity re medical treatment when she was seen, not on her capacity when the ambulance crew saw her.

Finding 78:
That SW5 should have had regard to 2.11 of the Code of Practice supporting the MCA and re-assessed Denise's capacity in the light of her repeated Unwise Decisions.

Finding 79:
That SW5 should have contacted the GP to discuss Denise's situation, the ongoing safeguarding referrals, her care and support needs and the possible need for a health or mental health assessment.

10.184 On 15 August 2019, ASC recorded that SW5 shared the above with her supervisor and it was agreed she would complete a Vulnerable Adult Risk Management (VARM) referral.

10.185 On 16 August 2019, ASC recorded that SW5 started to complete a VARM referral but, as she did so, felt it was not appropriate and contacted the VARM Lead, Team Manager of the Adult Safeguarding team**.** After discussion of the case and the work undertaken, it was agreed that a VARM referral "would not be appropriate as there was a reasonable plan recommended to mitigate the risk which had been shared. Also (Denise) has engaged with services and agreed that it is not consistent however she has demonstrated some willingness to work with agencies. Therefore, there are no justified reasons for a VARM". The Adult Safeguarding Team Manager suggested that Duty could complete a three month follow up meeting if ASC closed the case. SW5 said that this was a recommendation contained in her email of 13 August 2019" – see 10.175 above - but it wasn't. The case was never deallocated from SW5.

Finding 80:
This is a further example of professional optimism on the part of SW5.

10.186 On 16 August 2019, the housing association recorded a phone call from Denise's mother who hadn't heard from her for about a week and was concerned as she wasn't answering her phone. NHO2 visited at 12:15 but got no reply and phone calls went straight to voicemail. NHO1 tried to phone at 12:50 but it went to voicemail so left a message asking Denise to call back, as did TSO1. NHO1 visited at 13:15 and couldn't gain access but thought she could hear someone faintly in the background. She called on Neighbour1 who was very concerned at Denise's self-neglect and deteriorating health; he had had a text from Denise that morning saying she had fallen and couldn't get up. He didn't have a key to the flat but advised that Denise didn't lock the patio doors. NHO1 called TVP for assistance; they arrived at 14:00 and gained access to the flat and found Denise on the floor. She looked very emaciated and malnourished; her eyes were very sunken, she was gaunt and appeared very frail and dehydrated. TVP called an ambulance. Denise agreed she needed help cleaning the flat and that the housing association could arrange contractors do so but she wanted to be there when it was done. She refused to go to hospital, but the ambulance crew called the mental health paramedic who managed to persuade her to change her mind. The paramedics were unable to get a blood pressure reading due to the lack of a pulse and Denise's SATS were dangerously low. As she was put into the ambulance, it was suspected that she was going into cardiac arrest. She was taken to Milton Keynes University Hospital. There were an adult cat and two kittens in the flat and TVP tried to contact the RSPCA four times before deciding to leave sufficient food and water for them. TVP and SCAS agreed to raise safeguarding referrals; NHO1 agreed to arrange a change of locks (as Denise had gone to hospital without leaving any keys), arrange a deep clean of the flat and to contact the RSPCA about the cats in the property.

Finding 81:

The above is an example of good practice on the part of the Housing Association and NHO1 in particular, given the level of concern for Denise – suspected of going into cardiac arrest – the ambulance crew could have transported her to hospital by a Best Interests Decision under the MCA had the mental health paramedic not been available.

10.187 On 16 August 2019, TVP recorded receiving a call at 9:15 from a female who said the ambulance service had visited when she had a fall and they had removed her food. The call cut out and ringing back went to voicemail and TVP had no previous calls from the number. SCAS were contacted who had had no calls from the number overnight. As the caller had not sounded distressed, attempts were made to contact the caller over the next three hours. The caller rang back five times between 12:50 and 12:59 and identified herself as Denise but the line kept clearing. She said she wasn't injured and didn't want an ambulance. At 13:55, TVP recorded a phone call from NHO1 asking for assistance and officers attended at 14:07 to gain entry to the flat. They found Denise "on the floor and in a very frail and severely underweight condition with the appearance of an 80/90-year-old. An ambulance was called and (Denise) was transported to hospital". The flat was described as "in a very poor state, with flies and animal faeces and rotten food, and general 'hoarded' household mess". TVP contacted Denise's brother – outcome unknown – to advise him of her admission to hospital. "An Adult Protection Report was created, and MASH made a referral to the Adult Safeguarding Team on 19/08/19".

Finding 82:

That TVP followed their procedures correctly and acted promptly and effectively when contacted by NHO1.

10.189 On 16 August 2019 at 14:17, SCAS recorded a 999 call from TVP and an ambulance was despatched, arriving at 14:44. The crew completed a safeguarding referral due to self-neglect and immediate threat to life. Denise had not consented to and wasn't aware of the referral being made. The crew highlighted that Denise "cannot look after herself, is very weak, has poor mobility and does not meet the criteria for social care following assessment by social services and the property is deemed unfit for habitation according to (BFRS)." The crew also identified the property was a Fire Risk. As BFRS were not in attendance, it is unclear why they were referenced unless it is an allusion to previous comments of Watch Commander - see 10.11 and 10.12.

Finding 83:
That SCAS followed their procedures correctly and acted promptly and effectively when contacted by TVP.

10.190 On 16 August 2019, the GP Practice recorded receipt of an ambulance report "- Taken to A&E".

10.191 On 16 August 2019 at 15:49, Milton Keynes University Hospital Foundation Trust (MKUHFT) recorded Denise's arrival at the Emergency Department (ED); on assessment in ED, staff were "shocked at her presentation, primarily how emaciated she was". Denise said she had a friend who helped with her electricity and provided bottled water, but she had been unwell recently so not able to help currently. She said her health had deteriorated since the RSPCA removed her animals six weeks ago. She was described as "fully alert but lacks insight as to how unwell she is". She had "multiple category 2 and 3 pressure ulcers to her back and sacrum. Referred to Safeguarding Team re self-neglect and safeguarding alert raised in ED to MKC".

Finding 84:
That there is a difference between "fully alert" and having capacity to make any specific decisions and Denise's capacity should have been questioned on her admission to hospital.

Finding 85:
There is no record of ASC receiving the safeguarding alert from ED.

10.192 On 17 August 2019. MKUHFT recorded that Denise was admitted to Ward 3 for active treatment for malnutrition.

10.193 On 18 August 2019, MKUHFT recorded a review by the medical team who requested a Mental Health Review to determine whether a formal assessment under the Mental Health Act 1983 was required and referred Denise to the Dietician.

10.194 On 19 August 2019 MKUHFT recorded that Denise continued to be unwell as still not eating despite encouragement and requiring specific fluid replacement due to malnutrition

according to deranged blood results. She was “at huge risk of refeeding syndrome”. This is where shifts in fluids and electrolytes cause metabolic changes which can cause serious harm and sometimes death. It can occur in seriously malnourished patients and a careful refeeding plan is put in place by the Dietician to minimise the risk of this happening. Denise’s weight was recorded as 26.5k.

10.195 On 19 August 2019, the housing association recorded updates from TVP on Denise’s welfare – no details noted - and SW1 that arrangements have been made to remove the animals so that cleaning of the flat can start.

10.196 On 19 August 2019, ASC recorded “Information copied from (SCAS) Alert which was received into ASC” that Denise had been conveyed to MKUHFT ED; SCAS had been contacted by the Police having gained access to the flat after being contacted by a housing officer who had been contacted by a neighbour. The Alert noted that Denise had been assessed as not meeting criteria for social care a week before, that a “forced clean of house being arranged” and that the flat is “not fit for habitation according to (BFRS), due to squalor, cats, fleas animal excrement, fire hazard due to clutter. Injuries emaciated, dehydrated, weak”. As BFRS were not in attendance, it is unclear why they were referenced – see 10.189 above

10.197 On 19 August 2019, ASC recorded a phone call from the RSPCA to the ACCESS Team, having been contacted by the Police as Denise had been admitted to hospital, asking what ASC were doing under the Care Act regarding her pets; he was advised to contact the Hospital SW Team and that CSW would be advised of his call.

10.198 On 20 August 2019, the housing association recorded a home visit by NHO1 with Housing Association Response to complete a lock change and to meet RSPCA1 and SW5 to remove the animals from the flat and place them in a cattery, arranged by SW5. The RSPCA removed two kittens and one cat but were unable to locate the gecko. The locks were changed and the flat secured. NHO1 contacted the Housing Association Area Manager Response to ask that he arrange for the kitchen to be cleaned so the leak can be repaired and water re-instated so that the rest of the flat can be deep cleaned once the water is back on. Denise’s property was to be boxed up. NHO1 also emailed the Housing Association’s Customer Support Manager and Administrator updating them on her actions, asking if there is anything else she should do and advising them that she will visit Denise the next day.

Finding 86:
This is an example of good practice by the housing association and NHO1 to secure Denise’s flat, her animals and possessions and to start planning for her discharge from hospital.

10.199 On 20 August 2019, MKUHFT recorded that a social worker saw Denise to advise her that her flat was undergoing repairs and reconnection of the water.

10.200 On 20 August 2019, the housing association recorded an email from NHO1 to the Housing Association’s Customer Support Manager and Administrator advising that, further to her earlier email – see 10.198 above – the RSPCA has placed the cats in a cattery and no decision will be made about their long-term future until Denise returns home. NHO1 was to

visit Denise the following day to get her agreement to arrange for the repairs to be carried out.

10.201 On 21 August 2019, the housing association recorded an email from the Area Manager Repairs to NHO1 providing the costs of the environmental clean to the kitchen, which would be covered by PPP (Price Per Property). Denise's property would have to be bagged up, removed and then returned to the property once the clean was completed. An estimated cost to Denise of £2,525.40 is quoted.

10.202 On 21 August 2019, MKUHFT recorded Denise was visited by her mother and brother. She was still not able to eat but was drinking small amounts. She wasn't well enough for any further assessments regarding functioning or mobility.

10.203 On 21 August 2019, the housing association recorded an email from a Customer Support Administrator to NHO1 thanking her for her updates (see 10.198 and 10.200) and asking for details of the start and completion dates of the repairs and also photos once they are completed. On completion, the housing association will write to Denise reminding her of her tenancy agreement, that the works were a one-off and, that if she allows the property to deteriorate again, legal action will be taken.

10.204 On 22 August 2019, MKUHFT recorded a review of Denise's treatment plan by the doctors and the dietician for slow prescribed refeeding.

10.205 On 22 August 2019, the housing association recorded NHO 1 visited Denise in hospital; Denise agreed to the housing association arranging for contractors to clean the kitchen area so that the water can be turned back on and to the floor covering in the lounge being removed but wanted to be present when the rest of the flat is cleaned. NHO1 assured her that her property would be bagged up and not thrown away.

10.206 On 22 August 2019, ASC recorded a visit to Denise in hospital by a social worker and CSW; Denise said she wanted to return home but accepted she needed to build up her strength before doing so. She had found the letter from the housing association unclear and had been distressed by it but had been visited in hospital by NHO1 and agreed to the housing association assisting with cleaning and repairs while she is in hospital. SW5 and CSW advised that, while they would support her to return home, Denise would have to demonstrate that she could do so safely. They advised her that her kittens were safe. She had started some work on standing and transferring and was eating small amounts. The social worker recorded that "I think it was a really successful visit and left her upbeat…Fantastic effort and support from (CSW) really boosted (Denise's) mood". She also noted that Denise's mother and brother had visited the day before.

Finding 87:
A further example of professional optimism by ASC SW.

10.207 On 23 August 2019, the housing association recorded an email from NHO1 to Deputy Manager ASC Assessment Team confirming a meeting between them and NHM1 the following

week. She advised her of the outcome of her visit to Denise the previous day (see 10.206) that the work was likely to start in the middle of next week and pointed out that, while Denise has capacity, there is little they can do about the rest of the flat.

10.208 On 23 August 2019, MKUHFT recorded a review by a consultant and a mental health practitioner (a member of the Mental Health Liaison Team who work within MKUH but employed by CNWL), which did not identify any mental disorder but did not rule out an eating disorder. No further input was required from mental health services at this time as the medical plan is to continue with dietician involvement and daily blood tests.

10.209 On 23 August 2019, the GP Practice recorded an email from the mental health team (Mental Health Liaison Team) following their review appointment with Denise (see 10.208).

10.210 On 27 August 2019, ASC recorded receipt from MKUHFT of the reasons for Denise's admission – "Fall not eating and drinking severe cachexia and dehydration". Cachexia is a wasting disorder that causes extreme weight loss and muscle-wasting. It can be caused by a range of medical conditions but is most often associated with end-stage cancer.

10.211 On 27 August 2019, ASC recorded that SW5 was advised her locum contract would be ending at the end of September 2019; no reason is given.

10.212 On 29 August 2019, the housing association recorded a job being raised with Response team for a key safe to be fitted at Denise's flat.

10.213 On 29 August 2019, the housing association recorded a "Professional Meeting" attended by NHO1, NHM1, CSW, SW2, Team Manager Adult Safeguarding Team, Deputy Team Manager Assessment Team and Deputy Manager for access and re-enablement service to discuss how to coordinate the clean-up of Denise's flat to enable her to return and to discuss her ongoing support. The Chair, ASC Adult Safeguarding Team Manager, was to distribute notes of the meeting but there is no record of this happening.

10.214 On 29 August 2019, the housing association recorded a visit by NHO1 and CSW to see Denise; she told them she wanted to be better before she went home and would therefore be staying in a residential home while the flat was cleaned. They explained that the flat was infested with fleas/bugs and so her bedding and soft furnishings needed to be got rid of. They agreed to make a list of all that had to be destroyed before doing so and also agreed a list of what of her possessions Denise wanted to keep – mainly her collection of dolls and a few personal items - and which could be got rid of. They advised her that they would access grants etc to purchase new items and she would be in control of all purchases. The only white good that needed replacing was the washing machine. It was agreed that NHO1 would visit again the next week.

10.215 On 29 August 2019, ASC recorded a Professional Meeting was held, attended by SW5, ASC Assessment Team Deputy Manager, ASC Safeguarding Team Manager, ASC Community Support Worker, ASC Access Team Manager, and Housing Association Manager and

Neighbourhood Housing Officer (NHO). SW5 provided an update from MKUHFT that although Denise's Estimated Discharge Date is 2 September 2019, this is not confirmed as no diagnosis has been confirmed, she is waiting "a psychiatric review and further functional assessments". It was likely a temporary placement would be needed for further rehab while her flat was made fit for her return. The RSPCA had put her kittens in a cattery, but the gecko was thought to still be in the flat. The housing association thought that Denise's tenancy did not allow her to have pets and they will be looking to bar her having any pets in the future. NHO1 said she had visited Denise in hospital and had her agreement to remove the carpets and perishables from the flat and to bag up some items so that workmen could access the property to repair the leak and reinstate the water. Cleaners had started work but had had to stop due to a substantial flea infestation and NHO1 asked for support from ASC to arrange a quote from a pest control company to enable the work to continue. There was a discussion of whether or not Denise had capacity; NHO1 and CSW thought she did but the Safeguarding Adults Team Manager suggested that her continued hoarding behaviour might suggest otherwise and enable decisions and actions to be taken without her consent. The Deputy Team Manager Assessment expressed concerns that doing so might impact on Denise's willingness to work with agencies in the future. It was agreed that a list of items to be removed and work required to be drafted for Denise's agreement, which if not obtained or implemented "to make the flat habitable, a new MCA will be required." SW5 was to obtain a pest control quote and undertake any capacity assessment that is required, NHO1 to arrange the declutter and clean of the kitchen and the reinstatement of the water and NHO1 and CSW to draft the list for Denise's agreement. A follow up meeting was agreed to discuss progress and further action including discharge planning and ongoing support, but no date was set.

Finding 88:
While this is an example of good practice, it is not clear whether the "Professional Meeting" was held under the local hospital discharge or safeguarding procedures – both would have been appropriate.

10.216 On 29 August 2019, ASC recorded a phone call from CSW to (SW5); she and NHO1 had visited Denise in hospital and agreed the list of what was to be kept and what could be got rid of from the flat using photos of the flat. It was agreed to word her letter as to what to keep or get rid of to cover items that might be identified outside of the meeting. Denise agreed to have the flat fumigated and to go into rehab until her flat was ready. CSW described Denise as "optimistic and positive". SW5 agreed to update management "re MCA and list."

10.217 On 29 August 2019, ASC recorded a phone call from SW5 to Rentokil: a surveyor will visit the flat that day to quote for treating the whole flat. She also tried to contact Milton Keynes Pest Control to ask for a quote but got no reply.

10.218 On 30August 2019, ASC recorded a phone call to SW5 from Rentokil; it will take three visits separated by a week to treat the flat due to the fact that eggs can stay dormant for a period of time. They would need the flat decluttered as far as possible. Rentokil can start 24-

48 hours after quote is accepted and the property can be accessed four hours after each treatment. The quote should be available later that day. SW5 agreed to contact the housing association to suggest removing items from the flat after the first treatment. The record noted "Email updated and sent to Rentokil and housing."

10.219 On 4 September 2019, ASC recorded a phone call from SW5 to the Discharge Coordinator at MKUHFT in response to an email confirming her attendance at an MDT meeting on 6 September 2019.

10.220 On 5 September 2019, ASC recorded notification that Denise had died that day at 14:57. Denise's health had "suddenly deteriorated and she had pneumonia."

10.221 On 6 September 2019, ASC recorded that the Head of Assessment and Safeguarding "directed that (SW5's) employment with us is terminated by 13/09/2019. Management decided that due to concerns regarding her practice, it was decided that she should not have contact with clients or work from the office this week, the agreed plan was for (SW5) to work from home this week to complete some write ups of assessments."

11. Themes and Recommendations:

11.1 This SAR is focused on the events between 9 February 2016 and 5 September 2019, however, agencies were asked for details of any involvement with Denise and her family prior to those dates. As a result, there are two Findings that relate to events before the Review period.

11.2 The SAR had identified 88 Findings; these can be grouped into 12 Themes; invariably these Themes are not discrete groupings but have porous membranes so that Findings can fall into more than one and the Recommendations that follow also share areas of overlap.

Theme 1: Children in Need and Young Carers

Findings 1 and 2

11.3 In July 2003, TVP was in contact with Denise and referred her to ASC; both agencies were aware that Eric, her son, was living with her. At that time, he was 12 years old. Denise described herself as having panic attacks and hearing noises. Neither agency referred the family to Children's Services although ASC did suggest in a letter that she could contact CSC to discuss what support they could offer.

11.4 In 2004, TVP recorded an argument between Denise and Eric on his 13th birthday. There is no record of this being referred to CSC.

11.5 Eric was potentially a Child in Need and/or a young Carer but neither agency identified this or made an appropriate referral to CSC or an alternative support agency in the voluntary sector.

Recommendation 1:

That the MK Together Partnership seeks assurance that agencies are informed about services for and are making appropriate referrals for Children in Need and Young Carers

Theme 2: Domestic Abuse

Finding 2

11.6 In 2004, TVP recorded an argument between Denise and Eric on his 13th birthday and between 2007 and 2009 domestic incidents between Denise and her then-partner – identity not known.

11.7 Between the ages of 13 and 17, Eric was therefore experiencing Domestic Abuse, whether as a victim, perpetrator or witness is not known, but no referral was made to CSC.

11.8 The above occurred outside of the Review Period so have not been pursued by the Independent Author; the policies and procedures around Domestic Abuse may well have changed since 2009 so that similar incidents occurring now would be managed differently by TVP.

Recommendation 2:
That the MK Together Partnership seeks assurance that TVP are referring cases involving children to the appropriate support agencies, including CSC and the relevant Education agencies.

Theme 3: The Mental Capacity Act 2005

Findings: 15, 21, 22, 24, 26, 28, 30, 35, 50, 51, 52, 57, 58, 70, 77, 78 and 84

11.9 There was no evidence provided to the Review that Denise lacked the capacity to make any specific decision or decisions, however, there was evidence that the MCA was not implemented properly by all agencies in their involvement with her or that her capacity was ever formally assessed or even questioned until very late in the Review period.

11.10 The MCA requires an assumption that an adult has capacity to make decisions until it is demonstrated that they don't; this is not the same as stating that someone has capacity or that they are "fully alert" without completing an assessment - see Findings 24, 52, 57 and 84.

11.11 The MCA is quite clear in stating that capacity is decision and time specific; any assessment or statement as to someone's capacity must therefore be directly linked to a particular decision at a particular time – see Findings 22 and 77.

11.12 Any assessment of someone's capacity has to be based on whether or not they meet the two-stage test; the first stage is that they have an impairment or disturbance in the functioning of the mind or brain. If an assessment of someone's capacity is to be valid, it is essential that the person completing the assessment has access to the relevant information,

particularly any that would establish whether or not they meet this first stage of the test. There is no evidence that there was any attempt by either CSW or SW5 to check with any other agency or even within ASC to seek clarification on this point – see Findings 21 and 35.

11.13 The above point was thrown into starker relief when MPCC1 raised the possibility that Denise had a learning disability. The Review is not aware of the basis of this possibility, but that is irrelevant here: the possibility having been raised it should have been checked and Denise's capacity to make decisions about her health and welfare including accommodation issues should have been formally assessed – see Finding 50.

11.14 The suggestion that NHO1 could undertake a formal assessment of Denise's capacity again highlights a lack of awareness of the need for specialist advice re the two-stage test as well as an unrealistic expectation of an NHO – see Finding 15. It also highlights a lack of awareness of who is responsible for a capacity assessment: it is the decision-maker and an NHO may be the decision-maker for signing a tenancy agreement, for example, but this capacity assessment related to decisions regarding care and support needs and therefore was the responsibility of ASC.

11.15 Even if it had been established that Denise did not have a learning disability, this would not mean that she did not fall under the MCA; the impairment or disturbance in the functioning of the mind or brain does not have to be caused by a learning disability or brain injury. The MCA and its supporting Code of Practice recognises that capacity can be impacted on by a range of factors including coercive or controlling behaviour and manipulation. The Code of Practice also recognises that, while the MCA states that an adult who makes what others may consider to be unwise decisions should not be considered to lack capacity for that reason, an adult who repeatedly makes the same unwise decision should have their capacity re-assessed see 2.11 of the Code of Practice. Despite Denise continuing to make the same unwise decisions regarding her hoarding and self-neglect, no consideration was shown to reviewing her capacity to make these decisions – see Findings 28, 30 and 78

11.16 It is not clear what assessments CSW had been tasked with completing – see Finding 51 – or that she was qualified to complete them. CSW did at least have direct contact with Denise over a period of time, including access to her flat. SW5 made a statement as to Denise having capacity based on one meeting when she only spoke to Denise on her doorstep and without access to her flat – see Finding 58. No formal assessment of Denise's capacity was ever completed - see Finding 70 nor is it clear what the change of circumstances was that led to a formal capacity assessment being initiated – see Finding 51.

11.17 The above demonstrates a lack of awareness of the MCA within ASC and a failure to comply with its basic requirements in their involvement with Denise. It also demonstrates a lack of awareness of the MCA within the housing association as neither NHOs nor their managers challenged CSW or SW5's practice with regard to the MCA – see Finding 26. This may have been exacerbated by a lack of any escalation process or procedure by which they could have challenged it or sought clarification of the reasoning behind it.

Recommendation 3:
That the MK Together Partnership seeks assurance from ASC that it has reviewed and revised as necessary its policies and procedures regarding the MCAs to ensure they are fully compliant with the legislation and its supporting Code of Practice.

Recommendation 4:
That the MK Together Partnership seeks assurance that ASC and other member agencies are ensuring that their staff and those of services they commission are appropriately trained to ensure that they practice in compliance with the MCA and its supporting Code of Practice.

Recommendation 5:
That the MK Together Partnership seeks assurance that ASC and other member agencies have reviewed their policies to ensure that formal Capacity Assessments are completed by appropriately qualified staff and recorded in a consistent manner in accordance with the MCA and its supporting Code of Practice.

Recommendation 6:
That the MK Together Partnership seeks assurance from ASC that due attention is given to 2.11 of the Code of Practice supporting the MCA with regard to cases of self-neglect and hoarding in particular.

Recommendation 7:
That the MK Together Partnership seeks assurance that member agencies have developed, implemented and are monitoring the use of escalation procedures in cases where there are concerns about the implementation of the MCA.

Recommendation 8:
That the MK Together Partnership seeks assurance from ASC and member agencies that they have developed and implemented robust procedures to monitor the above recommendations.

Theme 4: The Care Act 2014

Findings: 19, 20, 23, 24, 51, 56, 57, 58, 61, 67, 68, 69, 70, 72 and 75

11.18 Denise was initially allocated to CSW for an "adult social care assessment"; it is not stated what exactly this assessment is – see Finding 51, but it has to be assumed that it is an assessment under s9 of the Care Act 2014, namely an assessment of her care and support needs. As will be suggested later in this report, it is the view of the Independent Author that the Access Team should not have decided whether or not the referral from the housing association on 15 February 2019 was a safeguarding concern, but even if ASC had screened the referral – there is no evidence that it was so screened - and assessed it not to be a safeguarding concern, it is of concern that a CSW rather than a SW was tasked with the s9 assessment in a case where self-neglect and hoarding were issues and safeguarding possibility an issue – see Finding 19.

11.19 Having been allocated the case, CSW should have met Denise at her flat to establish the exact degree of the self-neglect and hoarding that had caused the referral to be made rather

than meet her at the Civic Offices – see Finding 23. It is also of concern that CSW made assumptions about Denise's capacity and her care and support needs before either had been formally assessed – see Finding 24 - and state that she would have to pay for any service before any financial assessment had been completed – see Finding 24.

11.20 As has been said – see 11.16 above – it is not clear what the change in Denise's circumstances in June 2019 was that lead to SW5 being allocated to complete a "joint adult social care assessment" with CSW, nor is it clear what such an assessment is or how it is different to the assessment CSW had been completing since February 2019.

11.21 Any assessment under s9 of the Care Act should include input from any health services involved with the adult – in this case Denise's GP - as to their health needs. No such input was sought at any stage – see Finding 68.

11.22 SW2 had contact with Denise on two occasions, one of which was on the doorstep of her flat and the other by phone. It is not clear how this can be considered enabling her to assess either Denise's capacity or her care and support needs effectively – see Findings 57, 58 and 69. During the month of June 2019, there was no contact with Denise by either CSW or SW5 apart from one phone call from Denise, not to her, to advise that the RSPCA had removed some of her animals.

11.23 The highly questionable basis and quality of SW5's assessment of Denise's care and support needs also calls into question the quality of managerial oversight and supervision she received and which allowed her assessment to be completed with a view to closing her involvement with Denise – see Finding 72.

11.24 Denise cannot be described as cooperating with or fully engaging with her assessment/s by CSW or SW5, however, no consideration was given to involving an independent advocate to assist and support her as required under s68 of the Care Act.

11.25 The divergence between the housing association's experience and knowledge of Denise and her situation over a number of years and that described in SW5's assessment raises a question as to why the housing association did not challenge the assessment and the resulting lack of support from ASC or any referral to alternative support services – see Finding 75. This failure to escalate their concerns may again be due to the lack of any formal process or procedure by which to do so – see 11.17 above.

Recommendation 9:
That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice for receiving safeguarding concerns as identified by the referrer to ensure they are appropriately screened before allocation or disposal.

Recommendation 10:
That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice in allocating cases of self-neglect and hoarding and therefore possible safeguarding to unqualified staff.

Recommendation 11:
That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice in completing assessments under the Care Act 2014 to ensure they are holistic and comprehensive and that the subject is supported to participate fully in their assessment.

Recommendation 12:
That the MK Together Partnership seeks assurance from ASC that they have management processes in place to ensure that those at most risk in the community, particularly cases of self-neglect and hoarding, are seen frequently enough to ensure the risks they face are effectively monitored.

Recommendation 13:
That the MK Together Partnership seeks assurance from ASC that they have developed, implemented and are monitoring the use of escalation procedures in cases where there are concerns about the completion of assessments under the Care Act 2014.

Theme 5: Safeguarding

Findings: 4, 9, 11, 13, 16, 17, 28, 30, 35, 39, 40, 41, 43, 53, 59, 64, 65, 66, 68 and 85

11.26 There is a lack of consistency in the terminology used throughout the Review relating to safeguarding and the local multi-agency safeguarding procedures; this can only cause confusion between agencies and impact negatively on multi-agency working – see Finding 40.

11.27 Linked to the above, it is the view of the Independent Author that the CLO at the Access should not have refused to accept a safeguarding concern from the housing association but should have forwarded it to ASC for screening by the appropriate manager – see Finding 11.

11.28 BFRS should have raised a safeguarding concern with ASC when they attended Denise's flat on 14 February 2019; the housing association assumed they had done so but there is no record of one being made or received – see Finding 9. It is a concern that BFRS were not made aware of several 999 calls made by Denise during the Review period that were screened by TVFC as not requiring attendance by a fire crew. This is not to suggest that TVFC screened them incorrectly, but the fact that BFRS and other agencies working with Denise were unaware of these calls is of concern. Had this information been available, a more proactive approach to the safeguarding concerns should have occurred.

11.29 It is difficult to establish exactly how many safeguarding concerns or referrals were made regarding Denise's situation; this is partially because of the use of different terms – see 11.26 above – and partially due to the quality of recording in different agencies. Several times reference is made to a safeguarding referral going to be made but no confirmation of it having happened or been received. Some referrals that are recorded as being made are not recorded as being received and not all those that are recorded as being received are recorded as being screened or their outcome – see Findings 13, 53, and 85.

11.30 What is evident is that the screening process was not routinely followed and that on one occasion it took over a week for a safeguarding concern to be screened; had this been due to contact being made with other agencies to gather information to inform the screening, this might be understandable and acceptable but there is no evidence of any such contact being made – see Findings 35, 39 and 68 – nor of any reference being made to previous safeguarding concerns to monitor any changes or identify any patterns of behaviour – see Finding 41. Instead, the views of CSW and SW5 were accepted without reservation or checking – see Theme 7 below.

11.31 Despite Milton Keynes having established a VARM process, there was no referral to it as an alternative to Safeguarding as a multi-agency process to manage the complexities of Denise's situation – see Finding 4 - until 15 August 2019. Even then, SW5, despite having agreed with her manager to make the referral, discussed the case with the VARM Manager and agreed that "there are no justified reasons for a VARM" – see Theme 7. There is no record of this being ratified by SW2's manager.

11.32 There are numerous occasions where the state of Denise's flat is described as having deteriorated but no evidence of consideration being given by the housing association staff or managers to escalating their concerns to ASC or challenging the outcomes of the screening process – see Findings 16, 28, 30, 43, 65 and 66. Ultimately, NHO1 and TSO1 sought to identify alternative sources of support for Denise outside of ASC – see Finding 64 – but what was needed was a multi-agency procedure to manage and coordinate support for Denise – see Findings 28 and 64.

11.33 When NHO1 tried to raise a safeguarding concern on 15 February 2019 which ASC refused to accept, this should have been escalated by the housing association management as ASC should not refuse to accept a safeguarding concern, though they may screen one out – see Finding 16 – but no screening process is recorded for this safeguarding concern.

11.34 As has been commented upon earlier, the quality of SW5's assessment of Denise's care and support needs is of questionable quality; the same is true of her assessment that her situation was not a safeguarding issue. The state of her flat was deteriorating not improving and Denise's self-neglect, hoarding and poor care of her animals was well-known and documented as was the lack of progress of any interventions with her. SW5 had met Denise once when she wasn't allowed into the flat and spoken to her on the phone once to supposedly complete her assessment of her care and support needs. Combined with her claim that she was making progress with Denise, this is another example of SW5's professional optimism – see Theme 7.

Recommendation 14:
That the MK Together Partnership seeks assurance from BFRS and TVFC that they have reviewed and revised as necessary their procedures for screening 999 calls to ensure appropriate referrals-on are made.

Recommendation 15:
That the MK Together Partnership seeks assurance from member agencies that staff development opportunities for their staff and those of services they commission are consistent in the terminology they use in their safeguarding modules with the local multi-agency safeguarding procedures.

Recommendation 16:
That the MK Together Partnership seeks assurance that member agencies are consistent in the implementation of their internal screening processes to identify and raise safeguarding concerns with ASC.

Recommendation 17:
That the MK Together Partnership seeks assurance that ASC is screening safeguarding concerns in a holistic, effective and timely manner, ensuring any decision is multi-agency in nature.

Recommendation 18:
That the MK Together Partnership seeks assurance that ASC is recording and monitoring the receipt and processing of all safeguarding concerns.

Recommendation 19:
That the MK Together Partnership seeks assurance that any safeguarding concerns relating to self-neglect or hoarding that are screened out of the safeguarding procedures are automatically referred to the VARM procedures.

Recommendation 20:
That the MK Together Partnership seeks assurance that ASC has developed, implemented, promoted and is monitoring the use of an escalation process for other agencies to initiate when they are dissatisfied with the implementation of the local multi-agency safeguarding procedures.

Theme 6: Self Neglect

Findings: 4, 8, 41, 43, 44, 51 and 64

11.35 The housing association and BFRS were already aware of issues with Denise's flat at the beginning of the Review period in February 2016 when referrals were to be made to support services but not to any multi-agency co-ordinating procedures. The Care Act 2014 had been implemented by this time, which included self-neglect as a type of abuse covered by its safeguarding sections, but no safeguarding concern was raised. The Independent Author understands that BFRS had not updated its Safeguarding Procedure outside of its standard review period to reflect the new legislation and that the VARM had not been launched in Milton Keynes at this time.

11.35 When the housing association was contacted by Denise on 14[t]February 2019 about her leaking freezer, they had been aware of issues with the property over hoarding, trip hazards

and overloaded electrical circuits for three years but offered her no support, just advised her white goods were her responsibility to maintain – see Finding 8.

11.36 When Denise's flooded flat came to the attention of BFRS and the housing association, the VARM had been launched in Milton Keynes but neither agency raised a safeguarding concern as a result with ASC, or made a referral to the VARM – see Finding 4

11.37 That Denise was self-neglecting and hoarding was never in dispute; there were numerous attempts by the housing association to raise a safeguarding concern on the basis of Denise's self-neglect although when these were unsuccessful there were no attempts to escalate these concerns or to challenge the decision to screen the concerns out of the safeguarding procedures – see Finding 43.

11.38 When the safeguarding concerns were screened out of the safeguarding procedures, there was no referral to the VARM as a means of initiating a multi-agency response to coordinating the support offered to Denise and to monitoring her situation. Given the number of such concerns in a relatively short period of time, had the screening process included a review of any previous safeguarding concerns then a pattern should have been identified that would have suggested the need for a referral to the VARM – see Finding 41 and Recommendation 19 above.

11.39 On 7 June 2019, NHO1 recorded that ASC had now recognised Denise's self-neglect though it is not clear what had caused this change – see Finding 51 – but this still did not result in a referral to the VARM until 15 August 2019.

11.40 On 17 July 2019, NHO1 and TSO1 did try to refer Denise to alternative sources of support with her tenancy but these would not have had the same impact as a referral to VARM which would have brought a range of agencies together to support Denise and each other – see Finding 64.

11.41 Perhaps of most concern however is the failure of the housing association and ASC to pick up on the one known occasion when Denise suggested a possible cause of her self-neglect and hoarding behaviour on 26 April 2019 – see Finding 44. Throughout their involvement with Denise, all agencies focused their efforts on the symptoms rather than the cause of her self-neglect.

Recommendation 21:
That the MK Together Partnership seeks assurance that member agencies regularly update their Safeguarding Procedures to ensure their compliance with new legislation and or Statutory Guidance.

Recommendation 22:
That the MK Together Partnership seeks assurance that MKC has developed, implemented, promoted and are monitoring the use of the VARM in respect of all self-neglect cases that do not meet the criteria for a s42 Enquiry under the Care At 2014.

Recommendation 23:
That the MK Together Partnership seeks assurance that ASC and member agencies have reviewed and revised in the light of recent research their internal staff development opportunities and to those of services they commission relating to self-neglect and that these are robustly monitored to ensure their impact on practice.

Theme 7: "Professional Optimism"

Findings: 32, 59, 62, 74, 80 and 87

11.42 Across the Review period, the condition of Denise's flat continuously deteriorated as did her own physical presentation; this is recorded by the housing association and BFRS staff. Denise made little and sporadic attempts to comply with agreed plans for clearing and cleaning her flat to enable repairs to be carried out, as the RSPCA removed some animals, Denise obtained new ones which she kept in dirty conditions, she would refuse to allow staff access to the flat and was inconsistent in the information she gave agencies.

11.43 Despite and in full knowledge of the above, CSW and SW5 continued to claim that they were making good progress with Denise, had developed positive professional relationships and achieving changes in her circumstances and had "a reasonable plan to mitigate the risks" so that a referral to VARM was not needed – see Findings 32, 59, 62, 74, 80 and 87.

11.44 The above are all examples of "professional optimism" where staff convince themselves of the impact of their involvement and the commitment and capacity to change of the service user. Self-neglect cases are, by definition, complex ones to work with, requiring staff to balance issues around mental capacity and autonomy and responding to symptoms and causations. That is why staff working in this area benefit from multi-agency approaches, not only to coordinate the input of the different agencies but also to ensure that they don't lose a professional perspective of their involvement. The latter also requires close supervision and management overview to ensure that "professional optimism" doesn't gain traction. This latter will be picked up in Themes 10 and 11 as will be the relevant recommendations.

Theme 8: Multi-agency working

Findings: 14, 17, 42, 45, 46, 48, 49, 54, 55, 60, 63, 71, 79 and 88

11.45 Throughout the Review period, there are examples of the housing association and ASC working together in the sense of staff visiting Denise together; multi-agency working is more than just visiting service users together. It requires the sharing of information to inform joint planning and coordinated interventions.

11.46 ASC consistently failed to gather relevant information from the housing association, BFRS and Denise's GP to inform either their assessments of Denise's care and support needs or her mental capacity – see Findings 14, 55, 60, 71 and 79.

11.47 It is equally true that the housing association did not inform ASC of their intention to commence breach proceedings regarding Denise's tenancy – see Findings 46 and 63.

11.48 TVFC did not, in accordance with current screening procedures, make BFRS aware of their contact with Denise on 16 February 2019; BRFS was therefore unable to advise either ASC or the housing association of this or several other contacts that should have reinforced concerns about Denise's situation and led to a safeguarding concern being raised – see Finding 17.

11.49 Unusually, there were two occasions when SCAS didn't not inform the GP of contacts with Denise – see Finding 48.

11.50 Although they were first contacted on 14 February 2019, there is no record of the RSPCA attending Denise's property until 14 June 2019, despite increasing concerns for her animals and several referrals being made to them – see Finding 54.

11.51 The above are indicative of the importance of multi-agency working, particularly in cases of self-neglect and hoarding but also in the completion of holistic assessments of care and support needs and mental capacity. Had a multi-agency procedure such as the local safeguarding procedures or the VARM been initiated, there would have been a forum in which information could have been shared and interventions planned, coordinated and their implementation monitored. It would also have reduced the likelihood of agencies recording events happening in different dates and prevented CSW being identified as a social worker, which is a protected title – see Findings 42 and 47 – and ensured clarification about respective roles and responsibilities for both agencies and individual members of staff. The Independent Author has been advised that CSW had been known to introduce herself as a Social Worker; if this were the case, it would be another example of potential unprofessional practice – see Finding 37

11.52 When a multi-agency procedure is initiated after Denise's admission to hospital, it is not clear which procedure it is convened under – see Finding 88.

Recommendation 24:
That the MK Together Partnership seeks assurance that member agencies have reviewed and revised as necessary their procedures and practices and those of services they commission for sharing case-specific information with partner agencies.

See also Recommendations 5, 11, 16, 18 and 20 above

Theme 9: Recording

Findings: 7, 18, 45, 48, 85 and 88

11.53 As has been said earlier, there were occasions in the Review period where agencies disagreed on the dates of particular events; this can only have a negative impact on the effectiveness of multi-agency working – see Finding 45.

11.54 There were also numerous occasions where a contact is recorded, but the purpose, content and even the identity of the caller is not recorded – see Finding 7. In many instances, the agency is the housing association, but it also applies to ASC and the GP Practice.

11.55 There was evidence that information wasn't always communicated accurately and completely within ASC and at times ASC's information contradicted itself – see Finding 18. While some inconsistencies between agencies is understandable –see Findings 48 and 85 - though not acceptable, inconsistency within an agency suggests a lack of professional standards and management oversight.

11.56 On the one occasion a multi-agency meeting is convened, there is inconsistency in how that meeting is recorded; this suggests a lack of clarity about which multi-agency procedure is being initiated – see Finding 88.

Recommendation 25:
That the MK Together Partnership seeks assurance that member agencies have reviewed, revised as necessary and established monitoring processes to ensure their internal recording procedures and those of the services they commission meet at least minimum standards.

Recommendation 26:
That the MK Together Partnership seeks assurance that member agencies have reviewed and revised as necessary their processes for convening meetings under the local safeguarding procedures, the VARM and other multi-agency procedures to ensure they clearly identify the procedure being initiated and the status of the meeting concerned.

Theme 10: Professional Practice

Findings: 5, 8, 10, 12, 14, 20, 21, 22, 23, 27, 29, 31, 34, 35, 37, 38, 41, 44, 49, 56, 57, 58, 61, 67, 69, 72, 73 and 76

11.57. As can be seen from the above, this case raised serious concerns about the quality of professional practice across the agencies involved throughout the Review period. At the beginning of the Review period, the housing association should have recognised, having known her and had concerns about possible self-neglect and hoarding for three years, Denise's need for support when she contacted them about her leaking freezer – see Finding 8 – and they should have contacted the RSPCA on 15 February 2019 – see Finding 10.

11.58 When the housing association contacted ASC on 15 February 2019, they should not have been asked to contact the Urgent Care Mental Health Team; NHO1 should either have been transferred to the Team or the Team contacted to call her back – see Finding 12. An Access service should be just that, a single access point to Council services.

11.60 When Denise was allocated to CSW for an "adult social care assessment", this should have required a home visit but she was seen at the Civic Offices instead when CSW stated, without any assessment being completed that Denise had capacity and would have to pay for any services – see Findings 20 and 23. It is of concern that CSW should be tasked to undertake a formal assessment of Denise's mental capacity or that she should do so on her first contact with her with no background information and in relation to no specific decision, just her life style choice – see Findings 21 and 22.

11.61 Throughout CSW and SW5's contact with Denise – in SW5's case one meeting on her doorstep and one phone call – there is no evidence of any formal assessment being completed or shared with Denise or of any attempt to gather information from Denise or other agencies to illuminate any assessment – see Findings 14, 35, 41, 57, 58, 61, 67, 69 and 76. The above examples of poor practice should have been identified and rectified by their respective managers in supervision and before any assessment was agreed or signed off – see Finding 72,

11.62 "Social Worker" is a protected title; CSW should have ensured that other agencies were aware that she was not a social worker – see Finding 49.

11.63 There are records of referrals being made to possible support services for Denise, but no records of these being chased or feedback being sought on their progress and outcomes – see Findings 5 and 31

11.64 Denise had frequent contact with her GP Practice but normally by phone; she did not attend a number of appointments, but no DNA procedure is recorded as being initiated – see Finding 29. While it may be accepted practice to review and issue sicknotes and medication by phone, given the long-term nature of her health conditions she might have been expected to be seen at some stage during the Review period – see Finding 27. It is also unclear why the GP Practice continued to issue sicknotes after being advised by the DWP they were no longer needed but did not query the assessment that decided they weren't – see Finding 38.

11.65 The latter point above raises questions as to whether Denise in some way intimidated those working with her; she was not challenged, except on one occasion, about her not complying with agreed action plans or her behaviour generally – see Finding 34. On the one occasion she suggested a possible causation for her self-neglect and hoarding, this was not pursued either at the time or later – see Finding 44. There is no evidence of any policies or support systems available to staff in either the housing association or ASC for staff working with service users who are difficult to engage, which Denise certainly was – see Finding 36.

11.66 There is a lack of "professional curiosity" displayed by those staff working or trying to work with Denise and a lack of managerial oversight that might have identified and counteracted this.

11.67 This lack of managerial oversight is also reflected in the recording of SW1's comments about a colleague and SW5 advising the housing association how to meet their responsibilities as landlords – see Findings 37 and 73 – and the failure of ASC to make any contact with Denise during June 2019, despite her having been allocated to SW5 – see Finding 56.

Recommendation 27:
That the MK Together Partnership seeks assurance that member agencies and any services they commission have robust and effective DNA procedures.

Recommendation 28:
That the MK Together Partnership seeks assurance from the CCG that services they commission are reviewing effectively their processes for the issuing of repeat prescriptions and sicknotes.

Recommendation 29:
That the MK Together Partnership seeks assurance from ASC that it is operating an effective single-point-of-contact system for receiving contacts from the public and other professionals /agencies.

Recommendation 30:
That the MK Together Partnership seeks assurance from ASC that specialist assessments are being completed by appropriately qualified and experienced staff.

Recommendation 31:
That the MK Together Partnership seeks assurance from ASC that it has reviewed and revised as necessary its assessment procedures to ensure that they are holistic and that assessments are based on appropriate and sufficient contact with the adult concerned.

Recommendation 32:
That the MK Together Partnership seeks assurance that agencies are using "protected titles" correctly.

Recommendation 33:
That the MK Together Partnership seeks assurance that member agencies have developed, implemented and regularly review monitoring processes to ensure referrals to other agencies and services are progress-checked and feedback on their outcomes recorded.

Recommendation 34:
That the MK Together Partnership seeks assurance that member agencies have developed, implemented and monitor the effectiveness of procedures to support staff working with service users who are difficult to engage.

Recommendation 35:
That the MK Together Partnership seeks assurance that member agencies and the services they commission have developed, implemented and are monitoring the effectiveness of supervisory and management overview processes for complex cases and multi-agency procedures.

Theme 11: Good Practice

Findings: 3, 6, 16, 25, 31, 33, 47, 49, 54, 55, 64, 81, 82, 83, 86 and 88

11.68 Despite the large number of recommendations contained in this Report, there have also been numerous examples of good practice identified. These include situations where agencies responded promptly to Denise's situation and followed their internal procedures effectively and with due regard to her feelings and wishes – see Findings 3, 6, 33, 54, 82, 83, 86 and 88.

11.69 There are examples of good practice within ASC: CSW was supportive of Denise in pursuing the referral to the gardener and pointing out the need for Denise to cooperate with any agreed plans – see Findings 31 and 47. It was also good practice for SW5 and CSW to meet before SW5 started her assessment of Denise's care and support needs – see Finding 56.

11.70 It was good practice by BFRS to contact CSW on 29 May 2019 after contact with Denise on the basis of previous safeguarding concerns – see Finding 49.

11.71 The housing association, and NHO1 in particular, demonstrated their commitment to Denise and to trying to maintain her in her flat throughout the Review period. They continued to attempt to raise safeguarding concerns with ASC despite their lack of success, see Findings 16 and 25. NHO1 and TSO1 sought to identify alternative sources of support for Denise when ASC did not do so – see Finding 64 – and NHO1 and NHO2 persisted to gain access to Denise on the day she was admitted to hospital – see Finding 81. NHO1 also made sure Denise's flat was secure, that her animals were cared for and her possessions stored and was active with CSW in working with her for her discharge from hospital - see Finding 86

Recommendation 36:
That the MK Together Partnership asks the relevant agencies to formally recognise the above areas of good practice with the appropriate members of staff.

12. Conclusions:

12.1 This Review is focused on the events that led to Denise's admission to hospital on 16 August 2019; it is not considering the nature or quality of the medical treatment she received while in hospital. A referral was made to the SAB to consider holding a SAR on 27 August 2019, before Denise sadly died on 5 September 2019. At the time of this Report's writing, a Coroner's inquest had not been held and so no cause of death was known.

12.2 In hospital, Denise was treated for extreme emaciation and multiple pressure sores; what is not known to the Independent Author is the nature and likely cause of the pressure sores, which could have been caused while she was on the floor immediately before her admission. While in hospital, Denise developed pneumonia and died on 5 September 2019. There is no suggestion that her death was as a direct result of her self-neglect or the care and support she received before her hospital admission.

12.3 The Review was asked to consider five points in particular:

1. Missed opportunities to assess (Denise's) capacity and intervene sooner, particularly considering the amount of emergency calls she made.
2. Missed opportunities for agencies to work together to engage (Denise) with services.
3. How agencies shared information about their concerns for (Denise).
4. How agencies actively sought to risk-assess (Denise) and respond appropriately to the risk.
5. Workforce competency around self-neglect and hoarding.

12.4 Denise's capacity was never formally assessed throughout the Review period; instead it would appear that the assumption of capacity that is required by the MCA was retained despite the evidence of her repeated Unwise Decisions. These should have resulted in a review of her capacity but did not do so. In fairness to CSW, it is the view of the Independent Author that it is not appropriate to task an unqualified member of staff to either undertake a formal assessment of someone's capacity or to advise another agency to do so.

12.5 At the same time, it is appropriate to expect agencies to be conversant with the MCA and to escalate concerns about a service user's capacity if there is a difference of opinion with colleagues about the implementation of MCA procedures or practice.

12.6 There were therefore missed opportunities to formally assess Denise's capacity on each occasion that a safeguarding concern was raised or she failed to comply with the agreed plan of action to remedy the state of her flat.

12.7 The concern isn't that opportunities to intervene weren't taken sooner, but that the interventions were not referred into a multi-agency procedure for their co-ordination. Had such a referral been made, issues around Denise's capacity were more likely to have been identified and addressed.

12.8 As has been identified above, there were numerous opportunities for safeguarding concerns to be screened into the local multi-agency safeguarding procedures; even if it is accepted that they were correctly screened out – the Independent Author doesn't agree that this is the case – then a referral should have been made to the VARM. While it is of concern that ASC didn't make such a referral or even consider doing so until mid-August 2019, it is also of concern that the housing association or BFRS didn't do so either.

12.9 Even without initiating a multi-agency procedure, agencies could have worker better together to support Denise: there is no evidence that ASC liaised with Denise's GP or the housing association in the undertaking of either CSW or SW5's assessments. There is no evidence that the housing association liaised with ASC about their plans to take legal action against Denise over breach of her tenancy agreement.

12.10 Any information about Denise's situation and different agencies' concerns for her were only ever shared between individual agencies and this only at a very superficial level: information is not the same as intelligence. The latter is the product of interrogating information to put it into a context and with a purpose. Had a multi-agency procedure been implemented, then the information from ASC, the housing association, BFRS and the GP Practice could have been interrogated to generate intelligence to inform coordinated interventions.

12.11 The only time a risk assessment is considered during the Review period is in connection with the risk to staff attending Denise's flat to undertake repairs to her water pipes. No formal risk assessment of Denise's situation is considered or undertaken.

12.12 At the core of this Review is the competency of staff across agencies to work with cases of self-neglect and hoarding; Denise had been known by the housing association and BFRS to have issues regarding self-neglect and hoarding since at least February 2016, almost two years after the Care Act 2014 received the Royal Assent and almost a year after it was implemented. That gap of a year was put in place to enable local authorities and partner agencies to review and revise their internal and multi-agency procedures in order for them to be fit for purpose with the Act when it was implemented.

12.13 Self-neglect was a comparatively late addition to types of abuse identified in the Safeguarding sections of the Care Act's supporting Code of Practice with hoarding a sub-type, but the point is made that not all cases of self-neglect will meet the criteria for Safeguarding and will therefore need a different response. While there are concerns about the competency of staff to identify and work with cases of self-neglect, there are also concerns about the procedures and processes, both internal and multi-agency to support staff in this area.

12.14 Recent research by *Preston-Shoot and Braye* amongst others has identified the need to address the causes of self-neglect and hoarding, not just the symptoms. The responses of all agencies to Denise's situation was to deal or try to deal with the symptoms, albeit in ways that respected Denise's wishes and endeavoured to respect her autonomy. The research also suggests that developing a good working relationship with someone who self-neglects can take a long time and may be best achieved by someone who is not part of a statutory agency or with any obvious power-base or vested interest. The use of an Independent Advocate might have been of benefit and made any assistance more acceptable to Denise.

12.15 The above suggests a lack of awareness or competency with regard to self-neglect not only in front-line staff but in their managers too. This would appear to be true of agencies too, as there was no evidence of staff having access to support on working with service users who are difficult to engage.

12.16 Without a known cause of death, it is difficult to come to a conclusion as to the role of her self-neglect in Denise's death; however, given the three-week period that she spent in hospital, it seems unlikely that it was a direct cause. It is also difficult to reach a conclusion as to the likely impact of no formal assessment of her capacity on her situation; without a clear statement as to whether or not she had some form of learning disability, it is not possible to state definitively whether or not she did meet the first stage of the two-stage test for capacity – see 11.15 above.

12.17 Whatever the quality and duration of any care and support services offered to her, Denise might well have refused to accept any assistance or not cooperated with any proposed plan of action. However, agencies could have responded in a way that might have enhanced her quality of life and in a way that recognised that the duty to seek engagement lies with them, not with their service user.

13. Recommendations

Recommendation 1: That the MK Together Partnership seeks assurance that agencies are informed about services for and are making appropriate referrals for Children in Need and Young Carers.

Recommendation 2: That the MK Together Partnership seeks assurance that TVP are referring cases involving children to the appropriate support agencies, including CSC and the relevant Education agencies.

Recommendation 3: That the MK Together Partnership seeks assurance from ASC that it has reviewed and revised as necessary its policies and procedures re the MCAs to ensure they are fully compliant with the legislation and its supporting Code of Practice.

Recommendation 4: That the MK Together Partnership seeks assurance that ASC and other member agencies are ensuring that their staff and those of services they commission are appropriately trained to ensure that they practice in compliance with the MCA and its supporting Code of Practice.

Recommendation 5: That the MK Together Partnership seeks assurance that ASC and other member agencies have reviewed their policies to ensure that formal Capacity Assessments are completed by appropriately qualified staff and recorded in a consistent manner in accordance with the MCA and its supporting Code of Practice.

Recommendation 6: That the MK Together Partnership seeks assurance from ASC that due attention is given to 2.11 of the Code of Practice supporting the MCA with regard to cases of self-neglect and hoarding in particular.

Recommendation 7: That the MK Together Partnership seek assurance that member agencies have developed, implemented and are monitoring the use of escalation procedures in cases where there are concerns about the implementation of the MCA**.**

Recommendation 8: That the MK Together Partnership seeks assurance from ASC and member agencies that they have developed and implemented robust procedures to monitor the above recommendations.

Recommendation 9: That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice for receiving safeguarding concerns as identified by the referrer to ensure they are appropriately screened before allocation or disposal.

Recommendation 10: That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice in allocating cases of self-neglect and hoarding and therefore possible safeguarding to unqualified staff.

Recommendation 11: That the MK Together Partnership seeks assurance from ASC that they have reviewed and revised as necessary their practice in completing assessments under the Care Act 2014 to ensure they are holistic and comprehensive and that the subject is supported to participate fully in their assessment**.**

Recommendation 12: That the MK Together Partnership seeks assurance from ASC that they have management processes in place to ensure that those at most risk in the community, particularly cases of self-neglect and hoarding, are seen frequently enough to ensure the risks they face are effectively monitored.

Recommendation 13: That the MK Together Partnership seeks assurance from ASC that they have developed, implemented and are monitoring the use of escalation procedures in cases where there are concerns about the completion of assessments under the Care Act 2014.

Recommendation 14: That the MK Together Partnership seeks assurance from BFRS and TVFC that they have reviewed and revised as necessary their procedures for screening 999 calls to ensure appropriate referrals-on are made.

Recommendation 15: That the MK Together Partnership seeks assurance from member agencies that staff development opportunities for their staff and those of services they commission are consistent in the terminology they use in their safeguarding modules with the local multi-agency safeguarding procedures.

Recommendation 16: That the MK Together Partnership seeks assurance that member agencies are consistent in the implementation of their internal screening processes to identify and raise safeguarding concerns with ASC.

Recommendation 17: That the MK Together Partnership seeks assurance that ASC is screening safeguarding concerns in a holistic, effective and timely manner, ensuring any decision is multi-agency in nature**.**

Recommendation 18: That the MK Together Partnership seeks assurance that ASC is recording and monitoring the receipt and processing of all safeguarding concerns.

Recommendation 19: That the MK Together Partnership seeks assurance that any safeguarding concerns relating to self-neglect or hoarding that are screened out of the safeguarding procedures are automatically referred to the VARM procedures.

Recommendation 20: That the MK Together Partnership seeks assurance that ASC has developed, implemented, promoted and is monitoring the use of an escalation process for other agencies to initiate when they are dissatisfied with the implementation of the local multi-agency safeguarding procedures.

Recommendation 21: That the MK Together Partnership seeks assurance that member agencies regularly update their Safeguarding Procedures to ensure their compliance with new legislation and or Statutory Guidance

Recommendation 22: That the MK Together Partnership seeks assurance that MKC has developed, implemented, promoted and is monitoring the use of the VARM in respect of all self-neglect cases that do not meet the criteria for a s42 Enquiry under the Care At 2014.

Recommendation 23: That the MK Together Partnership seeks assurance that ASC and member agencies have reviewed and revised in the light of recent research their internal staff development opportunities and to those of services they commission relating to self-neglect and that these are robustly monitored to ensure their impact on practice.

Recommendation 24: That the MK Together Partnership seeks assurance that member agencies have reviewed and revised as necessary their procedures and practices and those of services they commission for sharing case-specific information with partner agencies.

Recommendation 25: That the MK Together Partnership seeks assurance that member agencies have reviewed, revised as necessary and established monitoring processes to ensure their internal recording procedures and those of the services they commission meet at least minimum standards.

Recommendation 26: That the MK Together Partnership seeks assurance that member agencies have reviewed and revised as necessary their processes for convening meetings under the local safeguarding procedures, the VARM and other multi-agency procedures to ensure they clearly identify the procedure being initiated and the status of the meeting concerned.

Recommendation 27: That the MK Together Partnership seeks assurance that member agencies and any services they commission have robust and effective DNA procedures.

Recommendation 28: That the MK Together Partnership seeks assurance from the CCG that services they commission are reviewing effectively their processes for the issuing of repeat prescriptions and sicknotes.

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Recommendation 34: That the MK Together Partnership seeks assurance that member agencies have developed, implemented and monitor the effectiveness of procedures to support staff working with service users who are difficult to engage**.**

Recommendation 35: That the MK Together Partnership seeks assurance that member agencies and the services they commission have developed, implemented and are monitoring the effectiveness of supervisory and management overview processes for complex cases and multi-agency procedures.

Recommendation 36: That the MK Together Partnership asks the relevant agencies to formally recognise the above areas of good practice with the appropriate members of staff.

Appendix A: Terms of Reference for Safeguarding Adults Review DENISE

Criteria for referral Care Act 2014:

- *An adult with care and support needs has experienced significant harm or died and there is suspected abuse or neglect (including family, institution, and service).*
- *There are suspected failures of the Safeguarding Board and associated professionals (including health and social care professionals) to discharge their safeguarding duties.*

BACKGROUND INFORMATION

In February 2019, Denise aged 59, suffered a leak in her Housing Association flat resulting in her water being cut off. The Housing Association was unable to fix the leak due to the hoard in her property. She was assessed as having capacity and did not agree to the hoard being removed. She lived with her animals in what is described as a cluttered and dirty home and following the leak lived with no water for six months.

In August 2019, Denise was found at her home on the floor. Her physical presentation was described emaciated and she did not have the energy to get up. She was taken to hospital. She had been referred to Adult Social Care (ASC) in February 2019 and was assessed in August 2019 with no formal service provided. Denise suffered from anxiety and arthritis. During her stay in hospital re-feeding was attempted however she passed away on the 5 September 2019.

1. Methodology and Scope

The scope of the review will be 9/2/16 when Denise first came to the attention of services for hoarding and 5 September 2019 when she passed away.

An external reviewer will be commissioned via the Milton Keynes Council procurement process and will have specific skills and knowledge in the area of self-neglect, hoarding and mental capacity.

The review will follow specific lines of enquiry including:

- Missed opportunities to assess Denise's capacity and intervene sooner, particularly with the amount of emergency calls she made.
- Missed opportunities for agencies to work together to engage Denise into services
- How agencies shared information about their concerns for Denise
- How agencies actively sought to risk assess Denise and respond appropriately for the risk
- Workforce competency around self-neglect and hoarding.

2. Agencies

- Milton Keynes Adult Social Care
- Milton Keynes University Hospital NHS Trust
- Thames Valley Police
- South Central Ambulance Service
- Bucks Fire and Rescue
- Housing Association
- GP

3. Publication

This review will be published but will be shared with on the MK Together website.

4. Family Involvement and Independent Review Author Report

The review will seek the involvement of Denise's family. It is known Denise had a son, but no details are known at this time.

Acronyms

AMR	Housing Association Area Manager Repairs
ASC	Adult Social Care (Milton Keyes)
BFRS	Bucks Fire & Rescue Service
BFRS1	Bucks Fire & Rescue Community Safety Co-ordinator
CLO	Customer Liaison Officer (MK ASC)
CSW	Community Support Worker (MK ASC)
ESA	Employment Seekers Allowance
HA	Housing Association
HAR	Housing Association Response
HARO1	Housing Association Response Operative
MHSCT	Mental Health Social Care Team
NHM	Neighbourhood Housing Manager (Housing Association)
NHO	Neighbourhood Housing Officer (Housing Association)
SW	Social Worker (MK ASC)
TWO	Tenancy Sustainment Officer (Housing Association)
TVFC	Thames Valley Fire Control
TVP	Thames Valley Police
UCT	Urgent Care Team