MK Together Partnership
Review Board

Safeguarding Adults Review:
Self-neglect Thematic Review

Overview Report

Concerning the care of ADULT 1, ADULT 2 & ADULT 3

Independent Reviewer

Pete Morgan BA, MA, MA & CQSW

Approved by MKT Review Board: 13 October 2020

Contents

1. Introduction

1.1 This Safeguarding Adult Review (SAR) was commissioned in response to three deaths in circumstances of self-neglect and where agencies had had varying levels of contact and concern about the individuals who died.

1.2 For the purposes of this review report and in order to protect the identities of those involved the subjects will be known individually as ADULT 1, ADULT 2 & ADULT 3 or jointly as the subjects.

1.3 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, are three human beings, who should be Adult 3eated with respect, and likewise their family members.

1.4 ADULT 1 was 75 years old and living alone at the time of their hospitalisation on 26 January 2019. He died on 18 February 2019, with the cause of death recorded as metastatic bladder cancer.

1.5 ADULT 1 was diabetic who had regular contact with his GP for a number of health conditions but he did not engage with the District Nursing Service to administer his insulin injections. He was known to hoard and was admitted to hospital after a fall in his home. Buckinghamshire Fire and Rescue Service had to assist in his removal from the premises.

1.6 Adult Social Care (ASC) had had no contact with ADULT 1 before his admission to hospital and no safeguarding concerns were raised before his hospitalisation. ADULT 1's medical notes do refer to him having large pieces of equipment on his stairs and that the premises were very cluttered.

1.7 ADULT 2 was 72 years old and living on his own at the time of his death. He had previously cared for his wife until her death in 2012. He had first come to the attention of ASC in December 2016 when he was admitted to hospital following a fall.

1.8. There was further involvement in May 2017 after concerns were raised by an elected member when a Community Support Worker (CSW) visited several times to Adult 3 to engage with him; despite some improvements to his living environment and an improved mood he continued to decline further support as he was being supported by a friend and it was deemed that no further support could be offered.

1.9 In December 2018, ASC became involved again when a Neighbourhood Officer raised concerns about the state of his tenancy and rent arrears and ADULT 2 continuing not to engage. Between 11 December 2018 and 26 February 2019, the CSW visited ADULT 2 seven times to try to engage with him but was unsuccessful on each occasion. On 21 December 2018 a police welfare visit was requested but the police did not report any concerns having seen him, when he had advised them that he sleeps a lot during the day.

1.10 On 27 February 2019, ADULT 2 was found dead in his tenancy by the Police after the CSW had visited and raised the alarm. He had not been seen for a couple of weeks.

1.11 Historically, ADULT 2 had appeared physically able but had reported being low in mood and there was some evidence of alcohol misuse and self-neglect. There had not been any concerns recorded re his mental capacity.

1.12 No Coroner's Inquest was held but his death certificate records the causes of his death as Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease and Hypertension.

1.13 ADULT 3 was 51 years old and living on his own in a one-bedroomed bungalow at the time of his death.

1.14 ADULT 3 first came to ASC's attention in February 2018 as the result of a referral from Milton Keynes Housing for an Occupational Therapy assessment; Housing also raised a safeguarding concern due to his reporting he was struggling with his mental health, was agitated, struggling to bath and frequently lost his keys.

1.15 ADULT 3 had been referred to mental health services by his GP in January 2018 and had been previously supported by secondary mental health services until September 2017. He had been diagnosed with paranoid schizophrenia and had a history of substance misuse.

1.16 ADULT 3 was visited by an Occupational Therapist (OT) on 19 June 2018, who recorded that his bath was full of items and could not be used and that there was mould. The OT found ADULT 3 to be aggressive.

1.17 In September 2018, ADULT 3 was detained under s136 of the Mental Health Act 1983 (MHA 1983) having been found by a member of the public walking down a main road saying he wanted to end his life. The member of the public then called the Police. ADULT 3 did not engage with the subsequent mental health assessment that was delayed to allow him to recover from some substance misuse, but was not detained and walked home. He admitted not having taken his anti-psychotic medication for two months.

1.18 On 27 September 2018, South Central Ambulance Service (SCAS) were contacted by ADULT 3's neighbour to advise he had a leg injury, had lost his keys and was going to sleep rough,

1.19 On 4 October 2018, Housing was advised by the OT Service that ADULT 3 had not cooperated with his assessment and that they should encourage him to agree to a bathing assessment. The OT Service closed their involvement with ADULT 3 despite recording that he was having difficulty maintaining his personal care.

1.20 ADULT 3 was again detained under s136 of the MHA 1983 in November 2018 after a further report of him walking in the middle of the road. He didn't engage with the mental health assessment under the MHA 1983 and he was arrested for wilfully blocking the highway

and an Appropriate Adult attended the Police Station to support him. The Appropriate Adult submitted a report to ASC which included some concerns, but these were not followed up and there was no further contact with ADULT 3 before he was found dead in his tenancy on 26 January 2019.

1.21 A Coroner's Inquest was held that concluded that he had died of natural causes, complications of Emphysema and Protein-Energy Malnutrition. The cases were referred to the MK Together Team for consideration by the Local Case Review Panel for a SAR on 13 and 15 March 2019 - see Appendix B.

1.22 The referral was considered on 28 and 29 March 2019, when the Case Review Panel agreed the criteria for a SAR had been met and therefore recommended to the Board's Independent Chair that a SAR be undertaken.

1.23 On 4 April 2019, the Board's Independent Chair confirmed that an SAR should be undertaken in accordance with the multi-agency Safeguarding Adults Review Procedure – see Appendix A.

1.24 This Report was authored on behalf of the MK Together Safeguarding Partners by Mr Pete Morgan, an Independent Consultant.

1.25 The administration and management of the Safeguarding Adults Review Procedure has been carried out by the Review Board.

1.26 This Review was commissioned under s44 of the Care Act 2014; its commissioning will be reported in the Board's Annual Report for 2019/2020 and its findings and their implementation will be reported in the Annual Report for 2020/2021 as required by the Act.

1.27 The Report was ratified by the Review Board at a meeting held on 13 October 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:

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

2.2 The business of the Board 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 May 2018, 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 are to be found in Appendix C.

4. The Scope of the Safeguarding Adults Review

4.1 The scope of the SAR was initially set as the period of one year prior to each subject's death namely:

ADULT 1 - 18 February 2018 to 18 February 2019
ADULT 2 – the 27 February 2018 to 27 February 2019 and
ADULT 3 – 26 January 2018 to 26 January 2019

Please note that in the cases of ADULT 2 and ADULT 3 these are the dates their bodies were found, not their actual death dates, which are not known.

4.2 The reason for this was that it would focus the Review on the period of time immediately prior to and any factors directly linked to the deaths.

4.3 Agencies were asked to include a summary of any earlier information about their involvement with the subjects or significant events if they considered them to be of particular relevance to the Review.

5. Information Trawls

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

5.2 These enabled appropriate Independent Management Reviews (IMRs) and chronologies to be requested to enable the Review Board to ensure the Review was in possession of all relevant information about single and multiagency support offered and received by the individuals and their families.

5.3 IMRs were requested from the following agencies with regard to their involvement with the subjects and, where relevant, their families:

- Milton Keynes Council Adult Social Care (ASC)
- Milton Keynes Council Housing (MKCH)
- Thames Valley Police (TVP)
- South Central Ambulance Service (SCAS)
- Compass Adult Substance Misuse Service
- The subjects' GPs

- Buckinghamshire Fire and Rescue Service (BFRS)
- Milton Keynes University Hospital Foundation Trust (MKUHFT)
- Central North West London NHS Foundation Trust (CNWL)

5.4 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.

5.5 A briefing session for the IMR authors was held on 16 August 2019. 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 to meet the required standard.

5.6 A Practitioners' Learning Event was held on 10 December 2019. This enabled practitioners who had either had direct contact with the subjects or were now in post in those teams/services that did, to consider how they had been able to work together to support the subjects, what had worked well, where practice and processes could have been better and what changes had taken place since to improve the quality of services.

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 Of the three subjects, ADULT 2 was known to have a son, but they were estranged at the time of his death. The son was contacted by letter to offer him the opportunity to contribute to the Review but he did not respond.

6.2 ADULT 3 was known to have two children and therefore presumably at least one ex-partner, however, there were no contact details for any of them.

6.3 ADULT 1 was known to have a sister-in-law; it was not known if he had a brother or if she was related to a former wife. The Review was provided with a telephone number for her and contact was attempted but the number was incorrect.

6.4 There was therefore no contact with or input to the Review from any family members or significant others.

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 and the Review did not identify any grounds for asking the Police to consider undertaking any retrospective criminal investigations in the light of its findings. The Police were represented on the Board.

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 Board sought expressions of interest in the role through the National Local Safeguarding Adult Board Chairs' Network and appointed Mr Pete Morgan as the Independent Author.

8.3 Mr Pete Morgan has been the Independent Chair of the Worcestershire and Hertfordshire Safeguarding Adults Boards, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. In the above roles, he has commissioned Serious Case Reviews as well as participated in them and their ratification by the relevant Safeguarding Adults Board. He has chaired and co-authored a Domestic Homicide Review for the Safer Wolverhampton Partnership, a Serious Case Review for the Walsall Safeguarding Adults Partnership Board, Safeguarding Adults Reviews for the Bedford Borough and Central Bedfordshire Safeguarding Adults Board, the Leicestershire and Rutland Safeguarding Adults Board, Northamptonshire Safeguarding Adults Board and the West Sussex Safeguarding Adults Board, was a member of an Independent Joint Serious Case Review Team for Newcastle Safeguarding Children and Adults Boards and was authoring an SAR for three other Safeguarding Adults Boards. He was a member of the Department of Health's Safeguarding Adults Advisory Group and is the Chair of the Board of Trustees, 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. He is also a member of the CPS West Midlands Hate Crime LISP.

8.4 He had 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 He 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 As has been mentioned previously, agencies providing IMRs were able to include brief details of any particularly relevant involvement they had had with the three subjects prior to the Review period.

9.2 ADULT 1 had been known to Milton Keynes University Hospital Foundation Trust (MKUHT) prior to the Review period for a number of specialist outpatient appointments and therefore to his GP, but not to other health or social agencies.

9.3 ADULT 2 had been known to MKUHT prior to the Review period, having been admitted in May 2009 after a heart attack; he was also admitted in June 2017 after a fall and being short

of breath. He had not been seen by his GP since October 2017 and had failed to keep outpatient appointments with the Heart Failure Clinic after September 2017.

9.4 ADULT 2 had also been known to the Police (TVP) prior to the Review period; they were contacted by a neighbour in December 2016 who had not seen him for a number of days. They visited and forced entry to find he had fallen several days earlier and couldn't get up. They arranged for his Adult Transport to hospital and raised a safeguarding referral due to the state of the property – medication strewn around, mould on the worktops, no fridge, dirty and the stairs were unsafe. No evidence of the outcome of this referral was made available to the Review.

9.4 ADULT 3 had been known to mental health services for some time prior to the Review period, both in Milton Keynes and in Leighton Buzzard where he was previously resident. He was known to MKUHT as a result of an assault that caused a broken elbow, but he only attended a single subsequent Fracture Clinic appointment, and an admission and discharge for an overdose immediately prior to the Review period. He was also known to TVP immediately prior to the Review period when he was the victim of a burglary.

10. Key Events and Analysis

10.1 ADULT 1

10.1.1 In January and March of 2018, contractors attended ADULT 1's property to complete the statutory electrical safety test but got no response so left a contact card each time; there was no response to the contact cards either.

10.1.2 The contractors referred the case back to Milton Keynes Council Housing (MKCH) in December 2018 as a result of no response from ADULT 1 to the contact cards. There was no contact with ADULT 1 from MKCH during the Review period nor were any other statutory safety checks carried out.

Finding 1:
That the contractors were tardy in informing MKCH of their failure to complete the electrical safety check and that MKCH should have noted this failure rather than rely on the contractors to notify them.

Finding 2:
That MKCH should have ensured that other safety checks, *eg* gas, were carried out and that an annual visit should have taken place during the period under review.

10.1.3 In September 2018, ADULT 1 was referred to MKUHT for a CT scan – it is not clear from the records available to this Review by whom – as a result of traces of blood being found in his urine. On 8 October 2018, he was admitted to MKUHT for an operation to resection a tumour in his bladder; the operation was cancelled as he was medically unfit due to unstable blood sugar levels.

10.1.4 On an unspecified date in November 2018, ADULT 1 attended MKUHT for a pre-assessment clinic; he refused to have any blood tests taken and said he didn't want the operation and he was advised he would be transferred back onto the waiting list. There is no recorded documentation around either of his decisions, such as a statement of his mental capacity to make them.

10.1.5 On 17 December 2018, ADULT 1 was taken to MKUHT by ambulance complaining of abdominal pain and he was admitted; it is noted that he had been seen by his GP three times and been prescribed antibiotics before attending the Emergency Department, MKUHT. It is also noted that he was unaware of his diagnosis nor was it discussed with him when he cancelled the operation – see 10.1.4 above

10.1.6 On 21 December 2018, ADULT 1 discharged himself from MKUHT to await surgery planned for 27 December 2018. He advised ward staff that his neighbours would administer his insulin injections; this is the first reference to his being insulin-dependent to manage his diabetes and was not challenged by the ward staff, nor was his mental capacity to discharge himself queried.

10.1.7 On 21 December 2018, ADULT 1 was visited at home by the District Nursing Team to administer the insulin injections; he had self-discharged from MKUHT without any medication and the District Nurse (DN) arranged and collected the prescriptions for the insulin and oral medication and had them made up.

10.1.8 On 21 December 2018, the DN made the second daily visit to administer the insulin but ADULT 1 was not in. She contacted him on his mobile phone; he was agitated and wouldn't return home for the injection and when she said she would visit the next morning he said 'No' and that he would ring the DN when he wanted the injection. The DN informed the GP's surgery of the above and raised an incident form which was appropriately reviewed under CNWL's procedures as requiring no further action.

10.1.9 On 22 December 2018, the DN contacted ADULT 1 to confirm he was happy for her to visit but was advised he was out and would be in that afternoon for his injection. When she visited, he wasn't in; she located him at a friend's house, where he said he went for his meals, and she checked his glucose levels and administered the injection. He declined a skin inspection but was given advice on pressure areas.

10.1.10 On 23 December 2018, the DN visited ADULT 1 twice at his friend's house to administer the insulin injection and showed the friend how to empty his catheter bag. This is the first reference to him having a catheter fitted or it being emptied. The DN visited twice daily until 27 December 2018 when he was admitted to MKUHT.

10.1.11 On 26 December 2018, the DN advised ADULT 1 to avoid sugary drinks and food and to drink plenty of water; he told her that he was anxious about the operation the next day as he was unsure what it was and that he was too unwell and not ready for it. She advised him to speak to his GP, which he did the following morning, making him late for the DN visit. The GP advised he attend the Emergency Department that afternoon, which he did, and he was

admitted due to possible sepsis from the catheter. The operation was re-booked for 4 January 2019.

10.1.12 On 4 January 2019, the operation was cancelled as ADULT 1 was too unwell. On 17 January 2019, ADULT 1's discharge home was discussed with an unspecified family member; ADULT 1 advised ward staff he had a self-employed housekeeper or carer but there is no record of a discharge package of care.

10.1.13 On 23 January 2019, the DN Service received a referral from MKUHT to facilitate his hospital discharge that named ADULT 1's Next of Kin as his sister-in-law and provided a contact telephone number for her. On 23 January 2019, ADULT 1 was discharged from MKUHT, taken by his sister-in-law**.**

10.1.14 On 25 January 2019, the DN attempted to visit ADULT 1; initially she got no response, but she contacted the friend who had a key to the property and gained access. ADULT 1 refused to let the DN enter the property but said he would see her the next day at his friend's house.

10.1.15 On the morning of 26 January 2019, the DN visited again and again got no reply at ADULT 1's address; she contacted the friend, who said they had argued the previous night but agreed to gain entry to his property again. She advised that ADULT 1 again refused to let the DN enter but that his catheter had come out; the DN called to ADULT 1 asking to come in but he again declined and said he would return to MKUHT later. She offered to call an ambulance, but he declined this offer too. The DN completed an incident form and a safeguarding referral. There is no record of ASC receiving the safeguarding referral; it is not clear which safeguarding referral was screened on 11 February 2019 – see 10.1.20 below.

10.1.16 On the afternoon of 26 January 2019, the DN visited again and only gained access to the property after the friend again used her key. The friend initially entered and advised ADULT 1 again had refused to let the DN enter but that he was on his upstairs lounge floor, unable to get up. The DN noted he was confused, in pain from his leg and she was unable to obtain any observational reading; she called an ambulance and SCAS requested the attendance of Buckinghamshire Fire and Rescue Service (BFRS) to help get ADULT 1 downstairs due to his physical size and ADULT 1 was admitted to MKUHT. It was noted that the property was cluttered and a fire risk; BFRS raised a safeguarding referral which was received by ASC on 28 January 2019.

Finding 3:
That the DN demonstrated good practice in ensuring she had contact with ADULT 1 when he was not making himself available to her and in completing an incident form and raising a safeguarding referral

Finding 4:
That ADULT 1's repeated Unwise Decisions in not co-operating with medical staff re blood tests, changing his mind about having the operation, allowing the DN to administer his

insulin regularly did not lead to his mental capacity being reviewed in accordance with 2.11 of the Code of Practice that supports the Mental Capacity Act 2005

Finding 5:
That appropriate discharge planning did not take place to facilitate ADULT 1's safe discharge from MKUHT

Finding 6:
That it is unlikely that the condition of ADULT 1's property had deteriorated rapidly prior to BFRS identifying it as cluttered and a fire risk but this had not been identified by the DN

10.1.17 On admission to MKUHT, he was noted to be 'vomiting coffee grounds', had allegedly refused his insulin injections for three days, was having pain in his left leg and with his catheter out – allegedly pulled out accidentally. He had a CT scan which showed the cancer in his bladder had spread.

10.1.18 On 28 January 2019, the DN contacted the Ward Sister at MKUHT to request an assessment of ADULT 1's care and support needs under s9 of the Care Act 2014 before he is discharged from hospital. On the same day, ADULT 1 was allocated within the Hospital Social Work Team, who were made aware of the safeguarding issues, his social isolation, the state of his tenancy and his failure to take his prescribed medication.

10.1.19 On 28 January 2019, ADULT 1 was seen by the palliative care team as there was evidence of metasteses of the bladder cancer and he was managed in accordance with the End of Life Pathway. On 4 February 2019, he was removed from the End of Life Pathway as his condition had improved.

10.1.20 On 11 February 2019, it is recorded by ASC that the safeguarding screening was completed, with the outcome that concerns were to be managed by the care management process around his discharge from hospital. It was also noted that he was not then fit for discharge.

10.1.21 On 18 February 2019, ADULT 1 died in hospital with the cause of death recorded as Metastatic Bladder Cancer. His sister-in-law was informed as his Next of Kin, having been kept informed throughout the period of his hospitalisation

Finding 7:
The referral by the DN for an assessment of ADULT 1's care and support needs under s9 of the Care Act 2014 was good practice.

Finding 8:
The process by which it was decided not to initiate a s42 Enquiry under the same Act is not clear; given ADULT 1's reluctance to engage with services this is a cause of concern as a person can refuse a s9 Assessment but not a s42 Enquiry

10.2 ADULT 2

10.2.1 In January and March of 2018, contractors attended ADULT 2's property to complete the statutory electrical safety test but got no response so left a contact card each time; there was no response to the contact cards either.

10.2.2 The contractors referred the case back to Milton Keynes Council Housing (MKCH) in December 2018 as a result of no response from ADULT 2 to the contact cards. There was no contact with ADULT 2 from MKCH during the Review period nor were any other statutory safety checks carried out.

10.2.3 The above is an exact repeat of what happened re ADULT 1 – see 10.1.1 and 10.1.2 above. **Therefore see Findings 1 and 2 above.**

10.2.4 On 7 September 2018, there was an exchange of emails between Neighbourhood Services, Milton Keynes Council and BFRS requesting a joint visit with a Housing Officer. The basis of this request is not recorded; BFRS asked for details of any fire issues or hazards but received no reply and the visit did not take place.

Finding 9:
Neighbourhood Services obviously had a concern for ADULT 2 that triggered the contact with BFRS which was neither resolved nor escalated

10.2.5 On 4 December 2018, an email was received by ASC from a Housing Officer requesting assistance for ADULT 2 as he wasn't engaging with her regarding the state of his tenancy, rent arrears and a Notice to Seek Possession.

10.2.6 On 11 and 18 December 2018, a Social Worker visited ADULT 2 but got no reply either at the door or on the phone; they also tried to speak to a neighbour on 18 December but with no success. On both occasions, a card was left asking ADULT 2 to contact them but with no response.

10.2.7 On 21 December 2018, the Social Worker called again, and again got no reply; this time they did speak to the neighbour and also to the local chemist to check if ADULT 2 was collecting his prescriptions. As he wasn't, TVP were asked to undertake a welfare visit which they did: they advised he was OK, but he had advised them he sleeps a lot and doesn't hear his door being knocked.

10.2.8 On 2, 14 and 24 January 2019, the Social Worker visited, on the latter occasion with the Housing Officer who had made the email contact – see 10.2.5 above. ADULT 2 didn't answer the door on any occasion and cards were left asking him to make contact on the first two visits; on the third visit it was agreed the Housing Officer would contact TVP and get back to the Social Worker if necessary but there is no record of this contact being made.

10.2.9 On 26 February 2019, TVP record contact from 'ADULT 2's support worker' saying she could get no reply at his address, that there was an odd smell coming from the property and

that there were flies present. The Police attended and found ADULT 2 dead and in a state of decomposition; they record that the property 'was in a bad condition' but give no details. ASC record that this visit took place on 27 February 2019.

10.2.10 The Review has been advised that his death certificate records the causes of his death as Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease and Hypertension.

Finding 10:
While it was good practice for the Social Worker and the Housing Officer to persist in attempting to contact ADULT 2 prior to Christmas 2018 and to request a welfare visit by TVP, it would have been best practice to have visited with TVP to enable an assessment to have been undertaken of ADULT 2's capacity given his repeated Unwise Decisions re his tenancy and the maintenance of the property.

10.3 ADULT 3

10.3.1 On 5 January 2018, subsequent to his admission to MKUHT after an overdose, ADULT 3 was referred to Compass Adult Substance Misuse Service (Compass) by CNWL's substance misuse mental health specialist for support as his substance misuse had been identified as the primary problem, not his mental health. An appointment was arranged for 9 January 2018.

10.3.2 On 8 January 2018, ADULT 3 attended an appointment with his GP for pain-relieving medication for his arthritis; he advised that he had recently been discharged from hospital after an overdose but was not seeing any mental health staff having had a row with a previous mental health worker. He described attempting suicide because he felt isolated and overwhelmed by life, was missing his children who he had not seen for eight years. He advised the GP that he had an appointment with Compass the following day.

10.3.3 On 28 January 2018, ADULT 3 called an ambulance due to abdominal pain; he was taken to MKUHT but discharged home the same day.

10.3.4 On 7 February 2018, he had an appointment with Compass when he commenced treatment via Buprenorphine.

10.3.5 On 17 February 2018, TVP was contacted by the sister of a third party, expressing concern that her brother was being taken advantage of by a group including ADULT 3. When the Police visited, ADULT 3 was present, but the alleged victim was happy for him to be there. ADULT 3 was not spoken to directly and a referral was made to the MASH re the alleged victim but not re ADULT 3.

10.3.6 On 26 February 2018, Housing referred ADULT 3 to the Occupational Therapy Service in ASC for an assessment for the conversion of a bathroom to a wet-room. The following day, a Housing Officer raised a safeguarding alert with ASC; during the screening process the community mental health service and his GP were contacted and the outcome was that no safeguarding issue was identified nor were any care or support needs.

Finding 11:
It is not clear what ADULT 3's need was that led to the referral to the Occupational Therapy Service or what the basis was for safeguarding alert being raised. While it is good practice that the screening process was multi-agency, there is no record of any feedback to ADULT 3 or Housing of the outcome of either of the referrals.

10.3.7 On 15 March 2018, TVP record an assault on ADULT 3 during an incident at his property involving two other adults; alcohol misuse was a factor in the incident, but no further action was taken.

Finding 12:
Given ADULT 3's known mental health and substance misuse issues, a safeguarding alert could have been considered if not initiated.

10.3.8 On 20 March 2018, the GP Practice records an assault on ADULT 3 and that he was referred to Improving Access to Psychological Therapies (IAPT) but that he refused as he was engaged with Compass**.**

10.3.9 On 26 March 2018, a Housing Officer contacted ASC to ask if ADULT 3 was known to them and was informed he wasn't open to them; it was noted by ASC that they were subsequently informed ADULT 3 had been reported to TVP for tampering with an electricity meter.

10.3.10 On 19 April 2018, TVP record an intelligence report that ADULT 3's tenancy along with others on the street was being used to dilute drugs prior to their sale; on 24 April 2018, TVP record an intelligence report that ADULT 3's tenancy is being used by drug dealers – 'cuckooed'.

10.3.11 On 30 April 2018, the GP Practice records that ADULT 3 was offered a health check by letter but he did not respond.

10.3.12 On 11 May 2018, TVP record concerns re Anti-Social Behaviour and drug related activities where ADULT 3 lived. It is noted that TVP Neighbourhood Policing Team (NHPT) and the Milton Keynes Council Anti-Social Behaviour Team were working together to obtain a 'full house closure' - see Glossary - of ADULT 3's tenancy but the outcome is not recorded.

10.3.13 On 16 May 2018, TVP was contacted alleging ADULT 3 had assaulted the caller's brother; this was the same caller and alleged victim as in 10.3.5 above. The alleged victim did not want to make a complaint; it was noted that this might be due to fear of ADULT 3, but this wasn't pursued, and ADULT 3 was not spoken to. Again, a safeguarding referral was made re the alleged victim but not ADULT 3.

Finding 13:
The above are examples of incidents where ADULT 3 came to the attention of TVP, but no referral was made despite him being known to have mental health and substance misuse

issues. Although none of the incidents are of major concern in their own right, they provide a picture of a level of need for social and health needs that should, if seen as a whole, have generated referrals on to a suitable multi-agency forum.

10.3.14 On 22 June 2018, ADULT 3 had an appointment with Compass re his heroin/crack cocaine addiction; they made a referral to 'health and wellbeing' but the outcome is not recorded and as Compass are no longer commissioned to provide services in Milton Keynes it has not been possible to confirm the referral's purpose or to whom it was made.

10.3.15 On 24 July 2018, TVP record an intelligence report that ADULT 3 may be sleeping in a tent; there is a record in the Patrol Plan – see Glossary - that ADULT 3 had told TVP on 16 July 2018 he was sleeping in a tent due to damp in his flat; this was shared with the NHPT, but no referral was made to another agency nor was ADULT 3 spoken to directly either.

See Finding 13 above

10.3.16 On 1 August 2018, the GP surgery tried unsuccessfully to contact ADULT 3 by phone, so they wrote instead; there was no response but the records don't show the reason for trying to contact him.

10.3.17 Overnight on 15/16 August 2018, ADULT 3 was taken to the Emergency Department at MKUHT with an injured right ankle, sustained when he was assaulted two days previously – it was an old avulsion injury rather than a recent fracture. He gave different explanations to the ambulance crew who took him to hospital and to the ED doctor. He said he was living on the street and had been released from prison a month ago.

10.3.18 On 22 and 29 August 2018, ADULT 3 failed to attend the Fracture Clinic at MKUHT; the GP Practice was advised.

Finding 14:
There are a number of instances of ADULT 3 not keeping appointments or not responding to contact from health services without any effective follow-up. While there is a balance to be struck between recognising an adult's autonomy, respecting their right to make unwise decisions and meeting a duty of care, given ADULT 3's history of mental health and substance misuse issues – including at least one suicide attempt – it would be reasonable to expect at least consideration to be given to a more interventionist implementation of agency DNA procedures.

10.3.19 On 18 September 2018, SCAS, while attending another incident requested TVP attend because of ADULT 3's behaviour; the Police Officer was approached by ADULT 3 in a threatening manner, holding a pen-knife; he was sprayed with CAPTOR - see Glossary -and arrested for possession of a bladed weapon and Public Order Offences. He was uncooperative until placed in a cell; he denied being threatening and explained he was only showing the Police Officer a corkscrew he used for opening bottles. No charges were brought. There was no suggestion that ADULT 3 was under the influence of either alcohol or drugs.

See Finding 13 above

10.3.20 On 24 September 2018, ADULT 3 was taken to a place of safety under s 136 of the Mental Health Act 1983 when he was found and detained by a member of the public walking in the road and threatening to kill himself. He was taken by TVP to the Campbell Centre, operated by CNWL on the Milton Keynes Hospital campus, after a delay of 24 hours to enable him to cease being under the influence of unspecified substances; he was assessed by an AMHP and two doctors and found not to be detainable; he chose to walk home. He admitted having used substances. The incident was referred to the MASH who decided no action was necessary as ADULT 3 was open to the Mental Health Team.

Finding 15:
The TVP response to ADULT 3 was timely and appropriate as was the assessment under the Mental Health Act 1983; there is no reason to question the outcome of the assessment. However, the referral to MASH was a safeguarding concern and therefore required a decision from the local authority not merely closure as ADULT 3 was open to another service.

10.3.21 On 26 September 2018, SCAS record that they attended ADULT 3 outside his tenancy having been contacted by a neighbour. He refused to go to hospital, and they assessed him as having the capacity to make that decision. ADULT 3 was described as having very few possessions with him, no keys to his tenancy and insufficient clothing to sleep outside. SCAS submitted a safeguarding referral to ASC. SCAS contacted TVP who attended later; they found ADULT 3 confused and unable to say where he lived. They record that they 'could see damage to the address' but that it was old. They persuaded ADULT 3 to let them take him to Emergency Department at MKUHT, where he was treated with antibiotics for an insect bite, but there is no record of his discharge destination or of any support being offered.

10.3.22 On 27 September 2018, ASC record receipt of the safeguarding alert from SCAS by the ACCESS Team but no safeguarding concerns were recognised and it was passed to the relevant Housing Officer rather than being screened through the Safeguarding Team or the MASH.

Finding 16
While the Review understands that the volume of alerts from SCAS is high, this does raise concerns about the nature and quality of the screening undertaken by the ACCESS Team and their level of awareness of safeguarding practice and process.

10.3.23 On 11 October 2018, ADULT 3 was detained under s136 MHA by TVP, having been seen by an off-duty police officer being verbally abusive to members of the public; he was initially taken to Milton Keynes Police Station and subsequently transferred to the Campbell Centre – see 10.3.20 above - by ambulance. TVP did not raise any referrals as ADULT 3 was left in the care of medical professionals at the hospital.

10.3.24 On 12 October 2018, an AMHP and two doctors attempted to assess ADULT 3, but he did not cooperate with the formal assessment though he had been speaking 'eloquently with no observable thought disorder'; he displayed no evidence of mental illness but did appear to

have ‘been using substances’. He was discharged from the s136 and advised to re-engage with Compass for his addictions. Whilst ADULT 3 was open to CNWL Mental Health Teams or being assessed by them, no evidence was observed of psychosis.

Finding 17:
It was good practice that ADULT 3 was transferred to the Campbell Centre rather than detained at the Police Station for the assessment by the AMHP.

Finding 18:
Given ADULT 3’s known history of mental health issues and substance misuse and accommodation issues, it is of some concern that no referral was made to ASC or an alternative support service by the AMHP

10.3.25 On 9 November 2018, TVP was contacted four times regarding ADULT 3 either causing a disturbance or putting himself at risk. On the first two occasions, TVP returned ADULT 3 to his home, on the third they failed to locate him and on the fourth he was arrested by TVP for an obstruction of the highway, having been found walking in and out of the traffic; he was taken into custody and seen by a member of the Liaison and Diversion Service (L&DS) after the Health Care Professional placed with the custody staff agreed with the Custody Sergeant to await their specialist assessment of ADULT 3’s mental state. He admitted taking crack cocaine and the L&DS member of staff gave him information about Compass and crisis services. They assessed him as having capacity and being fit to be interviewed, though he requested an Appropriate Adult under PACE 1984 support him in any interview, but it was decided not in the public interest to pursue a prosecution and ADULT 3 was released. He had to be physically removed from his cell and taken home restrained in leg restraints and handcuffs.

See Finding 18 above

10.3.26 On 18 January 2019, a male not previously referred to in this Review was arrested by TVP for reasons not known to or relevant to this Review and found to be in possession of ADULT 3’s bank card. He said he had permission to use the card. He was subsequently released from custody on 22 January 2019 with no further action taken.

10.3.27 On 26 January 2019, TVP were contacted by a third party to say someone was trying to break into ADULT 3’s tenancy. TVP attended the address and found ADULT 3 deceased inside. They had previously unsuccessfully attempted to contact ADULT 3 at least twice regarding his bank card, once by phone and once at his tenancy.

Finding 19:
Given TVP’s knowledge of ADULT 3 and the volatility of his situation, it is surprising that no referral on to either health or social care agencies was made when they were twice unsuccessful in contacting him about his stolen bank card.

11. Themes and Recommendations

11.1 This SAR is focused on the events that occurred in the 12 months prior to the deaths of the three subjects; it therefore covers slightly more than 12 months, namely from 26 January 2018 to 27 February 2019. As far as is known to this Review, there was no link or contact between the three subjects during their lifetimes.

11.2 The Findings identified in the Key Events and Analysis section will be grouped under the following Themes: Did Not Attend practice; Housing practice; the Mental Health Act 1983; the Mental Capacity Act 2005; the Care Act 2014; Awareness of Self-neglect; Police Investigations and Good Practice. Each Theme will be linked back to the Findings and to specific Recommendations.

- **Theme 1: Did Not Attend practice**

Findings 1 and 14

11.3 Common to both ADULT 1 and ADULT 2 was a failure by the contractors who visited to carry out statutory electrical safety tests to advise Housing of their not having done so do for nine months after their second unsuccessful attempt to gain access to the respective tenancies – see 10.1.1 & 10.1.2 and 10.2.1 & 10.2.2 above.

11.4 There are several instances where ADULT 3 either failed to keep appointments or didn't respond to contact from health agencies where there was no effective attempt to gain access to him to establish the reasons for this – see 10.3.11, 10.3.16 and 10.3.18 above.

11.5 As is recognised in Finding 14, there is a balance to be struck between respecting an adult's right to self-determination and agencies meeting their duty of care towards the adult. In cases where there are known concerns about the adult's wellbeing, as there were in ADULT 3's case, it is reasonable to expect agencies to at least consider how to implement their 'Did Not Attend' policies and to be flexible in their interpretation of them.

Recommendation 1:
That the MK Together Partnership seek assurance that MKCH has reviewed and revised as appropriate their Quality Assurance and Contract Compliance procedures for annual safety checks to ensure they address the concerns identified in this Review

Recommendation 2:
That the MK Together Partnership seek assurance that partner agencies have reviewed their DNA policies and procedures to ensure that adults with known health and social care needs are appropriately responded to when they miss appointments or fail to respond to contacts

- **Theme 2: Housing Practice**

Findings 1, 2 and 9

11.6 While, as outlined above, there are concerns about the way that the contractors failed to carry out the statutory electrical safety checks at ADULT 1 and ADULT 2's tenancies, there are also concerns about the lack of monitoring by MKCH of these checks or their undertaking of

other statutory annual checks and visits. There is, for example, no reference to the electrical safety checks being carried at ADULT 3's tenancy.

11.7 A Housing Officer did seek a joint visit with BFRS – see 10.2.4 above – to ADULT 2 but a request for further information from BFRS about fire hazards went unanswered. Again, a Housing Officer referred ADULT 3 to ASC for an Occupational Therapy assessment and raised a safeguarding concern but there is no evidence that feedback was sought or given on their progress – see 10.3.6 above.
See Recommendation 1 above

Recommendation 3:
That the MK Together Partnership seek assurance that MKCH has reviewed and revised as appropriate their procedures for annual visits to their properties, particularly where the tenants have additional health or social care issues.

Recommendation 4:
That the MK Together Partnership seek assurance that ASC has reviewed and revised as appropriate its procedures and practice governing the interface between s9 Assessments and s42 Enquiries under the Care Act 2014.

Recommendation 5:
That the MK Together Partnership seek assurance from Neighbourhood Services that they have reviewed and revised as appropriate their case management and escalation procedures

- **Theme 3: The Mental Health Act 1983**

Findings 17 and 18

11.7 ADULT 2 was known to have mental health and substance misuse issues, but it would appear that the latter was seen to be the primary issue and using the Mental Health Act 1983 was not considered until he began to exhibit more extreme behaviour dangerous to himself or others.

11.8 The use of s136 of the MHA 1983 was appropriate and ADULT 3's transfer from the Police Station to the Campbell Centre for his assessment by the AMHP was an example of good practice. However, his non-compliance with the assessment should have raised further questions about his mental health and/or mental capacity, neither of which happened – see 10.3.24 above.

11.9 Despite the knowledge of ADULT 3's history of mental health and substance misuse issues, there was no referral to other support services as a result of the AMHP's assessment – see 10.3.20, 10.3.21 and 10.3.24 above
Recommendation 6:
That the MK Together Partnership seek assurance that assessments under the Mental Health Act 1983 that do not result in an admission to hospital do generate appropriate on-referrals for support

- **Theme 4: The Mental Capacity Act 2005**

Findings 4 and 10

11.10 In the cases of all three subjects, there are examples of their making what, at best, could be considered Unwise Decisions as defined in the MCA 2005 – see 10.1.4, 10.1.6, 10.1.8, 10.1.14, 10.2.5, 10.2.6, 10.3.10, 10.3.15, 10.3.17, 10.3.19, 10.3.20, 10.3.21 and 10.3.24 above.

11.11 While the MCA 2005 requires a presumption of an adult's capacity to make a decision unless it has been established that they don't and that making Unwise Decisions is not proof that they lack capacity, 2.11 of the Act's supporting Code of Practice requires an adult's capacity to be questioned if they make a series of Unwise Decisions.

11.12 The combination of 11.10 and 11.11 above should have led to all three subjects' capacity to make specific decisions at specific times being questioned. Apart from 10.3.21 and 10.3.25, there are no references to any of the subjects having their capacity to make specific decisions questioned or assessed.

11.13 In 10.3.21, the ambulance crew deemed ADULT 3 to have the capacity to make the specific decision not to go hospital; in 10.3.25 the decision for which ADULT 3 had capacity is not specified and could relate to his being interviewed – though the AMHP still considered an Appropriate Adult under PACE 1984 was required to support him in any police interview – but not to his refusing to leave the police cell.

Recommendation 7:

That the MK Together Partnership seek assurance that partner agencies are appropriately training their staff in the implementation of the Mental Capacity Act 2005 and its supporting Code of Practice, in particular 2.11 re repeated Unwise Decisions.

Recommendation 8:

That the MK Together Partnership seek assurance from partner agencies that staff are implementing the Mental Capacity Act 2005 in accordance with its supporting Code of Practice, in particular 2.11 re Unwise Decisions.

- **Theme 5: The Care Act 2014**

Findings 5, 8, 11, 12, 13, 15 and 16

11.14 When ADULT 1 self-discharged from MKUHT in December 2018 – see 10.1.6 – there was no discharge planning to verify his claim that his neighbour would administer his insulin injections or to identify any other care and support needs he might have had.

11.15 When the District Nurse requested that ADULT 1 be assessed under s9 of the Care Act 2005 before he was discharged from hospital – see 10.1.18 – the Hospital Social Work Team were also advised of the safeguarding concerns relating to ADULT 1. After the screening process had been completed with regard to the safeguarding concerns, the decision was made not to initiate a s42 Enquiry under the Care Act 2005 but to manage the concerns via the care management process.

11.16 Given ADULT 1's previous reluctance to engage with services and his right to refuse a s9 assessment, not initiating a s42 Enquiry which he could not refuse, is a cause of concern.

11.17 In February 2018, a Housing Officer referred ADULT 3 to ASC for an Occupational Therapy assessment and also raised a safeguarding alert; while it is recorded that there were no safeguarding issues nor any care and support needs identified, there is no feedback to the Housing Officer nor any referral on to another support service.

11.18 ADULT 3 came to the attention of TVP on several occasions during the Review period – see 10.3.5, 10.3.7, 10.3.10, 10.3.12, 10.3.15, 10.3.19, 10.3.21, 10.3.23 and 10.3.25 above – when a safeguarding concern could, if not should, have been raised. Given their level of knowledge over a period of time of ADULT 3's history of mental health and substance misuse issue, this is of some concern. In fairness, TVP did raise a safeguarding concern on one occasion – see 10.3.20 above.

11.19 The incident on 24 September 2018 having been raised as a safeguarding concern by TVP – see 10.3.20 above – the Care Act 2014 places a duty on the local authority to undertake or cause to be undertaken such enquiries as it thinks necessary to enable it to decide whether any action is required and, if any , what and by who. On this occasion, there is no recorded multi-agency screening of the concern just the decision that no action was necessary as ADULT 3 was open to the Mental Health Team. This would appear to be a failure to carry out the above duty.

11.20 On 27 September 2018, ASC ACCESS Team received a safeguarding alert from SCAS but again merely forwarded the information to the relevant Housing Officer rather than proactively screening it or referring it to the Safeguarding Team or the MASH – see 10.3.22 above.
See Recommendation 4 above

Recommendation 9:
That the MK Together Partnership seek assurance from MKUHT and ASC that they have reviewed and revised as necessary their discharge planning procedures to ensure they address the concerns identified in this Review.

Recommendation 10:
That the MK Together Partnership seek assurance that TVP have reviewed their practice in relation to incidents involving adults with known mental health or substance misuse issues to ensure that their procedures re appropriate on-referrals address the concerns identified in this Review.

Recommendation 11:
That the MK Together Partnership seek assurance from ASC that they are meeting their legal duties under s42 of the Care Act 2014 in screening and responding to safeguarding concerns.

Recommendation 12:
That the MK Together Partnership seek assurance from ASC that staff in the ACCESS Team have received safeguarding Adults training and have in place robust and effective referral screening processes to address the concerns identified in this Review.

- **Theme 6: Awareness of Self-neglect**

Finding 6 and 13

11.21 When BFRS was called to assist in removing ADULT 1 from his tenancy for taking to hospital, they identified the property as being cluttered and a fire risk – see 10.1.16 above; this had not been identified by the District Nurse who had been visiting ADULT 1 or the ambulance crew who transported him to hospital in December 2018 – see 10.1.5 above.

11.22 It is unlikely that the state of the property would have deteriorated dramatically in just over a month, given that ADULT 1 was in hospital between 17 and 21 December 2018 and 26 December 2018 and 23 January 2019. This raises concerns about the level of awareness of self-neglect and hoarding to enable the identification and responding appropriately to instances of self-neglect and hoarding at a low-level of risk.

11.23 In addition to the above, there were concerns about the state of ADULT 2's property and his lack of engagement with Housing – see 10.2.5 above – and ADULT 3's mental health and substance misuse issues – see 10.3.10 and 10.3.18 above. However, there was no referral to a multi-agency forum that could manage low-level concerns of possible self-neglect that failed to meet the criteria for action under the safeguarding procedures; such a forum could prevent situations escalating to the point where the safeguarding procedures would need to be initiated.

Recommendation 13:
That the MK Together Partnership seeks assurance that partner agencies are training their staff to identify and respond to self-neglect and hoarding effectively

Recommendation 14:
That the MK Together Partnership seeks assurance that multi-agency forums have been developed and promoted in Milton Keynes to share information and coordinate responses to cases of low-level concerns

- **Theme 7: Police Investigations**

11.24 ADULT 3 was found deceased in his flat on 26 January 2019, having had no contact with services since early November 2018; his bank card was found in the possession of an adult with no other link to this Review on 18 January 2019.

11.25 Given the lack of contact with ADULT 3 for over two months and the level of knowledge about his situation it is surprising that the Police did not make any referral to health or social care when they were unsuccessful on two occasions to contact him about his bank card.

11.26 As no exact date is known for ADULT 3's death, it is not possible to know whether it could have been prevented had the Police made such a referral.

Recommendation 15:

That the MK Together Partnership seeks assurance from TVP that they have reviewed their practice and revised as appropriate their policies regarding referring on potential victims of crime when they are known to have health and social care needs.

- **Theme 8: Good Practice**

Findings 3, 7, 11, 15 and 17

11.27 The District Nurse supporting ADULT 1 demonstrated good practice in both her commitment to ensuring she had access to ADULT 1 when he was not in when she called to see him and in recognising that he had care and support needs beyond those she was meeting and therefore referred him to ASC for an assessment under s9 of the Care Act 2014 and raised a safeguarding referral – see 10.1.4 – 10.1.16 and 10.1.18 above.

11.28 In the case of ADULT 3, the screening of the safeguarding alert raised by the Occupational Therapist included contact with ADULT 3's GP and the community mental health service to provide a multi-agency perspective to the understanding of his situation – see 10.3.6 above.

11.29 The response of TVP to ADULT 3 behaving in a public place in a manner that gave them concerns as to his mental health was both timely and appropriate; in addition, his transfer from the Police Station to the Campbell Centre for the assessment to be carried by an the AMHP demonstrated an awareness of the possible impact of his arrest on the assessment – see 10.3.20 and 10.3.23.

Recommendation 16:

That the MK Together Partnership recognises the above examples of good practice and ask that this recognition be communicated to the relevant operational staff.

12. Conclusions

12.1 Rather than analyse the life and death of each subject, the Terms of Reference for this Review identified a number of issues to be addressed as to how the system did or didn't work together to maximise the care of the subjects, including but not limited to:

- Information sharing
- Workforce understanding of self-neglect and hoarding
- Understanding of what is possible and what is not possible within individual agencies
- Collective responses to individuals presenting as a risk to themselves
- The boundaries set by the application of thresholds and different legal requirements including the Mental Capacity Act
- Any barriers to joint working
- Links and gaps within the system
- How the picture of risk is built and reviewed by agencies

12.2 The simple answer to the above is that the system did not work to maximise the care and support offered to the subjects, however, simple answers often merely disguise the complexities of the questions. This is particularly true when there was very limited contact by the statutory agencies with any of the subjects. By its very nature, self-neglect will often isolate the individual from those agencies that could offer care and support services. 'The system' in the case of the three subjects is a combination of social and health care as enshrined in the Mental Health Act 1983, the Mental Capacity Act 2005 and the Care Act 2014, supported by various pieces of legislation relating to Housing.

12.3 As all three subjects were tenants of Milton Keynes Housing, annual safety checks and landlord visits could have identified issues of self-neglect and hoarding, but there is only reference to hoarding re ADULT 1, not the other two subjects. Concerns were raised about the state of ADULT 2's tenancy only in December 2018, three months before his body was discovered. ADULT 3 was a substance misuser with a diagnosis of paranoid schizophrenia and concerns about him related to his mental health, misuse of substances and possibly being "cuckoo-ed".

12.4 ADULT 1 was not known to ASC prior to his admission to hospital in January 2019. ASC were trying to engage with ADULT 2 to assess his care and support needs when his body was found. ADULT 3 had been assessed by ASC as not meeting the criteria for care and support services and therefore would not have met the criteria for the safeguarding procedures; he had also been assessed under the Mental Health Act 1983 on three occasions in the last four months of his life.

12.5 In addition, ADULT 2 was known to TVP for possible drug-related offences, but this information was held as 'intelligence' rather than acted upon in an operational sense in that he was never charged or prosecuted let alone convicted.

12.6 'The system' appears to have failed all three subjects not because it was not implemented properly, but because it was not designed to respond to situations such as theirs, where thresholds for a response under the Mental Health Act 1983 or the Care Act 2014 are not met.

12.7 This identifies the inherent weakness of thresholds: a threshold is a level that determines whether or not there is a response when what is needed is a filter to determine what response is appropriate or necessary. What 'the system' did not have was a multi-agency forum to address those cases which did not meet the thresholds contained in the Mental Health Act 1983 or the Care Act 2014.

12.8 Had such a forum existed, it would have bridged the gaps within 'the system', enabled information-sharing about individuals but also the remits and limits of agencies, managed and monitored risk management processes to facilitate joint working to provide collective responses to individuals presenting low-level risks to themselves and/or their immediate neighbours. It would also provide a forum to raise operational staff's understanding and awareness of self-neglect and hoarding.

12.9 It is not explicit with these three subjects, but it can be the case that by siting such a forum in the voluntary sector it would remove some of the stigma that may be attached to it in the perception of those likely to be referred to it if it is hosted by a statutory agency.

12.10 On the basis of the above, the following conclusions would appear to be appropriately drawn: with the possible exception of ADULT 3, the deaths of all three subjects are unlikely to have been prevented by more effective multi-agency working: ADULT 1 died in hospital with the recorded cause of death being Metastatic Bladder Cancer; ADULT 2's cause of death is not known due to the decomposed state of his body when he was found; ADULT 3 was also found dead in his tenancy and the cause of death is not known to the Review.

12.11 What is clear from the Review is that ADULT 2 and ADULT 3 may have had an improved quality of life in the last year of their lives if they had been referred into a multi-agency forum such as that proposed above that could have coordinated and monitored their care and support needs. Such coordination and monitoring would have provided the view over time that could have identified the possible lack of capacity regarding decisions about their health and welfare indicated by their lack of engagement with services.

12.12 The above does not mitigate against the fact that individual agencies could have recognised the lack of engagement and repeated Unwise Decisions that should have led to a review of whether or not ADULT 2 and ADULT 3 had capacity for those specific decisions. The above is not the case for ADULT 1, who had not had any contact with services other than his GP during the Review period until September 2018.

13. Recommendations

Recommendation 1:
That the MK Together Partnership seeks assurance that MKCH has reviewed and revised as appropriate their Quality Assurance and Contract Compliance procedures for annual safety checks to ensure they address the concerns identified in this Review

Recommendation 2:
That the MK Together Partnership seeks assurance that partner agencies have reviewed their DNA policies and procedures to ensure that adults with known health and social care needs are appropriately responded to when they miss appointments or fail to respond to contacts

Recommendation 3:
That the MK Together Partnership seeks assurance that MKCH has reviewed and revised as appropriate their procedures for annual visits to their properties, particularly where the tenants have additional health or social care issues.

Recommendation 4:
That the MK Together Partnership seeks assurance that ASC has reviewed and revised as appropriate its procedures and practice governing the interface between s9 Assessments and s42 Enquiries under the Care Act 2014.

Recommendation 5:
That the MK Together Partnership seeks assurance from Neighbourhood Services that they have reviewed and revised as appropriate their case management and escalation procedures.

Recommendation 6:
That the MK Together Partnership seeks assurance that assessments under the Mental Health Act 1983 that do not result in an admission to hospital do generate appropriate on-referrals for support.

Recommendation 7:
That the MK Together Partnership seeks assurance that partner agencies are appropriately training their staff in the implementation of the Mental Capacity Act 2005 and its supporting Code of Practice, in particular 2.11 re repeated Unwise Decisions.

Recommendation 8:
That the MK Together Partnership seeks assurance from partner agencies that staff are implementing the Mental Capacity Act 2005 in accordance with its supporting Code of Practice, in particular 2.11 re Unwise Decisions.

Recommendation 9:
That the MK Together Partnership seeks assurance from MKUHT and ASC that they have reviewed and revised as necessary their discharge planning procedures to ensure they address the concerns identified in this Review.

Recommendation 10:
That the MK Together Partnership seeks assurance that TVP have reviewed their practice in relation to incidents involving adults with known mental health or substance misuse issues to ensure that their procedures re appropriate on-referrals address the concerns identified in this Review.

Recommendation 11:
That the MK Together Partnership seeks assurance from ASC that they are meeting their legal duties under s42 of the Care Act 2014 in screening and responding to safeguarding concerns.

Recommendation 12:
That the MK Together Partnership seeks assurance from ASC that staff in the ACCESS Team have received safeguarding training and have in place robust and effective referral screening processes to address the concerns identified in this Review.

Recommendation 13:
That the MK Together Partnership seeks assurance that partner agencies are training their staff to identify and respond to self-neglect and hoarding effectively.

Recommendation 14:
That the MK Together Partnership seeks assurance that multi-agency forums have been developed and promoted in Milton Keynes to share information and coordinate responses to cases of low-level concerns.

Recommendation 15:
That the MK Together Partnership seeks assurance from TVP that they have reviewed their practice and revised as appropriate their policies regarding referring on potential victims of crime when they are known to have health and social care needs.

Recommendation 16:
That the MK Together Partnership recognises the above examples of good practice and ask that this recognition be communicated to the relevant operational staff.

Appendices

Appendix A

Terms of Reference for Safeguarding Adults Review re ADULT 1, ADULT 2 and ADULT 3

BACKGROUND INFORMATION

During the reporting year 2018-19, MKSB commissioned two local learning reviews for adults who had died and self-neglect was a presenting factor. Significant learnings were gained from the reviews and changes made to practice such as progress towards the implementation of a Vulnerable Adults Risk Management (VARM) Group. However, during February and March 2019, MKSB received a further three referrals for adults with care and support needs who died following disengagement with services whilst living in poor and hoarded conditions. Themes within the three incidents include elderly males, mental ill-health, isolation and alcohol misuse. All three gentlemen were also tenants of Milton Keynes Council Housing.

MKSB has therefore agreed that a thematic review into self-neglect and hoarding is the most appropriate and proportionate way to identify and embed local learning to further improve how we support residents in Milton Keynes presenting with self-neglect and hoarding risks.

Terms of Reference

1. **Methodology and Scope**
   The review will consist of agency chronologies and a practitioner's event, leading to a concise report with recommendations broken down into case issue, system issue, recommendation.

The scope of the review will be the one year period prior to each individual's death; however agencies will be asked to provide anything relevant that falls outside of the scope. Rather than analyse the life and death of each individual, the exercise will focus specifically on identifying trends and themes about how the system did or didn't work together to maximise the care of individuals, including but not limited to:

- Information sharing
- Workforce understanding of self-neglect and hoarding.
- Understanding of what is possible and what is not possible within individual agencies
- Collective responses to individuals presenting as a risk to themselves
- The boundaries set by the application of thresholds and different legal requirements including the Mental Capacity Act
- Any barriers to joint working
- Links and gaps within the system
- How the picture of risk is built and reviewed by agencies

The review will also take into account learning from two recent local learning reviews to assess the effectiveness of the changes made to multi-agency working since their completion. The reviewer may choose to facilitate a practitioner's event co-designed with the local Case Review Management Group (CRMG) to gain insight from practitioners and understand any key developments that have occurred since. The reviewer will complete a concise report outlining key events and recommendations.

The review will also take into account any learning from other Safeguarding Adult Reviews involving self-neglect and hoarding completed and published nationally.

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, care of elderly, mentally ill and or substance misusing adults in the community.

2. Agencies

Information for the desk top exercise will be provided by:

- CNWL – Adult mental health and district nursing
- Milton Keynes University Hospital Foundation Trust (MKUHFT)
- Thames Valley Police (TVP)
- Adult Services MKC
- Compass Adult Substance Misuse Services
- Milton Keynes Council Housing
- GP practices of three individuals
- Bucks Fire and Rescue
- South Central Ambulance Service

Where it is identified that other agencies, including charities have been involved with individuals, they will also be asked to provide case records relating to that intervention.

3. **Publication**

This review will be published on the MKSB Website and shared with:

- Milton Keynes Safeguarding Board
- Milton Keynes Health and Wellbeing Board
- SaferMK Board
- Milton Keynes Coroners office

A learning bulletin will be produced for agencies and key messages provided to senior leaders and commissioners within Milton Keynes.

Family Involvement and Independent Review Author Report

The review will not look in depth at the lives of individuals but rather systems and practices in multi-agency working. Where possible and appropriate the views of family will be sought