Telford and Wrekin
Safeguarding Adults Board

Safeguarding Adults Review re Case E

Overview Report

Concerning the care of E

Independent Reviewer

Pete Morgan BA, MA, MA & CQSW

Contents

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 E.

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, although deceased, should be treated with respect, and likewise their family members.

1.3 E was born in in Kidderminster in 1973 and was 43 years old at the time of his death. The family moved to Birmingham and then to Telford in the early 1980s. He attended local schools and trained as a welder, working in local factories.

1.4 E was the eldest of four brothers, one of whom died in 1986. His mother, who committed suicide, and father died in 2003 and 2004 respectively. At the time of his death, E was estranged from both his brothers and was not known to be in contact with any other extended family members.

1.5. E became estranged from his brothers after their parents' deaths following a dispute over ownership of the family home, of which E became the sole owner.

1.6 Little information regarding E's life was available to the Review due to a combination of his having had very little contact with services and his brothers not wishing to contribute to or participate in the Review. What contact he did have with services, other than the Department of Work and Pensions (DWP), was a result of his history of alcohol abuse, whether with physical or mental health services or the Police, but this did not lead to any in-depth assessment of his situation or his prior circumstances. E had a criminal record for minor offences, though he received several short custodial sentences prior to the period of this Review.

1.7 What is known is that he had been unemployed for a number of years and had never been married though he had had several long-term relationships, including one in which he had fathered a son. It is understood that the son and his mother had moved abroad several years ago and there is no known way of contacting them.
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1.8 E was not known to have any local support network or group of friends and had no relationships with his neighbours. His home had deteriorated in condition, with boarded-up windows and a boarded-up letter box, and mains services were often disconnected.

1.9 E was last seen alive on the 22nd September 2016 when he attended the Telford DWP Office; this was also the date of the last benefit payment to his bank account. He was sufficiently unwell that his appointment was re-arranged for the 6th October 2016,

an appointment he did not attend. As he did not make contact within 5 days, his claim was closed.

1.10 Concerns about the state of his property caused Telford and Wrekin Council and the Drug and Alcohol Recovery Service to attempt contact with E at the beginning of 2017, but he did not respond to letters or answer the door to callers.

1.11 On the 19th April 2017, the Police were called by a neighbour as 2 young people had entered the garden of E's property to retrieve their ball and discovered a dead body inside the house. The Police described the house as being 'in a state of disrepair' and that the body appeared to have 'been in situ for a prolonged period of time'. Following DNA analysis, the body was identified as E. There were no suspicious circumstances about the death and the matter was referred to the Coroner.

1.12 The Coroner's Inquest was opened on the 29th June 2017 and an Inquest Hearing on the 6th September 2017 it was determined that the medical cause of E's death was Not Ascertained, that he had been found lying next to his bed in his bedroom, having last been seen alive on the 22nd September 2016 and an Open Conclusion was recorded.

1.13 The case was referred to the Telford and Wrekin Safeguarding Adults Board (the Board) for consideration for a Safeguarding Adults Review (SAR) on the 26 July 2017. The referral was passed to the Safeguarding Adult Review Subgroup (the Subgroup) on the 19 December 2017.

1.14 The referral was considered on the 9 January 2018, when the Subgroup agreed the criteria for a Safeguarding Adults Review (SAR) had been met and therefore recommended to the Board's Independent Chair that a SAR be undertaken.

1.15 On the 11 January 2018, the Board's Independent Chair confirmed that an SAR should be undertaken in accordance with the Adult Safeguarding: Multi-agency policy and procedures for the protection of adults with care and support needs in the West Midlands http://www.telfordsafeguardingadultsboard.org/sab/info/1/home/4/information_for_professionals_carers_and_health_workers .

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

1.17 The administration and management of the Safeguarding Adults Review Procedure has been carried out by the Partnership Manager.

1.18 This Review was commissioned under s44 of the Care Act 2014; its commissioning will be reported in the Board's Annual Report for 2017/18 and its findings and their implementation will be reported in the Annual Report for 2018/19 as required by the Act.

1.19 The Report was ratified by the Safeguarding Partnership Executive (previously the TWSAB) at a meeting held on 27 September 2019.

2. Telford and Wrekin Safeguarding Adults Board's Safeguarding Adults Review Procedure

2.1 The Telford and Wrekin Safeguarding Adults Board has adopted the West Midlands Regional SAR Guidance (the Guidance), which sets out the Purpose of a SAR and the Criteria for SARs in Telford and Wrekin.

2.2 The Guidance also establishes the Procedure for making a referral for a SAR, the Framework and the Methodologies for undertaking a SAR as well as the Timescale within which it should be completed.

2.3 The above Guidance has been followed.

2.4 The Guidance can be found here
http://www.telfordsafeguardingadultsboard.org/sab/info/1/home/4/information_for_professionals_carers_and_health_workers

3. The Safeguarding Adults Review Panel

3.1 The Panel comprised individuals across a range of statutory, independent and voluntary sector agencies as below:

Agency	**Representative**
Department of Work & Pensions	Partnership Manager – Shropshire
Telford & Wrekin Clinical Commissioning Group (Chair)	Deputy Chief Officer and Executive Nurse
Telford & Wrekin Council (including Adult Social Care, Adult Safeguarding, Environmental Services and the historical Drug and Alcohol Services)	Assistant Director – Adult Social Care
West Mercia & Warwickshire Police	Detective Sergeant Statutory & Major Crime Review Unit
Midlands Partnership NHS Foundation Trust (Mental Health and the current Drug and Alcohol Service)	Head of Strategic Safeguarding
Shropshire Community Health Trust	Continence Specialist Nurse
Shrewsbury and Telford Hospital Trust	Safeguarding Specialist Nurse Adult Safeguarding
Shropshire Fire and Rescue	Head of Prevention, Protection & Response
Telford & Wrekin Council Safeguarding Adult Board	Partnership Manager
Independent Author	

3.3 The Panel met on the 3rd October 2018, the 26th October 2018, 10th January 2019, 25th March 2019, and 3rd May 2019.

3.4 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.

4. The Safeguarding Adults Review's Terms of Reference

4.1 The meeting of the Panel, held on the 3rd October 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.

4.2 The finalised Terms of Reference are to be found in Appendix A.

5. The Scope of the Safeguarding Adults Review

5.1 The scope of the SAR was initially set as the period from the 1st January 2016 until the 19th April 2017.

5.2 The reason for this was that it would focus the Review on a reasonable period of time prior to the last time E was seen alive and the discovery of his body to enable relevant lessons to be learnt from the nature and quality of services he was offered and provided with.

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

6. Information Trawls

6.1 Information trawls were completed on E to identify which agencies had had relevant contact with him during the period of the Review.

6.2 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 multiagency support offered and received by E.

6.3 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.

7. Independent Management Reviews (IMRs)

7.1 IMRs were requested from the following agencies with regard to their involvement with E:

- Department of Work and Pensions

- Midlands Partnership Foundation Trust (formerly South Staffordshire & Shropshire Healthcare Foundation Trust)
- Shrewsbury and Telford Hospital Trust
- Shropshire Community Health Trust
- Telford and Wrekin Clinical Commissioning Group
- Telford and Wrekin Council Adult Social Care
- West Mercia Police

7.2 In addition, Summary Reports were requested from the following agencies with regard to their involvement with E:

- National Probation Service
- West Midlands Ambulance Services

7.3 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 Author. The Single Agency recommendations are at Appendix B.

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

8. Family liaison and involvement

8.1 Contact was made on the 24 July 2018 with both of E's brothers by recorded delivery letter, offering the opportunity to meet or speak to the Independent Author, together or as individuals, and to do so accompanied by a supporter of their own choice advocate. They were also provided with information on Safeguarding Adult Reviews produced by the Telford and Wrekin Safeguarding Adults Board.

8.2 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 Board.

8.3 No reply was received from either brother to the above letters.

8.4 A further recorded delivery letter was sent to both brothers on the 1st February 2019 offering them the opportunity to see and comment upon the Findings and Recommendations contained in the final draft of the Report. The letter also informed them that the Board would decide what to publish as a result of this Review, and that they would be advised before any publication took place.

8.5 Reference is made in this Report to E visiting family members in Birmingham; it has not been possible to identify who these family members are, and they are not known to have tried to contact E or find out why he stopped visiting them.

9. Media Strategy

9.1 Media contact concerning the Review was the responsibility of the Board's Independent Chair in consultation with the Panel Chair and the Independent Author. Overall management was directed through Telford and Wrekin County Council's Communications Team.

10. Liaison with the Police

10.1 There had been no prosecutions relating to this case and there were therefore no issues re disclosure at the commissioning of the Review. The Police were represented on the Panel.

11. Legal Advice

11.1 Legal advice was available, as and when appropriate, from Telford and Wrekin County Council Legal & Democratic Services to ensure the Review process and final Overview Report maintained a commitment to safeguard the anonymity of E and complied with current legislation. Had any conflict of interest arisen due to the Services being required to provide an IMR, legal advice would have been provided by Telford and Wrekin CCG

12. Independent Overview Report

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

12.2 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.

12.3 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 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 a 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.

12.4 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.

12.5 He had no involvement, directly or indirectly, with any of the agencies contributing to this Review prior to being commissioned to write this Report.

13. Agency involvement prior to the Review period

13.1 As has been mentioned previously, agencies providing IMRs or Summary Reports were asked to include brief details of any particularly relevant involvement they had had with E prior to the Review period.

13.2 E had been known to the DWP as he was in receipt of long-term incapacity benefit at the time of his imprisonment in 2008. On his release in March 2009, he was in receipt of Employment and Support Allowance. DWP records state he was experiencing issues at his property, which had been set alight and had the door broken, was on a waiting list for help with his alcohol dependency and suffered from paranoia and depression.

13.3 E remained unemployed and in receipt of benefits and DWP records refer to E having 'suicidal tendencies', his brother's death in 1986, his mother's suicide in 2003 and his father's death in 2004. At one stage he was declared to be of No Fixed Abode, but that as due to the state of his property making it impossible for him to receive post, so that all contact had to be by phone or text.

13.4 In August 2012, E was found fit for work by the DWP Medical Examination Service; his GP disagreed with this and wished to refer him to mental health services. He had also had 2 seizures in 2011, it is thought due to his alcohol abuse. E advised DWP that he had had no help with his alcohol issues but was taking medication for his mental health issues. He expressed a wish to return to work but was aware that his employment record, health issues and criminal record were barriers to doing so.

13.5 E was known to the National Probation Service (NPS), but prior to 2010, with the result that the files have been destroyed. His criminal record was as follows:

- 17.05.2007 - 18 months Community Order for shoplifting and theft from shops and stalls
- 13.09.2007 - 18 months Suspended Sentence for possession of firearms or imitation firearms
- 03.10.2008 – 7 month custodial sentence for Breach Offences
- 21.04.2010 – 4 month custodial sentence for Actual Bodily Harm

13.6 The West Midlands Ambulance Service (WMAS) records show they attended E's home address for one incident on the 4th December 2011 when they transported him to the Princess Royal Hospital after he contacted them complaining of breathing difficulties. It should be noted that WMAS record calls by the address they visit; it is

likely that they also transported E to hospital on other occasions when he was found in the street.

13.7 The Shrewsbury and Telford Hospital Trust (SaTH) records show contact with E on seven occasions between May 2008 and December 2011. These contacts resulted from E's alcohol misuse, either directly due to his having fallen or collapsed due to being intoxicated, an injury sustained during such a fall or pains while intoxicated. It is notable that E would often either self-discharge or leave without being seen and not respond to letters requesting his return for further examinations.

13.8 E's GP records do not show any significant contact outside of the review period; they do record that he would spend periods of time with family in Birmingham but have no details of the family, so it was not possible to ascertain if he sought support from GP practices or walk-in centres while he was there.

13.9 The GP records show that E had a medical history of alcohol abuse, depression and epilepsy. The latter is not supported by any formal diagnosis or referral to the appropriate specialist services and is likely to be a possible explanation, subsequently discarded, of his seizures.

13.10 In addition to the court appearances recorded by the NPS, the Police records show that E was known to West Mercia Police but also to Staffordshire and West Midlands Police for a range of reasons, including offences committed by and to him. It is notable that all the incidents where E was the offender occurred between 2005 and 2009, for offences of domestic related threats to commit criminal damage, breach of the peace, public order and harassment as well as the offences for which he appeared in court – see 13.5 above.

13.11 Between May 2009 and June 2010, West Mercia Police held a Risk Management Plan (RMP) relating to E and his ex-partner.

13.12 Between 2005 and 2011, E was a victim of a number of crimes, including criminal damage, theft from a motor vehicle and burglary; he was also known to the Police for matters which included domestic related public order and harassment. During this period, it is estimated that E had been involved in excess of 90 non-crime related incidents, including matters relating to his alcohol misuse and domestic history with his ex-partner – in line with Force Policy, the main detail of these incidents has been destroyed. From 2011 to the commencement of the review period, E was involved in 8 incidents which a crime was not recorded against.

13.13 Adult Social Care (ASC) has no records prior to the Review period (January 2016) of any assessments or case notes relating to E in their electronic record system; however, there are some contacts that were recorded by the then Community Mental Health Team (CMHT), but these were not routinely entered and should not be considered a complete record of that Team's involvement with him.

13.14 In November 2005, an assessment under the Mental Health Act 1983 is recorded, requested due to concerns raised by his then partner that he was expressing thoughts of suicide, after which E was admitted to Castle Lodge Unit on an informal basis; following a brief period of follow up by the CMHT, E was discharged back to the GP

with no ongoing role identified for secondary mental health services. In June 2006, contact from E's GP resulted in a referral to another (unknown) agency, with the contact closed the same day and in November 2010, E's GP records contact was again made with ASC, but the contact as closed with an outcome of No Further Action after discussion in a referral meeting.

13.15 There is a history of referrals to the Drug and Alcohol Recovery Team dating back to 2011; there is no record of who made the referrals and no record of any assessment or interventions, which was most probably due to E not engaging with the service.

13.16 The Midland Partnership Foundation Trust (MPFT) has records of sporadic contact between E and mental health services from 2004, related to low mood and anxiety for which he was prescribed an antidepressant managed by his GP. The admission to Castle Lodge Hospital in 2005 was for one night only and after brief follow up by the CMHT he was discharged back to the care of his GP. In 2007, E was assessed by a psychiatrist to provide a report to a court relating to a Road Traffic Offence and while in prison in 2008, E was referred to the prison mental health team but was transferred to another prison before he could be seen – the referral was redirected to the new prison but there is no record of the outcome.

13.17 The above presents a picture of someone who chose not to engage with services, did not display symptoms or a level of social care needs to warrant either requiring his engagement or to raise the concerns of services to a level where they deemed there to be a need to question his capacity to make decisions relating to his physical and mental health needs.

13.18 There was, during this period, evidence of self-neglect, alcohol misuse and domestic abuse; this, in itself, was not sufficient to require escalation to a multi-agency forum or procedure such as the Multi Agency Risk Assessment Conference (MARAC) or the Care Programme Approach (CPA) and the Domestic Abuse, Stalking and Honour-based violence Risk Identification Checklist (DASH RIC) was only introduced in 2009, by which time the RMP was in place and incidents of domestic abuse had ceased.

13.19 In summary, E was known to local services but not was not recognised or assessed as a person with social or heath care needs that needed management beyond that provided by his GP and chose not to engage with services that could have provided additional support.

14. Sequence of events – 1st January 2016 – 19th April 2017

14.1 On the 11th January 2016, E attended his GP for a consultation, smelling of alcohol; he was signed off as unfit for work until the 31st March 2017 with a diagnosis of 'Alcohol problem drinking'. The GP Practice records noted that he was/had been 'under Nacro' and had a social worker; however, ASC have no record of any Social Worker working with E and he was not open to them at this time. He was given 'Lifestyle advice regarding alcohol'.

14.2 On the 27th January 2016 at 20.00, the Police records show that E contacted them to report that someone had broken into his house; he was upstairs but had heard them talking downstairs. The Police attended within 6 minutes but found no evidence of any break-in or intruders. They did record that they had difficulty accessing the property because of its condition. In the subsequent days, Scene-of-Crime officers visited the property as did an investigating officer to take a statement, but E did not answer the door or respond to voicemail messages.

14.3 On the 31st January 2016 the Police cancelled any further attempts to contact E re the above and closed the case. Despite the condition of the property and knowledge of E as having problems with alcohol abuse, no referral was made to social care or any safeguarding concern raised or even considered.

14.4 On the 2nd February 2016 at 15.23, E contacted the Police to report that someone had broken into his house; they had entered the garden by a hole in the fence made during the previous incident and entered the property via a downstairs window – he could hear male voices. He went downstairs while on the phone and said no one was there. The Police attended within 8 minutes and comment upon the state of the property but E could identify no new damage or anything having been stolen.

14.5 E is described by the officers as distressed, smelling of alcohol and urine and having told them he can't afford to repair the property. A referral to the Harm Assessment Unit (HAU) was made specifically notifying drug/alcohol agencies.

14.6 On the 8th February 2016 at 08.43, E attended Malinsgate Police Station, Telford, to request an update on the recently reported burglary. While there he threatened that he would shoot 'the woman who has done this … if she comes back to my house.' He smelt of alcohol. Checks were made with respect to firearms as E had claimed to have got his firearms licence back but there was no record of this and he was deemed to be a low risk and Police logs identified that this was a similar threat to one E made in 2013 but did not carry out. No further action was taken, including no further referral to the HAU.

14.7 On the 10th February 2016 at 11.13, ASC records show that the referral from the HAU – see 14.5 above – was received by the Safeguarding Team (ST) requesting either a mental health assessment or a referral to the Drug and Alcohol Recovery Service (DARS). Having screened the referral, the ST forwarded it to the Telford Integrated Community Assessment Team (TICAT).

14.8 On the 11th February 2016, the referral was screened by the TICAT Team Manager and forwarded to the Mental Health Team (MHT).

14.9 On the 15th February 2016 at 18.49, the Police record that E contacted them to report that his house was being broken into and that "'they' were trying to force their way through the front door", E was hiding in his bedroom upstairs. The Police attended and spoke to E over the fence; the officer took no further action and did not appear to link this with previous incidents.

14.10 On the 18th February 2016, E was allocated to SW1, a Social Worker in the MHT who opens an assessment in the computerised recording system.

14.11 On the 22nd February 2016 at 17.56, the Police record a silent 999 call from E's telephone number; no sounds of distress could be heard and attempts to ring him back were unsuccessful. Officers attended his address but could get no reply. No further action was taken.

14.12 On the 23rd February 2016, the DWP sought internal confirmation of whether or not a medical examination was required to support E's benefit claim.

14.13 On the 6th March 2016 at 16.43, E phoned the Police to report that someone had "put his windows through"; he hadn't seen them, only heard them but it had been going on for weeks. Police attended the property and spoke to a neighbour who advised that the particular window had been broken for months. The officer refused to enter E's house because of its condition and spoke to him outside: E admitted the window had been broken for some time and that it had been a hoax call. Despite the attending officer noting that a Vulnerable Adult incident had been logged recently, no further action was taken.

14.14 On the 8th March 2016, the DWP records show that E's ESA claim was suspended and disallowed from this date.

14.15 On the 21st March 2016, the GP records that E attended a consultation about his alcohol misuse, smelling of alcohol. He advised the GP that he had no support worker, was spending most of his time in Birmingham looking after relatives and that he had been referred by the Police to Early Help and Support at Addenbrooke House for support. He was advised to contact them.

14.16 On the 22nd March 2016, SW1 wrote to E offering him an appointment and giving his contact details.

14.17 On the 29th March 2016, the GP records that E attended a consultation to request a Fit Note to say he is not fit for work. This was issued on the basis of a diagnosis of Alcoholism until the 29th May 2016. He was advised again about his drinking and he was given the contact details for Aquarius.

14.18 On the 29th March 2016, E contacted SW1 to say things were not going well and arranged to meet him on the 31st March 2016 at his home.

14.19 On the 31st March 2016, E met SW1 as arranged; SW1 recorded that they spoke about the death of E's parents, including his mother's suicide, his own admission to the Castle Lodge Unit due to depression, his loss of his Personal Independence Payment (PIP) and his lack of Council Tax benefit. SW1 agreed to accompany him to the Job Centre about his benefits. SW1 also recorded that E was experiencing some delusions and paranoid thoughts and had been assessed by the Mental Health Assessment Team (MHAT) that E had reported a burglary and damage to his house to the Police, but they hadn't believed him, and that E's property was "quite the worst I've ever seen, glass everywhere."

14.20 That day, SW1 contacted EP1, Empty Property Officer with Telford and Wrekin Council (?) and was advised that E owed £10,000 Council Tax arrears, but that the

Council could arrange for the sale of the property for £30,000 if E wished to do so and clear his debt. They agreed that they do a joint visit to E to explain the above, that SW1 would accompany E to the Job Centre to try to sort out his benefit claim and that SW1 would ask E if he would be willing to have an assessment from the MHAT.

14.21 On the 1st April 2016, Wrekin CMHT (WCMHT) received a referral from SW1 requesting an assessment due to concerns that E was expressing some delusional ideas; the referral was accepted and the triage process as to commence by contacting E by phone. An urgent response was not deemed necessary as the referral highlighted no risks.

14.22 On the 4th April 2016, the DWP followed internal procedure by requesting a mandatory reconsideration of the Work Capability Decision made re E on the 8th March 2016.

14.23 On the 4th April 2016, SW1 accompanied E to the Job Centre and assisted him apply for Job Seekers Allowance (JSA) and PIP and discussed with him support from the Telford Job Junction. E advised him that he wanted to keep his home and "do it up".

14.24 On the 5th April 2016, the DWP progressed the mandatory reconsideration of E's benefits – see 14.22 above

14.25 On the 5th April 2016, SW1 contacted the Employment Allowance Team to provide his contact details for them to forward the ESA claim decision.

14.26 On the 6th April 2016, the Community Mental Health Nurse contacted E who agreed with the concerns that he was experiencing some paranoid thoughts and, despite disclosing he was still using alcohol, expressed some concern about engaging with alcohol services for fear he would "end up in Shelton Hospital like his mum did". After some reassurance, he agreed to attend for an assessment on the 28th April 2016.

14.27 On the 6th April 2016, the DWP transferred E from ESA to JSA

14.28 On the 7th April 2016, SW1 and EP1 met E at his home; discussed that it is worth £100,000 and the Council offer him £20,000 to renovate it provided he then sold it to pay them back. SW1 agreed to support a waiver of his Council Tax arrears on the grounds he didn't have the capacity to apply for an exemption.

14.29 On the 8th April 2016, the DWP record that a WSAR (Written Statement of Reasons) containing details of the effect of the law that was used to make the decision was issued to SW1 as requested – see 14.24 above. If a customer is not satisfied with a decision, they are advised to request a mandatory reconsideration by a Decision Maker – this subsequent activity is reflected in 14.31.

14.30 On the 11th April 2016, a letter was sent to E confirming the arrangements for his assessment on the 28th April 2016 as agreed – see 14.26 above – copied to his GP.

14.31 On the 15th April 2016, the DWP record that a further mandatory reconsideration was undertaken - see 14.29 above - and that the Decision Maker's original decision was not revised.

14.32 On the 18th April 2016, the DWP record "Note to say 'Council Tax deductions 12/5/16, balance £1043.59'

14.33 On the 18th April 2016, ASC records that SW1 phoned E as he had not responded to recent attempts to contact him; he also wrote to ESA requesting a review of the decision to disallow his claim, pointing out that his home was below acceptable human standards, that he was unable to understand the level of risk this posed to him, or the general level risk posed to him and lacked the ability to maintain his personal hygiene or that of his property.

14.34 On the 20th April 2016, SW1 made an unannounced visit to E's home, shouting through a hole in the front door. E replied and advised that he didn't answer the phone if he didn't recognise the caller. SW1 advised that EP1 will be visiting the next day with a contractor. SW1 and E are to meet the Council Tax Team to request they write off the Council Tax arrears.

14.35 On the 26th April 2016, SW1 accompanied E to the Citizens Advice Bureau for advice re his housing.

14.36 On the 28th April 2016, E did not keep his appointment with the Mental Health Team – see 14.26 above

14.37 On the 28th April 2016, the GP Practice records that they received a copy of a letter to E from the South Staffordshire & Shropshire Healthcare Foundation Trust resulting from his not keeping his appointment on the 28th April 2017 and asking him to contact them to arrange another appointment within 14 days or they will assume he does not want support from them.

14.38 On the 28th April 2016, the GP Practice records that they received a copy of a letter to E from the South Staffordshire & Shropshire Healthcare Foundation Trust resulting from his not keeping his appointment on the 28th April 2017 and offering him a new appointment on the 16th June 2016; if he doesn't attend, they will assume he does not want support from them.

14.39 On the 4th May 2016, E contacted the Community Mental Health Team requesting a new appointment; the Duty Nurse tried to ring him back but got no reply and left a message asking him to ring back.

14.40 On the 4th May 2016, ASC records show that SW1 recorded that E had not answered when he called the previous week to meet with the Council Tax Team which had been rearranged for the 10th May 2016; he had texted SW1 on the 3rd May 2016 to say he had been away with his family in Birmingham. SW1 accompanied E to Southwater to apply for a PIP as his application for ESA had been unsuccessful. SW1 recorded that he had no concerns for E's capacity re the security of his property.

14.41 On the 10th May 2016, ASC records show that SW1 accompanied E to Southwater to claim a Council Tax reduction on the basis that he lives alone. E disclosed that he had arranged for the person who ruined his property to be "beaten up"; *SW1* advised the Police of the above and told E that he had done so.

14.42 On the 10th May 2016, Police records show they received a call from SW1 to report that E had told him that he had organised persons to be 'beaten up' which had resulted in them being hospitalised. This incident had allegedly occurred in the week prior. SW1 explained that E was an alcoholic and that his property was in a poor state. E refused to cooperate or provide any further details when arrangements were attempted to be made with him and SW1.

14.43 On the 13th May 2016, the Duty Nurse at the CMHT, contacted E and arranged a new appointment for the 16th June 2016. He was advised that failure to keep the appointment would mean he would be discharged back to his GP.

14.44 On the 1st June 2016 at 20.31, the Police record that E contacted them to report that someone was "trying to kick the door in", that the door was broken, and he had no family or friends in the area. The Police attended, and E declined any assistance in repairing the door. The Police tried to speak to E's neighbours but could get no reply and could find no sign of any intruders. The incident was recorded and investigated solely as an attempted burglary without any recognition of E's support needs, resulting in no further action being taken.

14.45 On the 2nd June 2016 at 21.30, E contacted the Police to report that "someone was smashing his door in", naming the potential offender and alleging he kicks the door and leaves. E states the offender has left, and he hasn't actually seen him. The police are not able to attend for an hour and a half and get no response from E when they do. A message is left for him to contact the station, but the incident is closed the following day when he fails to do so.

14.46 On the 9th June 2016, ASC records show that SW1 made an unannounced visit to E's home; he got no reply though he thought he could hear E's phone ringing. The door looked as if it had been damaged from the outside. In supervision, SW1 agreed with is manager that he would close the case as there was no identifiable task for him to achieve with E that E couldn't manage on his own. Agreed he would make one more unannounced visit, and, if no response, put a letter through the door.

14.47 On the 16th June 2016, E failed to keep his appointment with the Mental Health Team; SW1 was advised and E was discharged from the service. There is no record of the GP being advised.

14.48 On the 24th June 2016, E failed to attend an interview with the DWP so his claim for JSA was closed.

14.49 On the 30th June 2016, the GP Practice records receiving a letter from the Princess Royal Hospital Emergency Department advising that E attended that day as the result of a fit. The records refer to "1 alcohol withdrawal fits; 2 Wernicke Korsakoff Syndrome, supportive care, medical admission". Later that day, a discharge summary was received by the GP practice advising that the admission was after a seizure in

town, the fit was likely alcohol related, the Alcohol Nurse has advised he wean his alcohol intake in conjunction with his community worker and E was discharged without follow up. There is no record of any contact from the acute hospital with ASC to inform of the presentation at A and E and the follow up plan.

14.50 On the 1st July 2016 at 14.56, the Police record that E contacted to report that there were two people smashing his house up; the Police attended and established nobody could have entered the property as they had to remove a board to do so, and E couldn't not have seen what was going on outside the property due to the windows being boarded up. E clarified that he had not heard or seen anybody but had contacted the police because he suffers from anxiety. E, who was described as "slightly intoxicated", said he had asked a friend to join him to prevent a similar incident occurring. "A HAU referral was made highlighting the issues of alcohol and safeguarding adults". ASC have no record of receiving this referral; any such referral would have been scanned into the system and, as E was still an open case, it would have been passed to SW1. There is no record of this.

14.51 On the 2nd July 2016 at 19.53, the Police record that E contacted them to report that someone had thrown a brick through his front window; he did not see anyone but named some possible suspects. He sounded intoxicated and couldn't remember the incident the previous day. The Police attended at 20.15, assessed the damage, reported the state of the property and failed to find the brick E claimed did the damage. A referral to HAU was made, again highlighting issues of alcohol addiction and safeguarding. ASC have no record of receiving this referral.

14.52 On the 4th July 2016, at 17.15, the Police record E contacted them to report someone was throwing "stuff" at his house, that bricks were being thrown but no damage occurred. He was vague in the information he provided. A PCSO attended and advised that every window at the house was broken, which was in a very poor state. No further action was taken.

14.53 On the 6th July 2016 at 03.02, the Police record that E contacted them to report that someone had broken into the house and were using the downstairs toilet; he phoned back ten minutes later to say he had forgotten his friend "Darren" was visiting and he hadn't been burgled. The Police did attend but E refused to answer the door; no further action was taken.

14.54 On the 18th July 2016, the DWP record that a short-term benefit advance was paid to E.

14.55 On the 22nd July 2016, ASC records show that SW1 recorded that E has not answered his calls or texts – dates not recorded – and that he believed E did not attend his appointment in June with the CMHT. After supervision, he wrote to E advising he was going to close the case in fourteen days but would meet him to discuss this if he contacted within that period. He also provided details of the Thrive drop-in and other help re benefits, domestic and housing issues.

14.56 On the 9th August 2016, ASC records show that SW1 finalised E's assessment and determined he met the eligibility criteria for support. It was noted that "We have not been able to have his benefits changed from JSA to ESA" and (E) did not attend his

appointment with the CMHT and would not attend DARS. (E) would also not follow a plan laid out by EP1 of the Empty Homes Team to help him repair his home" As E had disengaged despite various attempts to contact him, no services were to be provided and the case was to be closed.

14.57 On the 22nd September 2016, DWP records show that E attended the Telford office in support of his JSA claim but was sufficiently unwell that it was agreed that the appointment be rearranged for the 6th October 2016.

14.58 On the 6th October 2016, E failed to keep his appointment with the DWP; as he also failed to make contact within five days to rearrange the appointment again, his JSA claim was closed with effect from the 22nd September 2016.

14.59 ASC received concerns in January 2017 from members of the local community and the Ward Member and SW1 was asked to re-engage.

14.60 On the 5th January 2017, a Business Support Officer with TWC advised the Team Manager with the MHT and DARS that she had contacted the CMHT to ascertain their involvement with/knowledge of E and was advised that their only involvement had been to offer a screening appointment on the 28th April 2016 - see 14.36 above – which he did not keep so the case was closed.

14.61 On the 5th January 2017, the Team Manager also established that E had been referred to the low-level alcohol service (Impact) for assessment in September 2014 (no outcome shown) and invited for assessment by the DARS in February 2016 - see 14.7 above – but he failed to attend. She then asked DARS1*,* SW1 *and* EP1 to visit E within the week to offer support with his alcohol consumption, mental health and housing issues respectively. The Team Manager also updated the Interim Assistant Director (IAD), ASC on her actions by email.

14.62 On the 10th January 2017, DARS1 and SW1 met to share information re E and agreed to visit him on the 19th January 2017; a letter was sent to E to advise him of the visit.

14.63 On the 19th January 2017, DARS1 and SW1 visited E's address as arranged but got no reply; they left a calling slip offering a further appointment on the 1st February 2017.

14.64 On the 20th January 2017, the IAD contacted the Team manager for a further update on activity with E

14.65 On the 23rd January 2017, SW1 emailed DARS1 and EP1, copying in IAD confirming that he and DARS1 had visited E unsuccessfully and planned to do so twice more, followed up by letters if unable to see E. He added that he had asked EP1 if TWC could pay to do some cosmetic work on the property, placing a charge against its future sale as had happened with another service user, but had been advised that was not the current plan; he asked that this decision be reconsidered.

14.66 On the 23rd January 2017, there was an exchange of emails between the Team Manager and the IAD in which the IAD requested a more detailed update.

14.67 On the 24th January 2017, DARS1 emailed an update to the IAD, copying in SW1 and the Team Manager.

14.68 On the 1st February 2017, SW1 visited E's address on his own as DARS1 on sick leave but got no response.

14.69 On the 8th February 2017, SW1 confirmed by email with EP1 an unannounced visit to E on the 10th February 2017 to discuss work to the outside of his property but got no response.

14.70 On the 9th February 2017, IAD emailed SW1 and DARS1 advising that E is to be discussed with the local Councillor after further complaints about the state of the property and how E is living. IAD asks that they continue to try to contact E until she knows more of what the Councillor suggests should happen

14.71 On the 10th February 2017, DARS1 and SW1 visited E's property and got no response; further damage noted to the property with broken glass outside and a sofa in the garden. A neighbour advised he had heard no noise from the property for several days but that it was usual for E to be away for several days at a time. DARS1 took photos of the property and noted that the electricity meter was running on emergency. Agreed DARS1 would report the sofa as fly-tipping and write to E to let him know and to offer advice and support re the property.

14.72 On the 7th March 2017, DARS1 visited E's address and got no response; the sofa was still in the garden and then garage door looked to have been forced and was ajar.

14.73 On the 9th March 2017, DARS1 contacted the Environmental Health Department of TWC and was advised that they could not remove the sofa as it is on private property without E's permission. DARS1 was unable to give them E's contact details without his agreement.

14.74 On the 19th April 2017, the Police were contacted by a neighbour to report a dead body has been seen in E's property. The Police attended to find what transpired to be E's decomposing body in his bedroom.

15. Analysis and Recommendations

15.1 This SAR is focused on the events that preceded the discovery of E's body on the 19th April 2017. It has first of all to be acknowledged that the cause of E's death is not and never will be known; the Coroner recorded an Open verdict at the Inquest. It would however appear to the Author to be reasonable to assume that foul play was not a factor and that E most probably died of natural causes. Equally, although suicide cannot be entirely ruled out, there is nothing to suggest that E was in any way suicidal the last time he was seen alive.

15.2 The Coroner's Inquest recorded the date of death as the 19th April 2017. E was last seen alive on the 22nd September 2016 at the DWP offices in Telford; the Review is aware that the last payment into his bank account from the DWP is also dated the 22nd September 2016 but was not informed whether this was the last transaction on the account. Had there been further transactions, this might have reduced the period of time during which E died, but this would not have any impact on this Report's Findings or Recommendations.

15.3 It also has to be acknowledged that no one raised concerns about E's disappearance; he appears to have had few friends locally and was estranged from his two surviving brothers. The family that he is suspected of visiting regularly in Birmingham also appear to have made no efforts to contact him in the period between October 2016 and April 2017. It would appear that E was extremely social isolated, and, seemingly, by his own choice.

15.4 E was known to services, including mental health services, drug and alcohol services and the Police; although he was offered appointments for assessments of his care and support needs – see 14.36 above, for example – he did not attend, and the assessments were not completed.

15.5 E's failure to keep appointments was not consistently investigated thoroughly, if at all, despite it being a regular pattern in his behaviour. The Did Not Attend (DNA) policies of both the DWP and the mental health services, including DARS, were followed but the failure of E to respond to letters and phone calls was not seen as a possible symptom of an underlying mental health or alcohol misuse problem. Had a degree of 'professional curiosity' been exercised, for example a member of staff visiting his home or checks being made with other agencies or professionals, further investigations may have occurred. However, even when SW1 did visit E and endeavour to engage with him, initially focusing on his financial issues with a view to developing a relationship to enable him to try to address E's underlying mental health and alcohol misuse issues, E chose not to engage.

Finding 1:
That E's failure to attend for appointments or respond to letters or phone calls was not considered and responded appropriately to, given the knowledge agencies had about his physical and mental health issues

Recommendation 1:
That the Board seek reassurance from partner agencies and those services they commission as well as the DWP that they have reviewed and revised as necessary their DNA policies and procedures to ensure they are proportionate and fit for purpose and reflect the diverse care and support needs of their service users/customers

15.6 It is not clear if E was formally offered an assessment under s9 of the Care Act 2014. SW1 does 'finalise' E's assessment in August 2016 – see 14.55 – but does so without having seen him since the 10th May 2016 – see 14.41. Just what this assessment was is not clear from ASC's records, though it did demonstrate that E was eligible for services; it would appear that E was not informed of this, as he had disengaged, and the case was closed.

15.7 This raises concerns as to whether the ASC policy and procedure for assessing someone's care and support needs under the Care Act 2014 were fit for purpose but also ASC's policy and procedure for closing cases where care and support needs have been assessed but the adult does not engage; the provision of Independent Advocacy under s67 of the Care Act 2014 should have been considered as E was clearly not able to engage with the assessment process and had not refused support per se.

Finding 2:
That E's care and support needs were not effectively assessed under s9 of the Care Act 2014 and appropriate support was not offered to him

Recommendation 2:
That the Board seek assurance from ASC that it has reviewed and revised as necessary its Assessment Policy and Procedures to ensure that it is meeting its legal obligations under s9 and s10 of the Care Act 2014, including the provision of Independent Advocacy under s67 of the Care Act 2014

Recommendation 3:
That the Board seeks assurance from ASC that it has reviewed and revised as necessary its Policy and Procedures for closing cases to ensure that they are proportionate and fit for purpose and has required those services it commissions to do likewise.

15.8 Underpinning the above Findings and Recommendations is a concern at the lack of any formal capacity assessment being undertaken on E. This is not to suggest that he lacked capacity, though there was a suggestion that he might have suffered from Korsakoff 's syndrome, a form of dementia linked to alcohol misuse. While it is accepted that the Mental Capacity Act 2005 (MCA) requires an assumption of capacity in all adults, there is a distinction to be drawn between an 'assumption' and a 'presumption' of capacity.

15.9 The assumption of capacity is to be held until it has been demonstrated that an adult lacks capacity; however, 2.11 of the Code of Practice supporting the MCA requires 'further investigation' of their capacity if an adult makes repeated 'unwise decisions'. What E did was put himself at risk of serious harm by his behaviour, as

exemplified by his repeated failure to keep appointments, maintain his property or look after his physical or mental health – see 13.6; 13.7; 14.2; 14.3; 14.5; 14.13; 14.19; 14.36; .14.44; 14.49; 14.51 and 14.58. This failure to consider E's mental capacity lies with health and social care staff and the Police, all of whom had contact with him and had a level of knowledge, gained over time, of his behaviour and its impact on his life and wellbeing.

Finding 3:
That, despite there being grounds for further investigation, no consideration was given to whether E retained the mental capacity under the Mental Capacity Act 2005 to make decisions about his physical and mental health or the maintenance of his property

Recommendation 4:
That the Board seek assurance from its partner agencies that they, and the services they commission, have effective staff development opportunities to enable staff to effectively implement the Mental Capacity Act 2005 and its supporting Code of Practice

15.10 The Police had direct contact with E a total of twelve times during the period of the Review – in fact between the 1st January 2017 and the 6th July 2017, just over six months. On each of these occasions, E was either under the influence of alcohol or at his home, which obviously deteriorating in terms of its state of repair. On only three occasions was a referral to the HAU made – see 14.5; 14.50 and 14.51.

15.11 On the occasions when a referral to the HAU was correctly made, there was no follow-up on the outcome of that referral when E came to the Police's attention again. This concern has been raised with the Police, who have advised that there is not the capacity to follow up referrals to the HAU due to the number of referrals they receive. It is a concern that this is the case even when there are repeat referrals within a matter of days. On one occasion, the referral to the HAU resulted in action by ASC – see 14.7 above – but the others are not recorded by ASC.

15.12 ASC staff had more direct contact or attempted direct contact with E during the Review period than the Police; a member of staff described E's property as "quite the worst I've ever seen, glass everywhere." - see 14.19 above. At no stage was the condition of E's property or his physical or mental health considered as symptomatic of self-neglect.

15.13 This failure to identify possible if not actual self-neglect – see 15.9 above - would appear to be linked to the failure to consider the possibility of E lacking the capacity to make decisions about his general wellbeing, specifically his physical and mental health and the maintenance of his property.

Finding 4:

That those agencies and members of staff who had direct contact with E and visited his home address did not recognise the signs of possible self-neglect and therefore did not make the appropriate referrals for support for E

Findings 5:
That when an agency did make a referral due to concerns about E's wellbeing, when there was no apparent response and the concerns arose again, they did not escalate this.

Recommendation 5:
That the Board seek assurance from partner agencies that they, and the services they commission, have implemented staff development opportunities to ensure staff are able to identify self-neglect at an early stage and are able to raise appropriate referrals to seek support for the adult.

Recommendation 6:
That the Board undertake to work with other local community partnerships, such as the Health and Wellbeing Board, the Safeguarding Children Board and the Community Safety Partnership, to develop a multi-agency strategy and forum to manage cases of self-neglect before they deteriorate to the point of becoming an adult safeguarding concern

15.14 On the one occasion when a referral by the Police to the HAU is known to have generated a referral to ASC, despite 'safeguarding' being explicitly referred to, no consideration appears to have been given to bringing E under the aegis of the West Midlands Region Multi-Agency Safeguarding Adults Procedures, that TWC and West Mercia Police are signatories to.

15.15 The IMR from ASC acknowledges that their staff in mental health services were not aware of the above procedures and, at the time of the review period, SW1 had had no training in safeguarding adults and his supervisor had only completed basic adult safeguarding e-learning modules in August 2014 and April 2016 – this has since been rectified.

15.16 This a major concern; the local authority, not just ASC or its equivalent in a local authority, is the lead agency for the implementation of the Care Act 2014 and the sections relevant to safeguarding adults and the local police force is one of the three statutory members of the Board, along with the local authority and the local Clinical Commissioning Group.

15.17 The above concern is compounded by the fact that self-neglect is specifically included in the list of types of abuse contained in the Statutory Guidance supporting the Care Act 2014. While the Care Act 2014 was only enacted from April 2015, the period between it receiving the Royal Assent in May 2014 and April 2015 was for the specific purpose of enabling agencies to review and revise policies, procedures and practice in preparation for its enactment.

Finding 6:
That staff in the Police and ASC failed to recognise that E met the criteria for the undertaking a s42 Enquiry under the Care Act 2014.

Recommendation 7:
That the Board seek assurance from its partner agencies, but particularly ASC and the Police, that they have in place staff development opportunities to ensure all staff are aware of their obligations for safeguarding adults under the Care Act 2014 and its supporting Statutory Guidance and Making Safeguarding Personal

Recommendation 8:
That the Board review and revise as appropriate its monitoring processes to ensure adult safeguarding and Making Safeguarding Personal are embedded in the policies, procedures and practices of partner agencies and the services they commission

15.18 It would appear that, while E was known and possibly well-known to a number of agencies in Telford, nobody had an accurate and holistic knowledge of his situation and care and support needs; if any agency had had one, then it would be realistic to have expected that the issues round his capacity, possible self-neglect and mental physical health would have been recognised and addressed.

15.19 Had a safeguarding concern generated a s42 Enquiry under the Care Act 2014, this should have brought together all those agencies with knowledge of E and his situation to produce a coordinated care and support plan; this would also have had the advantage of not requiring E's agreement to take place: while an adult can refuse a s9 or s10 assessment under the Care Act 2014, they cannot refuse a s42 Enquiry.

15.20 The other multi-agency procedure that could have been initiated with regard to E was the Care Programme Approach (CPA); he certainly had a mental health diagnosis that was sustained, whether it was severe is not known because he never cooperated with a mental health assessment. This perhaps would indicate that it was, or at least merited further investigation.

15.21 Had the CPA been considered if not implemented with regard to E, the issue of his self-neglect would have been more likely to have been identified and addressed through any local self-neglect procedure or forum

Finding 7:
That despite having been known intermittently to mental health services for over 11 years and being prescribed medication for his mental health issues, it was never considered whether E met the local criteria for the CPA

Recommendation 9:
That the Board seek assurance from ASC and the Clinical Commissioning Group that the local criteria for the CPA are being implemented correctly and coordinated with other multi-agency procedures

15.22 Underlying all the above, is a lack of 'professional curiosity' on the behalf of the professionals who came or could have come in contact with E; this is perhaps exemplified by the numerous attempts to contact him in 2017 when he was already dead and his property was continuing to deteriorate but the decision was to visit and follow-up unsuccessfully visits with letters to a boarded up house and a man who had a history of not responding to letters – see 15.9 above.

15.23 This lack of looking beyond the presenting issue applies across all the agencies that came in contact with E and compounded if not caused the failure to identify his self-neglect and possible loss of capacity. While SW1 did discuss issues such as the death of his mother – see 14.19 above - this does not appear to have been given further consideration as a possible causal factor in his behaviour, other than explaining his fear of going into hospital, that needed addressing.

15.24 The exact degree of his social isolation is not and cannot now be known due to a combination of E's lack of engagement with services, his brothers' continued unwillingness to participate in or contribute to this Review and the lack of information about his family in Birmingham. His neighbour did report that he would be away from home for a couple of days at a time, but where he was and who with in not known.

15.25 Whatever the reason for E's lack of engagement with services, responsibility to engage does not just lie with the service user, but also with the service itself. The need for services to develop a long-term relationship with service users, particularly in cases of self-neglect, has been identified in research.

Finding 8:
That staff working with E did not look beyond the presenting issue to identify possible causes of his social isolation.

Recommendation 10:
That the Board seek assurance from partner agencies that they, and the services they commission, encourage staff to develop and exercise 'professional curiosity' when screening referrals and undertaking assessments and that this is effectively monitored through professional supervision and line-management procedures

16. Conclusion

16.1 On the basis of the above, albeit in the context of an Open conclusion from the Coroner's Inquest, it would appear to the Author reasonable to assume that E's death was not directly predictable or, therefore, preventable. However, it is possible to identify missed opportunities to engage with him and to identify self-neglect as being an underlying factor in his social isolation and lack of engagement with services – see 15.9 above.

16.2 Had these opportunities been taken, it is possible that E's wellbeing would have been promoted and his quality of life during the last ten to fifteen years of his life would have been enhanced.

16.3 What is also apparent is that the agencies who tried to engage with E did not make use of the multi-agency procedures and forums that could have facilitated a more holistic approach to supporting him and, in some cases, were not even aware of them see 13.18.

16.4 The above was compounded by the lack of a multi-agency strategy and forum for sharing concerns about cases of possible self-neglect and their management through a coordinated risk assessment process.

16.5 In reality, however, it is highly likely that, on the evidence of his behaviour over a number of years, he would not have engaged with services.

17. Recommendations:

Recommendation 1:

That the Board seek reassurance from partner agencies and those services they commission as well as the DWP that they have reviewed and revised as necessary their DNA policies and procedures to ensure they are proportionate and fit for purpose and reflect the diverse care and support needs of their service users/customers

Recommendation 2:
That the Board seek assurance from ASC that it has reviewed and revised as necessary its Assessment Policy and Procedures to ensure that it is meeting its

legal obligations under s9 and s10 of the Care Act 2014, including the provision of Independent Advocacy under s67 of the Care Act 2014

Recommendation 3:
That the Board seeks assurance from ASC that it has reviewed and revised as necessary its Policy and Procedures for closing cases to ensure that they are proportionate and fit for purpose and has required those services it commissions to do likewise.

Recommendation 4:
That the Board seek assurance from its partner agencies that they, and the services they commission, have effective staff development opportunities to enable staff to effectively implement the Mental Capacity Act 2005 and its supporting Code of Practice

Recommendation 5:
That the Board seek assurance from partner agencies that they, and the services they commission, have implemented staff development opportunities to ensure staff are able to identify self-neglect at an early stage and are able to raise appropriate referrals to seek support for the adult.

Recommendation 6:
That the Board undertake to work with other local community partnerships, such as the Health and Wellbeing Board, the Safeguarding Children Board and the Community Safety Partnership, to develop a multi-agency strategy and forum to manage cases of self-neglect before they deteriorate to the point of becoming an adult safeguarding concern

Recommendation 7:
That the Board seek assurance from its partner agencies, but particularly ASC and the Police, that they have in place staff development opportunities to ensure all staff are aware of their obligations for safeguarding adults under the Care Act 2014 and its supporting Statutory Guidance and Making Safeguarding Personal

Recommendation 8:
That the Board review and revise as appropriate its monitoring processes to ensure adult safeguarding and Making Safeguarding Personal are embedded in the policies, procedures and practices of partner agencies and the services they commission

Recommendation 9:
That the Board seek assurance from ASC and the Clinical Commissioning Group that the local criteria for the CPA are being implemented correctly

Recommendation 10:
That the Board seek assurance from partner agencies that they, and the services they commission, encourage staff to develop and exercise 'professional curiosity' when screening referrals and undertaking assessments and that this is effectively monitored through professional supervision and line-management procedures

Appendices

Appendix A

Terms of Reference for Safeguarding Adults Review E

Appendix B

Findings and recommendations from single agency reviews

Appendix A

SAFEGUARDING ADULTS REVIEW

CASE E

TERMS OF REFERENCE

Introduction

1. The purpose of Safeguarding Adults Review (SAR) Case E is to:

    a. Establish whether there are lessons to be learnt from the circumstances of Person E and the context and manner of his death about the way in which local professionals and agencies work together to safeguard adults at risk

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

    c. Inform and improve local inter-agency practice

    d. Improve practice by acting on learning (developing best practice)

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

2. The Safeguarding Adult Review Subgroup (the Subgroup) will consider any lessons learnt by each agency in conjunction with the findings of SAR Case E to develop a single inter-agency action plan for implementation. Responsibility for driving through any required process improvements will sit with the Chair of the Telford & Wrekin Safeguarding Adults Board (TWSAB).

3. The Subgroup will establish a Safeguarding Adults Review Panel (the Panel) to overview the progress of the SAR.

Terms of Reference for the Safeguarding Adults Review Panel

4. The Panel will comprise:

Agency	Representative (Job Title)
Department of Work & Pensions	Partnership Manager – Shropshire

Telford & Wrekin Clinical Commissioning Group	Deputy Chief Officer and Executive Nurse
Telford & Wrekin Council (including Adult Social Care, Adult Safeguarding, Environmental Services and the historical Drug and Alcohol Services)	Assistant Director – Adult Social Care
West Mercia & Warwickshire Police	Detective Sergeant Statutory & Major Crime Review Unit
Midlands Partnership NHS Foundation Trust (Mental Health and the current Drug and Alcohol Service)	Head of Strategic Safeguarding
Shropshire Community Health Trust	Continence Specialist Nurse
Shrewsbury and Telford Hospital Trust	Named Nurse, Adult Safeguarding
Shropshire Fire and Rescue	Head of Prevention, Protection & Response
Telford & Wrekin Council Safeguarding Adult Board	Partnership Manager

The Panel will be chaired by Christine Morris

In exceptional circumstances, substitutes are acceptable, provided they are of equivalent seniority.

4. The Panel is responsible for:

a) Ensuring the SAR is completed within the agreed timescales

b) Finalising the Terms of Reference of the SAR

c) Ensuring that relevant agencies are informed of the requirement to complete an Individual Management Report (IMR) and Chronology

d) Quality assuring the IMRs and Chronologies and identifying any need to commission further IMRs or obtain expert legal advice

e) Ensuring that each organisation is aware of its own responsibility to implement single agency lessons to be learned, in accordance with their

internal quality assurance and governance arrangements, to ensure adults with care and support needs are safeguarded

f) Making recommendations to the Subgroup for a multi-agency Action Plan, ensuring that there is no delay in the implementation of actions which will safeguard adults with care and support needs.

g) The Panel Chair will ensure that the Overview Author has all the completed documents

h) The Panel will make decisions on if/how to involve any of Person E's wider family in the Review

i) The Overview Report, an Executive Summary and Action Plan will be presented to the TWSAB for ratification.

Terms of Reference for the Safeguarding Adults Review

Scope

5. The SAR will cover the period 1st January 2016 to 19th April 2017.

6. The SAR will specifically consider the following questions:
   - Was the manner of the death of Person E predictable?
   - Was the death of Person E preventable?
   - Were the care and support needs of Person E assessed and responded to appropriately and effectively?
   - Was self-neglect considered/identified in this case?
   - Was the Mental Capacity Act 2005 implemented effectively and appropriately?
   - How well did agencies encourage and enable Person E to engage with them?
   - When Person E did not engage or disengaged, did agencies respond appropriately and proportionately and in accordance with their current policies and procedures
   - How well were the single and multi-agency safeguarding adults procedures implemented and coordinated?

Timetable

7. The SAR will follow the following timetable:

Initial SAR Panel Meeting to set ToR etc.	17th July 2018
Telephone conference with IMR Authors if required	Wk commencing 30th July 2018
IMR writers to submit chronologies and IMRs	14th September 2018

Consideration of IMRs by the Panel	3rd October 2018 at 11am
IMR authors to submit revised IMRs*	19th October 2018
Consideration of revised IMRs by the Panel	26th October 2018 at 12.30pm
Overview Report Author to submit first draft of Overview Report	16th November 2018
Consideration of draft Overview Report by the Panel	10th January 2019, 25th March 2019, and 3rd May 2019
Overview Report Author to submit Overview Report final draft	June 2019
The Panel to agree Overview Report	10 June 2019
Submission of Overview Report and Action Plan to the Adult Learning, Review and Training Subgroup	26 September 2019
Sign off of the Overview Report and Action Plan at the Safeguarding Partnership Executive1	27 September 2019

Terms of Reference for IMR authors

Individual Management Reports

8. The following agencies have been requested to submit an IMR. Each IMR will include a chronology of the agency's involvement and brief synopsis of any relevant involvement prior to the SAR period:
    - Department of Work & Pensions
    - Telford & Wrekin Council (including Adult Social Care, Adult Safeguarding, Environmental Services and the historical Drug and Alcohol Services)
    - GP practice (CCG)
    - West Mercia Police
    - Midlands Foundation Partnership Trust
    - Shrewsbury and Telford Hospital Trust
    - West Midlands Ambulance Services (brief summary)

1 New safeguarding arrangements were published on 29 June 2019 which abolished the Telford and Wrekin Safeguarding Adults Board and established the Telford and Wrekin Safeguarding Partnership Executive in its place.

- National Probation Service (brief summary)

9. IMRs must be completed by an individual who has had no direct, or line management involvement with this case.

10. Guidance will be provided to IMR writers as required.

11. IMR writers will be asked to focus on the following *in the context of section 6 above*:

    a. Consider what lessons could or have been learned by their agency and identify any missed opportunities to safeguard Person E during the time period (include areas of good practice)

    b. Consider the role and purpose of their agency's involvement and how well it shared information

    c. Consider the effectiveness of the work of their agency with Person E and any background to engagement – to include how well it worked with the various agencies involved with Person E

    d. Consider how well their organisation understood, documented and responded to risks associated with this case

    e. Consider the quality of their agency's work and the quality of their agency's management of the case

    f. Establish how well Mental Capacity Act 2005 was understood within their agency at each point of contact and whether a Best Interest's decision was considered at any point of contact

    g. Establish the extent to which their agency adhered to local policies and procedures relevant to this case.

Scope

12. The IMRs will cover the following period: 1st January 2016 to 19th April 2017 with a brief synopsis of any relevant prior involvement.

Timetable

13. IMR writers will observe the 14th September 2018 deadline for submitting their IMR and Chronology on the templates provided.

14. All chronologies and IMRs are to be submitted electronically to the Safeguarding Boards Business Office via secure email by the deadline dates.

15. The Overview Author will be asked to focus on the following *in the context of section 6 above*:

    a. What were the lessons learnt by each agency?

    b. Consider the effectiveness of the work of the various agencies involved with both the individuals

    c. Consider the role and purpose of each agency's involvement and how well the agencies shared information

    d. Consider the quality of the work of different agencies and the quality of their management of the case

    e. Establish how well Mental Capacity 2005 was understood by the various agencies at each point of contact and whether a Best Interests decision was considered at any point

    f. Establish the extent to which the involved agencies adhered to local policies and procedures relevant to this case

    g. Explore the quality of risk assessments and how these were undertaken.

    h. The views of Person E's family *and any significant others* on the above

Scope

16. The overview report will cover the following period: 1st January 2016 to 19th April 2017.

Timetable

17. The Overview Report Author will observe the following deadlines:

- Submission of first draft 16th November 2018
- Submission of final draft in June 2019.

18. The Overview Report is to be submitted electronically to the Partnership Management Team via secure email by the deadline date.

Appendix B: Single Agency Recommendations

West Mercia Police

Shrewsbury and Telford Hospital NHS Trust

Nº	Recommendation	Key Actions	Key Outcomes	Lead Officer	Start Date	Target date to complete
1	Increased knowledge for staff regarding the mental capacity act.	Continue with on-going training throughout the Trust.	Wider use of capacity assessments and Best Interest decisions taking into consideration past/present wishes, beliefs and values.	Helen Hampson	On -going	On-going process

Telford and Wrekin Council Adult Social Care

Nº	Recommendation	Key Actions	Key Outcomes	Lead Officer	Start Date	Target date to complete
1	Safeguarding refresher training to be delivered to all adult social care staff	Training pack to be developed covering key areas of safeguarding practice	Staff will have a clear understanding of their role in relation to: • Statutory responsibilities • Making safeguarding personal • Self-neglect • Consent • Balancing duty of care with proportionality of response	VW Service Delivery Manager Community Social Work and Safeguarding	February 2018	Completed
2	Safeguarding Training and annual update training to be mandatory for all staff	Staff development team to commission bespoke Safeguarding training	As above	SC Staff development Team Manager	April 2018	April 2019

		Adult Safeguarding Service Delivery Manage to ensure training covers all practice requirements		VW Service Delivery Manager Community Social Work and Safeguarding		
3	Implement a safeguarding practice competency framework for all adult social care practitioners	Safeguarding competencies assessment tool to be developed covering key safeguarding competency requirements Monthly audits of safeguarding case files to continue	Assurance of a fully competent workforce	VW Service Delivery Manager Community Social Work and Safeguarding	April 2018	Competency Framework has been developed and implemented. All staff to complete by end of December 2018
4	External audit of the Council's adult	Nominated Senior Officers from external partner agencies to be	The organisation can demonstrate that it has a quality monitoring system	VW Service Delivery Manager Community	April 2018	Completed. No improvement recommendations

	safeguarding practice to be carried out	identified as auditors, and briefed regarding the scope and timescale for the audit	that checks policy compliance against practice. The organisation has a training plan (in line with the TWSAB programme) which ensures staff and volunteers at all levels have appropriate knowledge of Safeguarding and competencies in relation to their role The organisation can demonstrate it has embedded making safeguarding personal	Social Work and Safeguarding		made by the auditors

5	Refresh of the Adult Social Care Quality Assurance Framework	Benchmarking with other local authorities to ensure inclusion of best practice in our approach to the development and delivery of our approach to quality assurance	Implementation of a robust framework to evaluate the quality of all aspects of Adult Social Care service delivery	C H-S Service Delivery Manager Service Improvement and Efficiency	April 2018	Completed
6	Workshop on self – neglect to be delivered for all adult social care staff	Training pack to be developed covering self- neglect best practice	Staff will have a clear understanding of self -neglect and how to respond to self-neglect concerns including the interface with adult safeguarding procedures, and the range of possible legal interventions	VW Service Delivery Manager Community Social Work and Safeguarding	October 2018	End of December 2018

7	Implement a mental capacity competency framework for all adult social care practitioners	Mental capacity competencies assessment tool to be developed covering key competency requirements	Assurance of a fully competent workforce	VW Service Delivery Manager Community Social Work and Safeguarding	October 2018	End of April 2019
8	The Midlands Partnership NHS Trust to review the above recommendations and implement as appropriate with respect to the DARS Team and other areas of the service as appropriate.	Lead Designated Officer from the Trust to co-ordinate a specific action plan addressing the key learning from the IMR	Assurance of a fully competent workforce	To be determined by the Trust	To be determined by the Trust	To be determined by the Trust