Cheshire East Safeguarding Adults Board

Safeguarding Adult Review – Mervyn

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Contents

1. Introduction

1.1. Mervyn[1] was an adult at risk who lived in a privately rented property. He was admitted to the Burns Unit at Wythenshawe hospital on 24th February 2020 following a house fire. He sadly died a few days later (28th February) from the effects of smoke inhalation and severe burns. He was aged 86 and White British.

1.2. The Safeguarding Adult Review (SAR) referral was sent by a Named Nurse/Matron – Adult Safeguarding at the Hospital and is dated 12th March. The referral form records that Mervyn had no known next of kin but Cheshire Police had traced family friends. **Commentary:** the referral was submitted in a timely manner.

1.3. The referral identified concerns around high risk self-neglect and hoarding, coupled with a refusal to engage with services. It was stated that Mervyn had been referred to Adult Social Care around 12 months prior to his death. He was assessed by Adult Social Care but declined input. He was deemed to have capacity to make this decision. The referral form also stated that Cheshire Fire Service had made several attempts to provide advice around fire safety but this was also declined by Mervyn.

1.4. The Cheshire Fire Service reported that Mervyn was living in a quarter of his living room as the rest of the property was inaccessible due to hoarding. There was a motorbike in the living room. He was using an outside toilet. He slept on the sofa and the only heating was from a 2 bar electric fire which was surrounded by piles of papers. This posed a huge fire risk both to Mervyn and to his neighbours as he lived in a terraced house. His kitchen was not useable and so he cooked in a microwave in the living room. He is reported to have gone to one of his neighbours' houses every day for breakfast and to have visited a friend weekly for a meal.

1.5. The referral also observed that it had been reported to the Hospital that Mervyn's GP suspected that he had dementia but that he refused to be formally assessed for this. However, the Independent Reviewer has been told that it was a Pharmacist who had made reference to Mervyn being muddled about medication and that there had been no mention of dementia.

1.6. He was admitted to Hospital with inhalation injuries, carbon monoxide poisoning and extensive burns following a house fire. It was established soon after arrival that the injuries were too significant for him to recover from and so he was provided with supportive care focussed on maximising comfort. Mervyn's death was referred to the Coroner. At an inquest in November 2020, a verdict of accident was recorded.

1.7. The referral raised concerns around the input of the agencies involved and what appeared to be a lack of intervention, escalation and multi-disciplinary team working in a high risk situation where there was a risk to both an individual and other members of the public.

[1] Mervyn is a pseudonym.

2. Safeguarding Adult Reviews

2.1. Cheshire East SAB has a mandatory statutory duty[2] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. Cheshire East SAB has discretion to commission reviews in any other circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always appreciated[3]. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. Cheshire East SAB concluded that the circumstances surrounding Mervyn's death of met the mandatory criteria for undertaking a SAR under Section 44 of The Care Act 2014. The SAB took the decision on 7th October 2020 to undertake a review. The decision had been delayed because the referral had been misdirected to a wrong email account.

2.5. The Serious Case Group Panel, when discussing the referral, observed that Mervyn was an adult at risk whose case was not open to any agency at the time of his death. He had been referred to Adult Social Care around 12 months prior to his death by his new landlord after he had to force entry into the property and was concerned at how Mervyn was living. A home visit was conducted by a Duty Social Worker, but Mervyn declined input and he was deemed to have capacity to make this decision. Adult Social Care did not notify Cheshire Fire Service of this referral and no referral was made to the High Risk Forum. Mervyn agreed that a letter outlining support could be sent to him and this was sent following the visit.

2.6. Mervyn had no running water. He was hoarding electrical items in boxes, mechanical parts, and children's toys. He was using an outside toilet that he flushed with a bucket of water. There was no inside bathroom, the property was an early 1900's terraced house and had never had a bathroom fitted. Mervyn had lived in the property with his mother since he was born; it was unclear when his mother died but it was believed his self-neglect escalated following this bereavement[4]. He owned a car and was still

[2] Sections 44(1)-(3), Care Act 2014.
[3] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[4] Without the full name of Mervyn's mother, the GP practice has been unable to trace whether or not she was registered at that surgery.

driving up to the time of his death. The history of the tenure of the property was unclear but his landlord had bought the property with Mervyn as a sitting tenant.

2.7. The Serious Case Group Panel was told that Cheshire Fire had tried to engage with Mervyn on 9 previous occasions, almost on a yearly basis, always with no answer even though there were indications someone was inside the property or on a few occasions there was a strong verbal refusal to engage in conversation. Letters were also sent and visiting cards put through the door. When attending the fire at the property, the house was very cluttered rather than extreme hoarding. This was not rubbish, more mechanical parts, like a cluttered shed environment but inside a property. Mervyn was not believed to be a smoker. Cause of fire was a two bar electric heater setting fire to a bag of rubbish next to a sofa when Mervyn was sleeping. There were school photographs of children in the property but no records of any family so Cheshire Fire Service was unsure who the children were in the pictures.

2.8. The combined chronology contains reference to a conversation between a Hospital Consultant and Mervyn's GP, following his admission with serious burns. The Hospital has recorded that the GP suspected that Mervyn had dementia but he had refused to be formally screened for this. However, the Independent Reviewer has been told that there are no annotations from the GP practice that suggest dementia. He very rarely visited the GP but received medication for heart disease on a repeat script from the local pharmacy. There is no trace of which pharmacies Mervyn used so it has not been possible to confirm whether or not any Pharmacist had any concerns. His GP was unaware of the extent of hoarding/self-neglect.

2.9. The Panel concluded that there had been a lack of professional curiosity, no evidence of assessment of executive capacity, and no referral to the High Risk Forum. The Panel believed that there were also Housing law/tenure issues around the lack of basic facilities. The Panel felt that partners had assumed that Mervyn was making a choice about the way he wanted to live.

2.10. SABs have discretion regarding the type of review most likely to promote effective learning and improvement action to prevent future deaths or serious harm reoccurring[5]. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[6]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

[5] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office, paragraph 14.164.
[6] Section 44(5), Care Act 2014.

3. Review Process

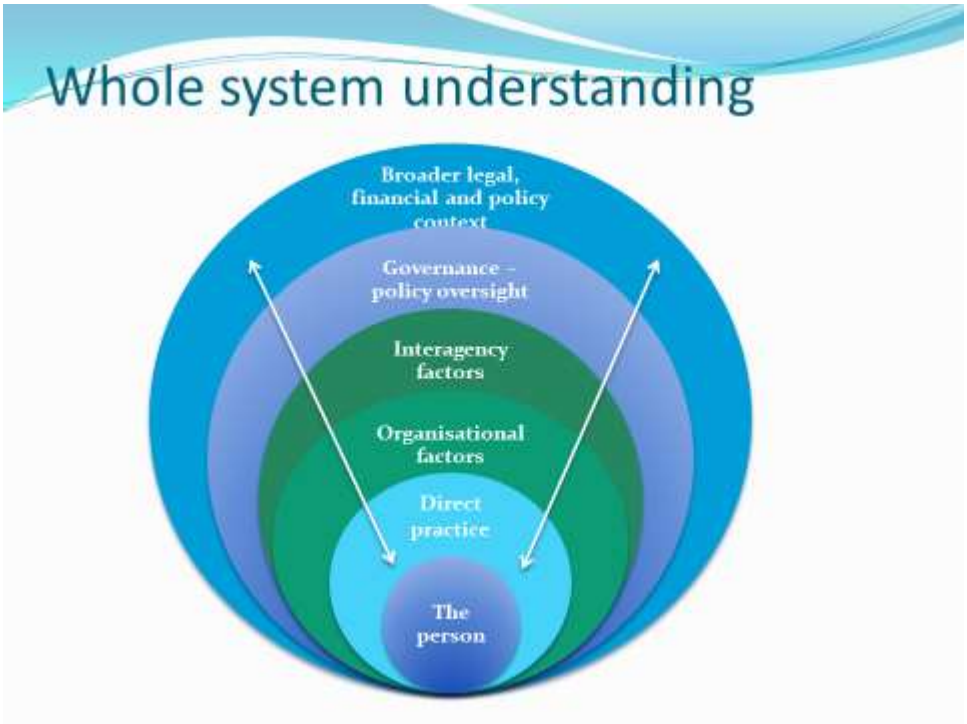
3.1. Focus

3.1.1. Specific key lines of enquiry or terms of reference were agreed for this thematic review, namely:

3.1.1.1. If there were ways agencies could have worked more effectively with regard to Mervyn to safeguard him and others.
3.1.1.2. Whether agencies could have communicated and shared information about Mervyn's circumstances more effectively and whether this case raises any general concerns about difficulties in information-sharing and communication.
3.1.1.3. If there were legal routes that could have been taken by any of the agencies that would have had a positive impact.
3.1.1.4. If there were any policy gaps that impacted on this case or on the action taken by organisations and agencies involved.
3.1.1.5. Whether there are any equality and diversity issues in relation to this case.
3.1.1.6. If there were any culture, status or reputation issues that impacted on this case.
3.1.1.7. Whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Mervyn.
3.1.1.8. The review would also be used as an opportunity to capture good practice and what worked well.

3.1.2. It was also agreed that the key lines of enquiry would explore assessment; mental capacity; use of adult safeguarding processes, especially Section 42 Care Act 2014, information-sharing, risk assessment, policies and procedures for self-neglect cases, recognition of the impact of life events and loss, and supervision and support for practitioners.

3.1.3. This review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.1.4. The information gleaned about the case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who self-neglect[7]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.2. Definitions

3.2.1. To inform the analysis, some terms will be used that require definition.

3.2.1.1. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury[8].

3.2.1.2. The Mental Capacity Act 2005 requires that there be impairment of mind and/or brain when assessing whether or not a person has decisional capacity. Disorder of mind or brain may include symptoms arising from alcohol or drug misuse[9]. There is evidence[10] that prolonged exposure to trauma affects brain development, especially on its executive, emotional and survival centres. There is also evidence that substance misuse, for example of alcohol, results in cerebral degeneration and cognitive impairment, and that nutritional deficiencies

[7] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[8] Care and Support (Eligibility Criteria) Regulations 2014.
[9] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office.
[10] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M. and Cloitre, M. (2005) 'Complex trauma in children and adolescents.' *Psychiatric Annals*, 35 (5), 390-398.

related to chronic alcohol misuse can precipitate cognitive impairment[11]. Thus, whilst language and visual/spatial awareness may be preserved, there may be impairment of executive functioning, the ability to plan, organise and implement decisions.

3.3. Methodology

3.3.1. Chronologies and IMRs were submitted by services that had been involved with Mervyn, namely:

- Cheshire East Council
- Cheshire CCG
- GP
- Pharmacy
- Cheshire Police
- Cheshire Fire and Rescue Service
- Wythenshawe Hospital (Manchester Foundation Trust)
- Landlord

3.3.2. Given the apparently limited contact that Mervyn had with services, the scope of the review covered what was known by the key services that had contact with him in the last few years of his life, with any significant earlier history also included as background.

3.3.3. The Independent Reviewer was supported by a Panel, comprising representatives from Cheshire East SAB, Cheshire East Council, Cheshire CCG, Cheshire Police and the SAB Service User Group Chair.

3.3.4. A virtual learning event was held, using Microsoft Teams, attended by practitioners and operational managers from both statutory and third sector agencies. The observations shared during those learning events have been incorporated into the analysis and recommendations that follow.

3.4. Family involvement

3.4.1. No relatives have been traced. Efforts were unsuccessful to trace and contact friends with whom Mervyn was known to have contact. It appears that he led a very socially isolated life.

[11] Restifo, S. (2013) 'A review of the concepts, terminologies and dilemmas in the assessment of decisional capacity: a focus on alcoholism.' *Australasian Psychiatry*, 21 (6), 537-540. Hazelton, L., Sterns, G. and Chisholm,T. (2003) 'Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices.' *General Hospital Psychiatry*, 25, 130-135.

4. The Evidence-Base

4.1. Reference was made earlier to research and findings from SARs[12] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

4.2. It is recommended that direct practice with the adult is characterised by the following:

4.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[13];

4.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[14];

4.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[15]

4.2.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[16], which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

4.2.5. Contact should be maintained rather than the case closed so that trust can be built up;

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[12] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[13] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[14] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[15] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

4.2.6. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[17];

4.2.7. Where possible involvement of family and friends in assessments and care planning[18] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

4.2.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[19];

4.2.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

4.2.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

4.2.11. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[20]; taking into account the negative effect of social isolation and housing status on wellbeing[21].

4.3. It is recommended that the work of the team around the adult should comprise:

4.3.1. Inter-agency communication and collaboration, working together[22], coordinated by a lead agency and key worker in the community[23] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[24]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[25];

4.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

4.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

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[17] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[18] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[19] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[20] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[21] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[22] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[23] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[24] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[25] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

4.3.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[26];

4.3.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[27];

4.3.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

4.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

4.3.8. Clear, up-to-date[28] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[29].

4.4. It is recommended that the organisations around the team provide:

4.4.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

4.4.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

4.4.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

4.4.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

4.4.5. Attention to workforce development[30] and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.5. SABs:

4.5.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[31] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[32]; strategic

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[26] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[27] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[28] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[29] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[30] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[31] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)

[32] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

agreements and leadership are necessary for the cultural and service changes required[33];

4.5.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

4.5.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[34];

4.5.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

4.5.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

4.5.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

4.6. This model enables exploration of what facilitates good practice and what act as barriers to good practice. The analysis that follows draws on information contained within the chronologies and discussions during the learning event and at panel meetings. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding is situated.

[33] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[34] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

5. Findings

5.1. Cheshire Fire and Rescue made six attempts to complete a home fire safety check. They were prompted by data from the NHS that Mervyn was over 65. The first occurred on 26th February 2008. Mervyn was seen and declined the assessment. The second attempt was made on 25th October 2012. On this occasion there was no response and a card was left requesting that Mervyn make contact. There was no response. The same occurred when a fire safety check was attempted on 26th July 2013.

5.2. On the final three occasions when a fire safety check was attempted, Mervyn was seen and gave a verbal refusal. These visits occurred on 11th February 2015, 21st January 2016 and 21st January 2018. No further visits were made.

5.3. **Commentary:** it does not appear that any concern was referred as a result of the repeating pattern of verbal refusals. It may have been that the extent of the home conditions were not immediately obvious to the operational crews who visited. Equally, as will be seen below, both Mervyn's landlord and Adult Social Care had some knowledge of the circumstances in which he was living and no referrals appear to have been sent to Cheshire Fire and Rescue, or information sought from the Service.

5.4. Cheshire Police had limited contact with Mervyn. In 2013 he was interviewed concerning an incident alleged to have taken place with a person within a family with whom he associated. He was assessed as having capacity to engage with the interview and therefore an Appropriate Adult was not present. The CPS decided that there would be no further action. The final involvement of Cheshire Police occurred on 24th February 2020 when a neighbour reported the fire. **Commentary:** Cheshire Police representatives at panel meetings have speculated that Mervyn may have become more socially isolated after the 2013 episode but this hypothesis cannot be proven.

5.5. Medical records for 2018 indicate that primary care practice requirements were met. Mervyn was offered but declined seasonal influenza vaccination. He was reminded of his medical review in April 2018 and this took place with the Practice Pharmacist on 2nd May. He was observed to have an ankle swelling and an appointment was made with his GP. His blood test results were reviewed on 22nd and 23rd May, and he was seen by his GP on 1st June. He was noted to have chronic kidney disease. His Statin was changed. Repeat blood tests were planned to monitor kidney function. **Commentary:** this was good practice.

5.6. On 24th July 2018 the results of a repeat kidney function test were reviewed, showing signs of improvement. On 29th September 2018 he attended and accepted his seasonal influenza vaccination. Medical records fall silent then until October 2019.

5.7. On 30th October 2019 Mervyn attended a medication review with the Practice Pharmacist. No concerns were recorded. He accepted the seasonal influenza vaccination. Blood tests were ordered. On 1st November the blood test results were reviewed. An urgent further review was recommended since hypercalcaemia[35] had been detected. On 4th November, his vitamin D results were noted to be low and an

[35] High calcium levels, the symptoms for which include abdominal and bone pain, confusion, depression and weakness.

urgent review was recommended. On 3rd December Mervyn attended a review with his GP. Improved fluid intake was advised. Further blood tests were requested to exclude other worrying causes of hypercalcaemia. On 5th and 6th December it was noted that his blood test results showed some improvement but calcium levels were still raised. Serum protein electrophoresis was normal[36]. A letter was sent to Mervyn on 16th December indicating a plan for review and consideration of referral to nephrology. **Commentary:** the responses to concerns about his physical health demonstrated good practice. However, primary care records contain no entries for 2020, which seems to suggest that the plans outlined in December 2019 were not followed through.

5.8. The first involvement of Adult Social Care is recorded on 4th February 2019. A safeguarding referral had been received from Mervyn's landlord. He was concerned about Mervyn and the condition of the property. He had struggled to gain access in the past but had forced entry to find the property cluttered and in a poor state. There was no answer when a Social Worker visited the property on 6th March. The Social Worker observed a "for sale" sign at the property and was concerned about the condition of a car and the letterbox full of letters. The following day the Social Worker spoke with the landlord on the telephone. He was apparently less concerned as he had recently seen Mervyn who appeared better and more active. Mervyn had told him that he had recently recovered from influenza. The landlord noted that Mervyn always refused help but had mentioned struggling with the garden.

5.9. On 12th March the Social Worker spoke to Mervyn on the doorstep; he refused to let her in. He advised that he lived downstairs with no bathroom, no hot water, a toilet outside, and an electric heater. He stated that he had a network of friends for socialising and meals, using his car to go shopping. He appeared in a poor state but there was no evidence of memory issues or lacking capacity. The Social Worker followed up with a letter the same day with contact details for Adult Social Care. The safeguarding referral was closed on 13th March because Mervyn had declined the offer of services. There was no further involvement from Adult Social Care until 24th February 2020 when an adult safeguarding concern was referred by the Hospital to which Mervyn had been admitted following the fire at his home.

5.10. **Commentary:** The landlord is to be commended for referring an adult safeguarding concern. The Social Worker made contact with the landlord who had referred the safeguarding concern; this was good practice. The Social Worker obtained some background information from the landlord and also ascertained Mervyn's wishes, in line with Making Safeguarding Personal; again, good practice.

5.11. **Commentary:** however, there are several practice shortfalls at this point, as reference back to the evidence-base in the previous section of this review will indicate. Individuals who self-neglect (lack of personal care and/or living with hoarding) often refuse services initially; time and persistence are required to establish a relationship of trust. The case was, arguably, closed prematurely with the result that risks were not fully assessed. One possible way in would have been to have offered support with the back garden, to establish a relationship. Secondly, a letter was sent to Mervyn even though the letterbox had been observed full of unopened letters; this might have indicated that communication by letter would be unlikely to prove effective.

[36] Used to identify types of cancer and serum protein diseases.

5.12. **Commentary:** thirdly, Adult Social Care in its contribution to the chronology can find no evidence of analysis as to why the safeguarding concern was not progressed to an enquiry. Section 42(1) outlines the three criteria for an enquiry, namely an adult appearing to have care and support needs, experiencing abuse and neglect (including self-neglect) and unable to protect themselves from that abuse/neglect as a result of their care and support needs. It would appear that there was sufficient evidence of all three criteria. That Mervyn was felt to have capacity and was refusing services is not relevant to the decision about whether to progress to an enquiry under section 42(2) of the Care Act 2014. Moreover, a care and support assessment can also be undertaken when the circumstances justify it, even though the individual is declining to engage[37].

5.13. **Commentary:** Adult Social Care, in its reflections on the chronology, has questioned whether the Social Worker talked to him about risks to see if he grasped them. As the evidence-base highlights, professional curiosity is key and robust risk assessments advised. Moreover, referral to Cheshire Fire and Rescue Service was indicated by what the Social Worker had been able to observe. Adult Social Care has also questioned whether discussions took place about the Social Worker continuing to visit to build trust and a relationship, whether a multi-agency meeting was contemplated and referral to hoarding specialists using a self-neglect pathway; all highlighted by the aforementioned evidence-base.

5.14. The chronology then moves to events on and after 24th February 2020, recorded by Manchester University NHS Trust (MFT). Mervyn was admitted with burns to his lower limbs and inhalation injury – carbon monoxide poisoning. The extent of his injuries was severe and he was transferred from the Emergency Department to ICU. A medical and social history was obtained from Mervyn, including his address, date of birth and the absence of family or next of kin. The fire had probably started when an electric heater ignited papers close by.

5.15. It was noted that he exhibited some confusion. The Consultant liaised with the GP and the Hospital's submission to the combined chronology refers to the GP suspecting that Mervyn had dementia but that he had refused screening. Feedback to the Independent Reviewer, however, indicates that there is no mention of concerns about possible dementia in GP practice records. Resuscitation was discussed with Mervyn and the extent of his injuries. Mervyn agreed that he wanted to be made comfortable. The plan was to transfer Mervyn to the Burns Unit, to administer pain relief, to offer Macmillan support and to complete medical illustrations. His case was reviewed by a Burns Consultant. Discussions amongst the medical staff concluded that palliative care was in his best interests as he was unlikely to survive his injuries. It was observed that Mervyn was giving confused answers and did not appear to understand the seriousness of his situation.

5.16. Mervyn was transferred to the Burns Unit the same day and the Hospital submitted an adult safeguarding concern referral to Cheshire East Adult Social Care for significant burns and a history of self-neglect. The plan was to make him comfortable, prescribe anticipatory medications, and begin the documentation for priorities of care for a dying person. Mervyn declined referral to the Hospital Chaplaincy.

[37] Section 11 Care Act 2014.

5.17. On 25th February MFT's chronology indicates a multi-disciplinary care assessment and delivery record. Mervyn had become more breathless and secretions were building up. He was requiring more mouth care and suctioning due to black soot. He died later. A friend who had been identified as a contact was notified.

5.18. **Commentary:** MFT's referral of an adult safeguarding concern was good practice. Good medical and nursing care was provided.

5.19. Mervyn's landlord was contacted when the combined chronology was being compiled. He had been the landlord until the property was sold in an auction in early 2020 with Mervyn as a sitting tenant. The landlord had offered to sell the property to Mervyn, and also to move him into an adjacent property while renovations were undertaken. Mervyn had refused both offers.

5.20. Mervyn was apparently born in the property and had lived there with his mother until she passed away. He received Housing Benefit. The landlord had been was worried about the state of the property and was concerned about the action which could be taken against him but Mervyn was adamant he would not move. The landlord was not aware of any family members. When he had visited the property, he had managed to get in a few times but Mervyn was always reluctant to let him in. There was a motor bike in living room and children's toys; he thought he was keeping things for other people to sell at car boot sales. The landlord advised him there was a fire risk and was concerned about the deterioration of the property and Mervyn's condition. After he sold the house, he saw him occasionally but only to make general passing comments and conversation.

5.21. In February 2019 when the landlord was able to gain access, the house was a tip, Mervyn was sleeping in a chair, with no food. The landlord offered to get a doctor, upset about his condition, but Mervyn refused all offers of assistance. The landlord was so concerned that he requested the Council to visit. After that, there might have been some improvement in the state of the house internally. However, the landlord also thought that Mervyn was becoming confused, judging by some interactions with him, for instance when the landlord brought in contractors to repair the roof and manage trees and ivy in the garden.

5.22. **Commentary:** there are parallels between the landlord suggesting increasing confusion and the GP's report to MFT of the possibility of onset of dementia. Attachment to place is a common feature in cases of self-neglect; also, attachment to possessions, some of which appear to have been connected with Mervyn's earlier employment. The significance of his family background was known to the landlord but not, perhaps, to practitioners who saw him, perhaps because involvement was episodic and, in the case of Adult Social Care, time limited.

6. Revisiting the Terms of Reference

6.1. The terms of reference, outlined in section 3.1.1, included a focus on good practice. Where appropriate, the commentary in section 5 has identified good practice.

Working Together

6.2. The terms of reference question whether agencies could have worked together more effectively, sharing information and communicating about their attempts to engage with Mervyn.

6.3. Cheshire Fire Service did not pass on information to any other agency following their abortive attempts to complete fire safety checks. For example, Housing Standards have no record of the repetitive pattern of unsuccessful fire safety check visits. Whilst information-sharing may not ultimately have led to the involvement of a hoarding service, inter-agency communication may have led to further efforts to engage with Mervyn.

6.4. That Cheshire Fire Service did not share information about the failed attempts to complete fire safety checks may have been influenced by the fact that their visits were initiated as a result of Mervyn's age rather than referral received. It may have also been because it would not have been possible to have seen inside the house if Mervyn had closed an inside door into the hallway when opening the front door[38]. Nonetheless, the evidence-base (section 4) highlights the importance of professional curiosity; the number of unsuccessful visits might have prompted contact with other services to ascertain if they were involved.

6.5. At the learning event it was noted that Fire and Rescue Services do not have a power of entry in situations akin to this case. It is possible, therefore, that people can become lost to the system. It was also observed at the learning event that Fire and Rescue Services can add a flag to their record system.

6.6. On the theme of agencies working together, it does not appear that Adult Social Care shared information with Cheshire Fire Service. At the learning event, reinforcing the importance of professional curiosity, it was observed that the absence of previous referrals and therefore knowledge about Mervyn was unusual; normally in Adult Social Care's experience, there is a longer history of attempted engagement.

6.7. Mervyn's GP may have had concerns about the onset of dementia but this apparently did not trigger consideration of his care and support needs and, therefore, referral for assessment to Adult Social Care. It appears, however, that the GP had never visited Mervyn at home; as observed at the learning event, since all contact was through clinic appointments, where he was not a regular attender, needs and risks could have been missed.

6.8. Each service appears to have worked in isolation. At the learning event a view was expressed that there are shortfalls in collaborative working in Cheshire East, and that more opportunities should be created to enable practitioners and operational managers to meet. Whether through workshops, panels or a forum for case

[38] Information received from Cheshire Fire Service based on their investigation of the fire.

discussion, such opportunities were seen as important in helping practitioners and managers to understand roles, responsibilities and available legal powers and duties.

Legal Powers and Duties

6.9. At the learning event it was noted that Cheshire Fire Service do not have a power of entry in situations of hoarding, however extreme. Given the risk of fire to those in the property and those living close by, this is a legal lacunae that has been noted in other SARs[39].

6.10. At the learning event it was noted that there was no gas in the property so annual gas checks were unnecessary. Five-yearly checks of electricity were only introduced in 2020, too late to have had any significance in this case. However, what this analysis highlights is the importance of SABs engaging with utility companies since their staff who read metres and conduct safety checks are in the forefront of prevention and protection from self-neglect. The same applies to Royal Mail, whose staff deliver post and may have seen Mervyn's letter box full of unopened mail. Other SARs[40] have drawn similar conclusions.

6.11. Housing Officers do have powers of entry when the condition of a property causes significant concern but this may not be widely known across services with responsibilities for safeguarding. Powers available to Environmental Health Officers may be more widely known. At the learning event it was suggested that practitioners in Housing Standards and Adult Social Care had a lack of knowledge and understanding of each other's powers and duties. The evidence-base (section 4) stresses the importance of legal literacy.

Policy gaps

6.12. During panel meetings and at the learning event it was acknowledged that Cheshire East SAB has published procedures on self-neglect. The procedures are currently being updated and it was agreed that the inclusion of a section on available legal rules would be beneficial.

6.13. On closer scrutiny the procedures refer to a multi-agency policy for managing risk in self-neglect (including hoarding) cases where the adult at risk has been assessed as having decisional mental capacity. Cases assessed as high risk can be referred to a forum led by the SAB. Cases assessed as low or medium risk may be referred to a multi-agency hoarding forum led by Strategic Housing in the local authority. A short report for 2017/2018 seen by the Independent Reviewer notes that 32 cases were referred and that the forum approach facilitated shared risk assessments, bespoke interventions by Cheshire Fire Service or by Police Community Support Officers, and engagement with faith groups and local charities.

6.14. Mervyn was not referred to either forum. It has been suggested at panel meetings that the referral pathway may be unclear for practitioners and that referrals

[39] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[40] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

are not seen as a routine part of working with people who self-neglect and/or hoard. At the learning event, some of those attending from outside Adult Social Care expressed doubts about how to raise concerns and about what level of risk or concern should prompt referral. It was suggested that the forums are not experienced as accessible and that their focus is too narrow, with hoarding foregrounded. It was also suggested that the dissemination of information about the process and how to use it would be helpful.

6.15. As already noted, procedures are being updated. In addition to outlining the legal powers and duties available to such agencies as Environment Health, Housing, Police and Adult Social Care, consideration should be given to producing a more extensive policy and set of procedures[41] that would cover both people with and without decisional mental capacity, the different types of risk management forums available and the interface between them, and the relationship between the Section 42 Care Act duty to enquire and the other mechanisms for sharing information and agreeing an approach to risk mitigation and management. Such a policy and set of procedures could also include care and support, safeguarding and risk assessment templates[42].

6.16. In addition to the terms of reference, key lines of enquiry were also identified (section 3.1.2).

Assessment and risk assessment

6.17. At the learning event Cheshire Fire Service participants agreed that the Service would always attempt engagement and try to ascertain if other agencies were involved. The latter does not appear to have happened in this case. There were six attempts to engage with Mervyn. The Independent Reviewer has been told that Cheshire Fire Service would not keep a record of what was observed during unsuccessful visits other than a note that an attempt had been made to engage. This approach would seem to limit the scope of (risk) assessment. Apparently also, a card is only left after the second visit, with details of how to make contact, and then a period of time is allowed to elapse before trying to engage again. An approach based on risk is balanced against not wishing to intrude when someone does not wish to engage.

6.18. At the learning event participants from the CCG observed that the GP Surgery did send letters encouraging Mervyn to engage and that this was common practice. Unbeknown to the GP practice, however, was that his letter box had been observed to be full of unopened mail. Other SARs have highlighted the risks of relying on letters[43]. A flag is available for electronic recording system for high risk patients but those at the learning event questioned whether there was sufficient outreach to high risk patients.

6.19. Adult Social Care did not persist with attempts to engage Mervyn; rather, his case was closed. At the learning event it was observed that care and support

[41] See, for example, Norfolk SAB *Self-Neglect Hoarding Strategy and Guidance Document*.
[42] See, for example, https://www.voicesofstoke.org.uk/care-act-toolkit and https://issuu.com/voicesofstoke/docs/safeguardingtoolkit
[43] See, for example, Salford SAB (2019) *SAR – Andy*. Also Salford SAB (2020) *SAR – Eric*.

assessment could have continued, using the power in section 11 Care Act 2014. It was also noted that Adult Social care often received referrals at a crisis point and that little prevention work was undertaken. Mervyn's situation was perhaps one example where time should have been allocated in an attempt to establish a relationship of trust, to address his social isolation and to focus on prevention and mitigation of risks as they were uncovered. Indeed, it was acknowledged at the learning event that Mervyn's case was one example where time was required to build a relationship, not least because of the possible underlying impact of trauma. It was also acknowledged, however, that the volume of work being referred into Adult Social Care had meant that choices were being made to prioritise high risk cases. Two points arise here, however. The first is that cases should not be closed without information-sharing between agencies in order to assess level of risk. The second is that, if Adult Social Care is not in a position to undertake longer-term prevention and engagement work, might another service be commissioned to provide this?

Mental capacity

6.20. In relation to persisting with attempts to engage, those attending the learning event expressed a particular dilemma, namely whether continuing to visit after a person had declined assessment and/or support was an appropriate expression of a duty of care or an intrusion with respect to their right to private and family life[44]. At a panel meeting, this dilemma was expressed as a tension between adopting a strengths-based approach and taking time to build a relationship that would then facilitate exploration of a person's life journey and its impact on the "here and now."

6.21. Those at the learning event also explored and questioned the narrative of lifestyle choice. It was observed that there was insufficient professional curiosity. Rather than immediately foregrounding his autonomy, further outreach may or may not have led to doubts concerning whether Mervyn had decisional capacity and whether his executive functioning was impaired.

6.22. NICE[45] has advised that "*practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction – for example people with traumatic brain injury. Structured assessments of capacity for individuals in this group (for example, by way of interview) may therefore need to be supplemented by real world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability."*

6.23. SARs have also highlighted the importance of assessing executive functioning. For example, "*To assess Ruth as having the mental capacity to make specific decisions on the basis of what she said only, could produce a false picture of her actual capacity. She needed an assessment based both on her verbal explanations and on observation of her capabilities, i.e. "show me, as well as tell me". An assessment of Ruth's mental capacity would need to consider her ability to implement and manage the consequences of her specific decisions, as well as her ability to weigh up information and communicate decisions*.[46]"

[44] Article 8 European Convention on Human Rights and Fundamental Freedoms.
[45] NICE (2018) *Decision-Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[46] Plymouth SAB (2017) *SAR – Ruth Mitchell*.

6.24. Noteworthy also at this point is a statement in the SAB's multi-agency policy for managing risk in self-neglect (including hoarding) cases. This refers to people's right to make unwise decisions where there is capacity. It would be more accurate to quote precisely what the Mental Capacity Act 2005 states and to clarify precisely how the Code of Practice that accompanies the Act[47] amplifies the five statutory principles. Accurate translation into local policy and practice of the principles is essential.

Use of safeguarding processes

6.25. When revising the SAB's self-neglect, it would be helpful to indicate when adult safeguarding concerns referred using the criteria in Section 42(1) Care Act 2014 should prompt an enquiry (Section 42(2)). Some concern was expressed at the learning event that referred self-neglect concerns were not channelled into adult safeguarding. Other SARs[48] have also reported this concern as well as finding that opportunities were missed to refer adult safeguarding concerns when the criteria in Section 42(1) appeared to have been met.

6.26. Concern has already been recorded from panel and learning event discussions that greater use could be made of multi-agency meetings, whether using Section 42(2) Care Act 2014 or the forums that comprise part of the SAB's self-neglect procedures. In any revision of SAB procedures, it would be helpful for agencies to clarify how decision-making regarding whether or not the local authority will undertake an enquiry, or cause one to be made (section 42(2)) can be challenged. At the learning event views were expressed that the forums had provided useful opportunities to share responsibility for decision-making about risk but individual agencies should provide feedback on the actions they had taken subsequently and follow-up meetings should be arranged to monitor the effectiveness of attempts at risk mitigation.

Organisational support for members of the team around the person

6.27. Those attending the learning event commented on how challenging some cases of self-neglect can prove for the practitioners involved. Peer and manager supervision was seen as an important forum within which to talk through case scenarios. Supervision and multi-disciplinary meetings were seen as useful opportunities to draw on different knowledge, experience and skills in order to identify options about how to intervene.

6.28. Panel members also endorsed the importance of support for staff working with challenging and complex cases. Panel members phrased this as needing to ensure that staff were working within a psychologically-informed environment[49]. It was noted that, before the onset of the Covid-19 pandemic, a peer hoarding support group had been established. The advent of working remotely had disrupted this initiative.

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[47] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office.

[48] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS. See also City of London and Hackney SAB (2021) *SAR – MS*.

[49] Or culture to use the term in the terms of reference.

6.29. Those attending the learning event also expressed the view that future training should focus on complexity, for example with respect to mental capacity assessment.

SAB governance

6.30. Although the terms of reference and the key lines of enquiry did not explicitly foreground the contribution of the SAB to service enhancement, this SAR has shone some light both on the contribution of the SAB hitherto with respect to working with adults who self-neglect, and where a strategic focus could be helpful going forward.

6.31. The SAB has run a Hoarding Conference and has foregrounded self-neglect and hoarding in its newsletters. The local authority's membership of Research in Practice has meant that it has been possible to commission outside trainers to facilitate workshops on the best evidence for working with adults who self-neglect. The SAB has undertaken deep dives into cases and invited practitioners to SAB meetings to discuss cases. This has enabled senior leaders across partner agencies to be aware of the challenges often involved.

6.32. However, Mervyn's case has prompted questions about how partner agencies can best respond when people are socially isolated. Both the learning event and the panel meetings have explored how the SAB might seek to raise awareness amongst third sector organisations and faith groups of adult safeguarding in general and socially isolated individuals in particular. This SAR has provided an opportunity to consider the role of Police Community Support Officers, with their community-facing remit, and whether there is more that they can do to reach out to individuals who are rarely seen. Their training and supervisory support is important to ensure that they are aware of signs of abuse and neglect (including self-neglect) and know the pathways for referring adult safeguarding concerns[50].

6.33. This SAR has also provided an opportunity to reflect on awareness-raising with the Post Office and with Utility Companies[51], and amongst private and social landlords, again so that they are cognisant of signs of abuse and neglect (including self-neglect) and know the pathway for referring adult safeguarding concerns.

[50] See Leeds SAB (2020) *SAR – Mr Mrs A*.
[51] See Herefordshire SAB (2020) *SAR – Samuel*.

7. Conclusion and Recommendations

7.1. Contact with Mervyn was limited. Nonetheless, review of the work attempted with Mervyn has enabled the spotlight to be shone on work with adults who self-neglect (including hoarding) more generally. His "human story" has enabled those who have participated in this review to express professional curiosity about how effectively adult safeguarding systems perform.

7.2. Cheshire East SAB has clearly engaged with self-neglect. It has sought assurance through the collection and analysis of data, through a conference and training it has promoted learning and development, and it has developed procedures. Nonetheless, this review has identified the need to further develop the procedures and to consider how to raise community awareness in order to prevent or safeguarding people from the risks associated with self-neglect.

7.3. Data seen by the Independent Reviewer indicate that there has been a marked increase in adult safeguarding referrals (Section 42(1) Care Act 2014) where hoarding and self-neglect generally are the primary causes of concern.

	April 2019-March 2020	% of all referrals	April 2020-October 2020	% of all referrals
All adults	119	7%	339	16%
Adults 65+	81	3%	189	7%

7.4. There has also been an increase in the number of adult safeguarding enquiries (Section 42(2) Care Act 2014).

	April 2019-March 2020	% of all enquiries	April 2020-October 2020	% of all enquiries
All adults	25	2%	22	2%
Adults 65+	10	2%	14 (to September 2020)	2%

7.5. As at 31st October 2020, there were 15 open Section 42 enquiries involving self-neglect and adults 18+, representing 4% of all open enquiries. There were 8 open cases involving adults 65+, representing 3% of all open enquiries.

7.6. These figures put into context the concerns expressed, especially during the learning event, about the challenges presented when working with complex cases involving self-neglect.

7.7. This SAR has analysed how practitioners and services worked with Mervyn through the lens of an evidence-base for best practice. **Recommendation One:** Cheshire East SAB should consider undertaking an audit of self-neglect cases in order to identify the degree to which practice corresponds with the components of the evidence-base.

7.8. Self-neglect procedures are currently under review. **Recommendation Two:** Cheshire East SAB, in revising its self-neglect procedures, should consider providing more

extensive guidance that corresponds with the components of the evidence-base. This would include a section on available legal rules and templates to assist with risk assessment, care and support assessment and safeguarding decision-making. It should include guidance about alternative ways of attempting to engage when people do not attend appointments or respond to offers of support. It should encourage trauma-informed practice.

7.9. Mervyn was socially isolated. The conditions in which he was living were barely known, other than to the landlord. **Recommendation Three:** Cheshire East SAB should consider how to raise community awareness about socially isolated people who may be at risk of abuse and neglect (including self-neglect) and how to ensure that private and social housing landlords, along with staff working for the Post Office, Utility Companies and delivery services have an understanding of adult safeguarding and knowledge of referral pathways.

7.10. It is clear from the data presented above that the majority of referred adult safeguarding concerns do not progress to an enquiry. In Mervyn's case it is arguable that there was a missed opportunity to refer an adult safeguarding concern when he declined the Social Worker's offer of care and support assessment. **Recommendation Four:** Cheshire East SAB should consider undertaking an audit of decision-making surrounding Section 42 Care Act 2014.

7.11. Self-neglect cases often raise complex challenges relating to assessment of mental capacity. Participants at the learning event referred to such challenges, captured in the narrative about lifestyle choice, and expressed the desirability for case law updates and further training opportunities. **Recommendation Five:** Cheshire East SAB should consider including case law updates in future newsletters and should ensure that local guidance and learning opportunities accurately present the Mental Capacity Act 2005 principles and provisions, and cover executive as well as decisional capacity.

7.12. There does not appear to have been any follow-through when Mervyn did not apparently respond to the communicated need to review the results of medical tests. **Recommendation Six:** Cheshire East SAB should consider whether it is necessary to review with the CCG the guidance given to GPs and other health care providers regarding outreach to patients at risk and/or with complex presentations when scheduled appointments and/or health check reviews are missed.

7.13. This SAR is not alone in highlighting the risks of fire deaths as a result of hoarding. In this instance, Cheshire Fire Service were unaware of the extent of the risk, partly because information derived from the landlord was not shared. In other cases, Fire and Rescue Services have been able to complete fire safety checks and to take fire prevention steps, but individuals have still died as a result of fire. **Recommendation Seven:** Cheshire Fire Service should consider sharing the findings of this review with other Fire and Rescue Services to prompt a whole system conversation about what can be learned from SARs involving fire deaths and whether to recommend any changes in procedures, practice and/or law. **Recommendation Eight:** Cheshire East SAB should consider reinforcing through procedures and multi-agency training a whole system approach, that involves information-sharing and multi-agency meetings, when assessments and/or services are being declined, and/or when individuals appear to be at risk of abuse and neglect (including self-neglect).