Safeguarding Adult Review
Overview Report in respect of

‘Dorothy’

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Contents

1. Introduction

This case review focuses on the case of Dorothy. Dorothy was a 77 year old female who died in January 2019. At the time of her death she lived with her daughter, 47 years, in Peterborough.

After being found unresponsive by her family, Dorothy was admitted to Peterborough City Hospital in January 2019 and died on the same day. She had a large open wound from an untreated breast cancer tumour which had become necrotic with metastatic deposits throughout both lungs.

She also had several other sores consistent with being sedentary in one position for large periods of time. She had a small bruise on her head which was caused by a fall. Her feet were soft, white and wrinkly as if exposed to the cold or wet for long periods of time. She also had a bedsore to the right side of her hip.

2. Methodology

Following the death of Dorothy, Cambridgeshire Constabulary completed a referral to the Adult Safeguarding Board's Safeguarding Adult Review (SAR) sub-committee for consideration of the completion of a SAR. Safeguarding partners were requested to provide relevant information and the case was considered by the SAR subcommittee in 2019.

When all of the information was obtained there was a unanimous decision by partners that the case did not meet the criteria for a statutory Safeguarding Adult Review. However, it was felt that a review of the case could provide some learning for those agencies involved with Dorothy before her death and wider safeguarding partners.

Reviews should be proportionate to the complexity and nature of the particular case. In this case the review panel decided that a proportionate and strength-based review, using chronologies and a facilitated agency meeting to draw out the good practice and areas for learning would be used.

3. Scope of the review

This case review is focused on the period of time from November 2016 when Cambridgeshire Fire and Rescue Service attended the property of Dorothy and subsequently made a referral to Peterborough Adults Social Care, until Dorothy's death in January 2019.

Few agencies were involved with Dorothy, consequently little is known about her or her daughter. Cambridgeshire Fire and Rescue Service visited Dorothy in November 2016 due to her fire alarm sounding for an hour. This visit resulted in a safeguarding referral to the housing provider and Adult Social Care. The referral was in respect of concerns for Dorothy's daughter. They visited again with the housing provider at the end of November.

Dorothy displayed hoarding behaviours and the housing provider attempted to support Dorothy to address this due to the fire risk that was posed to the other residents residing in the properties either side of Dorothy and her daughter. In February 2018, Peterborough City Council Homelessness team became involved as Dorothy and her daughter were facing homelessness as a result of possible eviction by the housing provider. Both agencies made further attempts to support Dorothy and her daughter to clear the property but had limited success.

Contact was made with Adult Social Care on seven occasions during the review period in relation to either Dorothy or her daughter, as well as a number of referrals made previous to

the review period. Dorothy was deemed to have capacity following these earlier referrals and the concerns referred to Adult Social Care did not meet the safeguarding criteria.

Dorothy had very little contact with her GP. She was last seen in July 2008 and she was asked to follow up a month later, but she did not do so. In December 2016, as a result of the safeguarding referral made by the Fire Service, a community matron was requested to visit Dorothy. There is no record that this happened.

The East of England Ambulance Service and Peterborough City Hospital were only involved on the day of Dorothy's death.

4. Summary of Agency Involvement

2016

Cambridgeshire Fire and Rescue Service attended the property of Dorothy on 5th November 2016 due to the fire alarm sounding for an hour. Dorothy and her daughter were not present, but the Fire Service noted 'severe hoarding' and restricted access to the property as a result. Referrals were made to Adult Social Care and the housing provider by the Fire Service.

The housing provider made a home visit on 29th November and offered support to Dorothy regarding the home environment and the fire risk posed by the level of clutter. Dorothy was described in their records as being 'verbally abusive' and declined the offer of support.

Adult Social Care completed a joint home visit with the housing provider on 8th December 2016 following discussions between the two agencies regarding the consideration of eviction by the housing provider due to the state in which the property was being kept. There was also discussion regarding Dorothy's daughter's learning difficulties and her potential needs. During the home visit, support was offered to Dorothy to reduce the level of clutter within the property which was again declined. Dorothy and her daughter were, described in Adult Social Care's records as being verbally abusive which prevented either of the professionals from speaking with Dorothy's daughter alone to assess her needs. It was agreed that housing enforcement action would continue, and safeguarding would close.

The housing provider continued to visit the property in respect of Dorothy's hoarding behaviour: on 22nd December 2016, the clutter image rating tool was used to assist in explaining to Dorothy the level to which the property needed to be cleared. It was noted that there were pets present in the property. A letter was provided stating that a Notice Seeking Possession would be served due to the condition of the property.

2017

The Notice Seeking Possession was then served on 10th February 2017.

A further home visit was conducted by the housing provider on 23rd February where it was noted that there had not been any improvement in the condition of the property and the consequences of this were explained to Dorothy. A skip was offered but refused by Dorothy and she was again recorded as being verbally abusive.

Contact between the housing provider and Cambridgeshire Fire and Rescue Service on 8th March 2017 agreed that a home visit should be undertaken by the fire service in six weeks to determine whether progress was being made in respect of decluttering the property.

The housing provider then visited the property on the same date and observed some progress in terms of the cleanliness of the property and set further targets with Dorothy to reduce the level of clutter.

On 16th March a joint home visit was undertaken between the housing provider and a Homelessness Prevention Officer from Peterborough City Council. Some small improvements were noted, and further targets were set with Dorothy. However, by the next visit by the housing provider on 24th March, progress to clean and declutter the property had halted, although on this occasion Dorothy did accept support in cleaning and clearing areas of the property and further targets were set.

Four further visits were made to the property by the housing provider in April and May 2017. On one occasion Dorothy and her daughter were not at home, but on the three occasions where the property was seen, there was deemed to be little to no improvements being made in the condition of the property.

During a further home visit on 6th June by the housing provider the property was recorded as being 8 to 9 on the clutter image rating tool which uses ratings from 1-9. It was noted as 'filthy' and the garden was recorded as being 'overgrown'. A further visit was undertaken by the housing provider three days later and it was noted that the condition of the property remained the same. Again, targets were set.

On 19th June a letter was sent to Dorothy outlining impending court action regarding the property. A further home visit was conducted on 30th June where it was noted that no progress was being made to declutter the property and the clutter image rating remained at 8-9.

Two visits were made by the housing provider in September 2017 to the property, both record no progress as having been made and the clutter image rating remaining the same at 8-9. This situation is recorded by the housing provider as having remained the same throughout various visits in October 2017. On 20th October two sacks of rubbish were removed from the property by Dorothy's daughter during a visit undertaken by the housing provider.

Four home visits were then undertaken by the housing provider in November 2017. Dorothy and her daughter were not at home on one occasion. On another the property was noted to be in the same condition as on previous home visits. On two of the visits, the Neighbourhood Manager offered to refer Dorothy to the housing provider' Specialist Intervention Team who could provide more intensive support in improving the condition of the property. This offer was not accepted on either occasion.

2018

The housing provider visited the property again on 18th January 2018 and found there to be no further improvement in the condition of the property. A referral to Adult Social Care was made regarding concerns for Dorothy and her daughter and their potential eviction from the property due to its condition. No action is recorded as having been undertaken by Adult Social Care in response to this referral. The housing provider also contacted Cambridgeshire Fire and Rescue Service, as well as Peterborough City Council's Homelessness Team. All three agencies shared concerns regarding the restricted access to basic facilities within the property such as washing and cooking as a result of Dorothy's hoarding behaviour. A joint visit between the housing provider and the Homelessness Team was arranged to offer further support to reduce the level of clutter in the property.

This home visit was completed on 16th February. It was recorded that Dorothy was initially verbally abusive towards the professionals from the housing provider and the Homelessness Team but that once the seriousness of the situation was explained to her, she was willing to engage with the Housing Solutions Officer. Photos were taken of the property which was described as 'in very poor condition, unsanitary and extremely cluttered'. It was also recognised that Dorothy and her daughter had possible learning difficulties and were 'struggling to cope', although they continued to refuse offers for support and were difficult for agencies to engage. A follow up visit was arranged, and targets were set to clear the property.

On 20th February, the housing provider informed the Homelessness Team that they were proceeding with the eviction of Dorothy and her daughter from their property and had instructed solicitors to this end. A joint visit was completed on the same day and it was noted that some progress had been made but this was deemed to be 'not sufficient'. Dorothy was again verbally abusive.

A referral to Adult Social Care was made by the Homelessness Team on 22nd February which included the photos of the property taken on 16th February.

Another home visit was attempted on 23rd February, but no one was present in the property. On 1st March The housing provider and the Homelessness Team visited again and noted small improvements to the conditions within the property, but it was noted that the clutter image rating remained the same. Targets were set to continue these improvements.

A further home visit by the housing provider and the Homelessness Team on 8th March noted no further progress had been made and a specific target to clear the bathroom within the property was set. The following day, the housing provider shared photographs of the property with the Homelessness Team evidencing the lack of improvements that had been made in the condition of the property.

On 15th March The housing provider and the Homelessness Team arranged to make a further joint visit to the property of Dorothy and her daughter. It was expressed within the communication that Dorothy and her daughter did understand the gravity of the situation and that if they continued to be disengaged from the support being offered by the Homelessness Team, this support would not be able to continue. A joint visit was completed the following day and it is recorded that no progress had been made to improve conditions within the property and that Dorothy 'made it explicitly clear' that she did not wish to receive ongoing support from the Homelessness Team. There were no further interactions with Dorothy by the Homelessness Team from this date.

The housing provider visited the property on three further occasions during Junes and July 2018 but were unable to gain access as there was no one present within the property. On 18th September the housing provider instructed their solicitors firm to seek possession of the property due to its condition and the non-engagement of the tenants Dorothy and her daughter.

A letter was sent to Dorothy on 5th November detailing the evidence that would be presented in court when requesting possession of the property. On 7th November a Court Hearing was held at Peterborough County Court. Dorothy did not attend, and an outright possession order was granted for 28 days. The housing provider made a referral to Adult Social Care two days later on 9th November informing them of the possession order for the property. The referral was made via a phone call and the housing provider records state that Dorothy's daughter's learning difficulties were highlighted, and the previous involvement Adult's Social Care had had with both Dorothy and her daughter.

A duty worker from Adult Social Care made a telephone call to Dorothy and her daughter on 13th November following the referral from the housing provider, but received no response. Two further phone calls were made on 16th November, again with no response. On 21st November, records suggest Adult Social Care were able to speak with Dorothy over the telephone as there is a record of contact between Adult Social Care and The housing provider which states that Dorothy had been verbally abusive and refused to engage. As a result Adult Social Care requested that The housing provider contact them again once the eviction notice had been served, as this had not yet occurred, to allow them to make contact with Dorothy at that point, in the hope that Dorothy might be willing to accept support. There are no further recorded contacts on Dorothy's daughter's file until her mother's death.

On 18th December the housing provider contacted Adult Social Care to inform them that an eviction date was set for 8th January 2019. The housing provider also made contact with Peterborough City Council Housing Needs team (previously known as the Homelessness Team), as well as with the RSPCA due to the presence of animals within the property. Adult Social Care made a telephone call to Dorothy but received no response. Records are unclear as to whether a 14 day letter was sent, but there is no recorded contact between Adult Social Care and Dorothy.

2019

On 8th January 2019 three representatives from the housing provider: two neighbourhood managers and a carpenter, and two bailiffs attended the property of Dorothy and her daughter to carry out the eviction. Dorothy refused entry but her daughter was persuaded to allow entry by a bailiff. Dorothy was described within records by the housing provider as 'sat on the sofa with a blanket over her legs' and 'verbally abusive'. Dorothy informed those present that 'her legs were not working' so she was asked by one of the neighbourhood managers whether her arms were working and she demonstrated that they were by waving them around. Dorothy's daughter stated that her mother was not on any medication, so the neighbourhood manager offered to call a doctor on Dorothy's behalf. Dorothy refused this but her daughter agreed to walk to the doctor's surgery later in the day to request a doctor to visit Dorothy. The bailiffs were unwilling to continue with the eviction without the presence of Adult Social Care and both the bailiffs and the housing provider agreed to contact Adults Social Care to request this for two weeks' time. The neighbourhood manager noted that Dorothy was 'alert, vocal and sitting on the sofa with a blanket on her which was not unusual.'

On 23rd January the housing provider contacted Adult Social Care to inform them that a second eviction date had been set for 31st January and requesting a presence from Adult Social Care on this date. On 24th January Adult Social Care contacted the housing provider to confirm whether the housing provider had been in contact with the Housing Needs Team.

On 25th January 2019 Adult Social Care were notified by Cambridgeshire Constabulary that Dorothy had passed away the previous day. Adult Social Care then passed this information onto the housing provider. The Police requested a section 42 enquiry due to the condition of the property which they described as 'shocking', and severe concerns for Dorothy's health, including 'pressure sores to her bottom and an open chest wound believed to be due to cancer'. They also described Dorothy as appearing neglected and that her family had suggested she had refused care from her GP.

Adult Social Care agreed to make contact with Dorothy's daughter to determine her needs. Contact was made by Adult Social Care with the housing provider who cancelled the eviction notice and a joint visit was discussed. Further discussions were held between the Police and Adult Social Care concerning Dorothy's GP contact details. Adult Social Care made contact with a relative of Dorothy and her daughter who confirmed that neither had had contact with the GP for a number of years. Attempts were also made to contact Dorothy's daughter by Adult Social Care, but these were unsuccessful. The Police informed Adult Social Care that they had supported Dorothy's daughter by providing her with food and she was staying with a relative, whose contact details they provided to Adult Social Care.

It was agreed that an assessment would be undertaken by Adult Social Care of Dorothy's daughter to determine her care and support needs. This assessment was completed on 29th January 2019.

5. Analysis and Learning

A facilitated multi-agency meeting was held on 11th March 2020 which included representatives from Adult Social Care, The housing provider and the Adult Safeguarding

Partnership Board. This group were asked to consider the details within the combined chronology and the following key themes, the aim of which was to extrapolate learning for those agencies who had been involved in the case, as well as those in the wider safeguarding adults' workforce.

a) *Were Dorothy's need appropriately identified and addressed?*
b) *Were Dorothy's daughter's needs appropriately identified and addressed?*
c) *Is there evidence that agencies worked well together?*
d) *What (if anything) could have been done differently?*
e) *Any good practice identified?*
f) *What is the overall learning?*

a) Were Dorothy's need appropriately identified and addressed?

It was considered by the group that the referral to Adults Social Care made by the Fire Service in November 2016 was an example of good practice. There was also agreement that at that time, Dorothy would not have met the criteria for support from Adult Social Care as she did not have identified care and support needs. On balance however, it was felt that Adult Social Care could have been clearer regarding their role with those professionals who were already involved and the reasons why they took no further action, as well as communicating this with Dorothy and her daughter.

Later on, when referrals were made to Adult Social Care in November 2018 and January 2019 by The housing provider because they were moving forward with the eviction of Dorothy and her daughter from the property, the group agreed that an opportunity to gather information and investigate further into both women's' needs was missed.

It was noted that other agencies had recognised both Dorothy and her daughter as being in need of support. Prior to December 2016 an organisation called SEETEC had made a referral to Adult Social Care regarding Dorothy's daughter and later the bailiffs who attended the property in January 2019 felt it inappropriate to continue with the eviction of Dorothy and her daughter. The group considered both occasions to be good practice examples of occasions where potential care and support needs were identified.

The overall opinion of the group regarding Dorothy's needs was that her poor mental health, as indicated by the hoarding behaviour she displayed, had not been met. It was recognised that bespoke support for Dorothy would not necessarily have been available, and given Dorothy's reluctance to engage with the support she was offered, she may not have been willing to accept this support. However, it was agreed that this remained a gap in services for those people who display hoarding behaviour.

Finally, it was agreed by those present at the facilitated agency meeting, that there was an absence of health agencies supporting Dorothy throughout the period of the review. The role of Dorothy's GP was considered and it was felt that, had the GP been aware of Dorothy's hoarding behaviour, and understood the mental health indications, the offer of mental health support might have been made.

b) Were Dorothy's daughter's needs appropriately identified and addressed?

The agencies present at the facilitated agency meeting agreed that Dorothy's daughter's needs had unfortunately been lost amongst the hoarding behaviour displayed by both women and the behaviour expressed by Dorothy towards those professionals who were attempting to engage with them both. The group expressed the opinion that the dominance of the mother's behaviour had overshadowed the daughter's needs. It was recognised in a discussion

between the housing provider and Adult Social Care in December 2016, that they had experienced difficulty during a joint visit in speaking with Dorothy's daughter alone as her mother was always present. There does not appear to have been any further attempts made however.

It was also recognised that recording by Adult Social Care could have been clearer in separating those needs of Dorothy's daughter from her mother's. Some information concerning both women was recorded on Dorothy's daughter's file and some on Dorothy's, some information was duplicated across both records but overall recording was not consistent and this was considered to have compounded the lack of recognition of Dorothy's daughter's needs.

c) Is there evidence that agencies worked well together?

Following the first referral by the fire service in November 2016, a joint visit was undertaken to Dorothy and her daughter by the housing provider and the fire service to explain the fire risk posed by the clutter with the property. This was then followed by a joint visit between the housing provider and Adult Social Care in December 2016. There were multiple joint visits between the housing provider and the PCC Homelessness Team in February and March 2018. All of these joint visits between agencies are considered to be examples of good practice in facilitating information sharing and promoting engagement with Dorothy and her daughter.

d) What (if anything) could have been done differently?

It was suggested at the facilitated agency meeting that the correct procedure for Adult Social Care to have offered support to Dorothy's daughter following any of the referrals having been received, would have been to close the case to safeguarding and manage it under the complex case management process. This process existed in the time period considered by this review, although it was accepted by the agencies present that the process is much clearer now than it had been in 2016.

In addition to the missed opportunity to assess Dorothy's daughter's needs independently of her mother and the absence of mental health support for Dorothy, the agencies present at the facilitated agency meeting recognised that there were some instances within the records held by Adult Social Care where recording was unclear. This relates to the information recorded concerning Dorothy's daughter and Dorothy which was not clearly linked to either mother or daughter, as well as the information recorded by a duty worker following the referral by the housing provider in November 2018.

Additionally, the agencies agreed that the referral made by the PCC Homelessness team in February 2018 which included recent photographs of the property should have been followed up when they did not receive a response from Adult Social Care.

It was considered to have been unclear what feedback had been offered to the housing provider following the referrals they had made to Adult Social Care. Agencies agreed that greater clarity concerning the role of Adult Social Care in this case would have been beneficial.

Lastly it was agreed by agencies that the 14 day letter which was sent to Dorothy in December 2018 by Adult Social Care was not an appropriate action for someone who displays hoarding behaviour. The process now to close a safeguarding referral where there has not been engagement from the subject and the concerns are relating to self-neglect or hoarding behaviour, is for a visit to take place followed by discussions with a manager.

e) Any good practice identified?

Some examples of good practice have been identified in the earlier sections of this report: joint visits undertaken by the agencies involved and the regular contact that the housing provider had with Dorothy and the regular visits they made to the property.

The Homelessness Team, now known as Housing Needs, made a total of nine visits to Dorothy and her daughter in five weeks to offer support, demonstrating considerable involvement over a short period of time despite Dorothy not engaging. They also used photographs of the condition of the property to support a referral to Adult Social Care.

Cambridgeshire Fire and Rescue Service's referral to Adult Social Care in November 2016 demonstrates good practice on the part of this agency. Additionally, a referral had been made by SEETEC who had worked with Dorothy's daughter, concerning her learning needs, demonstrating recognition of safeguarding by that agency.

During the visit to the property on 8th January 2019 when the housing provider attended with bailiffs to evict Dorothy and her daughter from the property, the housing provider demonstrated good practice in asking Dorothy if she were able to move her arms. She had stated that she was unable to move her legs and the representative from The housing provider was concerned that she may have had a stroke so asked Dorothy if she were able to move her arms, to which Dorothy's response was to wave her arms around. All agencies agreed at the facilitated agency meeting that it was also good practice for the housing provider representative to enquire further as to who Dorothy's doctor was in order to support Dorothy and her daughter to receive the healthcare Dorothy may have needed.

In addition, during the same visit, the bailiffs who attended did not continue with the eviction as they had recognised Dorothy's and her daughter's needs and vulnerabilities and felt that Adult Social Care should be present at any future action to evict the women.

Lastly, following Dorothy's death on 25th January 2019, Cambridgeshire Constabulary responded to the needs of Dorothy's daughter by providing her with food and ensuring she had somewhere to stay. This again was considered to be an example of good practice demonstrated by that agency.

f) What is the overall learning?

All agencies involved agreed that the needs of Dorothy's daughter had been overshadowed and as such, any opportunity to support her had been missed. She should have received an assessment in her own right and her case could have been managed by Adult Social Care under their complex case management process. The process would have included a professionals meeting which could have included her GP and possibly a mental health representative. This should have been supported by clearer recording allowing for Dorothy's daughter to be considered as a separate individual.

Adult Social Care could have been clearer to both the other professionals and Dorothy and her daughter themselves regarding their role and the support they may have been able to offer. The records did not suggest that sufficient attempts to engage both women had been made.

It was also agreed that further investigation by Adult Social Care should have been undertaken following the referral received in November 2018 when it appeared that eviction of Dorothy and her daughter was imminent, and then again in January 2019 when the bailiffs suggested they would not go ahead with an eviction without the presence of Adult Social Care.

There was an absence of health agencies in this case. Dorothy had been displaying severe hoarding behaviour for many years: she had been rehoused in 2007 for this reason. However,

there were no indications from the records considered as part of this review that she had been offered mental health support for this behaviour. When discussing this at the facilitated agency meeting, the agencies agreed however that such specialist support was not available at the time and remained unavailable now. Available support for people who display hoarding behaviour is now discussed at the district led Hoarding Panels. These groups bring together safeguarding partner agencies across the county to consider what support might be appropriate in each individual case. The Panels have facilitated closer working relationships and a shared understanding of hoarding. There have also been incidences where funding has been used from the Disabled Facilities Grant to aid with clearing clutter from a property.

In February 2018, the Homelessness Team made a referral to Adult Social Care which was supported by photographs of the property. This referral was not recorded on Adult Social Care records and it is reasonable to have expected the Homelessness team to have contacted Adult Social Care due to the lack of response from them. All agencies present at the facilitated agency meeting agreed that all referring agencies should be aware of their responsibility to follow up referrals with Adult Social Care if they do not receive a response.

6. Recommendations

The following multi-agency recommendations have been formulated based on the learning arising from this case. Consideration was made to previous case reviews where similar learning has arisen and work is being undertaken to improve practice. Additional recommendations are not included here relating to the use and promotion of multi-agency meetings to support professionals and share information, or support for professionals working with those clients who present as hard to engage.

I. The partners of the Safeguarding Partnership Board should ensure that full and accurate records are kept for each adult in a household when there has been contact with those adults. This should allow for a greater understanding of each adults' needs and therefore a more individualised assessment of those needs.

II. The Safeguarding Partnership Board and partners should support practitioners to increase their skills and confidence in consideration of mental capacity for people who self-neglect and do not engage.

III. Similarly, the Safeguarding Partnership Board and partners should support practitioners to increase their skills and confidence in exploration of mental health problems for people who self-neglect and specifically those who display hoarding behaviour.

IV. The partners of the Safeguarding Partnership Board should consider the support made available to those people who display hoarding behaviour and face eviction and homelessness and how this support is evidenced.