



Keeping Adults Safe  
in Shropshire  
Board

# Keeping Adults Safe in Shropshire Board Safeguarding Adult Review Number 2: Mr E



## **Introduction**

It is usual to start each Board meeting with a person's story and the situation of Mr E was presented to the Keeping Adults Safe in Shropshire Board by the Shropshire Fire and Rescue Service. The Board asked that a Safeguarding Adult Review (SAR) was undertaken not because a duty was met to do so but in order to understand what could be learned to prevent others being in this situation in the future.

## **Professionals associated with the review**

The professionals' designations of those who contributed to the review process were:

- Detective Sergeant, West Mercia Police
- Service Manager Adult Safeguarding, Shropshire Council
- Adult Safeguarding Lead Nurse, Shrewsbury and Telford Hospitals NHS Trust (SaTH)
- Adult Social Work Team Manager, Shropshire Council
- Station Manager, Prevention, Shropshire Fire and Rescue Service
- Emergency Planning Manager, Shropshire Council Emergency Planning Unit
- Housing Services Manager, Shropshire Council
- Senior Social Worker, Emergency Duty Team, Shropshire Council
- Team Manager, Mental Health Social Work Team, Shropshire Council
- Head of Clinical Practice, West Midlands Ambulance Service NHS Foundation Trust

## **Process of the review**

Two "round table" discussions were held where those involved worked to agree a combined chronology of events. From these discussions, a series of recommendations emerged to form part of the action plan that would be sent to the Board for their approval.

## **Terms of reference for the review**

The purpose of conducting this SAR was to:

- Establish what lessons can be learned from the particular circumstances of a case in which professionals and agencies work together to safeguard adults
- Identify what those lessons are, how they should be acted upon and what is expected to change as a result
- Review the effectiveness of procedures both of individual organisations and multi-agency arrangements
- Improve practice by acting on the findings (developing best practice across the organisations)
- Improve inter-agency working to better safeguard adults



- Make a difference for adults at risk of abuse or neglect

The review covered the following time span:

- What happened immediately after the Fire Service were called to Mr E's address
- Twelve months leading up to Mr E's evacuation

The purpose of the timespan is to understand what if anything could have been done in order to have prevented Mr E from being in this situation.

### **The person's involvement**

Mr E is aware of the Safeguarding Adult Review process. He was asked the following questions by his housing support officer:

- 1) Does he think he has been helped enough over the years and if not, what kind of help would he have liked?** Mr E's view was *"no, no help at all. Mr E states that the problems with rubbish started when he wanted a new bin and the council wouldn't provide one, so he had nowhere to put his rubbish.*

*He states that the Council helped him with a grant to help fix his roof, however, when he went back for more help he was told that there were no more grants available and so the property got into a complete state of disrepair."*

- 2) Specifically, what are his views of the help he has had from:**

- the Council? – *"no help"*
- the hospital? – *"very short-staffed at the hospital, which means that he was left on his own for over an hour"*
- the Police? – no comments made
- the Fire Service? – *"Good. They were very helpful and got him out of the property when it flooded."*
- Housing? – *"Good - no complaints."*
- Other services? - no comments made



- 3) What can he remember about the night his house flooded?** – *“Mr E can remember the fire men shouting his name up the stairs and carrying him out of the property. He can remember them rolling up fire hoses and the water being very high. He was taken to hospital and luckily managed to take his money from the property. When he was there he was left on his own in a room due to staffing issues. He dried the money out at the hospital.”*
- 4) Are there any message in particular he would like to give to group of staff meeting to discuss the support he has received over the last year?** – Mr E said *“Why didn’t the Council help with my bins and another grant to stop my property getting into that condition?”*
- When I went to the hub in Oswestry the women didn’t want to speak to me.*
- I asked to speak to Social Services but I was told that nothing else could be done for me - I was left to my ‘own devices’.*
- 5) Can we put his views into our report?** – Mr E gave his permission to add this information to this report.
- 6) Would he like to know about any recommendations and would he like a copy of the report?** – Mr E said he wanted to know the recommendations that came from this report.

### **Summary of events**

On 12<sup>th</sup> January 2016, 00:03hrs the Fire service were called to respond to six properties that had flooded.

Mr. E was living alone at his address. The Fire Service were advised he had no family and none of the neighbours were willing to accommodate him that night. It appeared to the fire service that Mr E hoarded a lot of items in his home. Using the Clutter Image Rating Scale, the Fire Service assessed his property at “9” which is the highest the scale goes.

The police and ambulance service were also in attendance. The assessment by the ambulance service concluded that there were no medical grounds to take him to hospital. No other issue had been identified that required Police to remain and they therefore left the scene. Mr E required temporary shelter. It was a cold, wet night and the Fire Service were not happy to leave him without support. He was an owner/occupier and had no insurance. Following contact with the Emergency Duty Team and the Emergency Planning Team, it was felt that there was no other option than for him to be taken to hospital.



Due to the late hour of the initial contact of the on-call Housing Team Member it was decided to let him stay at Royal Shrewsbury Hospital (RSH) and the Housing Team would contact him via RSH (he doesn't own a mobile) to arrange alternative short-term accommodation. Unfortunately, he refused to engage later that morning and the Housing Team requested the Hospital Social Worker attend to assist.

Mr E is now living in rented accommodation having sold his own home. With the intensive support provided by Housing Services, his hoarding is now under control.

### **Analysis**

The review identified that the Emergency Duty Team was difficult to get hold of which resulted in contact being made with Emergency Planning and Out of Hours housing support separately. This raised questions for those involved in the first meeting in particular:

- Are separate out of hours systems an efficient and joined up way of working?
- Do separate out of hours systems provide the best service to the person needing them?

There were no clinical issues that suggested Mr E required admission to hospital therefore those in attendance at the first meeting agreed his admission was not an appropriate use of hospital resources. This prompted questions about the current arrangements for provision of accommodation of a person in circumstances such as in this case.

In analysing the year leading up to Mr E's evacuation from his house, it became apparent that Mr E was known to both the Social Work and Safeguarding Teams.

His hoarding behaviour and poor physical health condition was well known to the local authority from at least 2013. The first safeguarding concern was appropriately closed in line with the Board's guidance on self-neglect. The concern was signposted to the social work team to undertake an assessment in order to get Mr E the help he needed to be able to maintain a safe environment where he could cook and use his toilet.

They made numerous attempts to contact him, but the assessment did not take place until the second safeguarding concern was received as a result of his evacuation from his property. The assessment eventually undertaken was considered by those present in the second meeting to be inadequate and reaching inappropriate conclusions about his eligible needs; it concluded he could meet his own needs without the support of others. This has been proved not to be the case.

Formally recorded actions with the Shropshire Council staff involved are going to be considered by the Team Manager outside this process and Mr E is going to be allocated a social worker who will be able to bring his assessment up to date.



## **Conclusion**

Had earlier assessments correctly identified Mr E's needs, work may have been undertaken to support him to bring his environment under control or move if appropriate. We cannot be sure that he would not have required evacuation from his property however what is clear is the seriousness of his care and support needs could have been minimised providing him with a better quality of life.

## **Recommendations**

### *Recommendation 1 Shropshire Council*

Telephone system review for Emergence Duty Team (EDT) to enable messages to be left.

### *Recommendation 2 Shropshire Council*

Review of staffing levels in EDT to ensure emergencies are responded to appropriately.

### *Recommendation 3 Shropshire Council.*

Review the use and effectiveness of out of hours emergency accommodation provision for adults who have been or who are presenting with eligible care and support needs

### *Recommendation 4 Shropshire Council*

Review of whole system out of hours including any related contracts and staff remuneration.

### *Recommendation 5 Keeping Adults Safe in Shropshire Board*

On review of the KASiSB Self-Neglect Practice Guidance and Procedure; ensure all Board Members disseminate the policy appropriately throughout their organisations.

### *Recommendation 6 Keeping Adults Safe in Shropshire Board*

On review of the KASiSB Risk Assessment Risk Management Guidance; ensure all Board Members disseminate the policy appropriately throughout their organisations.

### *Recommendation 7 Keeping Adults Safe in Shropshire Board*

Produce an escalation document that includes calling "professionals meeting" when it is clear there are concerns and a range of agencies involved.



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*Recommendation 8 Shropshire Council*

Use the report to organise a series of multi-agency training events about working people who self-neglect.

*Recommendation 9 Shropshire Council*

Refresh knowledge and understanding of social care staff on how to use and apply national eligibility criteria for adults with care and support needs.