Background

This SAR is about Mr C, a man in his early 60s who died in June 2019. He had a diagnosis of bipolar affective disorder, depression, involvement with mental health services in his early years, diabetes and a pinned hip which affected his mobility.

In March 2019 he was made homeless after falling into rent arrears and losing his tenancy. With the help of his son contact was made with Housing Services and Mr C moved into a shared council house with his own room. Concerns were raised by people living with Mr C about his personal hygiene and his ability to care for himself.

In the months preceding his death, he admitted himself to hospital three times due to a non-blanching rash, later open wounds on his legs and extreme leg pain. Each admission led to an inpatient stay.

Background

Plans had been made to reassess Mr C's support needs by Housing Services but this did not take place due to his first admission to hospital. After the second hospital stay, District Nurse visits were arranged to provide wound care. These efforts were severely hampered, often by Mr C's refusal of treatment due to the pain he experienced. After the third admission, support was agreed through an emergency reablement package and the unsuitability of his accommodation highlighted to Adult Social Care by carers.

An urgent Occupational Therapy review was requested because Mr C could not use the stairs needed to get to the toilet. The day after this review was requested, and a week after his third hospital admission discharge Mr C was admitted for the fourth and final time, having suffered multiple strokes from which he later died.

Review

The Havering Adults Safeguarding Board commissioned a SAR as a key statutory criteria had been met.

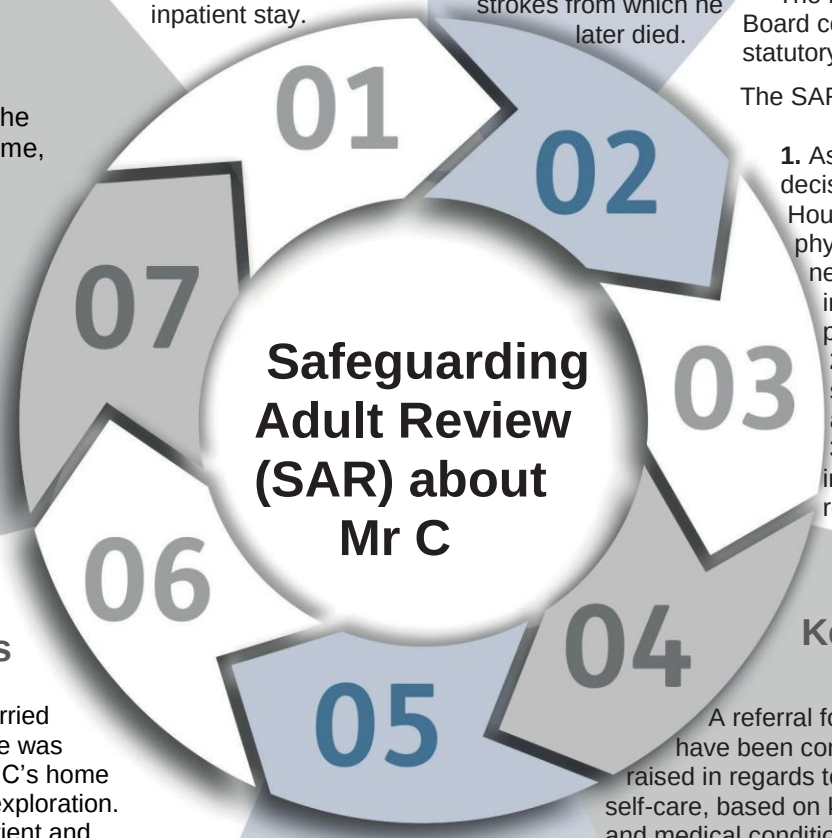
The SAR focussed on three areas:

1. Assessment and placement decision making processes by Housing Services for adults with physical and mental health needs and self-neglect, facing imminent homelessness to provide appropriate housing.
2. Agencies to work together to support someone vulnerable and respond appropriately.
3. Hospital discharge planning including delivery and effective reablement support.

Further Reading

To receive information about the multi-agency training programme, please email:

safeguardingpartnerships@havering.gov.uk



Key Findings

Further OT assessment was carried out and whilst a package of care was considered, concerns about Mr C's home circumstances needed further exploration. There was a gap between inpatient and community services which assessment failed to bridge to fully understand Mr C's lived experience and the full extent of concerns.

Efforts were made in the Havering Access Team (HAT) to expedite urgent responses. This was achieved via direct emails being sent to Mr C's allocated social worker in the Community Team. But, by not opting to use the team's main email, meant that responses did not benefit from senior oversight to help identify any errors or issues.

Key Findings

A referral for a Care Act Assessment should have been considered when concerns were raised in regards to Mr C needing prompts about self-care, based on known mental health diagnoses and medical conditions and mobility issues, as well as to explore the extent to which his family could fulfil a caring role for him.

Responses to early signs of neglect, as well as care and support needs should have involved Adult Social Care.

Housing services are an important partner in efforts to safeguard people with care and support needs, and especially for those with changing medical/mobility needs and who have been housed after being made homeless. There should be routine liaison between Hospital Assessment Teams and Housing Tenancy Teams to ensure reablement packages are not commissioned in isolation from knowledge held by housing staff including information about self-neglect.

Key Findings

An initial Occupational Therapy (OT) assessment conveyed housing and social care needs. Mr C and his son expressed a a need for sheltered housing. Both should have triggered a referral to the Joint Assessment and Adult Social Care Team for a Care Act Assessment.

Mr C was discharged with a reablement package. Carers were prompt and persistent with concerns regarding discharge, citing Mr C's mobility issues and the unsuitability of his accommodation. Notably that his bedroom was on the ground floor and his bathroom positioned on the 1st floor. Also that necessary equipment i.e. a standing hoist or commode was not in place, and that he had no bedding, personal clothes, toiletries and limited food. District Nurses did complete a mental capacity assessment of Mr C due to his prior refusal for wound dressings. During assessment Nurses were confident that Mr C had mental capacity.

Havering Safeguarding Adults Board

7-minute briefing