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**Council and care agency ‘failed to safeguard welfare or dignity’ of man who died in squalid flat.**

Cornwall council and the provider it commissioned lacked curiosity and concern as pensioner's situation worsened, safeguarding adult review finds. A council and a care provider failed to safeguard the welfare and dignity of an older man who self-neglected and died alone in squalid conditions, a safeguarding adult review (SAR) has found.

The investigation, carried out on behalf of the Cornwall and Isles of Scilly Safeguarding Adults Board, found Cornwall council’s adult social care service showed “no apparent concern” that the 70-year-old, ‘Paul’, was living surrounded by buckets of faeces and bottles of urine.

Meanwhile paperwork carried out by Carol Spinks Homecare, which the council commissioned to care for Paul, contained “disrespectful and dehumanising” language that the review said raised questions about the fitness of its organisational culture.

Paul was found dead in his first-floor council flat in May 2016, days after his advocate and a community matron raised concerns about the environment, he was living in. He had been receiving home care services since early March, but the investigation found no evidence he had been properly involved in his needs assessment, nor provided with an advocate to overcome his ‘substantial difficulty’ in being involved – contrary to Care Act 2014 requirements.

Apart from the advocate and community matron, professionals failed to work in partnership to safeguard Paul or consider his wishes or feelings, the SAR concluded.

“It is sadly true that information from agencies provided for this review tells us very little about Paul himself,” the report said, which it pointed out was contrary to the requirement to consider wishes and feelings as part of the duty to promote wellbeing in section 1 of the Care Act.

**Previous referrals**

Paul, who had mental health problems and longstanding breathing difficulties, exacerbated by smoking, had lived alone in his flat for many years. He had no known family locally. Paul was well-known by housing officers as a “feisty” character and was in dispute with owner-occupier neighbours who complained about noise from his flat. There was also evidence suggesting he was being harassed by them.

Cornwall’s adult social care department was aware of Paul from at least 2014. That year he was referred three times, refusing help on the first two occasions before the council concluded on the last that he did not meet its ‘substantial’ threshold under the pre-Care Act Fair Access to Care Services eligibility criteria. This assessment did not take into account the concerns raised by the agencies responsible for the first two referrals and the council did not undertake a risk assessment before concluding he was ineligible – which the SAR concluded was a missed opportunity to prevent harm.

From summer 2015 though, an advocate from local Age UK services, who was praised throughout the SAR, had helped him around social isolation and financial needs.

Besides the advocacy support, Paul had also been assisted by a friend, ‘Ms B’. But their relationship had broken down after an argument in early 2016, prompting his re-referral to adult social care.

**‘No involvement in assessment’**

The care package subsequently commissioned by Cornwall council in March 2016 comprised daily washing, food preparation and prompts to take medication, and twice-weekly cleaning. But the council’s assessment did not appear to consider his emotional wellbeing, or how the care plan might enhance his independence or dignity, the SAR said.

Nor did it explore addressing the risk Paul might resist the cleaning of his living room, where he spent most time, the review found. It noted that the support plan required cleaning to areas of the flat that Paul seldom visited, and which were – unlike the living room – “immaculate” when he was found dead.

“There is no evidence Paul was effectively involved in the assessment of need that took place on 2nd March 2016,” the review concluded. It added that there was no evidence Paul had been offered appropriate advocacy to address the “substantial difficulty” he was clearly likely to have faced in being involved in his assessment, as required by section 68 of the Care Act. This was despite the fact that he “was not entirely unwilling [to accept services],” the review said. “This was not a man who totally refused to engage; this was a man who was anxious and scared.”

**‘Safeguarding deficiencies’**

One key source of anxiety for Paul was the ongoing conflict with his neighbours, which the review said care workers were “very aware of”. On 29 March 2016, the agency contacted the council to say he had stopped eating due to distress over complaints about the noise of his oxygen pump. “Again, on 25 April, the agency contacted the adult social care brokerage team and stated that [Paul] had, ‘received a threatening letter… they noticed his front door locks have been forced’,” the review went on.

Yet on neither occasion were the concerns escalated into safeguarding procedures. “The response to this issue by agencies… indicates a deficiency of understanding of [local] multi-agency safeguarding adults’ procedures and of their respective responsibilities,” the review said.

The investigation found neither the council nor care agency showed concern for the increasingly filthy conditions Paul was living in as his health deteriorated and he self-neglected, issues which were raised twice by the advocate and community matron. A visit by the council’s rapid response team on 10 May led to no action beyond reminding the agency to follow the care plan, and scheduling a review that was never carried out due to Paul dying. Three days before his death the advocate and matron found him “having a bowl of faeces under his chair, confused about his medication, [with] food dating back to 2013 in his fridge” the review said. He did not appear to have been showered, or to have had his shopping done, as per his care plan.

**‘Inappropriate approach to working with people’.**

The review concluded that notes recorded by the care agency in the wake of the two professionals raising concerns about Paul appeared primarily to be intended as a back-covering exercise the in the event of future criticisms. There was little effort to change their approach to deliver a better service to Paul, the review found.

Care Quality Commission (CQC) inspections of Carol Spinks Homecare both before and after Paul’s death identified concerns with how well support was being carried out by the agency, which is now rated ‘good’, including around how well plans reflected needs and risks. The review observed that while some workers appeared to have carried out their tasks well, the tone and language contained in material provided by the agency to the inquiry revealed an “inappropriate approach to working with people”. It added that Paul’s advocate and the community matron had been left to fill gaps left by statutory services, which showed no “Professional curiosity” as to how his anxiety might affect his physical wellbeing, paid scant attention to his self-neglect, and at no time considered whether his capacity to make decisions in relation to his self-neglect be assessed.

**‘Learning to better support people’.**

In a statement responding to the review, Cornwall council said it accepted all the findings, had worked with the safeguarding board to establish a self-neglect policy and had created a ‘high- risk panel’ to work with people showing challenging behaviours.

“Local authorities across the country are all learning more about how they can better support people who self-neglect since the Care Act 2014 set it out as one of its key considerations,” the council’s strategic director for adult care and support, Helen Charlesworth-May, said, “Our social work practice in this area has greatly improved,” Charlesworth-May added. “This includes making sure the person is at the heart of the discussion about how we can support their independence and maintain their dignity, as well as considering [their] social needs so they are able to develop and maintain relationships with their family, friends and the wider community.”

Robert Peck, the registered manager and named individual at Carol Spinks Homecare, said the facts of the safeguarding adult review were correct but that the agency had always tried to deliver a high standard of care and had taken steps to ensure the language it used was appropriate. “There are a number of lessons to be learnt from this sad episode; the agency totally accepts this and has taken these on board,” Peck said.

“It was admitted and minuted at a safeguarding meeting the agency had with the commissioning body that [we had] received inadequate information regarding the care package and Paul’s particular circumstances and needs,” Peck added. “While the agency did contact the commissioning body regarding various concerns, the agency did not follow these up in a concerted manner in order to achieve a satisfactory and progressive outcome. These matters have been addressed.”

Peck said that reporting and follow-up procedures at Carol Spinks Homecare had been updated, with a staff member appointed specifically to oversee this work. “A revised policy relating to neglect has been issued and circulated to care staff in light of the lessons learnt following the SAR,” he said.