Adult Practice Review Report

Cardiff and Vale Safeguarding Adults Board
Concise Adult Practice Review

Re: *APR 04/2017*

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

A Concise Adult Practice review was commissioned by Cardiff and Vale Safeguarding Adult Board on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Multi Agency Adult Practice Reviews. The criteria for this review are met under Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People: Volume 3, Section 6.1

"A concise adult practice review will be commissioned where an adult at risk who has not on any date during the 6 months preceding the date of the event, been a person in respect of whom the local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, has :
Died; or
Sustained potentially life threatening injury; or
Sustained serious permanent impairment of health"

The reviewers were Debbie Pachu, Designated Nurse, National Safeguarding Team, Public Health Wales NHS Trust and Claire Jackson, Safeguarding Specialist, Abertawe Bro Morgannwg University Health Board. The Panel chair was, Detective Inspector (DI) Clayton Ritchie, South Wales Police.

The terms of reference for this review can be found in Appendix 1.

Circumstances resulting in the review

A referral was received by Cardiff and Vale Safeguarding Board from South Wales Police in respect to a 59-year-old woman (Adult C) who passed away at her home address where she resided with her adult son.

Adult C was found deceased at her home address by ambulance crew in November 2017, following a telephone call from Adult C's son, who had found his mother in the lounge with an internal door on top of her. The door was believed to have fallen from its hinges due to general poor repair. The cause of death was recorded as ischemic heart disease, coronary artery atherosclerosis and infected venous ulcers of lower limbs.

South Wales Police attended the scene and upon examination, Adult C was noted to have sores to her lower limbs, which appeared to be infected. The home conditions were noted to be poor and in a state of disrepair. Medication was found at the address and it was apparent this had not been taken.

Adult C's son was perceived by some agencies to be her sole carer, however the relationship between them had been described by a neighbour as being acrimonious. Background information presented by the Police and Adult Social Care supports this view.

During the timeline there had been four calls to the Police by a neighbour, concerned about difficulties in the relationship and shouting at Adult C's home address. Adult C's son had health difficulties, however these are outside the scope of the review and therefore cannot be explored. Adult C had also been suffering from arthritis, which had affected both knees, and her mobility had become increasingly limited. She was reported within GP records to be housebound.

Following Adult C's death no criminal neglect was established, however, there was evidence of self-neglect. Adult C was presumed to have capacity and had repeatedly declined opportunity for medical treatment, both her and her son had failed to engage effectively with agencies despite frequently initiating requests for support.

This Concise Review covers the period from 2nd of September 2016 to 10th November 2017. This begins following a welfare referral from Housing and ends when Adult C passes away at her home, resulting in an emergency call to Welsh Ambulance Services.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Identification of Good Practice

There was evidence of good practice from agencies such as the Police, who following a third party report that described Adult C's son shouting at Adult C, attended the home and submitted a Public Protection Notice (PPN) to the Local Authority First Point of Contact due to their concerns about Adult C's home conditions.

Police documentation made at the time clearly indicated their concerns regarding Adult C. Even though she denied arguing with her son, officers identified other vulnerability and risk associated with Adult C's social circumstances that may have indicated additional care and support needs.

Following receipt of the PPN completed by the Police, a joint visit was instigated between Independent Living and Adult Social Services. This however resulted in no engagement from Adult C.

The District Nursing Service had made considerable efforts to gain access to the home which they believed to be over and above the criteria set out in the District Nurses Policy in respect of missed appointments.

Housing welfare had made numerous attempts to engage with Adult C and her son to resolve their financial difficulties and to prevent eviction.

Information sharing and multi-agency working

During the timeline covered by this review, multiple agencies had been involved with Adult C and her son. The family had been in contact with: Housing, Police, Independent Living Services, Adult Social Services, GP, District Nursing and Occupational Therapy Services.

Many of the agencies' representatives had no knowledge of each other's involvement. All the professionals involved shared the same difficulties with engagement, and all were making multiple efforts to resolve issues that were impacting on Adult C's health, welfare or financial wellbeing.

Despite the many efforts to engage with Adult C and her Son, it is evident that the majority of agencies were working in isolation. In addition to this, agencies held information on their systems that was not effectively communicated between members of their own agency or those of partner agencies.

Following the incident in March 2017 for which a PPN was submitted and shared with Adult Social Services, a marker could have been placed on Police recordings regarding Adult C identifying her as vulnerable so that officers attending subsequent calls would have been alerted of the concerns raised previously.

Independent Living Services were trying to progress a disabled facility grant to make home adaptations, whilst at the same time housing services were trying to negotiate Adult C downsizing to avoid eviction due to rent arrears. Neither department were aware of each other's action. Practitioners at the learning event recognised progressing the home adaptation would have been counterproductive due to the eviction notice being considered.

The District Nursing Service tried to engage with Adult C following a referral made by her GP on completion of a house call. The house call was initiated due to concerns that Adult C's son had attended the surgery requesting analgesia on behalf of his mother.

It was noted by the GP that requests were being made for prescriptions for Adult C that exceeded the frequency of the repeat prescription schedule. It is documented within the GP records that when refused medication for his mother, Adult C's son had on one occasion "stormed out of the surgery". As a result the GP practice began monitoring prescription requests.

Following the house call the GP noted within their records Adult C to be unkempt, smelling of urine, having oedematous infected legs with possible ulceration. Accurate diagnosis was difficult due to excess sloughing and oozing. Examination was hampered by Adult C's refusal to open the curtains. The GP expressed considerable concern in respect of Adults C's home conditions at this time.

In addition to making a referral to the District Nursing Service for further assessment and treatment, the GP offered to make a referral to Adult Social Services, for an assessment of care and support. Adult C declined a referral to Adult Social Services but agreed to the referral to the District Nurse. The GP recorded that Adult C had capacity to make this decision.

In total the District Nurses made four home visits to Adult C following the first referral from the GP; unfortunately the District Nurses were unable to gain a response from Adult C and her son at this time.

A second referral was made to the District Nursing Service following a second visit by a GP, again noting Adult C to be unkempt and smelling of urine with "sloughy, swollen, weeping legs", which she had been self-treating. District Nurses went on to make a further four attempts to visit but were ultimately refused entry to the property by Adult C's son.

The Phlebotomy Service attempted to visit Adult C at the request of the GP, but did not get a response.

There was evidence that the District Nursing Team and the Phlebotomist had been concerned about their inability to access the property and they had informed the GP practice of their difficulties. Recordings at this time indicate that this information was not directly shared between professionals, i.e. the District Nurses and the GP. The information had been relayed via administrative staff acting on behalf of the GP and District Nursing Team. This resulted in the GP service being aware of some but not all of the failed visits by the District Nurses.

Practitioners at the learning event explained there are no formal meeting arrangements between the District Nursing Service and the GP to discuss complex cases. The District Nurses were not aware of the GP's concerns in respect to Adult C's home conditions, or of the concerns about the frequent requests for pain medication made by Adult C's Son.

Engagement with Services

It was evident from professional documentation and the views expressed by practitioners at the learning event, that engagement between Adult C and services was challenging; characterised by a failure to keep appointments, a lack of effective engagement with services and deferred responsibility and decision making to her son.

Whilst there was evidence that each of the agencies' representatives tried to engage with Adult C in a productive way, no one was able to successfully build a rapport with Adult C. This had an impact on the professionals ability to develop a constructive relationship with Adult C and hampered attempts to resolve issues with rent arrears, imminent eviction, deteriorating health, home repairs and home adaptations.

Interactions with Adult C were further influenced by her son's unpredictable and volatile behaviour, resulting in professionals ultimately documenting the need to visit the home in twos.

District Nursing Team risk assessments indicated home visits to be inappropriate due to risk posed to clinicians. These concerns were not escalated as being either indicative of potential risk to Adult C, nor were they seen as having an impact on Adult C's ability to engage with agencies.

Self – Neglect

From the recordings within the timeline there is evidence to suggest that self-neglect may have been a feature in Adult C's presentation. Self-neglect can include a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings. The complexity and multidimensional nature of self-neglect means it is difficult to detect and

diagnose. Self-neglect can have profound consequences for the health and well-being of older people. It is characterised by an inability to meet one's own basic needs, which can be both intentional and unintentional and is an increasingly common presentation (Gibbons et al, 2006).

The GP's records indicated that when Adult C had been seen at home due to a request for treatment for her ulcerated legs, she had presented as unkempt, smelling of urine, barefoot, dressed in clothes that were torn. Furthermore, there were visible sores to the lower limbs that were described as "oozing" in need of further assessment and treatment by the District Nursing Service.

The police report indicated that Adult C's home conditions were "squalid and in a poor state of repair with electrical repairs needed as a matter of urgency". Furthermore, a recommendation from Occupational Therapy for a disabled facilities grant, indicated the need for adaptations to Adult C's home to provide her with accessible hygiene facilities that would better meet her personal care needs.
Evidence suggests that a common feature in self-neglect is a reluctance to engage with agencies offering support in respect of health and welfare (Gibbon's et' al, 2006). Effective measures to engage clients, who self-neglect, require a multi-agency approach, which can take time to effectively implement and affect change. These measures rely on the ability to develop a rapport with clients to facilitate engagement and to understand the individuals' needs and wishes.

The review highlighted that whilst Adult C and her son had requested help with her physical health, finances, home adaptations and repair they were reluctant to engage with professionals and would frequently refuse support. This meant that agency representatives were unable to work with Adult C in order to effectively deliver an appropriate level of service to address her needs.

Professionals at the learning event recognised that all the agencies involved with Adult C were experiencing difficulties in respect to engagement, however they had been unaware of each other's involvement when they were trying to engage Adult C. Practitioners felt that on reflection a multi-disciplinary, coordinated approach may have helped to facilitate engagement and to better understand Adult C's needs and wishes.

Capacity and Consent

Professionals involved with Adult C indicated that it was their belief that Adult C had capacity to make decisions about her health, welfare and finances. This was evident from views expressed by professionals at the learning event and within health and social care records.

Many expressed that the presumption of capacity was the paramount consideration in determining Adult C's willingness to engage with services, and referred to the Mental Capacity Act principle of presumed capacity.

The reviewers acknowledge that the principles of the Mental Capacity Act must be followed when working with individuals in order to ensure a rights-based approach when offering health and social care interventions. Furthermore, they acknowledge that individuals have a right to make an informed decision in respect to their health and wellbeing even if that decision may appear unwise to others.

The Mental Capacity Act also dictates that practitioners must take all reasonable steps to ensure that individuals are fully informed of the consequences of their decisions and actions. Practitioners must satisfy themselves that they have taken adequate steps to ensure not only fully informed consent, but also fully informed withdrawal from services.

There is little evidence from records made by agencies' representatives during the timeline, that any professional had the opportunity to discuss the implications of Adult C's actions in respect to her health and social care needs. This was in part due to the pattern of missed appointments with Adult C and her son. Adult C's son would often make appointments or contact agencies on behalf of Adult C requesting for example information in respect of direct payments, or to acquire medication. However, when Adult C was approached by professionals for help with these issues she would decline to engage if her son was not present.

It was unclear to the professionals involved how the relationship between Adult C and her son impacted on her ability to make autonomous choices. For example when District Nurses tried to visit the home for the eighth and final failed appointment they were prevented from entering by her son who was documented as being "under the influence". Housing officials were not always clear as to whether Adult C was fully aware of her financial situation. For example, when agencies attempted to inform her of her imminent eviction due to housing arrears, she did not appear to be aware that her rent was not being paid. Adult C stated to the local authority housing representative at the time "her rent is being paid and that her son makes all the rent payments on her behalf". This is something that the housing representatives knew to be untrue yet her understanding of her circumstances went unchallenged.

A joint visit was undertaken between Independent Living and Adult Social Services, which resulted in no further action, due to Adult C refusing the workers access to her property resulting in a short interaction with services on the doorstep. A number of interactions with professionals took place either on the door step, through a letterbox or through an open window.

From the limited interactions between Adult C and professionals, it is difficult to see how any one agency could have assessed Adult C as being able to make a fully informed decision about her ongoing needs.

Many professionals throughout their involvement with Adult C, maintained that they did not have reason to suspect that Adult C lacked capacity. During the learning event, however, the District Nursing team representatives informed the review that on their final home visit they had made a referral to Mental Health Services. This was because they had become concerned about Adult C's mental health. They believed that her presentation may have indicated that mental health difficulties may have had an impact on her capacity at this time. There was no record within the district nursing or GP documentation of this referral being made. Discussion with Adult C's GP following the learning event highlighted that recordings made following the second house call indicated that whilst Adult C was presumed to have capacity, this may have needed to be reviewed at a later date. Which may have indicated assessment of capacity to be considered.

Adult at Risk Threshold for Referral

From the records and discussions with practitioners during the learning event, it was evident that Adult C's presentation suggested that she was an Adult at Risk. Despite this there was no evidence that any one professional considered making an adult at risk referral to the local authority.

The District Nurses risk assessment highlighted risks to professionals visiting the home due to the son's behaviour, home safety and conditions. This assessment did not however translate to a consideration of a safeguarding concern for Adult C. Documentation within the GP records indicated that the District Nurses believed Adult C's son was influencing her decisions in respect to accepting care. Despite their concerns the District Nurses did not consider the need to discuss the situation with the Health Board Safeguarding Team, or with Adult Safeguarding within Adult Social Services.

During the learning event, the Local Authority housing team recognised that Adult C's financial circumstances could have been influenced by her son, however at the time of their involvement they did not consider that she may have not been fully aware of her circumstances in respect to unpaid rent. This was despite her denial of being in arrears as she believed her son was maintaining payments.

It was also noted at the learning event that historic information was held on police systems in relation to Adult C's son which, had he been her carer (as some agencies had presumed), could have raised additional concerns for Adult C's wellbeing. Police records did not indicate that Adult C's son had any caring responsibility for his mother and therefore

the PPN submitted to Adult Services in relation to concerns about Adult C's health and wellbeing did not include his details or background information. Had an adult at risk report been made to the local authority by one of the agencies involved with Adult C, this would have brought in to question the caring responsibilities of her son and the information held by police would likely have been shared.

The Social Services and Wellbeing (Wales) Act 2014 (Section 128) Duty to Report an Adult at Risk places a duty on relevant partners of a local authority to report any adult they suspect to be at risk. This does not require evidence at the time of the referral that actual abuse or neglect to have taken place. The aim is to protect people who need it and to help them to prevent abuse or neglect. There is little evidence from the records of professionals involved during the timeline that this was considered. Where it was considered practitioners ultimately defaulted to the position that Adult C was refusing services and had capacity to do so.

Working Together to Safeguard People Volume 6 – Handling Individual Cases to Protect Adults at Risk recognises that consent is a significant factor in deciding what action to take in response to a concern or allegation in respect to an Adult at Risk. Identified within the document however, are circumstances when due to their care and support needs, Adults at Risk may be unable to protect themselves. Professionals in these circumstances should use professional judgment to assess if the adults needs for care and support affect how far they are able to exercise informed choices free from pressure or duress. Consideration should not only be given to consent or capacity to agree to an Adult at Risk enquiry but also the nature and effect of the adults needs.

The view of the adult to decline an assessment may be overridden where a professional believes that despite capacity there is high risk to health and welfare of the individual.

The Social Services and Wellbeing (Wales) Act 2014 places a duty on the local authority to consider if the adult thought to be at risk is not making decisions freely, when deciding the nature of their enquires. Had an adult at risk referral been initiated, full consideration of the above could have been made under the adult safeguarding processes.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes:-

Recommendation 1

All agencies should ensure all information pertaining to an individual believed to be at risk or in need of support is shared with staff members within their own agency working with that individual to ensure a robust

risk assessment is conducted. There should be adequate systems in place to facilitate this.

Recommendation 2
Agencies should ensure that staff are aware of the definition of an adult at risk and their responsibilities under section 128 of the Social Services and Wellbeing (Wales) Act 2014. Lack of consent should not be a barrier to making a referral if professional judgement dictates that there is an ongoing risk to health and welfare of the adult at risk.

Recommendation 3
All agencies should be alert to the potential influence of carers and significant others on an individual with care and support needs, to ensure decisions are made freely and not under duress and in the adult's best interest.

Recommendation 4
Agencies should have an ongoing auditing and monitoring process of records to provide assurance that an individual's wishes and feelings have been considered and evidences informed decision making.

Recommendation 5
The Regional Safeguarding Board should consider the introduction of a Multi-Agency Self Neglect Policy and associated training so that frontline practitioners can recognise indicators of self-neglect and are able to recognise when this may present as a safeguarding concern. A multi-disciplinary and/or multi-agency approach should be adopted when working with adults if self-neglect is suspected.

Recommendation 6
Health and Social Care agencies to ensure the availability of safeguarding advice, support and supervision and reinforce professionals' responsibility to access that service.

Statement by Reviewer(s)			
REVIEWER 1	Debbie Pachu	**REVIEWER 2 *(as appropriate)***	Claire Jackson
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- ● I have not been directly concerned with the individual or family, or have given professional advice on the case ● I have had no immediate line management of the practitioner(s) involved. ● I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ● The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- ● I have not been directly concerned with the individual or family, or have given professional advice on the case ● I have had no immediate line management of the practitioner(s) involved. ● I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ● The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)* 		**Reviewer 2** *(Signature)* 	
Name *(Print)*	Debbie Pachu	**Name** *(Print)*	Claire Jackson
Date	July 2019	**Date**	July 2019

Chair of Review Panel (Signature) 	
Name *(Print)*	Clayton Ritchie
Date	July 2019

Appendix 1: Terms of Reference
Appendix 2: Summary Timeline

Adult Practice Review process
To include here in brief: ● *The process followed by the SAB and the services represented on the Review Panel* ● *A learning event was held and the services that attended* ● *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
Cardiff and Vale Regional Safeguarding Board chair notified Welsh Government in February 2018 that it was commissioning a Concise Adult Practice Review in respect of case APR4/2017. The services represented on panel consisted of: South Wales Police Cardiff & Vale University Health Board Cardiff Council Adult Services Cardiff Council Housing Department Cardiff Council Independent Living Services Cardiff Council Occupational Therapy Services Cardiff & Vale RSB Business Unit A learning event was held on the 28th February 2019 and was attended by representation from the following agencies: South Wales Police Cardiff & Vale University Health Board Cardiff Council Adult Services Cardiff Council Housing Department Cardiff Council Independent Living Services Cardiff Council Occupational Therapy Services The GP was unable to attend the learning event. However, the reviewers met with the GP on 28th March 2019 and the comments and feedback provided was incorporated within the report. Adult C's son as her only known family member was notified in writing of the decision to undertake the APR and was given the opportunity to meet independently with the reviewers for his view to be represented. Additional attempts were made by South Wales Police liaison to liaise with the son, to facilitate engagement, however this was unsuccessful.
X☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Bwrdd Diogelu Oedolion Rhanbarthol Caerdydd a'r Fro
BDORhCaF
C&VRSAB
Cardiff & Vale of Glamorgan Regional Safeguarding Adults Board

Cardiff & Vale of Glamorgan Regional Safeguarding Board

Terms of Reference for an Adult Practice Review (Concise)
Re: APR 4/2017

Introduction

A concise adult practice review will be commissioned by the Regional Safeguarding Adults Board (RSAB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. A concise adult practice review will be commissioned where an adult at risk who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be ***September 2016 – 10th November 2017***

- The following services will produce a timeline of significant events of its involvement with the Adult, for the timeframe above. A merged timeline will then be produced.

  - *South Wales Police*
  - *Cardiff & Vale University Health Board (GP/District Nursing)*
  - *Cardiff Community Occupational Therapy*
  - *Cardiff Council Independent Living Service (ILS)*
  - *Cardiff Housing*
  - *Cardiff Adult Social Services*

Core Tasks (for a concise/extended adult practice review *(delete as appropriate)*

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.

- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review not already requested by the CPR/APR Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the RSAB for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Regional Safeguarding Adults Board (RSAB)

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review panel* completes the report and action plan.

- RSAB send Report and Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the CPR/APR Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSAB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the RSAB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Summarised Timeline APR 4/2017

2nd September to 20th March 2016	2nd September 2016 Housing finance services - Referral triggered due to rent arrears. First recording during the review period, which resulted in three ineffectual contacts. **16th September 2016 -** ILS Referral made by housing welfare liaison team for direct payments. **27th September 2016 -** Case closed by welfare liaison team due to 3 ineffectual visits. Adult C is unaware as to why the welfare team visited. Son not present. Housing finance services also closed their case due to three failed appointments. **17th November 2016 -** Tenancy officer followed up with visit to the family home, however no action was taken as the tenant was not home. Follow up letter sent. **20th December 2016 -** Case closed by Tenancy Officer as no further complaints were received. **8th January 2017 -** Housing Finance Services contacted Adult Cs son to book an appointment to discuss Adult Cs tenancy issues. **11th January 2017 -** First Occupational Therapy contact received from Adult Cs son, requesting an assessment regarding Adult C having mobility issues.

	12th January 2017 - Housing Finance Services spoke to Adult C regarding outstanding rent arrears. Adult C was informed that payments not being made, with Adult C responding that her son was making payments. **16th February 2017-** Adult Cs son turns up for General Practitioner appointment instead of his mother, requesting a medication review, as his mother is unable to attend the appointment due to limited mobility. On the same day the Housing Liaison and Finance team visited the family home and handed Adult Cs son an application form for Direct Housing Payments through a window.
20th March 2017 to 13th June 2017	**22nd March 2017 GP** home visit, noted that Adult C was unkempt, with unmet health needs. Referral made to district Nursing team, for further assessment and treatment. **23rd March** – District nurses closed case due to four failed appointments, **28th March 2017** Public Protection Notification (PPN) generated following a report from a neighbour regarding a dog barking and Shouting at Adult C's home address. Officers note poor living conditions, with one referring to home conditions as squalid.

	4th April 2017- Referral opened on Care First Adult Services database by Independent Living Services (ILS) contact officer following receipt of the PPN. **21st April 2017-** Case opened by ILS contact officer on Care First Adult Services Database. **27th April 2017 -** Decision made to progress the referral even though Adult C did not consent. This was due to concerns about her mobility, self-care and the presence of a large dog. No immediate risk was identified that required an urgent visit at this time. **7th May 2017** - Police record show that a Neighbour had contacted them due to concerns that Adult Cs dog had been in the garden for the last two days with no sight of Adult C . No PPN generated as officers felt there was no concern when they attended. **13th May 2017** – Police received further contact from the same neighbour expressing concerns about Adult Cs welfare. No PPN submitted as no concerns at this stage. **17th May to 20th June 2017** – Five requests are made to the General Practitioner during this time period requesting repeat pain medication for Adult C. Requests are made by both Adult C and her son.

	19th May 2017 - Occupational Therapy Assessment completed. Stair-lift recommended to facilitate access to the upstairs bathroom. Adult C declined this offer. **24th May to 30th May 2017-** Three further contacts are attempted by the housing liaison team to discuss rent arears. Adult C declined these requests, as her son was not present. **7th June 2017 -** ILS attempted a home visit but did not gain access.
14th June to 10th November 2017	**20th June 2017** – Adult C requests a further prescription for pain medication from the General Practice. **22nd June 2017** – Housing liaison closed Adult Cs case due to lack of engagement from the family. **14th July 2017 -** Housing finance advised Adult C that rent payments were not being made and they were progressing an eviction notice. Adult C advised them that they needed to speak to her son. **1ST August 2017-** GP records indicate that the district nurses are awaiting further instructions from GP as they had not managed to engage with Adult C. They were concerned about Adult Cs deteriorating health. They could see the house was cluttered and thought the son's presentation to be a cause for concern. The GP tried to contact Adult C that same day and left a message on the answer machine asking her to ring back. GP also sent a letter that day.

	7th August 2017 Adult C refuses entry to the Housing repair team. Case closed as they had no power to compel the tenant to comply. **23rd August 2017 -** Housing finance telephone Adult C, as they needed to discuss tenancy issues with her. Adult C put the phone down, stating she could not hear. **28th August 2017**- District Nurses Lone Worker Risk Assessment completed. Identified risks to Adult C. **29th August 2017** – Police attended the home due to neighbour reporting a domestic incident after hearing shouting at the family home. When police arrived, there was no disturbance. The TV was on loud and there was a large dog. No PPN was submitted as no concerns raised by attendance. **14th September 2017 –** Housing finance possession proceedings start. **10 Nov 2017** 999 call received Ambulance Service from Adult Cs son reporting that he had found his mother on the floor and she appeared to be deceased.