Safeguarding Adults Review

Following death of "Mr A" – an adult at risk

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Enfield Safeguarding Adults Board

ENFIELD Council

Contents

1 INTRODUCTION

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review (SAR), undertaken on behalf of the Enfield Safeguarding Adults Board (ESAB), relating to a man who is referred to as 'Mr A' throughout to maintain his confidentiality.

The SAR is not intended to attribute blame but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Enfield in the future.

1.2 The review was conducted in the light of the following legislation;

The Care Act 2014 – Section 44 Safeguarding Adult Reviews

A Safeguarding Adult Board (SAB) must arrange for there to be a case review involving an adult with needs for care and support (whether or not the local authority has been meeting any of those needs), if there is reasonable cause for concern about how the SAB, participating members or other individuals worked together to safeguard the adult, and condition 1 or 2 is met.

Condition 1 is met if –

(1) The adult has died, and

(2) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

Condition 2 is met if –

(1) The adult is still alive, and

(2) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.3 The Department of Health Care and Support statutory guidance – published to support the operation of The Care Act 2014[1], states:

Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that the partner agencies could have worked more effectively to protect the adult.

and

The following principles should be applied by SABs and their partner organisations to all reviews:

(1) There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.

(2) The approach taken to review should be proportionate according to the scale and level of complexity of the issues being examined.

1 http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

(3) Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

(4) Professionals should be involved fully in the reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

(5) Families should be invited to contribute. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

1.4 It is vital, that individuals and organisations are able to learn lessons from the past, reviews and trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs, their response will be defensive, and their participation could be guarded and partial.

The process for undertaking SARs should be determined locally, according to the specific circumstances of individual circumstances. No specific model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died and/or have been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

1.5 A referral for a safeguarding review was made by the Enfield Strategic Safeguarding Adult Service. The SAR for Mr A was agreed on 04/01/2017. The panel of board partners had the consensus that the most appropriate methodology was a Multi-Agency Partnership Review, with an independent author commissioned to write the review. The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved. SARs are not to apportion blame, but to identify learning and how we can as individuals, organisations and as a partnership identify alternative responses and ways of working. Its purpose is not to hold any individual accountable. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.

1.6 The partners whom took part in this review included:

(1) London Ambulance Service (LAS)

(2) LBE Departments

(3) North Middlesex University Hospital NHS Trust (NMUH)

(4) Metropolitan Police Specialist Crime Review Group.

(5) London Borough of Enfield (LBE) Council Housing

(6) Local GP

(7) Eastbrooke House Residential Care Home

(8) Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT)

(9) LBE Safe and Connected

(10) London Fire Brigade

Two multi-agency learning events were held on 04/05/2017 and 24/05/2017 for partners to share their Individual Management Review (IMR) reports, to challenge one another and to share learning and recommendations.

The review provides a chronology of known partner contact with Mr A from 01/08/2013 to his death on 08/12/2016. In addition, agencies were asked to give a summary of any involvement with the deceased which falls outside the scope of the review and to identify any events that they think are significant.

The deceased did not have any immediate family involved in his life at his time of death but his long-term friend and informal carer was contacted and has taken part in this review.

2 BACKGROUND

2.1 Mr A was a 70-year-old white Irish male whom lived alone in a first-floor council owned sheltered accommodation flat since 2008. This is accommodation for people aged 60 years and over. He had no apparent family members involved in his life and had a limited social network, which included his long-term friend and his informal carer (Ms D). Alcohol and cigarette use feature as lifestyle choices up until a period of hospitalisation and a suspected diagnosis of vascular dementia and had a stroke in 2015, two years before his death.

2.2 He became known to Enfield Social Services on the 02/12/2014 following a referral from his Sheltered Housing Officer. Since that time Mr A had intermittent contact with a number of different agencies including The Enfield Access team, Community Nursing, The Enfield Housing Team, North Middlesex Hospital, Enfield Police and Enfield Safe and Connected Services.

2.3 On 05/12/16, Mr A contacted the Enfield Safe and Connected Service via his pullcord in his flat. They subsequently contacted the London Fire Brigade (LFB) and London Ambulance Service (LAS). On arrival at the property, the LFB rescued him and he was provided with first aid and conveyed to the Royal London Hospital. Sadly, two days later he died. The cause of death was recorded at the Royal London Hospital as being a Smoke Inhalation Injury and was linked to his Associated Condition – Dementia. An inquest held at Barnet Coroners Court on 13/04/2017 confirmed that as the cause of death.

2.4 The review acknowledges the concern and efforts of individuals and agencies who endeavoured to assist Mr A and acknowledges this and the need to identify good practice, however, the focus of the review must look at missed opportunities and on the learning that is identified.

3 TERMS OF REFERENCE OF THE SAFEGUARDING ADULTS REVIEW

3.1 SAR Methodology

This SAR is being carried out using the Multi-Agency Partnership Review methodology. The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved. SARs are not to apportion blame, but to identify learning and how we can as individuals, organisations and as a partnership identify alternative responses and ways of working.

A multi-agency partnership review methodology is being used to provide an opportunity for each organisation who had contact with Mr A to collaboratively consider how they worked together and the factors which influenced and contributed to his death. This review's methodology is done by giving organisations an opportunity to complete an 'organisational report', which is then shared with all partners contributing to the review. The Safeguarding Adults Board Panel has decided in this case for an independent author who will provide additional challenge and scrutiny. All partners whom had contact with Mr A will then come together to consider what occurred, the systems and structures in place at the time, and any learning and recommendations. The independent author will then draft a report which is shared with partners in its final form, before presentation to the Safeguarding Adults Board.

It should be noted that all organisations are expected to put in place any immediate remedial action that has been identified; the SAB Officer will contact organisations directly to collate information in relation to this.

3.2 Timeframe

SARs are expected to be completed within a six-month timeframe. This SAR was agreed by Board Panel members on the 4th January 2017.

Two reflective learning sessions were held in May 2017. The review was unable to be conducted within the desired six-month timescale and this was not achievable due to the complexity of factors involved and information that came to the fore once the review was underway. The reasons for the delay are explored within this report. This review acknowledges that wherever possible, steps to address some of the learning identified have not been delayed awaiting publication.

The final report was presented to the Safeguarding Adults Board on (DATE)

3.3 Organisations Involved

(1) North Middlesex University Hospital NHS Trust

(2) London Ambulance Service

(3) London Borough of Enfield. A single response which incorporates the following teams: Access Service, Multi-Agency Safeguarding Hub, Housing, North Middlesex Hospital Social Work Team, Care Management Team, Safe and Connected Service, Environment (building).

(4) General Practitioner (notification to NHS England)

(5) London Fire Brigade

(6) Enfield Community Service (BEH-MHT)

(7) Eastbrooke House Residential Care Home

Additional information may be sought from partners to contribute to the narrative of this case or where gaps in information may be identified. This would be identified by the Independent Author and co-ordinated by the SAB Officer.

The Independent Author will meet with family and/or caters as required and determined by the Panel.

3.4 Organisational Reports

A template is provided to enable all organisations to collect and present their findings.

Organisational reports should include:

(1) Chronology of input from first contact or notification of the case involving Mr A from August 2013 to date of the death.

(2) Narrative of organisations involvement. This will provide the additional information gleaned from interviewing staff, reviewing records and reflecting against organisational policies, procedures and practice. This is about reconstructing how professionals saw the case at the time and why they chose the actions they took.

(3) Challenges and Opportunities. This section is for consideration at the organisational level – looking at aspects of the case, the practice and the factors that influenced the work the professionals did – and at the partnership level, in terms of the perception of how well partners did or did not engage in actions being undertaken. This section is an opportunity to look at the broader significance and the wider issues in the system.

(4) Lessons Learnt. All organisations will have lessons learnt; some may already be embedding into practice, while others through the process of this review, may be identified. Where there are lessons for other organisations or partners, this is the place to note them and why you feel undertaking these could be of benefit.

3.5 Parallel Enquiries

A SAR is not to apportion blame and there are instances where other action may be required to hold individuals to account. Organisations may be required to undertake internal investigations and/or use of disciplinary procedures if required.

3.6 Publication

The ESAB is committed to sharing learning from all SARs. Reports will be anonymised and made available wherever possible. In the interest of preserving anonymity.

3.7 Engagement with the Individual/family

While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together – including how learning and accountability can be reinforced both in and across agencies and services – it is imperative that the views of the individual/family are included in this.

Firstly, this is in recognition of the impact of the case. In doing so it enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to be all agencies working as part of the ESAB.

The chair of the ESAB is responsible for informing the family of the updated review and that an independent author has been appointed.

All Individual Management Reviews are to include details of any family engagement that has taken place or that is planned.

The author of the review contacted Ms D, Mr A's carer and subsequently met with her and members of her family and she wished to be involved in the process and her views are recorded throughout this report.

4 EVIDENCE SUBMITTED TO SAFEGUARDING ADULTS REVIEW

A complete list of all written reports, which were submitted to the SAR Panel, including the name of the author and a brief description each document can be found in the Appendices to this report

5 CONTENT OF THE SAFEGUARDING ADULTS REVIEW

Full Integrated Chronology

Summary of Key sections to the review

The independent author has compiled a detailed integrated chronology of the circumstances leading up to, surrounding and following Mr A's death, from all the reports and documents submitted for this review.

To help agencies understand the key periods of the agencies interventions with Mr A, the full chronology has been subdivided into a series of separate summaries, which have been included in this report, as set out below.

(1) 05.02.2002 – 04.12.2014 (Summary of early indicators of emerging risks)

(2) 08.12.2014 – 31.03.2015 (Period of hospitalisation and arrangements for discharge)

(3) 10.04.2015 – 17.08.2015 (Respite placement and events following discharge home)

(4) 06.11.2015 – 31.10.2016 (Analysis of partner involvement – information gathering and assessment)

(5) 05.11.2016 – 07.12.2016 (Escalating Concerns and deterioration)

(6) 5th December 2016 – The Day of the Fire

The following sections of the report set out summaries of all agency involvement for each period of the chronologies (as above). There is then a brief analysis of each period, with learning identified for all relevant agencies. The author then makes summary recommendations within each of the chronologies based on the analysis and learning identified. Each section should be read with any further details sought from the relevant section of the Appendices, as required.

5.1 Chronology 1: 05.02.2002 – 04.12.2014

October 2007

(1) Mr A was living in one room in shared accommodation. He was diagnosed with osteoarthritis and was assessed by the Sheltered Housing Officer to determine if whether or not, he would be eligible for sheltered accommodation. Of note at this stage it is determined that he could verbally communicate but was unable to read or write.

January 2008

(2) Mr A received treatment for his arthritis but this was unsuccessful. By the end of January in 2008, Mr A had viewed and started a tenancy at a first floor flat in Enfield, with Ms D (his carer) shown as his Next of Kin. Mr A signed a Support Plan (which stated that he did not want to have additional support) which would be reviewed in 6 months' time and completed a self-assessment which showed that he was able to live independently. On the 30/01/2008, sheltered housing noted that Mr A completed a self-assessment form relating to his ability to live independently and covered aspects of communication, hobbles and managing money and benefits.

October 2009

(3) Following a community alarm activation, Mr A is taken to hospital following a fall at home and concerns are recorded that it may have been alcohol related.

January 2010

(4) Mr A continues to sign support plans stating he did want to have support. A Sheltered Housing risk assessment was carried out, stating that there was a high risk of accidents to himself and others due his alcohol abuse. Mr A did not consider that he had an issue and refused to sign or agree the assessment.

May 2011

(5) On the 20/05/2011, the smoke alarm was triggered, although Mr A stated that there was apparently no smoke in the flat. Mr A wanted the alarm siren to be turned off and Safe and Connected disconnected the smoke detector, reconnecting it again three weeks later.

July and December of 2013

(6) Mr A went to the Accident and Emergency department at Chase Farm hospital, presenting with head injury (due to intoxication from alcohol).

October 2014

(7) Mr A was identified as a heavy smoker, drinker and someone who struggled with hoarding and wore dirty clothes. The Sheltered Housing Officer raised concerns regarding his mental health with the Sheltered Housing neighbourhood officer. On the 15/10/14, the Metropolitan Police Service (MPS) were contacted by a member of the public on behalf of Mr A, who had received letters from Bedfordshire Constabulary regarding an incident which had taken place.

(8) On the 19/10/14, Mr A agreed and signed a support plan which identified that he needed to refer himself to GP due to his drinking, mental health and arthritis.

November 2014

(9) A support plan is discussed by the Sheltered Housing officer about his lifestyle and concerns regarding alcohol and smoking. Concerns regarding his ability to retain information are raised and a referral made to the estate manager to resolve fire and health and safety issues caused by Mr A's hoarding in the flat. There is an agreed time frame set to deal with the disposal of unwanted items. Ms D is part of these discussions and offers to help Mr A tidy the flat. She explained to this review that she and her family were his main support. She confirmed that Mr A couldn't write at all and could only read a little. She explained that she had always helped with his shopping on a Saturday, even when he had a girlfriend in his life. She did however take a step back from being involved in these tasks whilst he was in a relationship, allowing him space and respecting his privacy.

(10) Following the deterioration of that relationship, Ms D became more involved again with Mr A. He enjoyed boot sales and she found that his hoarding of microwaves and other broken items had increased to the point that he may struggle to get out of the flat in the event of a fire. She arranged removal of these items, working with housing to achieve this. She said that he had gone into arrears with his rent and helped him with her own money in order to pay this back as she was worried he may lose his tenancy.

(11) Ms D expressed concern that as Mr A became more unwell that he was more vulnerable to those he associated with or came across would take advantage of him. She said that during the time when she wasn't taking an active part in his life that his heating had been turned off as the bill hadn't been paid and she arranged for this to be reconnected.

December 2014

(12) A referral was made into the Councils Access Team (who at that time were carrying out adult social care functions) on 04/12/2014 by the Sheltered Housing Officer relating to his hoarding and inability to cope. It requests consideration of a Care Package.

5.1.1 Analysis: Chronology 1 (05.02.2002 – 04.12.2014)

(1) During this initial time period, Mr A's health and lifestyle choices began to become visible to professional agencies i.e. hospital, housing, adult social care. From the outset of his housing placement it is recorded that Mr A could not read or write, yet this vital component to a person-centred approach did not appear to feature as a consideration as part of any future engagement with Mr A. If it was the case that Mr A was unable to read or write, then this may have impacted his ability to fully access services and understand options available to him. The carer states that she assisted Mr A to read the letters that he received from Bedfordshire Police.

(2) Risk indicators (alcohol misuse, accidents in the home, cigarette use and hoarding) start to become apparent. The risk reduction focused on the removal of additional hazards within the home, consideration should have been given to early engagement with the London Fire Brigade.

(3) A referral was made to Adult Social Care by the Sheltered Housing Officer which highlighted concerns, self-neglect, inability to cope and hoarding and related fire and safety issues.

(a) The LFB Home Fire Safety Risk Referral Matrix provides staff with a guide to help them risk assess high, medium and low fire risk factors.

5.1.2 Key Learning Points: Chronology 1 (05.02.2002 – 04.12.2014)

(1) The importance for all professionals to record, retain and share information regarding an individual's preferred method of communication, any access requirements that need to be in place to ensure that a person-centred approach can be delivered.

(2) Individuals cannot lead risk free lives and it is entirely appropriate to ask an individual to self-refer to a GP. In doing so, professionals need to be confident of an individual's ability to make that referral, be assured their mental capacity to both make that referral and retain that information for a sufficient time period to carry out the request. If staff were not confident that Mr A would remember the information, then they should not have asked him to contact the GP himself and instead a best interest decision to share information should have been explored.

(3) Raising all statutory and support organisations awareness of the need for early intervention and referral to the London fire brigade when factors that may include self-neglect, hoarding, alcohol and indoor smoking risk factors are identified.

5.1.3 Recommendations: Chronology 1 (05.02.2002 – 04.12.2014)

Multi-Agency Recommendation 1

The ESAB seeks assurance that LBE multi-agency organisations case management systems and training inputs encourage and support staff to help keep people safe by being able to communicate effectively with them by:

Recording preferred method of communication / contact for an adult with care and support needs, whether that is through language or other communication or access needs.

Recording any requirements for reasonable adjustments and note this when they have been completed.

Multi-Agency Recommendation 2

That the ESAB seeks assurance that ongoing Mental Capacity Act training considers the inclusion of an input regarding an adult's executive capacity to ability to self-refer to other organisations or support services. This should include: does the person have mental capacity to understand how to make the referral? do they understand what actions they need to do to keep safe? do they understand the implications to their well-being by not making the referral?

5.2 Chronology 2: 08.12.2014 – 31.03.2015

December 2014

(1) The Sheltered Housing Team requested an assessment for a package of care and this is subsequently logged on the Care First system. The access team spoke to Ms D who indicated that Mr A would not accept help and fed this information back to the Sheltered Housing Team, but it was agreed that an assessment would be carried out.

(2) A further attempt is made to contact another of Mr A's friends to discuss Mr A's needs, it was unsuccessful and a letter regarding the request for assessment was sent to Mr A.

(3) During the period of December 2014 to May 2015, the Sheltered Housing Service Managers had a reduction to their budgets. This meant that there were no sheltered housing officers on site and whilst daily calls were being covered by colleagues across the service, this impacted on file notes around any activity involving Mr A. Ms D expressed concern at the reduction of on-site wardens at Mr A's sheltered accommodation. She felt that this resulted in no one being on site from a Wednesday through until Monday morning, she felt that this had a significant impact on Mr A's wellbeing (and other residents). She describes him as a lonely man and he enjoyed the events in the common room.

February and March 2015

(4) On the 16/02/2015, Ms D becomes concerned about Mr A's physical and mental health and he was taken to the North Middlesex Hospital Accident and Emergency Department, where he was admitted with a history provided by the LAS noted his deteriorating mental state, a painful knee and fast heart rate. On 16/03/2015 a consultant psychiatrist instructed a referral to

memory clinic on discharge. The stroke team confirmed a likely new stroke (cerebellar lesion). They recommended an application for Deprivation of Liberty Safeguards (DoLS) application and that he may need placement in his best interests. The mental health liaison team agreed with the capacity decision. They agreed to refer him to the memory clinic. There is limited information available about this decision and no evidence provided that this referral happened.

(5) The IMR for the North Middlesex Hospital describes his behaviour as challenging. He was recorded as being non-compliant with medication and observations with evidence that he refused some meals and personal care. He was treated in hospital where concerns are raised by physiotherapy department that he was at risk of falls, had poor safety insights and was subsequently described as being back at baseline (an original starting point in non-diagnostic assessment of health needs). A section 2 notification of intended discharge from hospital was raised to consider Mr A's needs, whether he would return home or placed elsewhere.

(6) His diagnosis was complex including stroke and vascular dementia.

(7) In hospital, a Computerised Tomography (CT) scan indicated that Mr A had a right cerebellar lesion indicating that he had a new stroke. His behaviour was described as challenging and some evidence noted of refusing personal care and meals. A mental capacity assessment was conducted which determined he lacked mental capacity to consent to treatment and discharge destination.

In due course, a section 5 notification is sent through to inform social care that he was now medically fit to leave hospital but will need social care support after he left. A continuing health care checklist was completed but did not trigger a full assessment and there is no best interest assessment on his file.

(8) Following the section 5 notification a social worker in the hospital team was allocated to Mr A and she made contact with Ms D, who explained to the social worker that she was supporting Mr A in a carer's role. The social worker came to the decision that the best option for Mr A would be for him to be in a residential placement as he lacked capacity or the ability to make informed decisions and choices. It is not evidenced that this decision was communicated to Mr A. A social worker at the hospital also noted that Mr A was confused and unable to engage in discharge planning or care needs assessment. The social workers view on the placement is supported by the Occupational Therapy Team who outlined that Mr A always needed supervision due to the confusion, recurrent falls, aggressive behaviour and non-compliance with taking medication. Despite Ms D view that Mr A should return home and be supported by community-based care, a decision was taken that Mr A will trial residential care before being placed permanently.

(9) Representatives from the residential home visited Mr A to assess him. The social worker informed Ms D that Mr A was being discharged to the home on 31/03/2015 for a four-week respite placement to see how he feels about being in residential care. A new Section five notification (hospital discharge) was issued outlying the agreed measures and Ms D drove him to the placement where she signed the assessment papers.

5.2.1 Analysis: Chronology 2 (08.12.2014 – 31.03.2015)

(1) A safeguarding concern was not raised for Mr A on admission to hospital. One suggested explanation given was that the LAS had previously raised one and that Mr A was discharged to

a place of safety. It transpired that the LAS had in fact made a referral for Mr A as an adult at risk (welfare concern) rather than raising any specific safeguarding issue. London Ambulance Service referrals of safeguarding or welfare concerns were shared with social services on the same form.

(2) On admission the medical notes did not suggest that Mr A was in an acute phase of alcohol detox and medical notes document that the carer states he hasn't been drinking for months. This is of note as Mr A does not appear to be using alcohol from this point and it therefore doesn't feature as a potential risk factor. Within learning events, the hospital reflected that the discharge notes for Mr A were not robust and there was scope for improved working practices around consideration of the Mental Capacity Act, Safeguarding and Deprivation of Liberty requirements (DoLs). A DoLs application was not made for Mr A.

(3) Critically, the final discharge summary does not include the diagnosis of vascular dementia nor did it advise the GP to refer Mr A to the memory clinic or other support services to support him in this transitional phase. It is not clear that details of these services were made available to Ms D either.

(4) Whilst a Mental Capacity assessment (MCA) was carried out in respect of treatment and his discharge destination there does not appear to be thought given to how Mr A's voice in the process could be heard and how he might have been able to participate in decision making as outlined in principle 2 of the Mental Capacity Act 2005. This is a key requirement when a decision is being taken to place an adult in a residential setting. In the learning events, the hospital shared that Mr A had agreed to the placement but the decision-making process and his views do not appear to have been evidenced.

(5) Mr A was assessed as lacking capacity and the Mental Capacity Act requirements should have been applied and a Best Interest process then follow including reference to the statutory checklist. This would have included consideration as to what he would want.

(6) Ultimately his move to the care home was an unlawful deprivation of liberty if he lacked capacity to make the decision and no best interest process was followed.

5.2.2 Key Learning Points: Chronology 2 (08.12.2014 – 31.03.2015)

(1) Where changes are made to existing arrangements around adults with care and support needs and opportunities for interaction and observation may vary, it becomes more incumbent on all agencies to ensure strict compliance with the Mental Capacity Act and Best Interest. MCA is time and decision specific.

(2) There is no next of kin in the legal sense, e.g. no lasting power of attorney. Carer and appropriate advocacy are raised within this review. Ms D is identified in the healthcare records under the next of Kin /Emergency contact relationship and is noted as 'friend'. Mr A had no apparent immediate family members and thus a quest to seek out friends or carers opinions in decision making comes to the fore.

North Middlesex University Hospital

(3) Safeguarding referrals to be made when concerns come to the attention of Health staff, assumptions must not be made that this has been actioned by others.

(4) That when Mental Capacity or Best Interest decisions are made that the views of the adult concerned are not only sought but fully documented. This is a key requirement of the Best Interest Statutory Checklist. It should also document options on how the adult can be supported in this process.

(5) The diagnosis of Vascular Dementia may have raised doubts as to Mr A's capacity. A diagnosis may be an indicator that he may lack capacity to make a variety of decisions relating to his health, care, risk awareness and safety. A diagnosis of Vascular dementia may mean that someone has times of lucidity or fluctuating capacity. Mental Capacity is decision specific. In this case a Continuing Health Check was done (CHC) regarding his treatment and discharge arrangements but he did not meet the criteria. Therefore, arguably there was a greater role to support Mr A at this stage from adult social care.

(6) Discharge planning notes must be robust with considerations clearly documented and quality assured to ensure safeguarding issues, MCA and DoLs considerations and the voice of the adult (including access to advocacy). They should evidence reasonable adjustments.

(7) It is vital that any medical diagnosis and instructions for follow on care and support are clearly documented in discharge planning notes.

(8) To ensure discharge planning notes document how a decision has been taken for short and long-term care options. Discharge planning options should involve supported decision making and the exploration of other options that family or carers may initially discount.

(9) Management oversight of final discharge plans or determining the outcome of a review.

Adult Social Care Staff, Mental Health, Community Matrons and Hospital Discharge teams

(10) Despite an obvious deterioration in Mr A's condition there is no apparent consideration for whether Ms D could cope with her role as carer, whether that role was sustainable or whether she required an assessment, advice, support or information in line with carers rights legislation.

(11) In poor health herself, in recovery from cancer and having asthma, she explained that she was genuinely concerned that social services wouldn't allow her to continue supporting Mr A because of her health and that may have been a barrier to her asking for help earlier.

Hospital SW Discharge Team

(12) There needs to be more managerial oversight of reviews and final discharge plans. Appropriate referrals to long term teams are actioned timely and with sufficient information about the case.

(13) Application of the Mental Capacity Act was a legal requirement before Mr A was discharged. There needs to be clear understanding by hospital teams of the Deprivation for Liberty Standards (DoLs), both of their own responsibilities whilst someone is in a hospital setting and that of the role of the local Authority and any placement that follows.

North Middlesex University Hospital

(14) All staff have received training on safeguarding and the process to follow. This learning has been shared at the Safeguarding Learning Events and being imbedded by Matrons across

the hospital. Level 1 and Level 2 training now include discussions around the responsibilities on staff for raising concerns. Ward groups use a colour coded scheme to ensure that all staff know if a patient is subject to a safeguarding enquiry or concern and/or DoLs.

(15) Awareness and training have been provided to all appropriate staff. Weekly email updates to Clinicians, Matrons and Ward Managers about DoLs requirements, compliance levels and changes in case law. This is subject to audit and review by the Safeguarding Adults Lead. On-going training at departmental and ward meetings facilitate an opportunity to capture new staff and reiterate the requirements.

5.2.3 Recommendations: Chronology 2 (08.12.2014 – 31.03.2015)

Multi-Agency Recommendation 3

That the ESAB ensures that LBE agencies provide staff with information to assist when a person identifies in a carer's role. They should be reminded of their duties under Section 10 of the Care Act which sets out carers' legal rights to a carer's assessment and support. The Care Act gives local authorities a responsibility to assess a carer's need for support, where the carer appears to have such needs.

Multi-Agency Recommendation 4

Professionals should consult those closest to a person who may lack mental capacity to help understand their wishes and feelings and to make a decision in that person's best interests.

It is recommended that the person the adult wishes an organisation to communicate with on their behalf is referred to as their 'nominated point of contact 'and not as 'next of kin' unless a legal basis for that authority has been established either through the Office of the Public Guardian (OPG), Lasting Power of Attorney or the Court of Protection. Carers or family members should not be asked to provide consent to care plans, financial assessments or other interventions without having a legal basis to do so.

http://mentalcapacityresources.co.uk/uploads/3/4/7/8/34787700/next-of-kin-booklet.pdf

Multi-Agency Recommendation 5

That the ESAB seeks reassurance from the NMUH Clinical Director that a documentation audit is completed of discharge summaries to ensure accuracy and quality of information. This should focus on discharge planning in the Care of the Elderly ward and the learning and recommendations from this review.

5.3 Chronology 3: 10.04.2015 – 17.08.2015

April 2015

(1) A support plan and financial assessment for Mr A was conducted by a social worker and presented to Ms D who did not sign as she did not want to be liable for Mr A's finances. This request illustrates a misunderstanding of Ms D's role and of their relationship.

(2) After a six week stay in hospital, he stayed at a residential setting which provided 24-hour care for a four-week period. Whilst there Mr A displayed some concerning behaviour. He tended to wander and he climbed over a 6-foot fence twice, on 31.03.2015 and then again on 21.04.2015, in order to try and go home. Mr A's smoking also came to attention of staff to the extent that they kept his lighter at night time, to prevent him smoking in his room as they felt he did not understand the associated risks.

(3) He was seen by a dentist and a GP in the residential setting who conducted a heath check and provided a prescription for his medication. It is not clear if the GP was aware this was a respite placement or if they were involved in the decision-making process that took place between the home manager, Ms D and the social worker who together decided it would be best for Mr A to return to his home environment with additional support. A referral was recorded as being received by the Community Matrons from the GP to review medication and carers.

May 2015

(4) Following Mr A's discharge from respite, the Community Matron (CM) visited him at home. The CM stated that Mr A had no memory of his time in hospital. He was now back living in his first-floor sheltered housing flat. The CM described him as a heavy smoker with no intention of cutting down. He smoked roll up cigarettes which he was reported to only smoke in the lounge area. No evidence of hoarding or clutter was noted. There were no burn marks on furniture or the carpet. There was a pull cord in the home which the CM felt Mr A was capable to reach if an emergency arose. A smoke alarm was noted as being in the flat but it was not routine practice for a CM to test them.

(5) The Nursing Care plan indicates memory loss which was caused by Vascular dementia. The CM felt that Mr A would not engage with other services or visit the GP so any health reviews would need to be conducted at home. The CM described him as wanting to be left alone and as being 'known for being difficult and aggressive at times' – although it is not clear whether this was ever directed towards the CM. To the contrary the CM describes having a good relationship with him as they shared a similar cultural background and he enjoyed playing music when the CM visited.

(6) The initial care plan made by the CM indicates that she would visit every 4-6 weeks or more often if needed initially although. This would later reduce due to the level of support that the CM felt was being provided by Ms D.

(7) Ms D Contacted Sheltered Housing to let them know about Mr A's hospital admission, informed them of a diagnosis of dementia and a referral for input from social services with a visit to conduct an assessment. The visit by the Community Matron was recorded as taking place on 20/5/15. There is no face to face follow up social work visit to Mr A only via telephone which is a missed opportunity to intervene especially with a diagnosis of dementia and the associated risks by him living at home

June – July 2015

(8) Safe and Connected Service confirm that smoke detectors in Mr A's flat are both being tested every month. The Sheltered Housing office (SHO) was in contact with Ms D to organise an assessment of need via the access team, highlighting potential carer stress stating she

gets tired and has her own medical problems. The SHO was concerned that Mr A may lack capacity and refuse services. The Access team advised that Mr A would need to be seen by a medical practitioner for them to step in without his consent, the screening assessment was not completed as they were unable to arrange a time for the social worker and Mr A to do this, as Mr A had no phone. The case was closed pending further contact.

(9) Mr A was visited by CM who provided advice about smoking and cutting down alcohol consumption. It was recorded that his memory is poor but he could still find his way round the local area with support from Ms D.

August 2015

(10) The SHO raised a safeguarding concern due to Mr A being diagnosed with dementia and wanting his care arrangements formalised which was sent through to the Multi-Agency Safeguarding Hub (MASH). MASH requested a capacity assessment for Mr A as he was resistant to support. When it was confirmed there are no specific safeguarding issues, the SHO states she will take up her request with Adult Social Care.

5.3.1 Analysis: Chronology 3 (10.04.2015 – 17.08.2015)

(1) Upon placement in the residential setting, staff took the decision to remove Mr A's lighter from him at night. This is an apparent common practice where there are concerns regarding fire risks. The question remains if there was concerns that he may start a fire within a controlled environment, what were the risks going to be for him at home and how they could have been mitigated.

(2) The behaviour displayed by Mr A was interpreted as him not settling in the residential setting but there does not seem have been active consideration regarding the suitability of that accommodation for his needs and DoLS referral. The home felt the behaviour being displayed may be because he was unable to drink alcohol. They described him as being confused and ending up by accident in other resident's rooms. As the placement in respite was based on Mr A being medically fit to leave, what other additional care and support needs were considered.

(3) The Supreme Court held that in all cases the persons compliance or lack of objection is not relevant[2]. The acid test is that the person is subject to continuous supervision and control and not free to leave. However, the fact he was trying to leave should have alerted them for the need for a DoLs authorisation. This was a missed opportunity to have his needs fully assessed under DoLS and a best interest decision made. This was a significant omission on the part of the Care Home.

(4) As the placement in respite was based on Mr A being medically fit to leave but having other support needs. It is not clear how the circumstances that existed, suggested that it was not safe for him to return to home directly from hospital had changed. Neither does it seem to have been explored whether he could have actually returned home from hospital with a suitable level of care support. The hospital social worker retained ownership of the case for some time and there appears to have been little case management oversight documented.

2 http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2015/07/DOLS-in-the-Hospital-Setting-Updated-June-2015.pdf

(5) The risk assessment and decision-making process for leaving respite care and returning home appears to have been led by personal opinion(s) rather than supported by a decision-making case management model, that would have prompted professionals to consider a person-centred approach which balances choice with protection. Whether these decisions are made in isolation by a professional or driven by the choice of a carer or family and without further assessment, planning or legal process then such actions will not be Care Act compliant. The residential setting felt that it was Mr A's wish to return home and that the care home environment wasn't suited to him. Mr A was restless at night, not sleeping for long periods which the decision makers involved interpreted meant that would be better at home. It is not suggested that any night time care was to be put in place for Mr A on returning home and therefore how this could be monitored.

(6) Ms D told the review that there were two significant points that gave her concern after Mr A left hospital. She felt that his daily care following the hospital admission for the suspected stroke and whilst in respite weren't appropriate to his needs. She visited every day and thought he was dirty or was wearing other people's clothes. He was confused and would urinate in the sink in his room. She felt that his care wasn't to standard because staff knew that she was coming in daily that there was too ready an acceptance to 'leave her to do it'. This was combined with the fact that Mr A's behaviour towards strangers would be increasingly challenging as his health and mental condition worsened. Ms D explained her motivation was to help Mr A to lead as an independent life for as long as possible but says she explained to social services that when she needed help or that she was no longer able to meet his needs, she would ask. Ms D accepts that she didn't ask for help until latter stages of 2016 however equally no-one had been checking with her to see if she needed any additional support.

(7) There is again little evidence of documented consideration by the professionals involved at this stage of decision making processes of compliance around mental capacity, best interest's decision making or use of Deprivation of Liberty Safeguards (DOLS). The sense in the learning events was that these areas are now much more firmly embedded in practice.

(8) The home visits by the CM presented key opportunities to identify risk and respond to identify need. The GP did not attend the home address and appears to have had little contact or involvement with him.

(9) The care plan by the CM was not amended to reflect the level of intervention required. This has been taken as a learning point by the CM team. There are long gaps between recorded visits (up to six months) which may indicate missed opportunities to assess memory, cognitive function and safety in the home. The CM stated that she did call in when visiting other patients in the same road but that this wasn't always documented, therefore there is no supporting evidence of this. This has been taken as a learning point by the CM Team. Mr A was not referred to memory/alcohol services.

(10) The advice that was given by the access officer from Adult Social Care to the Sheltered Housing Officer, that a medical practitioner was needed to decide Mr A's mental capacity was inaccurate. In addition, the Section 9 assessment requirements under the Care Act did not happen.

(11) Although there was a suggestion that Mr A may not engage with services, there is nothing presented that suggested that he actually declined an assessment at this stage. Even if he

had declined Section 11 of the Care Act 2014 states that an adult can decline an assessment unless s/he lacks capacity to decline or s/he is at risk of being abused or neglected. This period of activity again does not prompt a Mental Capacity Assessment.

A letter was sent from the Access team but as we know he had difficulties with reading and writing and therefore, this could have prevented him from responding. It appeared there was little or no management oversight on this case work.

(12) Social work hospital files also showed that there was no follow up after the discharge to the community. A six weeks review was recorded as telephone only via Ms D. A face to face visit by either the original social worker or via the Case Management Service (CMS) is likely to have more positive outcome for Mr A in the community or initiated further work to respond to his needs.

(13) Critically, the lack of face to face contact and the missed opportunities that were available to assess need may have impacted decision making and outcomes at this stage. The lack of a full screening assessment effectively meant there was little or no communication or involvement with Mr A's GP. This combined with the errors in hospital discharge notes saw Mr A 'fall through the net' at an important point of intervention. There was also a missed opportunity when he came to the attention of the MASH, when arguably more could have been done.

5.3.2 Key Learning Points: Chronology 3 (10.04.2015 – 17.08.2015)

(1) Staff to ensure face to face adult at risk participation in assessments are recorded and this is also subject to supervision. (Risk mitigation – The access team has taken the decision to complete home visits in more circumstances than they used to.) Reasons for not having face to face contact should be recorded and subject to supervisor, especially in cases involving those with dementia or other declining cognitive function.

(2) All agencies should be aware of 'iceberg' conditions that may exist for carers. Staff should be encouraged to have professional curiosity.

Hospital Social Work Discharge Team/Enablement Assessment Team/reviewing Team/CMS

(3) Need to ensure all cases are reviewed timely and appropriately. This includes ensuring that systems are in place to support hospital SW team with six-week reviews. There is a yearly target for reviews in place.

(4) A decision not to have face to face reviews needs to be recorded. This is particularly important for cases like Mr A's. He went from someone who was not known by ASC living in the community, who then went into a placement and then returned to the community with no ongoing formal support.

5.3.3 Recommendations: Chronology 3 (10.04.2015 – 17.08.2015)

Multi-Agency Recommendations 6

Adult Social Care and NMUH SW Discharge Team

The ESAB seeks assurance that NMUH and adult social care consider reviewing their existing

risk assessment procedures to reflect the learning identified within this review. This should include consideration given to the potential benefits of development and implementation of a good practice guide for social workers which could provide an example of a structured risk assessment form – (risk minimisation plan) to include:

- Documented efforts to engage adult in options for long term care – desired outcome
- Care and Support Needs
- Lifestyle and Behaviour considerations
- Details of any complex needs
- Mental Capacity and Best Interest Decisions (person centred decision making)
- Preferred method of communication
- Any communication or support needs
- Risk factors (This should utilise the LFB Home Fire Safety Risk Referral Matrix to inform decision making and outcomes (5.1.1.)
- Referrals to support services
- The risk management plan to be supervised and subject to review

Multi-Agency Recommendation 7

That the ESAB sends a letter to highlight the key learning points for domiciliary and residential providers. This letter should highlight to residential units the potential benefits to them and their residents. This may include assisting them with good practice and compliance around effective discharge arrangements, mental capacity, DoLs, valid best interest decisions and risk management.

5.4 Chronology 4: 06.11.2015 – 31.10.2016

Following a period of activity after Mr A returned home from Eastbrooke House, there was a period of several months where Mr A had little or no contact with agencies other than two home visits noted by the Community Matron in November 2015 for medical checks. They reviewed his Care Plan in February 2016 but there was no record that Mr A was seen.

April 2016

(1) On the 06/04/2016, Mr A was recorded as found wandering by police for the first time. He was only able to provide his name and police created a Merlin Adult Coming to Notice report (ACN) to notify Adult Social Care of the incident. (16PAC083555). Arrangements were made by the SHO to fit a second smoke alarm and put a request in for a comprehensive assessment, following the incident on 06/04/2016 which would help to determine Mr A's needs and create a long-term plan.

(2) On 12/04/2016, the access team gathered information from previous hospital reports,

information from the respite placement and the SHO, who shared the possibility of safeguarding concerns. Access states that a comprehensive assessment of needs 'may' have been required and that the information would be passed back to the manager who duly advises contact to be made with Ms D to support Mr A through the assessment process. The case would be transferred to CMS (Case Management Service) for a comprehensive assessment of needs to be carried out.

(3) Following this request, the access team spoke with Ms D and formed the opinion that Mr A is well supported by Ms D and he was functioning well within his own routine. Ms D advised that she would contact Adult Social Care if required and advises Mr A would need support at a face to face assessment. No safeguarding concerns were identified. The SHO contacted the access team advising she was 'worried' as she felt that Mr A was vulnerable due to his dementia. The access team agreed with Mr A's current support network and the case was closed.

May 2016 to October 2016

(4) Throughout the next few months, there were several occasions where Mr A was visited at home by the Community Matron in order to take blood samples, he refused to attend the GP Practice and engage with male nurses who attended his home. He did engage well and comply with female community matron requests.

(5) Following one such visit in October 2016; the CM explains that his memory is very poor and he now forgets who Ms D is. The SHO contacted Ms D to see if he was warm enough during the current cold weather. Ms D felt that he had deteriorated and had been wandering on a number of occasions. Ms D had put her contact details in his pocket in case he was found wandering then she could be contacted directly to come and pick him up. Mr A was referred to the Council Access team for an assessment of needs. They advised the SHO they didn't have a role to play at this time.

5.4.1 Analysis: Chronology 4 (06.11.2015 – 31.10.2016)

(1) From April 2016, a decline in Mr A's mental health comes to the attention of agencies. The information gathered by the Councils Access Team suggests this was based on hospital reports, information from the referrer and the carer. It was not clear whether the information gathered included Community Matrons and whether there was access to (and included) information gathered within the police report.

(2) The information gathering that did take place outlines that Mr A presented as an adult with care and support needs. There were indications that mental capacity to participate in an assessment may have been an issue but that he would engage with some professionals. It appeared that the Councils Access Team took a position that they did not have a role to play at this stage based on information provided solely by Mr A's carer. The referral for needs assessment did not come to fruition.

(3) The Care Act places a duty on the Local Authority to promote well-being. Local authorities have a general duty, when undertaking adult social care functions with an individual, to promote their well-being.: "Where it appears to a local authority that an adult may have needs for care and support, the authority must assess: (a) whether the adult does have needs for care and support, and, (b) if the adult does, what those needs are.

(4) There were significant concerns for Mr A's wellbeing. The weather is noted as being particularly cold and there was a reference to him being found wandering on a number of occasions which by its very nature presented a risk to his health and wellbeing. An assessment of needs was required at this stage.

5.4.2 Key Learning Points: Chronology 4 (06.11.2015 – 31.10.2016)

Adult Social Care

(1) Like the circumstances that prompted the recommendation to consider the development of structured risk assessment roles, similar issues presented in this review where individual social workers and other staff were performing 'information gathering' roles. The collection of information they gathered on Mr A largely appeared to be based on their own professional opinion. Whilst this is an important and integral part of social work it does appear to leave both organisations and individuals more open to missed opportunities, genuine mistakes, errors or omissions as well as a breach of their statutory duties.

(2) There are opportunities to examine and make improvements to working practices to ensure compliance by the Local Authority around staff understanding their responsibilities under Section 1 of The Care Act.

5.4.3 Recommendations: Chronology 4 (06.11.2015 – 31.10.2016)

Multi-Agency Recommendation 8 – ESAB (Adult Social Care, Community Matrons and other relevant LBE agencies)

That the ESAB seeks assurance from relevant agencies that consideration is given to reviewing their existing case management tools to improve a person-centred and wider approach to information gathering. This should include a focus on reoccurring themes such as mental capacity assessment, best interests and the role of carers. The tool could also have information on how Adult Social Care, Community Matrons and other organisations can best utilise the MASH, understand the role of access teams and explore opportunities of how valuable information from other agencies can better inform decisions. This could be supported by case examples and team discussions about what does good information gathering look like.

5.5 Chronology 5: 05.11.2016 – 07.12.2016

November 2016

(1) Mr A's cognitive ability appeared to have had a significant decline with him demonstrating repeated and worrying patterns of behaviour. On 5/11/2016, Police were called by a member of public who found him confused on a doorstep in N21. Upon finding the carers details in his pockets, they took him home. Ms D advises that she will contact his social worker. The report is passed from the police public protection desk to YE MASH (Enfield) on 21/11/16.

(2) On 19/11/2016 a member of the public flagged down police officers having found Mr A in a dishevelled state by the A10 carriageway. He was returned home. This report is also passed to Adult MASH on 21/11/16.

(3) On 24/11/2016, police are called again to Mr A being found and state he is 'seemingly suffering from dementia'. This report is passed by police on 2/12/16 to MASH.

(4) On 28/11/2016 at 14:57, a member of public called police to report that Mr A is on a building site and is disorientated. They took him back home and met with his carer. (16FOU011443 and cad 5103/28Nov refers). Later again that night he is found by a passer-by in the road at the junction of Great Cambridge Road, N21. They bring him to a police station. This incident is added to a previous report. This incident was dealt with by the police team specialising in the investigation of missing people – the 'Misper' team and not shared with the MASH team. (16FOU11443 and CAD5103Nov16)

(5) Ms D utilises the Community Matrons as her point of raising concern about Mr A's decline. Ms D states that she had now become worried that he would get run over, assaulted or exploited and that she could no longer cope with his needs. On one occasion, she received a phone call from a bus driver in London Bridge. Mr A had become lost and disorientated. She went out on that and many other occasions at night time after receiving calls from members of public to go and collect him.

(6) Having just completed a care plan a few weeks prior, the CM visit Mr A at home on 29/11/16 (together with Ms D) and report that at times he becomes very confused. They contact the access team on the phone to request an assessment. The CM IMR (Individual Management Review) documents that Enfield Social Services consider the call as urgent, and plan to visit Mr A after the 8/12/2016. The CM considered that the use of access and sensory alarms may have been useful but this was not actioned as there was no written referral.

(7) The MASH unit noted the call from the Community Matron and that they would request a full needs assessment for Mr A and that the Community Matron had suggested that it might be useful to install telecare equipment. They inform Ms D that a full needs assessment has been requested and that they will arrange this through her as Mr A has dementia. The access team were notified of the request.

December 2016

(8) On the 02/12/2016, the Community Matron attempted to contact MASH again to follow up on the referral as Mr A had wandered again. A message is left on the answer phone. No written referral is made and the CM goes on leave believing they had put the necessary measures in place. No written referral is made again on this occasion.

(9) On the 05/12/2016, there is a serious fire at Mr A's flat.

(See Day of the Fire on 05/12/2016)

(10) Mr A is assessed as a medium priority by the Access Team on 05/12/2016. Unaware of the events that had taken place later that day the social worker contacted Ms D the following day to agree a home visit.

5.5.1 Analysis: Chronology 5 (05.11.2016 – 07.12.2016)

(1) Whilst it is impossible to give a definitive medical insight to the sudden decline of Mr A's mental state at the end of November 2016, it is clear that like other older people, his health and

wellbeing may have taken a sudden and dramatic turn from what had been his ongoing health, care and support needs.

(2) Such was his behaviour at this time, numerous members of the public were sufficiently concerned about him to contact the police. In addition, his carer explained that there were other incidents that she managed herself when she was contacted directly by passers-by. Mr A was found in potentially dangerous surroundings – building sites and main carriageways. This in itself posed a significant risk to his health and safety.

Metropolitan Police Service

(3) The Metropolitan Police Service utilises an IT system called Merlin to record adults and children who may have vulnerabilities. Adults can be recorded as Missing (MISPER), Found (FOU) or as an Adult Coming to Notice (ACN). Mr A came to the notice of police in a confused state on 06/04/2016 and 5/11/2016. On both occasions, officers completed an Adult Coming to Notice form and complied with the agreed process for Enfield Police which is that incidents are reviewed by Enfield (YE) Public Protection team who gave the incident a RAG rate (risk assessment grading) as GREEN.

(4) The MPS Multi-Agency Safeguarding Hub (MASH) RAG rating options are:

- BLUE: No identified additional needs
- GREEN: When adult's needs are not clear or not known
- AMBER: When complex needs are likely to require longer term intervention from statutory or support services
- RED: Acute needs identified. These cases may also require police intervention

(5) The MPS MASH resource guide provides guidance to staff reviewing RAG rating reports on information sharing timelines. For cases RAG rated green, these reports should be shared with Enfield Adult MASH within three days. The incident of 5/11/2016 was not referred until 21/11/16 which was outside the time frame detailed.

(6) When Mr A comes to the attention of police again on 19/11/2016 near the A10 carriageway, officers correctly completed an adult coming notice report. The report was again rated GREEN, despite there being a recent incident. This report was passed on 21/11/16. It is not documented within the LBE report whether the police reports were viewed or shared further but as Enfield operates with a high volume of Adult Merlin's, lower grading may impact on a response.

(7) On 24/11/2016 (16PAC292780) a Merlin Adult Coming to Notice report is correctly competed but again is RAG rated as GREEN. Mr A was now presenting on numerous occasions with dementia and in circumstances where his behaviour and mental health presented a risk to himself. This report was not shared with YE adult mash until 02/12/2016. (this was outside guidelines for sharing green referrals)

(8) Mr A comes to police attention twice on the 28/11/2016. On the first occasion when he is found on the building site (16FOU011443 and 5103/28Nov 16), officers completed a Found

report. There are two types of circumstances where found reports can be utilised by police officers. Category 1: Where we know the name of the person, but do not have an address. Category 2: Where we do not know the name or address. In these circumstances the officers knew his name and address. Found reports are subject to a different overview process. They are not reviewed by the YE PPD (Enfield Police Public Protection Desk) team but are completed and supervised. Unlike Merlin ACN and Misper reports, these reports therefore do not attract intelligence gathering or a follow up risk assessment process.

(9) Later the same day when another member of the public found Mr A, this time by a busy road (CAD9212/28 Nov 16) officers add an additional entry to the found report created earlier. The completion of reports in this manner meant that the YE PPD would not be aware of either incident or be in a position to risk assess or mitigate the risk.

(10) The 16 FOU011443 incident should have resulted in the completion of an ACN report. If the officers had considered Mr A as missing and completed a Misper report, this too would have resulted in a review of the report and the system allows for the creation of an ACN where there is actionable information to share with partners.

(11) The CAD9212/28 Nov 16 incident also required the completion of a Merlin ACN. Another incident where a person is identified as vulnerable or has having mental ill health should not be added to a previous report. During police analysis for this review, an issue with the daily management of police found reports were identified and measures taken to ensure these reports were appropriately dealt with locally in the future.

(12) On 5/12/2016 Police were called to the fire at Mr A's flat. He was found in a life-threatening condition within the property. Officers attended the incident but no report was completed. This incident required the completion of a Merlin ACN in respect of Mr A. The information in previous Merlin reports (and found reports) is searchable and should be included within any new report to ensure a full picture from police Intel is gathered.

5.5.2 Key Learning Points: Chronology 5 (05.11.2016 – 07.12.2016)

(1) Mr A was presenting to the MPS with mental ill health. Ms D was viewed as a means to return Mr A to a 'place of safety'. There does not appear a recognition of the ongoing and escalating risks that Mr A was encountering wandering on building sites and near busy carriageways, unaware of the danger to himself and his surroundings.

There does not appear to have been consideration of Sec 136 Mental Health Act[3] to access immediate treatment at hospital and critically that of Mental Health Services. The police reports suggest that Mr A presented as an older, calm and compliant person and thus his condition meant that he may not have been considered as a risk to others (or himself) and that opportunities to intervene in his mental health crisis were missed.

Adult Social Care

(2) A management review suggests that it was the concerns from the Community Matron on 29/11/16 that were the prompt to conduct the full needs assessment. As a result of this referral, a date was in fact set for adult social care to conduct an assessment but this actually

3 http://www.legislation.gov.uk/ukpga/1983/20/contents

turned out to be just after the day that Mr A died. The 29/11/16 was the day after Mr A had been dealt with twice by police. It is not clear why a review of Mr A's file at this stage would not have highlighted that an assessment under Section 9 of The Care Act was overdue given the escalating risks, a general lack of oversight on the case and the practice was not person centred. Mr A had still not been seen face to face by anyone from the Access Team. A medium priority is given by the access team. It is not clear whether this decision is subject to management oversight. It is not evidenced in the LBE IMR what information gathering took place to inform that decision.

(3) The recording of a medium priority decision by the access team for Mr A also seems to be at odds with the Community Matrons view that the access team identified the call to them on 29/12/2016 as urgent (although this refers to a visit after 8/12/2016). Are all priority decisions shared in writing to avoid confusion between agencies about the agreed level of risk? It was apparent to the review that information gathering to inform risk assessments varies across agencies and this may affect interventions. It highlights the importance of good risk assessment and standardisation of working practices where possible.

(4) There was an apparent failure to identify, recognise and respond to a sudden decline in Mr A's cognitive ability and to identify that a crisis health intervention was required. There also appears to be an over reliance on Ms D's perception as a carer to identify risk and need.

Community Matrons

(5) The Community Matron had established a good relationship with Mr A and his carer. They were well placed to make holistic assessments regarding Mr A's health and social assessments. His relationship with the CM is described as 'good' by the carer. The CM caring for him felt that he did not have a high level of need but kept him on her caseload to support the carer.

By the 29/11/16, Mr A was in need of immediate mental health crisis intervention due to cognitive decline. It is apparent that the mechanisms to access that intervention or methods to escalate concerns were either not known or not accessible.

(6) There is a need to strengthen practice in respect of accessing and escalating the need for immediate need for mental health crisis (due to cognitive decline) intervention. Existing arrangements for other adult's emergency uplifts to care packages may also need strengthening.

(7) There is a need for management oversight for the retention of cases. Staff are reported to carry high workloads and lower level cases need to be appropriately signposted for health and well-being intervention but with clear pathways for re-referral if required. The reason for retention in this case was to provide support to the carer. There is a fine balance to be struck between promoting independence at home and need for risk assessment and decision making.

(8) There is a need to strengthen practice in respect of early referrals to appropriate agencies to ensure the best support is available to service users. Community Matrons were unaware of additional Mental Health Services that may have provided additional support to Mr A and his carer.

(9) Ongoing risk assessment is a dynamic process and care planning needs to include actual and potential risk (applicable to adult social care too).

(10) There were missed opportunities to discuss and review the case within a multi-disciplinary setting and that the perceived silo working may have been a contributory factor.

(11) There is a need for case management oversight both of individuals visit and contact records and to ensure that team manager reviews of individual cases are recorded and actioned. A review of a care plan in isolation does not give true oversight of actual or potential risk.

(12) Risk assessment is a dynamic process and care plans must be reviewed in the patient's home or following a home visit and amended accordingly to reflect changing circumstances.

(13) All patients with declining cognitive function should be discussed at the Multi-Disciplinary Meeting (MDT).

(14) That Community Matrons are aware of how to utilise, refer and escalate an adult of concern to both the GP and Adult Social Services to additional services such as the Crisis Intervention team, The immediate Care Team and their Community Mental Health Nurse or the Memory Service. The NHS Serious Incident Report states that the CM do not currently have authorisation to refer patents directly to the Memory Service and that it must be done via the GP. This information requires clarification to staff as the CM could let the GP know that they had made referral directly.

(15) Community Matrons should make the adult, family and or carers aware of these services and any voluntary organisations that may also be able to provide support. The service is to produce a service directory to identify the range of services available to health care professionals and in the community.

(16) The needs of carers must be addressed. Health professionals must ensure they engage with and listen to carer concerns. Evidence this has occurred should be in the patients record.

(17) Consideration to be given for an annual carers assessment for patients who have high needs/ and or cognitive function.

(18) To move towards an electronic system of documentation on the RIO IT system ensuring that the Trusts documentation standards are met and that care plans are individualised, person centred and involve the patient's carers.

Risk Mitigation

(19) Actions identified for Community Matrons will be overseen by the Community Matron Manager. The action plan will be overseen by the Trust Integrated Safeguarding Committee.

Community Matrons and GP Practices

(20) During the review it was identified that Mr A whilst not attending the practice was subject of discussion between professionals at a Multi-Disciplinary Team meeting at the GP Practice.

Wider learning Point

(21) LBE and partners need to promote a culture for practitioners to request a Professionals meeting when a number of agencies are involved with an individual and additional support is needed.

5.5.3 Recommendations: Chronology 5 (05.11.2016 – 07.12.2016)

MPS Recommendation 9 – Enfield Borough Operational Command Unit-Senior Leadership Team

It is recommended that YE BOCU SLT:

- Conduct a debrief of all the reporting officers and supervisors involved in the incidents relating to CADs 5103/28 Nov 16, CAD 9212/28Nov16, CAD 7269/5Dec16 to remind staff of the expectations to create and appropriately supervise reports where someone is identified as being vulnerable using the Vulnerability Assessment Framework.

- That PPD staff involved in the report management of PAC 16PAC272628 and 16PAC292780 are advised to share in a timely way reports where vulnerability has been identified.

MPS Recommendation 10

That all Enfield MPS Borough Operational Command Unit (BOCU) staff are reminded of the potential risks that an adult with dementia or other declining cognitive function may face and that staff are aware of the importance to maximise opportunities to access crisis health intervention. This is especially important where there is no apparent safeguarding concern and reports managed locally may not currently benefit from an Adult MASH input e.g. a general welfare concern. In addition, all staff are to be reminded of their responsibilities to identify that actions taken are likely to have a meaningful impact on immediate risk.

MPS Recommendation 11 – Service Wide

During the review it was noted that Enfield Borough had identified an issue with their open MERLIN found reports. It is recommended that each MPS borough review their current and future arrangements for the strategic and daily management of Found reports to:

- Consider whether the existing IT related inability to create an ACN from a Found report presents any organisational risk.

- Consider whether the lack of additional over view process and existing supervision arrangements for Found reports presents any organisational risk

- Consider whether the current arrangements for closure of Found reports when complete presents any organisational risk.

MPS Recommendation 12 – Service Wide

It is recommended that all MPS staff involved in the daily completion of Merlin ACN and Misper reports are reminded of the potential risks involved to adults who are affected by cognitive impairments. (In particular those that involve significant and degenerative decline). Misper, Mental Health, Vulnerability and Adult at Risk and MASH resource guides should be reviewed to ensure they raise awareness of these conditions, tactical options, the importance of meaningful risk assessment and need for intervention to ensure their immediate safety, mental health and care and support needs.

Multi-Agency Recommendation 13

ESAB seeks assurance that Community Matrons consider working with partners to develop and implement a structured case management tool to promote the use of an effective Information management system to assist and inform Community Matrons, Housing, ESC and CMS to determine the need for emergency health or social care intervention.

This to include supervisory oversight and agreed escalation process for adults in immediate need for mental health crisis (due to cognitive decline) intervention. LFB Home Fire Safety Risk Referral Matrix to inform decision making and outcomes. (5.1.1.) Consideration should be given to a review of how emergency uplifts to care packages are applied and who is aware of them.

Multi-Agency Recommendation 14 – Community Matrons

That the ESAB ensures that Community Matrons develop a protocol with Safe and Connected to ensure that care planning by Community Matrons involves a check to see if an adult has a community alarm at home, whether one is required and agree a process to share regular updates to Safe and Connected.

Multi-Agency Recommendation 15 – Community Matrons

That the ESAB ensure that Community Matrons have a clear assessment process to refer vulnerable patients who are a fire risk to the LFB, particularly for patients who have a degree of cognitive loss and are smokers. Elderly patients with substance misuse and/or mental health issues can be directly referred to the LFB for a house fire – risk/smoke alarm assessment. This should be informed by the work of the Fatal Fire Working Group.

Multi-Agency Recommendation 16 – Community Matrons

Verbal referrals to MASH should be followed up in writing with a copy sent to the GP and presented by the Community Matron at the MDT meetings.

Ensuring a process of communication with the wider MDT when concerns increase and additional support is needed.

Multi-Agency Recommendation 17 – LBE, Community Matrons, the Safeguarding Team and the Lead GP

To agree a gold standard example of the organisational structure and management of multi-disciplinary meetings (MDTs) with a focus on

Primary care –

- Developing a format on how the MDT meetings are recorded and ensuring actions are completed
- Ensuring records of discussion at the MDT meeting are reflected in the patient's records, including the needs of identified carers
- How GPs escalate concerns for adults or carers who develop additional needs or warrant intervention from social services

- Ensuring referrals by the wider MDT team are shared with the GP practice and reflected in the patient notes

5.6 Chronology 6: 5th December 2016 – The Day of the Fire

IMR Submission by Enfield Safe and Connected (ESC)

(1) As part of the agreed Terms of Reference for this review, Enfield Safe and Connect were requested to complete an Individual Management Review (IMR) containing a full chronology and actions taken involving Mr A. This was to be completed to understand the circumstances that led to the incident, providing a report with conclusions and recommendations.

(2) An IMR that provided a management investigation for this case was supplied to the review. During the two learning sessions, the contents of these documents were discussed at length but there still remained a lack of clarity around various aspects of information submitted within the reports. Specifically, there are a number of statements within the IMR, which contradict statements from other information that has been reviewed. The IMR itself lacked sufficient detail to allow the review to give a considered comment in respect of the key events that took place and an insight into the human and contributory factors that played out from the point at which Enfield Safe and Connect received the call for assistance by Mr A.

(3) It is not for this review to apportion blame but to maximise learning and highlight issues that raise concern. In order to obtain a full and accurate picture, there were matters that required clarification. As a result, the author of this review requested a review of the original IMR submission.

(4) A further report was then produced to look at the events leading to the fire on 05/12/2016 and this supports the information provided in the original IMR. Independence and Wellbeing Enfield Ltd. took over the management of Enfield Safe and Connected shortly before the incident on 05/12/ 2016. Prior to this Safe and Connected were positioned as part of LBE departments.

(5) On the day of the fire, Ms D explained that Mr A was in good spirits. She left him at 15.20 to go and sort out her dog and planned to return after 19.00hrs. She was aware that a neighbour's son was with him from 15.30-16:30.

(6) At 18.32.34 on 5/12/2016 Mr A contacted the Enfield Safe and Connected (ESC) via a pull cord alert. The call took approximately 30 seconds to connect. It is voice recorded throughout. The advisor tried to establish if Mr A was ok. There is only one verbal response from Mr A when they advisor then says 'hello' and he says 'Yes', In the background a constant alarm and Mr A coughing can be heard.

(7) At 1 minute and 14 seconds into the call the telecare advisor (TA) tells Mr A she is sending the mobile warden to him. At 1 minute and 48 seconds into the call a female voice can be heard stating 'fire alarm, fire alarm '. This is not being stated to Mr A but appears to be a conversation between the two members of staff in the room. One is the Telecare advisor, the other the mobile response officer. Based on the summary of the call logs provided by Safe and Connect the 'mobile' was on the call at this time. At this point there is clear acknowledgement from staff that there is a fire within Mr A's property.

(8) Despite numerous attempts by the mobile response officer from 1 minute and 55 seconds into the call (asking three times if there is a fire) there is no further response from Mr A. There are no further verbal communications from him. In a staff interview, the mobile response officer explained that she could hear some alarm in the background but was trying to establish if everything was ok.

(9) Records from Safe and Connected indicate that the advisor took another call at 18.34 and the mobile response officer left the office to attend his flat. The advisor then took over the management of the call from Mr A and was alone in the office. There is a period of approximately four minutes when the call with Mr A is left open but there does not appear to be a member of staff on the call or actively listening to it and the advisor was dealing with other calls.

(10) The call is resumed by the advisor at 7 minutes in at which point the advisor is heard saying (comment addressed towards Mr A) that they will be calling the ambulance and fire brigade. These calls for assistance are made after 7 minutes and 11 seconds to the London fire Brigade (LFB) and after 9 minutes and 32 Seconds to the London Ambulance Service (LAS).

(11) The remainder of the audio recording has periodic comments from the advisor directed towards Mr A informing him that help is on the way. There is no response from Mr A and sounds of laboured breathing can be heard. 15 minutes into the call a male's voice (assumed to be the LFB) is heard in Mr A's flat and the call is disconnected at 18.51.23.

(12) At 18.45 The LFB arrive on the scene and find Mr A unconscious on the living room floor. First aid is administered. They are supported at the scene by the LAS and the MPS. Mr A is then taken to the Royal London Hospital where he is treated for his injuries. He subsequently dies on the 8/12/16 at 02.00.

Fire brigade – Alarm activation

(13) The LFB Fire Investigation Review Page 8, Point 10.2 stated that 'it is believed the smoke detector in the bedroom operated initially, and this is heard actuating in the background by the telecare operator. The telecare system was then operated by the operation of a pull cord within the property which raised the alarm'.

5.6.1 Analysis: Chronology 6 (Day of the Fire)

ESC – Alarm Activation – Staff Accounts

(1) The ESC provides a critical frontline service that connects vulnerable and older adults to which trained telecare advisors (TA) can provide an instant response via telephone link in times of need. If people need direct help a Telecare Mobile Response officer can take the decision to deploy to the address (as is the case on 5/12/16). The review has not been able to establish how many times the mobile responses officers deploy to addresses in these circumstances and critically to explore and reflect fully the reasons why on the night of 5/12/16 the mobile response officer took the decision to leave the office to attend the flat as a course of action instead of calling emergency services at 1 minute 48 seconds into the call when there was an acknowledgement by staff that there was a fire alarm operating.

(2) After the event, the advisor reflected in an interview with their management that a fire alarm could

not be heard actuating but what could be heard were noises that suggested it could have been Mr A trying to pick himself up. The review has considered reasons why this could have been the case as the audio recording of the night has a clear and constant alarm sounding. Staff also acknowledge a fire alarm on the audio recording and later to emergency services and ask the emergency operator if they too can hear it. There is no additional information to suggest that there were any issues with the phone system itself or any other external factors that may provide an explanation as to why the alarm would not have been audible to the advisor. Subsequent entries made in the entry made in the ESC call log also refer to a fire alarm.

(3) This review has also considered what information was available to assist the call centre staff dealing with alarm activations involving Mr A (and other service users) prior to and including the night of the fire, what information was (or should) have been known to the organisation.

ESC Case Management

(4) Mr A was originally referred to Community Alarms on 21.01.2008 just prior to moving into his sheltered accommodation. The Initial referral form was completed on behalf of the tenant and contained basic details. At this stage Mr A is recorded as having arthritis. There was no further information available regarding any needs assessment or risk assessments (which were agreed at that time to completed by Housing). There are no records available to confirm the information gathering that took place to assist reviews. There are only two updates to the original tenant information sheet. One in 2009 and one in 2014, one that requested that Ms D was removed as Next of kin from Mr A's Jontek record. This does not appear to have been done and there is no further information in relation to the request. Call centre staff acknowledge after the incident on 05/12/16 that Mr A was 'known to the service for some time, known as a smoker and a drinker '. It is evident that information that may inform decision making that is personally known to staff in the call centre is not recorded on the system.

(5) There is no call information relating to Mr A prior to 19.08.2014 available from Jontek (the call system that records contact from service users). From that date to the end of 2014 call data indicates that Mr A had seven calls logged, two of which relate to a fire alarm being activated because of a use of a candle. No information is available whether at this time the service knew any more that Mr A having arthritis or whether any information was shared with partners.

(6) In 2015 there are 30 call logs (grouped together are 19 incidents). These are mostly in error. One entry suggests 'confusion' but no further information. One occasion noted where Mr A is locked out of his home.

(7) In 2016 there are 46 call logs (grouped together are 28 incidents) A significant increase on the year before and with an escalating trend of incidents where Mr A is locked out and can't get into his flat. One occasion notes Ms D raising concerns that he has had no heating for a year.

5.6.2 Key Learning Points: Chronology 6 (Day of the Fire)

Service Expectations of Enfield Safe and Connected (Now Independence and Well-being Enfield Ltd)

(1) As well as providing a frontline response service, Safe and Connected appear to be well placed to identify emerging patterns and concerns for those using their services and work

with partners to safeguard those who may be at risk of harm. It hasn't become clear in this review whether this role was an expectation on the service at the time of the fire. If it wasn't an expectation at that time does this then represent a future opportunity to develop a preventative role that to enhance future service delivery? Enfield Health and Safety Unit have since reviewed Safe and Connected services post this incident for compliance.

Individual Risk Management and Sharing Information

(2) There does not appear to have been professional curiosity regarding the individual management of incidents. Staff have access to upload key information they hold to Care First (An adult Social Care IT system), but there is no evidence in this review that this happened or that the service use the system.

Tenant Information Records

(3) When tenant records are first entered and at the review stage, the ESC service issues paperwork and reminders prompting updates pertinent to ESC service delivery. This should include assessment at the outset, a six-week review, service tests and annual reviews. This current arrangement does vary if the service users are seen through another arrangement such as Sheltered Housing, where SHO's are responsible for reviewing the residents and forwarding updates to ESC. It is apparent in this case that this is not happening as it should. Staffing levels are suggested as a contributory factor.

(4) Mr A was recorded as having a medium level of service. This appears to have been determined from the outset. It does not appear that this varied as his care and support needs increased and his demand on ESC services increased. The IMR states that service users and carers are encouraged to provide updates on a change to their needs.

(5) It is evidenced in this review that the only update provided by the carer to ESC was not actioned and that there was no entry on the tenant information to reflect Mr A's deteriorating mental health. Mr A as we know could not read or write. It is not recorded who completed the form on his behalf. With his level of assessment, he could access help via a and have a visit from the mobile response officer. In the absence of any meaningful updates noted on the system from housing, Ms D or Mr A any call response was based on the information being held in the call logs by staff and any personal judgement staff made.

(6) The frequency, gravity and escalation in the types and volume of calls being received by Mr A does not appear to inform decision making by staff receiving the calls or resulted in any positive safeguarding interventions or result in any other visits from the response officer.

(7) Safe and Connect do not have sufficient understanding of the needs and risks for those in sheltered accommodation. They are not involved regularly in reviews for these clients.

(8) The Incident Management Review conducted identified that the calls to emergency services by Safe and Connected on the night were made outside the agreed timeframe in their procedures. Analysis of the calls made by Mr A suggests that human factors may have affected the response to Mr A. He made repeated demands on the service. Does frequent use of services lead to an inadvertent perception of a reduced risk to an individual or staff becoming inured to the risks?

ESC – Partnership Working and Information Sharing

(9) As well as providing a frontline response service, Enfield Safe and Connected (IWE) are well placed to identify emerging concerns for those using their services. Enfield Safe and Connected was managed during the time frame for this review by Council's Finance, Resources and Customer Services (FRCS). It is not apparent in this review how information or concerns on some of the most vulnerable services users in Enfield shared with housing or adult social care. Or how this this happen in reverse.

ESC – Organisation issues

(10) There have been many changes to the Enfield Safe and Connected Services over the last few years. At the time of publishing this report, the service is being managed by Independence & Well Being Enfield Ltd (IWE). Three weeks before the incident IWE agreed to take over the day-to-day management, with the Council's Finance, Resources and Customer Services (FRCS) department maintaining responsibility for the service. Jurisdiction to employ or manage the staff remained with FRCS. The review recognises that there are a number of organisational concerns that feature as contributory factors for consideration.

Staffing Levels

(11) Staffing levels on the night show there were two members of staff working when there were meant to be four. There were vacancies on the team and the ability to meet direct service needs has been highlighted as a concern within this review. This may have a direct impact in ability to provide training, team meetings and supervision.

Training

(12) There are notable concerns raised within this review regarding the current provision for training for staff. Whilst it was acknowledged in the learning events that some initial input has been given to staff from the London Fire Brigade. Arrangements for ongoing and structured training for all emergency type situations needs immediate consideration. Existing arrangements places the organisation (and therefore its users) at future risk. The organisations IMR reflected that training was to be reviewed and strengthened.

(13) Training Services should be bespoke to the needs of both their staff and customers. The call log records relating to Mr A indicate both a lack of professional curiosity and an understanding of risks (not just fire related) but on the well-being of service users. An example of this is the fact that Mr A was noted as not having had heating for over a year but this did not prompt further exploration for a vulnerable man living in sheltered accommodation. There is an opportunity that learning from this review can develop training to assist staff in understanding the needs and risks for their client groups.

Supervision of ESC Staff

(14) All staff to understand the principles of 1-2-1, have a signed 1-2-1 agreement and an agreed, consistent schedule of meetings. 1-2-1s to have an agreed two-way agenda plus section for AOB. Discussions to include positive feedback as well as areas to develop. Consider alternative supplementary groups – Peer Support sessions.

(15) Team meetings to be held regularly, timings to be considered to cover as many staff as possible. The agenda should include a slot for service development, utilising the collective staff experience to forward plan. The meetings should be documented with clear actions as discussed and agreed in the meeting.

Learning opportunities

(16) How can better use be made of information held on the Jontek system? Staff need to be encouraged not to view incidents in isolation, to consider relevant referral of information. Staff need to utilise the opportunity to upload key information they hold to Care First.

(17) This frontline service has a real opportunity to play a key role in Health, Wellbeing and Prevention requirements under the Care Act.

(18) Communication channels both across the service and with associated services need to be formalised and consolidated, aiming for defined and agreed approach to working, consistency of information sharing.

Fire Brigade Fire Investigation

(19) The London Fire Brigade conducted an investigation into the probable cause of the fire. They determined that the probable cause of the fire was accidental and most likely smoking related with the fire occurred on the bedding and the mattress in the bedroom. The fire was non-suspicious.

(20) Of note in the Fire Investigation report at (5:6) it states:

A chair in the right-hand corner of the room had a small number of burn marks on its surface. The carpet in the living room also had some small burn marks visible. A number of cigarette butts were noted on the floor and on a low table.

(21) Also in the Fire Investigation report at (5:19) it states:

Following excavation of the end area a number of cigarette ends were found partially concealed under the water pipes, on the floor at the head end of the bed.

(22) The observations within the LFB report suggest that Mr A regularly smoked in both the living room and bedroom of the flat. He did have a hardwired domestic type detection system fitted in the property, consisting of smoke alarms in the living room, and bedroom with a heat detector in the kitchen. A further smoke alarm fitted in the living room was linked to the Telecare system.

(23) The Fire Investigation report (10:4) it notes that no home fire safety was recorded on the Home Fire safety database for the property. This was because he was out when they visited and they did not return.

(24) At the learning events, a senior officer from LFB reflected that there had been extensive efforts on behalf of the service to work with LBE on raising awareness with staff of the importance of referring clients for these visits and the use of the LFB Home Fire Safety Risk Referral Matrix to inform decision making and outcomes. (5.1.1.) This review acknowledges the ongoing work

that the LFB and LBE is doing as part of the Fatal Fire Working Group and its efforts. There are agreed processes for checks to communal parts of sheltered housing and arrangements for testing fire alarm to conduct visits to vulnerable residents. Over 1000 visits have been made to Enfield Residents.

(25) It appears that Mr A was either not in or didn't respond when then the LFB attended to conduct the visit. There are agreed processes for checks to communal parts of sheltered housing and arrangements for testing fire alarm.

(26) The LFB was keen to stress to the learning events how vital it is that staff who deal with residents maximise the use of risk assessments to identify those at increased risk of fire. This features as a major part of the work undertaken by the Fatal Fire Working group. Mr A did not have a LFB home visit and had not been referred for one and as such there was a missed opportunity to provide advice or equipment to help prevent a future fire. The LFB shared with the review that at the time of the fire the LFB had completed 15 visits to residents in the block and had a further 19 to do.

Home Fire Safety Learning Points

(27) This review has reflected that some of the themes that have featured in other preventable fire fatalities across London existed again in this case namely:

(a) Lack of Fire safety (risk factors such as smoking and hoarding)

(b) Lack of Information sharing across agencies

(c) Lack of assessment of mental capacity with regards to risk taking behaviour (cigarette smoking a main theme)

(d) Lack of engagement with informal carers

(28) These themes are well known, consistent and frustrating. It appears that working practices in this case, like many other fire deaths did not recognise or pull together sufficient information to risk assess the risks to Mr A. This review has concluded that in order to prevent similar fire related deaths that fire risk assessment must feature as a mandatory requirement within organisations procedures and daily working practices for those working with adults with care and support needs. This is why the LFB Home Fire Safety Risk Referral features as a main part of the recommendations.

(29) Reflecting on the LFB Home Fire Safety Risk Referral, Mr A had many of these risk factors (many of which were visible to agencies) which with information collated would have given clear indications that he was at high risk of a fire within his home.

Reflections from Mr A's Carer (Ms D)

(30) As with many carers Ms D wanted to support Mr A to remain within his home and with as much independence as possible. She accepts that on reflection she may not have shared some concerns as she had genuine fears about not being allowed to continue to care for him. The details of every incident are not available but it is clear to this review that she managed many challenges on her own. There is evidence that agencies were keen to utilise her in the

carers role and on reflection also gave disproportionate weight to her views as part of decision making in Mr A's life rather than applying the principles of the Mental Capacity Act 2005 and seeking his views and wishes, supported decision making and obtaining his consent.

(31) Of significance she described returning to the flat as planned that night to find it on fire. She expressed anger that despite the role she had played in Mr A's life that in the immediate aftermath following such a terrible incident that she became invisible in the process and that she was left feeling unsupported, frustrated and distraught at what had happened to her friend. She was contacted by staff on 7/12/16 (two days after the fire) to arrange his needs assessment.

(32) Ms D welcomes this review and was keen to participate to find out what missed opportunities there were and to prevent others having a similar experience.

Learning Point

(33) Whose responsibility currently is it to update and cross reference case management records when a serious incident occurs? In the immediate aftermath of similar traumatic incidents what arrangements are in place to keep family or friends aware of initial actions that may be taken or that they should be informed of and can they be improved?

5.6.3 Recommendations: Chronology 6 (Day of the Fire)

Multi-Agency Recommendation 18

That the ESAB establishes clarification from LBE of the assurance and governance frameworks around ESC for the next three years, which confirm to the LBE that ESC is able to meet needs of clients.

Multi-Agency Recommendation 19 – Information Sharing

That the ESAB ensure that examples of good working practices are sought from similar services in London to inform IWE service planning. A review of existing LBE tenant information sharing arrangements is conducted between Housing, Adult Social Care and ESC to ensure that it is fit for purpose. This should be subject to a six-monthly review of practice to ensure compliance.

Multi-Agency Recommendation 20 – Enfield Safe and Connected – FRSC and LFB – Recording on the Jontek IT system

IWE currently utilises the Jontek system. That the ESAB seeks assurance that:

(1) The Jontek IT system is fit for future agreed service delivery purposes. Specifically, this must include:

(a) A joint review between the LFB and Safe and Connect (LSE) on the current use of the Jontek system to ensure that in the event of a fire that any use of pullcord and/or smoke alarm activations identify the possibility of fire as the primary reason for activation and need for assistance. (when an alarm is made, it is the system that activates first that can be seen on the Call Centre screen). A fire alarm will not override a pull cord on the screen but can be heard in the background as a beep. The type of alarm received informs the response.

(b That the system is able to produce information on any themed or group trends and any other required analytical reports.

(c) IWE to review current recording on Jontek and IWE to ensure that relevant medical diagnosis are accurately recorded on relevant systems (i.e. when Mr A diagnosis of dementia became known to the service)

(2) FRCS to review Jontek call logs to inform reviews for both Sheltered Housing and other tenants.

(3) The FRCS review of call logs includes the identification of potential high risk or high-volume vulnerable clients to check for any immediate safeguarding action that may be required. Consideration should be given to the creation of a critical service user list going forward.

(4) Call log reviews should utilise the LFB Home Fire Safety Risk Referral Matrix to inform decision making and outcomes. (5.1.1.)

(5) IWE to ensure that future relevant updates are made to tenant information records. (This should include more professional accountability for information added and by whom)

(6) IWE to scope how it can share information on call logs to inform individual tenant case reviews. This should include seeing what types of reports can be pulled, to reduce manual activity and a discussion with partners as to who needs this information, when they need it and what use they will make of it.

Multi-Agency Recommendation 21 – Record Access

That the ESAB seeks assurance from LBE

(1) That a service level agreement is developed on what information is recorded on tenants, how this is recorded and where. Consideration should be given to making this a short but clear internal process. Incidents should be recorded outside of the Jontek system to ensure accessibility.

(2) That the service can demonstrate that relevant information on tenants and details of incidents that involve them (particularly those of a serious nature) are quality assured and are accessible when required. This should also include an agreed time frame for record retention.

(3) In this SAR review there were challenges accessing relevant records within the service and this hindered aspects of the review of events during this incident.

Multi-Agency Recommendation 22 – for IWE and Housing

That the ESAB seeks assurance that:

(1) A clear protocol is agreed between ESC, FRSC and Sheltered Housing on agreed responsibilities for completing reviews.

(2) That agreement is gained that call logs will be shared to inform reviews by the Sheltered Housing officer.

(3) Update the Basic Tenant Information Sheet to include risks more clearly and whom is completing this form.

(4) Ensure relevant Information from Housing is added when received.

(5) Recording of the tenant information sheet annually onto the Jontek system.

(6) Agreement that call logs will be shared to inform reviews by SHO.

Recommendation 23 – Housing Reviews (Inclusive of Partnership)

That ESAB seeks assurance that Housing:

(1) Conduct a review of timelines of reviews and who are included – i.e. short checklist of possible partners that hold information and that it is recorded on the system who the reviews are shared with.

Multi-Agency Recommendation 24 – Serious Incident Management

ESAB / Council / IWE

(1) The council seeks assurance the IWE work with emergency services to create an accessible guide toolkit to assist call centre staff to inform staff on how to respond to emergency and time critical situations.

(2) That IWE ensure that all staff are aware of situations that need automatic escalation to a manager and are aware of the process for escalation both in and outside of standard working hours.

(3) Review the current Procedures manual to ensure a useful and accessible document for staff. This to include learning from this review and an agreed process for recording incidents. The procedures need to be user friendly (current ones are considered by users to be difficult to use) Bite sized accessible information available for reference; refresher slots and experience sharing in 1-2-1 or team meetings. Consider interactive meetings with other agencies e.g. Housing to improve working practices.

(4) That the ESAB seeks assurance that the council review the guidance to staff on deployment of the mobile response officer during the management of a serious incident.

(5) That the ESAB seeks assurance that the IWE review the guidance to advisors on the management of additional calls during a serious incident.

Recommendation Multi Agency Recommendation 25 – Access Team (LBE)

(1) Set date for Service review

(2) Communication channels both across the service and with associated services to be formalised and consolidated, aiming for defined approach to working, consistency of information sharing.

(3) Review joint working with organisations i.e. Sheltered Housing, Emergency Services and Adult Social Care to ensure communication and information exchange regarding service user needs Is current and timely. Consider across – team emergency planning exercises.

(4) Senior Management Relationship Building

Multi-Agency Recommendation 26 – FRCS

(1) Review staffing and current vacancies particularly in regard to shifts and protected team development time.

(2) Develop working standards for staffing levels after completion of other scoping related recommendation to ensure that staffing levels are reviewed to ensure resilience.

(3) Review staffing and current vacancies particularly in regard to shifts and protected team and development time. Develop Working Standards for staffing levels.

(4) Review available staffing to ensure that KPI standards are met and maintained and TSA accreditation is retained.

Multi-Agency Recommendation 27 – Staff Training and Supervision FRCS

(1) Review training for compliance and to ensure that all staff aware of what training is mandatory for LBE and for the team. Staff need the necessary time to access and complete training. Maintain a local training matrix for easy to review status and develop an annual training plan for the service.

(2) Review service specific training and the best way to provide this, i.e. if a formal course had been attended; shared learning and job shadowing; regular slots to learn about equipment and fitting to ensure all staff have a comparable skill level; 'top tips' sessions in the house.

Multi-Agency Recommendation 28 – London Fire Brigade and LBE Sheltered Housing

That the LFB and Housing give consideration to agree a follow up process for residents that are not in or do not respond to information left. As part of the extensive work being carried out by the LFB that involves fire safety visits to Sheltered Housing residents across Enfield, It is vital that a return visit by the LFB is made as soon as possible or that information on those residents who are not seen is shared with Housing. Information gathering should take place to establish existing care and support needs and whether there are fire risk factors as per the Home Fire Safety Risk Referral Matrix. Similar principles for follow up should be reflected for vulnerable residents not in sheltered accommodation.

6 WIDER OPPORTUNITIES FOR LEARNING

6.1 Community Confidence in Fire Safety Management

Since the date of this fire, there has been a significant amount of work undertaken by LBE and the Fatal Fire Working Group which has had additional focus in light of the terrible fire that took place at Grenfell Tower in June 2017. The impact of any fatal fire in a community has a profound effect on those affected and in light of recent events, residents in Enfield need to be assured that lessons learnt and recommendations that are made are long lasting and impactive to prevent other deaths. They also may require additional reassurance that services provided are fit for purpose and that partners will continue to work together to keep those at risk of harm safe.

6.2 Use of Section 42 Care Act 2014 in Safeguarding Adults Reviews and Individual Accountability

Under Section 44 of the Care Act 2014, local Safeguarding Adult Boards (SABs) are required to undertake a SAR when an adult in its area dies or suffers significant harm as a result of abuse or neglect, whether it is known or suspected, and where there is concern that the partner agencies could have worked more effectively to protect the person at risk.

The quality of an Individual Management Review submitted in this case prompted a professional discussion as this review encountered some challenges that possibly may not have occurred if a Section 42 Care Act Enquiry had been conducted first.

Whilst a section 42 implicitly refers to a safeguarding enquiry being conducted when someone is alive there does not appear to be any legal reason to prevent a Section 42 enquiry happening first to prevent delays to the process, an adverse impact to information gathering and crucially ascertaining the full circumstances surrounding a death and ensuring all options for appropriate action can take place in a timely manner.

The interaction of Section 42 with Section 44 in this way needs clarification and development of a London wide protocol that sets out an agreed position would provide this.

In light of the subsequent information gathering and analysis of events during this review, the Local Authority and other agencies have key issues that are still under consideration.

6.3 Recommendations

Multi-Agency Recommendation 29 – ESAB

That the ESAB raises an agenda item to the London Safeguarding Adult Board Chairs for a discussion about whether there is a general consensus for a need for clarification on the circumstances in which a Section 44 Care Act Review should take place without a Section 42 Enquiry taking place first. Further consideration could then be given to referring to the London Safeguarding Adult Board with a view to developing revised good practice guidelines.

Multi-Agency Recommendation 30 – ESAB

That the ESAB considers the impact in this particular review of the need for necessary additional information gathering and decision making required following the commissioning of the review with a view to establishing whether those delays had an adverse impact on the ability of any of the agencies involved to take any appropriate action. The Board should also consider what internal or multi-agency steps may be necessary to ensure that future challenges of a similar nature are to be avoided.

6.4 Individual Management Reviews – Learning Point

There were also challenges highlighted in this report relating to the completion of Individual Management Reviews. It is apparent that staff who may not have had experience in doing so are

required to fulfil this role and may benefit from additional support to complete these reviews. It is vital that staff have a full understanding of what is required within the report, the level of detail and an appreciation of the significance of the content and implications of IMR's which remain widely used within the SAR and other review processes. Staff identified to complete future IMR would benefit from attending a SAR author briefing.

7 THEMES OF LESSONS LEARNT

7.1 Recording, Supervision and Sharing Information

- The importance for all professionals to record, retain and share information regarding an individual's preferred method of communication, any access requirements that need to be in place to ensure that a person-centred approach can be delivered.
- Safeguarding referrals to be made when concerns come to the attention of health staff, assumptions must not be made that this has been actioned by others.
- It is vital that any medical diagnosis and instructions for follow on care and support are clearly documented in discharge planning notes.
- To ensure discharge planning notes document how a decision has been taken for short and long-term care options. Discharge planning options should involve supported decision making and the exploration of other options that family or carers may initially discount.
- Management oversight of final discharge plans or determining the outcome of a review.
- There needs to be more managerial oversight of reviews and final discharge plans. Appropriate referrals to long term teams are actioned timely and with sufficient information about the case.
- Community Matrons – There is a need for management oversight for the retention of cases. Staff are reported to carry high workloads and lower level cases need to be appropriately signposted for health and well-being intervention but with clear pathways for re-referral if required. The reason for retention in this case was to provide support to the carer. There is a fine balance to be struck between promoting independence at home and need for risk assessment and decision making.
- Community Matrons – There were missed opportunities to discuss and review the case within a multi-disciplinary setting and that the perceived silo working may have been a contributory factor.
- Community Matrons – There is a need for case management oversight both of individuals visit and contact records and to ensure that team manager reviews of individual cases are recorded and actioned. A review of a care plan in isolation does not give true oversight of actual or potential risk.
- Community Matrons – Risk assessment is a dynamic process and care plans must be reviewed in the patient's home or following a home visit and amended accordingly to reflect changing circumstances.

- All patients with declining cognitive function should be discussed at the Multi-Disciplinary Meeting (MDT).

- That Community Matrons are aware of how to utilise, refer and escalate an adult of concern to both the GP and Adult Social Services and additional services such as the Crisis Intervention team, The immediate Care Team and their Community Mental Health Nurse or the Memory Service. The NHS Serious Incident Report states that the CM do not currently have authorisation to refer patents directly to the Memory Service and that it must be done via the GP. This information requires clarification to staff as the CM could let the GP know that they had made referral directly.

- To move towards an electronic system of documentation on the RIO IT system ensuring that the Trusts documentation standards are met and that care plans are individualised, person centred and involve the patient's carers.

- Actions identified for Community Matrons will be overseen by the Community Matron Manager. The action plan will be overseen by the Trust Integrated Safeguarding Committee.

- During the review it was identified that Mr A whilst not attending the practice was subject of discussion between professionals at a Multi-Disciplinary Team meeting at the GP Practice.

- LBE and partners need to promote a culture for practitioners to request a Professionals meeting when a number of agencies are involved with an individual and additional support is needed.

- IWE – There does not appear to have been professional curiosity regarding the individual management of incidents. Staff have access to upload key information they hold to Care First (An adult Social Care IT system), but there is no evidence in this review that this happened or that the service use the system.

- As well as providing a frontline response service, Enfield Safe and Connected (IWE) are well placed to identify emerging concerns for those using their services. Enfield Safe and Connected was managed during the time frame for this review by FRCS. It is not apparent in this review how information or concerns on some of the most vulnerable services users in Enfield shared with housing or adult social care. Or how this this happen in reverse.

- IWE – All staff to understand the principles of 1-2-1, have a signed 1-2-1 agreement and an agreed, consistent schedule of meetings. 1-2-1s to have an agreed two-way agenda plus section for AOB. Discussions to include positive feedback as well as areas to develop. Consider alternative supplementary groups – Peer Support sessions.

- IWE – Team meetings to be held regularly, timings to be considered to cover as many staff as possible. The agenda should include a slot for service development, utilising the collective staff experience to forward plan. The meetings should be documented with clear actions as discussed and agreed in the meeting.

- IWE – How can better use be made of information held on the Jontek system? Staff need to be encouraged not to view incidents in isolation, to consider relevant referral of information. Staff need to utilise the opportunity to upload key information they hold to Care First.

- ESC – This frontline service has a real opportunity to play a key role in Health, Wellbeing and Prevention requirements under the Care Act.

- IWE – Communication channels both across the service and with associated services need to be formalised and consolidated, aiming for defined and agreed approach to working, consistency of information sharing.

7.2 Early Intervention, Assessment and Review

- Raising all statutory and support organisations awareness of the need for early intervention and referral to the London fire brigade when factors that may include self-neglect, hoarding, alcohol and indoor smoking risk factors are identified. (systems)

- Staff to ensure face to face adult at risk participation in assessments are recorded and this is also subject to supervision. (Risk mitigation – The access team has taken the decision to complete home visits in more circumstances than they used to.) Reasons for not having face to face contact should be recorded and subject to supervisor, especially in cases involving those with dementia or other declining cognitive function.

- Need to ensure all cases are reviewed timely and appropriately. This includes ensuring that systems are in place to support hospital SW team with six-week reviews. There is a yearly target for reviews in place. (systems)

- A decision not to have face to face reviews needs to be recorded. This is particularly important for cases like Mr A's. He went from someone who was not known by ASC living in the community, who then went into a placement and then returned to the community with no ongoing formal support.

- There are opportunities to examine and make improvements to working practices to ensure compliance by the Local Authority around staff understanding their responsibilities under Section 1 of The Care Act.

- As well as providing a frontline response service, Safe and Connected appear to be well placed to identify emerging patterns and concerns for those using their services and work with partners to safeguard those who may be at risk of harm. It hasn't become clear in this review whether this role was an expectation on the service at the time of the fire. If it wasn't an expectation at that time does this then represent a future opportunity to develop a preventative role that to enhance future service delivery? Enfield Health and Safety Unit have since reviewed Safe and Connected services post this incident for compliance.

- When tenant records are first entered and at the review stage, the ESC service issues paperwork and reminders prompting updates pertinent to ESC service delivery. This should include assessment at the outset, a six-week review, service tests and annual reviews. This current arrangement does vary if the service users are seen through another arrangement such as Sheltered Housing, where SHO's are responsible for reviewing the residents and forwarding updates to ESC. It is apparent in this case that this is not happening as it should. Staffing levels are suggested as a contributory factor.

- ESC – Mr A was recorded as having a medium level of service. This appears to have been determined from the outset. It does not appear that this varied as his care and support needs increased and his demand on ESC services increased. The IMR states that service users and carers are encouraged to provide updates on a change to their needs.

- It is evidenced in this review that the only update provided by the carer to ESC was not actioned and that there was no entry on the tenant information to reflect Mr A's deteriorating mental health. Mr A as we know could not read or write. It is not recorded who completed the form on his behalf. With his level of assessment, he could access help via a pendant and have a visit from the mobile response officer. In the absence of any meaningful updates noted on the system from housing, Ms D or Mr A any call response was based on the information being held in the call logs by staff and any personal judgement staff made.

7.3 Identifying and Managing Risk

- Like the circumstances that prompted the recommendation to consider the development of structured risk assessment roles, similar issues presented in this review where individual social workers and other staff were performing 'information gathering roles'. The collection of information they gathered on Mr A largely appeared to be based on their own professional opinion. Whilst this is an important and integral part of social work it does appear to leave both organisations and individuals more open to missed opportunities, genuine mistakes, errors or omissions as well as a breach of their statutory duties.

- Mr A was presenting to the Metropolitan Police Service with mental ill health. Ms D was viewed as a means to return Mr A to a 'place of safety'. There does not appear a recognition of the ongoing and escalating risks that Mr A was encountering wandering on building sites and near busy carriageways, unaware of the danger to himself and his surroundings.

- There does not appear to have been consideration of Sec 136 Mental Health Act[4] to access immediate treatment at hospital and critically that of Mental Health Services. The police reports suggest that Mr A presented as an older, calm and compliant person and thus his condition meant that he may not have been considered as a risk to others (and himself) and that opportunities to intervene in his mental health crisis were missed.

- A management review suggests that it was the concerns from the Community Matron on 29/11/16 that were the prompt to conduct the full needs assessment. As a result of this referral, a date was in fact set for adult social care to conduct an assessment but this actually turned out to be just after the day that Mr A died. The 29/11/16 was the day after Mr A had been dealt with twice by police. It is not clear why a review of Mr A's file at this stage would not have highlighted that an assessment under section 9 of The Care Act was overdue given the escalating risks, a general lack of oversight on the case and the practice was not person centred. Mr A had still not been seen face to face by anyone from the Access Team. A medium priority is given by the access team. It is not clear whether this decision is subject to management oversight. It is not evidenced in the LBE IMR what information gathering took place to inform that decision.

4 http://www.legislation.gov.uk/ukpga/1983/20/contents

- The recording of a medium priority decision by the access team for Mr A also seems to be at odds with the Community Matrons view that the access team identified the call to them on 29/12/2016 as urgent (although this refers to a visit after 8/12/2016). Are all priority decisions shared in writing to avoid confusion between agencies about the agreed level of risk? It was apparent to the review that information gathering to inform risk assessments varies across agencies and this may affect interventions. It highlights the importance of good risk assessment and standardisation of working practices where possible.

- There was an apparent failure to identify, recognise and respond to a sudden decline in Mr A's cognitive ability and to identify that a crisis health intervention was required. There also appears to be an over reliance on Ms D's perception as a carer to identify risk and need.

- The Community Matron had established a good relationship with Mr A and his carer. They were well placed to make holistic assessments regarding Mr As health and social assessments. His relationship with the CM is described as 'good' by the carer. The CM caring for him felt that he did not have a high level of need but kept him on her caseload to support the carer.

- By the 29/11/16, Mr A was in need of immediate mental health crisis intervention due to cognitive decline. It is apparent that the mechanisms to access that intervention or methods to escalate concerns were either not known or not accessible.

- There is a need to strengthen practice in respect of accessing and escalating the need for immediate need for mental health crisis (due to cognitive decline) intervention. Existing arrangements for other adult's emergency uplifts to care packages may also need strengthening.

- Ongoing risk assessment is a dynamic process and care planning needs to include actual and potential risk (applicable to adult social care too).

- The frequency, gravity and escalation in the types and volume of calls being received by Mr A does not appear to inform decision making by staff receiving the calls or resulted in any positive safeguarding interventions or result in any other visits from the response officer.

- Safe and Connect do not have sufficient understanding of the needs and risks for those in sheltered accommodation. They are not involved regularly in reviews for these clients.

- The Incident Management Review conducted identified that the calls to emergency services by Safe and Connected on the night were made outside the agreed timeframe in their procedures. Analysis of the calls made by Mr A suggests that human factors may have affected the response to Mr A. He made repeated demands on the service. Does frequent use of services lead to an inadvertent perception of a reduced risk to an individual or staff becoming inured to the risks?

7.4 Training

- NMUH – All staff have received training on safeguarding and the process to follow. This learning has been shared at the Safeguarding Learning Events and being imbedded by Matrons across the hospital. Level 1 and Level 2 training now include discussions around

the responsibilities on staff for raising concerns. Ward groups use a colour coded scheme to ensure that all staff know if a patient is subject to a safeguarding enquiry or concern and/or DoLs.

- Awareness and training have been provided to all appropriate staff. Weekly email updates to Clinicians, Matrons and Ward Managers about DoLs requirements, compliance levels and changes in case law. This is subject to audit and review by the Safeguarding Adults Lead. On-going training at departmental and ward meetings facilitate an opportunity to capture new staff and reiterate the requirements.

- There are notable concerns raised within this review regarding the current provision for training for staff. Whilst it was acknowledged in the learning events that some initial input has been given to staff from the London Fire Brigade. Arrangements for ongoing and structured training for all emergency type situations needs immediate consideration. Existing arrangements places the organisation (and therefore its users) at future risk. The organisations IMR reflected that training was to be reviewed and strengthened.

- Training Services should be bespoke to the needs of both their staff and customers. The call log records relating to Mr A indicate both a lack of professional curiosity and an understanding of risks (not just fire related) but on the well-being of service users. An example of this is the fact that Mr A was noted as not having had heating for over a year but this did not prompt further exploration for a vulnerable man living in sheltered accommodation. There is an opportunity that learning from this review can develop training to assist staff in understanding the needs and risks for their client groups.

7.5 Fire Risk Identification and Management

- The London Fire Brigade conducted an investigation into the probable cause of the fire. They determined that the probable cause of the fire was accidental and most likely smoking related with the fire occurred on the bedding and the mattress in the bedroom. The fire was non-suspicious.

- Of note in the Fire Investigation report at (5:6) it states:

- A chair in the right-hand corner of the room had a small number of burn marks on its surface. The carpet in the living room also had some small burn marks visible. A number of cigarette butts were noted on the floor and on a low table.

- Also, in the Fire Investigation report at (5:19) it states:

- Following excavation of the end area a number of cigarette ends were found partially concealed under the water pipes, on the floor at the head end of the bed.

- The observations within the LFB report suggest that Mr A regularly smoked in both the living room and bedroom of the flat. He did have a hardwired domestic type detection system fitted in the property, consisting of smoke alarms in the living room, and bedroom with a heat detector in the kitchen. A further smoke alarm fitted in the living room was linked to the Telecare system.

- The Fire Investigation report (10:4) it notes that no home fire safety was recorded on the Home Fire safety database for the property. This was because he was out when they visited and they did not return.

- At the learning events, a senior officer from LFB reflected that there had been extensive efforts on behalf of the service to work with LBE on raising awareness with staff of the importance of referring clients for these visits and the use of the LFB Home Fire Safety Risk Referral Matrix to inform decision making and outcomes. (5.1.1.) This review acknowledges the ongoing work that the LFB and LBE is doing as part of the Fatal Fire Working Group and its efforts. There are agreed processes for checks to communal parts of sheltered housing and arrangements for testing fire alarm to conduct visits to vulnerable residents. Over 1000 visits have been made to Enfield Residents.

- It appears that Mr A was either not in or didn't respond when then the LFB attended to conduct the visit. There are agreed processes for checks to communal parts of sheltered housing and arrangements for testing fire alarm.

- The LFB was keen to stress to the learning events how vital it is that staff who deal with residents maximise the use of risk assessments to identify those at increased risk of fire. This features as a major part of the work undertaken by the Fatal Fire Working group. Mr A did not have a LFB home visit and had not been referred for one and as such there was a missed opportunity to provide advice or equipment to help prevent a future fire. The LFB shared with the review that at the time of the fire the LFB had completed 15 visits to residents in the block and had a further 19 to do.

- This review has reflected that some of the themes that have featured in other preventable fire fatalities across London existed again in this case namely:

  (a) Lack of Fire safety (risk factors such as smoking and hoarding)

  (b) Lack of Information sharing across agencies

  (c) Lack of assessment of with regards to risk taking behaviour (cigarette smoking a main theme)

  (d) Lack of engagement with informal carers

- These themes are well known, consistent and frustrating. It appears that working practices in this case, like many other fire deaths did not recognise or pull together sufficient information to risk assess the risks to Mr A. This review has concluded that in order to prevent similar fire related deaths that fire risk assessment must feature as a mandatory requirement within organisations procedures and daily working practices for those working with adults with care and support needs. This is why the LFB Home Fire Safety Risk Referral features as a main part of the recommendations.

- Reflecting on the LFB Home Fire Safety Risk Referral, Mr A had many of these risk factors (many of which were visible to agencies) which with information collated would have given clear indications that he was at high risk of a fire within his home.

7.6 Carers and Support

- There is no next of kin in the legal sense, e.g. where there is no lasting power of attorney. Carer and appropriate advocacy are raised within this review. Ms D is identified in the care records under the next of Kin /Emergency contact and is noted as 'friend'. Mr A had no apparent immediate family members and thus a quest to seek out friends or carers opinions in decision making comes to the fore.

- Despite an obvious deterioration in Mr A's condition there is no apparent consideration for whether Ms D could cope with her role as carer, whether that role was sustainable or whether she required an assessment, advice, support or information in line with carers rights legislation.

- In poor health herself, in recovery from cancer and having asthma, she explained that she was genuinely concerned that social services wouldn't allow her to continue supporting Mr A because of her health and that may have been a barrier to her asking for help earlier.

- All agencies should be aware of 'iceberg' conditions that may exist for carers. Staff should be encouraged to have professional curiosity.

- There is a need to strengthen practice in respect of early referrals to appropriate agencies to ensure the best support is available to service users. Community Matrons were unaware of additional Mental Health Services that may have provided additional support to Mr A and his carer.

- Community Matrons should make the adult, family and or carers aware of these services and any voluntary organisations that may also be able to provide support. The service is to produce a service directory to identify the range of services available to health care professionals and in the community.

- The needs of carers must be addressed. Health professionals must ensure they engage with and listen to carer concerns. Evidence this has occurred should be in the patients record.

- Consideration to be given for an annual carers assessment for patients who have high needs/ and or cognitive function.

- As with many carers Ms D wanted to support Mr A to remain within his home and with as much independence as possible. She accepts that on reflection she may not have shared some concerns as she had genuine fears about not being allowed to continue to care for him. The details of every incident are not available but it is clear to this review that she managed many challenges on her own. There is evidence that agencies were keen to utilise her in the carers role and on reflection also gave disproportionate weight to her views as part of decision making in Mr A's life rather than applying the principles of the Mental Capacity Act 2005 and seeking his views and wishes, supported decision making and obtaining his consent.

- Of significance she described returning to the flat as planned that night to find it on fire. She expressed anger that despite the role she had played in Mr A's life that in the immediate aftermath following such a terrible incident that she became invisible in the process and that she was left feeling unsupported, frustrated and distraught at what had happened to her friend. She was contacted by staff on 7/12/16 (two days after the fire) to arrange his needs assessment.

- Ms D welcomes this review and was keen to participate to find out what missed opportunities there were and to prevent others having a similar experience.

- Whose responsibility currently is it to update and cross reference case management records when a serious incident occurs? In the immediate aftermath of similar traumatic incidents what arrangements are in place to keep family or friends aware of initial actions that may be taken or that they should be informed of and can they be improved?

7.7 Mental Capacity

- Individuals cannot lead risk free lives and it is entirely appropriate to ask an individual to self-refer to a GP. In doing so, professionals need to be confident of an individual's ability to make that referral, be assured their mental capacity to both make that referral and retain that information for a sufficient time period to carry out the request. If staff were not confident that Mr A would remember the information, then they should not have asked him to contact the GP himself and instead a best interest decision to share information should have been explored.

- Where changes are made to existing arrangements around adults with care and support needs and opportunities for interaction and observation may vary, it becomes more incumbent on all agencies to ensure strict compliance with the Mental Capacity Act and Best Interest. MCA is time and decision specific.

- That when Mental Capacity or Best Interest decisions are made that the views of the adult concerned are not only sought but fully documented. This is a key requirement of the Best Interest Statutory Checklist. It should also document options on how the adult can be supported in this process.

- The diagnosis of Vascular Dementia may have raised doubts as to Mr A's capacity. A diagnosis may be an indicator that he may lack capacity to make a variety of decisions relating to his health, care, risk awareness and safety. A diagnosis of Vascular dementia may mean that someone has times of lucidity or fluctuating capacity. Mental Capacity is decision specific. In this case a Continuing Health Check was done (CHC) regarding his treatment and discharge arrangements but he did not meet the criteria. Therefore, arguably there was a greater role to support Mr A at this stage from adult social care.

- Discharge planning notes must be robust with considerations clearly documented and quality assured to ensure safeguarding issues, MCA and DoLs considerations and the voice of the adult (including access to advocacy). They should evidence reasonable adjustments.

- Application of the Mental Capacity Act was a legal requirement before Mr A was discharged. There needs to be clear understanding by hospital teams of the Deprivation for Liberty Standards (DoLs), both of their own responsibilities whilst someone is in a hospital setting and that of the role of the local Authority and any placement that follows.

7.8 Organisational Factors

- There have been many changes to the Enfield Safe and Connected Services over the last few years. At the time of publishing this report, the service is being managed by Independence & Well Being Enfield Ltd (IWE). Three weeks before the incident IWE agreed to take over the day-to-day management, with the Council's Finance, Resources and Customer Services (FRCS) department maintaining responsibility for the service. Jurisdiction to employ or manage the staff remained with FRCS. The review recognises that there are a number of organisational issues that feature as contributory factors for consideration.

- Staffing levels on the night show there were two members of staff working when there were meant to be four. There were vacancies on the team and the ability to meet direct service needs has been highlighted as a concern within this review. This may have a direct impact in ability to provide training, team meetings and supervision.

- There were also challenges highlighted in this report relating to the completion of Individual Management Reviews. It is apparent that staff who may not have had experience in doing so are required to fulfil this role and may benefit from additional support to complete these reviews. It is vital that staff have a full understanding of what is required within the report, the level of detail and an appreciation of the significance of the content and implications of IMR's which remain widely used within the SAR and other review processes.

8 SUMMARY AND OBSERVATIONS BY THE INDEPENDENT AUTHOR

8.1 Mr A was an older male who for some time had a limited support network. His lifestyle featured some excessive use of alcohol and smoking. He had existing health, care and support needs which meant that he was eligible for Sheltered Housing which he took up in 2008 where it was identified that he couldn't read or write. Other risk factors that were identified included issues with hoarding and self-neglect. Ms D was his long-term friend and informal carer who had a pivotal role in his life and engagement with agencies involved in this review.

8.2 Mr A's excessive use of alcohol isn't as visible following his hospital admission in 2015 where he was treated for a further stroke and given a diagnosis of Vascular Dementia. As a result, a mental capacity assessment is conducted in respect of his ability to decide on his medical treatment and hospital discharge arrangements. He is found to lack mental capacity to make those decisions but this is the only time where a documented mental capacity decision that places Mr A at the focus of care and planning takes place. There is a consistent theme of noncompliance and significant failures to deal with legal requirements under the Mental Capacity Act, Best Interest Decision and DoLs from this point forward which has significant impact on events that follow.

8.3 His clinical diagnosis or request for referral did not feature as part of his hospital discharge notes. As a result, his GP has little knowledge of him and this also a consistent theme from other agencies. Other than an input from the Mental Health Liaison Team in hospital in March 2015, there does not appear that Mr A had any further follow up or engagement with Mental Health Services. There

are significant omissions over the ensuing months to deal with Section 1 Care Act responsibilities around his health and wellbeing.

8.4 Following a challenging stay for Mr A in respite care, a decision is reached then between Mr A's social worker, the residential placement and Ms D that he should return home. As well as Mr A's 'voice' being missing in this decision making, there is also an absence of a person-centred approach to assessing need. No Mental capacity assessment or an evidenced best interest decision is documented. There is also no DoLs application. These are significant omissions. In addition, there does not appear to have been a fact-based structured risk assessment that would inform his short and long-term care and support.

8.5 Mr A then returns to his home. His carer notifies Sheltered Housing of his diagnosis of dementia and the Community Matron attend his address infrequently. His smoking at home features again and additions made to smoke alarms within his flat. The Sheltered Housing officer contacts Adult Social Care to arrange an assessment of need. Unfortunately, they are provided with inaccurate information and the case is closed. Another attempt is made to refer via the mash but no apparent safeguarding concerns are identified. This may have been a missed opportunity to address Mr A's self-neglect issues as a safeguarding enquiry which may have elicited a different response.

8.6 There were significant omissions around Care Act requirements to assess Mr A. He was sent letters with contact details that he could not read and the lack of a full screening assessment again impacted on opportunities to access intervention and support. The only health care professional to see Mr A within his home environment was the Community Matron and this presented another missed opportunity to identify need. There were also failures to deal with legal requirements to support Ms D, his carer.

8.7 The lack of legal literacy is a reoccurring theme. During 2016 Mr A increasingly comes to the attention of numerous agencies because of his deteriorating mental health. However individual agencies manage these incidents in isolation. Information gathering is poor and this impacts on how risks that Mr A faced were dealt with. He increasingly comes to the attention of police where he is found in a variety of unsafe situations. By November 2016, Mr A's mental health has now deteriorated significantly and he comes to the attention of staff in a and escalating manner. Many staff were 'flagging' up these incidents but this review has identified that there is scope for significant improvement on how agencies can work together when a person is in need of immediate mental health intervention due to their declining cognitive condition.

8.8 Prior to the fatal fire, Mr A had not been subject to a fire risk assessment or referred for a LFB Home Fire Visit that, in all probability would have highlighted that he was at high risk of a fire occurring at his home address. This would also have meant that additional measures could have been considered to reduce the fire risks or to provide additional care planning or support measures.

8.9 On 5/12/16, the LFB report concludes that the probable cause of the fire was due to Mr A's smoking materials with the likely seat of the fire being on his bed in the bedroom. There being no phone in the flat, Mr A tried to summon help via his pull cord that was connected to the ESC Jontek system.

8.10 The circumstances of this call to Safe and Connected have been subject to extensive review and recommendations are made within this review in respect of the events of that night. There remains contradictory information that this review has not been able to provide an explanation for. Included in that analysis was consideration around the delay in alerting emergency services. It is not for this

review to determine whether if alerted sooner Mr A might have survived but as in all cases for smoke inhalation the review must acknowledge that there is a need for a time critical intervention when a fire is known or suspected. In addition, this review has reflected that as well as opportunities for intervention on the night of the fire whether Mr A's care and support needs and the events' prior to 5/12/16 may also have exposed him to other risks of likely harm. He was after all, wandering at night-time, in cold weather and near motorways in a confused and disorientated state. It seems that on reflection that there was indeed a likelihood that harm caused (other than fire related) may have occurred due to the gaps in service provision identified in this review.

8.11 Startlingly, at no point during the entire time frame of this review was Mr A seen in person by Adult Social Care and there were repeated missed opportunities and gaps in service provision. His voice, his wishes and his interests were therefore never truly heard or adequately considered. It isn't a question that Mr A's decline or need was invisible to services. It was occurring in clear sight of agencies who seemed individually or collectively powerless to provide a time critical response to prevent harm coming to him. It is the view of the author that his death was preventable. The recommendations in this report reflect the complexities of reasons that contributed to why that may have been the case. More importantly they present an opportunity to ensure that other adults like Mr A with declining cognitive function will in the future be able to access and receive the help they require at the point they require it.

Maria Gray, Independent SAR Author
On behalf of the Enfield SAB

9 REFERENCE LIST OF DOCUMENTATION USED

(1) Organisational Reports

(1) LBE SW Discharge Team at North Middlesex Hospital Chronology

(2) SAR: MULTI AGENCY PARTNERSHIP REVIEW FOLLOWING DEATH OF MR 'A'

(3) Eastbrook House Care Home Chronology

(4) LFB Fire Investigation Report Incident Number: 165356

(5) London Ambulance Service NHS Trust Chronology

(6) Barnet, Enfield and Haringey Mental Health NHS Trust Chronology

(7) Fatal Fire: Safe and Connected Management Investigation

(8) Independence and Wellbeing Enfield Chronology

(9) Jontek Calls Review Print Report

(10) London Borough of Enfield Chronology (Sheltered Housing)

(11) Government Legislation

(12) The Mental Health Act 1983

(13) The Care Act 2014

APPENDIX 1: Chronology 1 (05.02.2002 – 04.12.2014)

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
05.02.2002	North Middlesex University Hospital	GP	A referral letter was sent to Mr X XXXXXX regarding an appointment for Urology.	
24.10.2007	LB Enfield	Assessment Officer	Visited on the 4th December 2007. Housing Assessment form for housing was received 24.10.2007. JG had been living in one room in shared accommodation. This assessment identified his condition was osteoarthritis, and that he could verbally communicate but was unable to read or write.	
12.11.2007	LB Enfield	Medical Assessment Officer in Community Housing	JG was allocated high medical grade/points for allocation.	
14.11.2007	LB Enfield	Housing Assessment Team	JG was award 290 points for his housing application.	
04.12.2007	LB Enfield	Assessment Officer	Report dated 04.12.2007 identified his current home as bring one room over an empty shop, with the only access being a fire escape, the room had no heating and hot water, which affected his osteoarthritis. He had been attacked by tenants. The GP treatment for his osteoarthritis was unsuccessful.	The recommendation was that he needed a more secure environment to live, and that he would benefit from Sheltered Housing Officer support.
14.12.2007	LB Enfield	Sheltered Assessment	This assessment was for the sheltered housing, which recommended his situation for sheltered housing.	
21.01.2008	LB Enfield	Voids and Re-Letting Officer	JG viewed 21 Norton House and provided details of his next of kin CS, friends and GP, and his medical condition was identified as arthritis.	
28.01.2008	LB Enfield	Voids and Re-Letting Officer	JG tenancy of 21 Norton Close commenced. Mrs CS was recorded as the Next of Kin.	
30.01.2008	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want to have a support plan; to be reviewed in a years' time. He confirmed that he wanted a call on Monday and Thursday.	
30.01.2008	LB Enfield	Sheltered Housing Officer	JG completed a Self-Assessment form, this was related to his ability to live independently, and covered hobbies and interests, communication, managing money, benefits, physical health, social network, taking care of himself and his home.	
11.05.2009	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want to have a support plan.	To be reviewed in 6 months.
17.05.2009	LB Enfield	Sheltered Housing Officer	Accident report form completed, JG had tripped up the concrete steps leading to his flat at 10:00pm.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
29.10.2009 2:00 AM	LB Enfield	Community Alarm Report	JG had a fall inside his flat and sustained a graze to his head, the ambulance service was called and he was taken to Chase Farm Hospital, the ambulance service kept his keys and was given a hospital form with all his details on.	
29.10.2009	LB Enfield	Sheltered Housing Officer	JG had returned home at 8:00AM from hospital, the Sheltered Housing officer spoke to him, about his behaviour about the night before, he denied he was drunk.	
17.11.2009	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want to have a support plan.	To be reviewed in 6 months' time.
06.01.2010	LB Enfield	Sheltered Housing Officer	Supporting People risk assessment carried out, which identified JG as being at risk from alcohol abuse, resulting in accidents to self and others. JG did not consider that he had a drink problem and refused to sign or agree to the contents of the risk assessment.	
17.05.2010	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
28.07.2010	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	
14.02.2011	LB Enfield	Sheltered Housing Officer	JG signed Support plan waiver which confirmed he did not want a support plan.	
15.03.2011	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	
20.05.2011	LB Enfield	Community Alarm Report	The report confirmed the smoke detector had been triggered, JG said there was no smoke and no one in the property has been cooking, he also confirmed there was no problem in the flat, and wanted the alarm siren to be turned off, he had waved paper and opened windows and doors. A mobile warden attended and the smoke detector was disconnected and test calls made from all of the pull cords. The smoke detector was reconnected. The safe and connected records show the 13th June 2011; however, this could be when the notes were written up, and the alarm could have been reconnected earlier, but we are unable to ascertain if this was the case.	
15.08.2011	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
03.07.2012	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
03.07.2012	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	
17.01.2013	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
17.01.2013	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
27.07.2013	Barnet, Enfield & Haringey Mental Health NHS Trust	Accident & Emergency Dept. Chase Farm Hospital	Presented with head injury – intoxicated.	
31.07.2013	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
31.07.2013	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	
03.12.2013	Barnet, Enfield & Haringey Mental Health NHS Trust	Accident & Emergency Dept. Chase Farm Hospital	Presented with head injury – intoxicated.	
11.01.2014	Metropolitan Police	Metropolitan Police	On 11.01.2014, JG was arrested for assaulting his partner SS after they returned home from a local public house. JG grabbed SS by the throat and punched her in the head. SS called the police but the call was terminated by JG. JG on interview admitted pushing SS to the neck and also the head. SS declined to provide a statement. JG received an Adult Caution for Common Assault.	
11.02.2014	LB Enfield	Sheltered Housing Officer	JG signed Support Plan waiver which confirmed he did not want a support plan.	
11.02.2014	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require a daily visit.	
13.10.2014	LB Enfield	File note from Sheltered Housing Officer	Email to Neighbourhood Officer – that JG was identified as having hoarding issues, dirty clothes, blocking the fire exit and the boiler. It was noted that he was a heavy drinker and heavy smoker, questioned if he had mental health issues. As soon as SHO was aware, JG agreed for his friends to be contacted and they were willing to assist him in clearing the flat.	
15.10.2014	Metropolitan Police	Metropolitan Police	On 15.10.2014, a member of the public called police to report that JG had received two letters from Bedfordshire Constabulary, the letter apparently sought that he attend for an interview regarding an incident in Bedfordshire. Bedfordshire Constabulary were updated.	
19.11.2014	LB Enfield	Sheltered Housing Officer	JG signed a daily call variation sheet, stating he did not require daily visits.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
19.11.2014	LB Enfield	Sheltered Housing Officer	Support plan was discussed with JG and signed. The plan was set up following the SHO concerns about his lifestyle, including drinking/smoking. Identified twice weekly trips to the pub with his friends, and that he was drunk. The SHO has spoke to JG regarding his drunken behaviour, but he never remembers. This plan followed the identification that his property was very dirty and he had started to hoard microwaves, tables and fridges. The SHO would refer JG to the Estate Manager to resolve the fire and health and safety issues caused by the hoarding issues. The Estate Manager set timescales and monitored progress over several months and the Sheltered Housing Service supported them with regards to disposing of unwanted items and furniture. CS has been contacted and she was supporting him to remove the items in his property, and would after clearance visit weekly and arrange to clean his property. The support plan identified he needed to refer himself to the GP relating to his mental health, drinking and arthritis for a check-up as he was not taking his medication, relying on pain killers. He did not want to give up drinking and did not want support.	
04.12.2014	LB Enfield	Sheltered Housing Officer	Referral to Adult Social Care by the Sheltered Housing Officer, relating to his hoarding and struggling to cope, the referral requested a consideration for a Care Package.	

APPENDIX 2: Chronology 2 (08.12.2014 – 31.03.2015)

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
08.12.2014	LBE SW Discharge Team at North Middlesex Hospital	Referral: Sheltered Housing to Access	ER, Sheltered Housing Officer requested an assessment for a package of care. Screening tool and activity raised.	
09.12.2014	LBE SW Discharge Team at North Middlesex Hospital	Screening request	Request made on system.	
10.12.2014	LBE SW Discharge Team at North Middlesex Hospital	Telephone call to: Access Team	CS, informal carer. Advised that she had no way of contacting JG either expect when she saw him on a Saturday to do some shopping. ER (SHO): Gave access worker JG's friend's number called H. They left a voicemail asking H to give Access a call back when he is with JG to complete a screening assessment.	
10.12.2014	LB Enfield	Sheltered Housing Officer	SHO received a telephone call from the Screening Officer from the Access Team, said that they had spoken to CS following the SHO referral, and said that JG would not accept the help. The SHO explained her concerns and told her that his friend H would assist in the care, the contact number for H was passed to the screening officer, and it was agreed JG would have an assessment.	
12.12.2014	LBE SW Discharge Team at North Middlesex Hospital	Telephone call to: Access	H advised for reasons for call but no time to discuss so call ended. H did not pick up when called again at the mutually agreed time so message was left for him.	
12.12.2014	LBE SW Discharge Team at North Middlesex Hospital	Standard Letter to: JG	Letter sent to JG advising him of the referral and the wish to undertake a screening assessment. JG asked to contact the team.	
December 2014 – May 2015	LB Enfield	Sheltered Housing Services Manager comment	During this period, there was no Sheltered Housing Officer on site; whilst daily calls and SP were being covered by colleagues across the service. This would account for the lack of file notes between this period.	
16.02.2015	London Ambulance Service NHS Trust	JG	An ambulance attended JG as it was reported that he was feeling unwell. It was reported by JG's friends that they were concerned as his mental health and mobility had worsened. Following ambulance staff's assessment JG was conveyed to North Middlesex Hospital. A safeguarding referral was submitted to the local authority.	
16.02.2015	LBE SW Discharge Team at North Middlesex Hospital	Referral from London Ambulance Service (LAS)	Concerns raised about JG's mental health and mobility. JG was taken to North Middlesex University Hospital (NMUH) following the call from CS.	
16.02.2015	North Middlesex University Hospital	Emergency Department	JG had to be taken to ED with a history of fast AF and confusion. LAS Report indicated that home environment was not clean and there was evidence of hoarding. JG was also found to be unkempt and there was little food in the kitchen.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
16.02.2015	North Middlesex University Hospital	Consultant for Gastroenterology	Dr XXXXXXX XXXXXXXX (Consultant in Gastroenterology) admitted JG with a history of confusion, fast AF and 2-month functional decline (ward T3).	
21.02.2015	Metropolitan Police	Metropolitan Police	On 21.02.2015, a member of the public called police to report that the day prior his call, a person unknown had thrown items from the window of 21 Norton Close, EN1 3PX. The caller stated he believed the occupant was in hospital. Officers attended and could not gain entry to the property or speak to the original informant. The officers then spoke with the site manager who agreed to complete a welfare check at 21 Norton Close, EN1 3PX and to contact the police should there be any more issues/problems.	
20.02.2015 + 23.02.2015	North Middlesex University Hospital	Physiotherapy Department	Physiotherapy assessments. Risks of falls, poor safety insight and subsequently back at baseline.	
20.02.2015	LBE SW Discharge Team at North Middlesex Hospital	Section 2 Notification in NMUH	Assessment request for JG – to look at care needs at home or alternative condition.	
04.03.2015 10.03.2015 12.03.2015 16.03.2015	North Middlesex University Hospital	Occupational Therapy	04.03.2015 – OT Assessment records knowledge of LAS concerns raised. 10.03.2015, 12.03.2015 and 16.03.2015 – Non-compliant reduced capacity. No record of capacity assessment. 16.03.2015 – CT head scan – revealed right cerebellar lesion, possible new stroke. Confusion screening: negative. Prescribed Digoxin. Throughout admission: Challenging behaviour, noncompliance with medication or orbs. 17.03.2015 – CT done under GA – cerebellar infarct. JG continues to be non-compliant with medication, obs. Evidence of refusing personal care and some meals. 23.03.2015 – CHC declined. Recommendation EMI bed and funding for nursing. 24.03.2015 – MCA completed by Dr XXXXXXXXXXXX (FY1, found to lack capacity to consent to treatment and discharge destination). 25.03.2015 – Section 5 submitted to Enfield Social Services.	
25.03.2015	LBE SW Discharge Team at North Middlesex Hospital	Continuing Health Care checklist and Section 5 scanned onto system: NMUH.	Continuing Health Care (CHC) checklist by nurse (did not trigger for full assessment) and Mental Capacity Act assessment carried out by Doctor. When at NMUH, JG was showing challenging behaviour, inability to make appropriate choices even with support, no best interest assessment on file.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
25.03.2015	LBE SW Discharge Team at North Middlesex Hospital	Section 5 notification to Social Worker (SW) team in NMUH	Section 5 for EDD (Estimated Day of Discharge) 30.03.2015. Social Worker got case allocated today to assess JG on the ward. No Occupational Therapy reports available.	
25.03.2015	LBE SW Discharge Team at North Middlesex Hospital	SW phones friend. NMUH	CS explains to SW that she supports JG, she pays rent, does shopping – SW informed that best option for JG would be for residential placement due to lack of capacity and inability to make informed choices and decisions. Section 5 withdrawn as no Occupational Therapy (OT) report available.	
27.03.2015	North Middlesex University Hospital	Enfield Social Worker	27.03.2015 –Enfield Social Worker deemed JG to be confused and disorientated, unable to engage in discharge planning or care needs assessment.	
27.03.2015	LBE SW Discharge Team at North Middlesex Hospital	OT Discharge summary report: NMUH.	Multi-disciplinary decision outlines that JG needs supervision always due to the confusion, recurrent falls, aggressive behaviour and non-compliance with meds.	
27.03.2015	LBE SW Discharge Team at North Middlesex Hospital	SW calls CS	Discussion around JG to trial residential care before being placed permanently, friend CS would like for JG to go home and try wherever this would work with community based care. SW responds that Multi-Disciplinary Team (MDT) would be concerned with him being alone during the night time.	
30.03.2015	North Middlesex University Hospital	EastBrook House Assessment	XXXX XXXXXXX from EastBrook House visited JG to assess. No outcome recorded.	
30.03.2015	LBE SW Discharge Team at North Middlesex Hospital	SW calls CS	SW speaks to CS to inform her that JG is being discharged to EastBrook House on the 31.03.2015 for a 4-week respite placement to see how he feels about being in residential care. CS agrees to drive JG to placement.	
30.03.2015	LBE SW Discharge Team at North Middlesex Hospital	New Section 5 issued.	New discharge notification issued to ward.	
31.03.2015	LBE SW Discharge Team at North Middlesex Hospital	Discharge to EastBrook House	CS drives JG to EastBrook House, signed assessment paperwork.	

APPENDIX 3: Chronology 3 (10.04.2015 – 17.08.2015)

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
From April 2015	LB Enfield	Sheltered Housing Services Manager comment	Supporting People Grant was withdrawn from the Service, and as a result a £422K was cut from the service which meant the staff at schemes and peri-schemes no longer had a support plan, risk assessments, etc as the funding had been withdrawn. From this date, the residents still have daily call if required and provide a lower level of support. The emphasis of the role is now more focussed on premises control and compliance. With the reduction in staff, the duties of the Sheltered Housing officer were not reassigned, they are still supporting tenants as best they can and continue to make timely referrals to appropriate agencies as their roles are now considerably Health and Safety focussed.	
10.04.2015	LBE SW Discharge Team at North Middlesex Hospital	Appointment made with Mr G and CS.	Meeting scheduled with SW, JG and CS for the 14th April to agree support plan and sign financial assessment referral form.	
14.04.2015	LBE SW Discharge Team at North Middlesex Hospital	Meeting in EastBrook House: NMUH	SW meets with JG, CS and male friend in EastBrook House. CS is unable to sign support plan and financial referral form as she does not want to be liable for any cost (however, she deals with JG's finances).	
21.04.2015	LBE SW Discharge Team at North Middlesex Hospital	Email from EastBrook House manager.	SW uploads email from home manager to say that JG has climbed over a 6-foot fence on the 31st March, and then again on the 21st of April and was later brought back to the home. No repeating incidents reported in the 3 weeks in between, however staff have to be vigilant all the time. Asking for long term plans for JG.	
27.04.2015	LBE SW Discharge Team at North Middlesex Hospital	Review of placement by SW from NMUH	Between the home manager, CS and the SW, they concluded that JG should have the chance to return to his home environment with his friend CS's support. CS is to monitor JG and SW is to liaise with CS regarding his progress.	
05.05.2015	LBE SW Discharge Team at North Middlesex Hospital	Phone call from NMUH SW to CS	Phone call made to get some update regarding JG's progress and CS stated that he is by her house most of the time, but will sleep in his flat at night time. She states that she assists JG with taking his medication, but she also stated that she sometimes gets tired as she has her own medical problems. SW informed of available care support and Direct payments for JG but CS felt that she might not be entitled to support. SW states she will call again next week to see how she goes.	
06.05.2015	LBE SW Discharge Team at North Middlesex Hospital	Review scanned and posted: NMUH	Review scanned onto care store and copies posted to CS and EastBrook House. No further notes on file of work by Hospital Social Work team.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
11.05.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	North Middlesex Hospital inpatient summary to GP	68-year-old gentleman admitted with confusion and fast atrial fribulation (AF) on 16.02.15 following a 2 month decline in function. Tests revealed a cerebellar lesion (stroke). Behaviour in hospital described as challenging. JG was reviewed by Dr L who suggested that he would need a placement in his best interests. Summary indicates a formal capacity assessment revealed a lack of capacity. No other information about this is given on the summary. Discharged to nursing home on 31.03.2015.	
14.05.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	GP referred to Enfield Community Matrons	Referral indicates the need for a review of medication and carers.	
20.05.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	FACE contact background information form completed by CM	JG described as: White Irish; Christian; Retired. Alerts: known risks to self – memory loss, wandering, smoker. Assessment: Patient had right sided CVA in February 2015, spent a long time in hospital and in respite care. Home for the last 3 weeks, no memory of his time in the hospital. JG reports he is happy to be left alone and not to be disturbed. Would like to be rehoused closer to friend CS. Day to day activities such as shopping and cleaning are supported by his friend CS. Would like a ground floor flat. Smoking: JG smokes a 'lot' and becomes angry at the mention of cutting down. Would not consider attending a day centre. Safety and Risk: JG is at risk of getting lost when out walking. Smokes rollups in one room only. Has a working smoke alarm.	
20.05.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records and RiO records. Community Matron Nursing Care Plan	Home visit following referral from GP. Records indicates JG was referred to the community nursing team to assess his medication and any needs for a carer. JG liked to be called "Sean" and lived on the second floor of a sheltered housing property. His female friend CS was present. C, or family members visited JG 3 times daily. It is noted that JG was reluctant to accept formal carers. JG was discharged from NMUH following a CVA. JG is described as a heavy drinker in the past and a heavy smoker. JG is described as largely self-caring and likes to go out walking most days. Nursing Care Plan indicates memory loss with '? Vascular dementia?'. Community Matron to visit every 4 to 6 weeks.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
25.05.2015	LB Enfield	Sheltered Housing Officer	CS spoken to the Sheltered Housing Officer to confirm JG had been out of hospital for a few weeks and had been diagnosed with dementia and has had a referral for input from Social Services (Adult Social Care). A Social Worker would be visiting him on the 25.05.2015 to carry out an assessment. There was a discussion around the daily call being introduced and having a pendent alarm. JG appeared confused.	
29.05.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Retrospective entry to RiO	Entry on RiO made 29.05.2015 – refers to visit on 20.05.2015 as above.	
June 2015	LB Enfield	Safe and Connected and Sheltered Service	The smoke detectors are tested on a regular basis, it used to be 6 monthly and smokers monthly. But now the smoke detectors in the flat including the one not connected to Safe and Connected are both tested every month.	
01.06.2015	LB Enfield	Sheltered Housing Officer	The SHO had a discussion with Mrs W (the carer), the social worker would phone CS/JG to carry out an assessment over the phone and to arrange a face to face assessment.	
10.06.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records and RiO records	Home visit by Community Matron. Friend CS present who continues to support JG. Medical check completed. Records indicates JG was clean and well dressed, eating and drinking well. CS reports JG has good and bad days and has no memory of being in hospital. RiO records indicate that JG swears a great deal and is sometimes very forgetful.	
07.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Referral: Sheltered Housing to Access	AW (SHO) requesting an assessment of needs. Request highlights potential carer stress and social isolation as the key reasons.	
08.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Screening: requested	Access Manager requested screening assessment.	
20.07.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron	Home visit. CS present. JG reported to walk to the pub most days to meet friends – drinks 1 to 2 pints. Advice given to cut down on alcohol consumption and smoking. JG reports he will never give up smoking but will try to reduce alcohol intake. Also walks to CS's house. JG's memory is poor but be can find his way around the local area. Good support from his friend CS.	
27.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Access to CS.	CS told worker that JG requires help with medication but refuses assistance from anyone other than herself so she manages his medication and keeps it at her home. She does his meals. Assistant Team Manager (ATM) gave advice that unless JG is deemed to lack capacity that services cannot be provided without his consent. ATM asked ASO to call referrer to see if JG would agree to undertake screening with her. Left message to contact Access.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
28.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Access	Telephone call made from AW (SHO) who agreed to ask JG to come into the office to complete assessment. AW was concerned that JG lacked capacity to make his own decisions and that they may refuse services. Access Officer (ASO) explained that JG would have to be assessed by a medical practitioner to be deemed not to have capacity for Access to step in without his consent. ASO explained that this would be matter for JG's GP. Plan to await call back from AW and JG.	
29.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Access to/from referrer	To AW: Message left to contact Access. From AW: AW said she has been unable to arrange a time for herself and JG to complete a screening assessment – user has no phone. AW informed that she could call back at any time to complete screening but that the case would now be closed pending further contact from AW and JG.	
29.07.2015	LBE SW Discharge Team at North Middlesex Hospital	Standard letter: Access to Mr G.	Sent to JG advising him of the referral and the wish to undertake a screening assessment. JG asked to contact team.	
10.08.2015	LB Enfield	Sheltered Housing Officer	Safeguarding Adults Alert for dated the 10.08.2015; the referral was due to JG being diagnosed with dementia and wanted his care arrangements made more formal.	
12.08.2015	LBE SW Discharge Team at North Middlesex Hospital	Email referral by Sheltered Housing Officer to Multi Agency Safeguarding Hub (MASH)	AW completed a referral to MASH requesting a capacity assessment for JG, as he was resistant to support.	
14.08.2015	LB Enfield	Multi-Agency Safeguarding Hub	Sent email to the Sheltered Housing Officer, seeking more clarity over the referral.	
14.08.2015	LBE SW Discharge Team at North Middlesex Hospital	MASH email to referrer	Referrer asked if there were any safeguarding issues. If not a referral for an assessment may be more appropriate (referral form included in email).	
17.08.2015	LB Enfield	Sheltered Housing Officer	Sheltered Housing Officer confirmed that there were no specific safeguarding issues and would follow up with Adult Social Care.	
17.08.2015	LBE SW Discharge Team at North Middlesex Hospital	Email from referrer: MASH	AW emailed to confirm there were no safeguarding issues and she would follow up with Adult Social Care. No further action was taken by MASH.	

APPENDIX 4: Chronology 4 (18.08.15 – 31.10.16)

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
06.11.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron – paper records and RiO records	Home visit. JG continues to visit the pub daily, reported to be drinking half a pint only. Enjoys talking about the past and playing music. Medical check completed.	
13.11.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron – paper records and RiO records	Home visit to administer flu vacation. CS present. Medical check completed. RiO record states his memory is poor and that he is walking to the pub every day.	
12.02.2015	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper record	Care plan reviewed/ signed by CM – no record that JG was seen.	
06.04.2016	Metropolitan Police	Metropolitan Police	On 06.04.2015, a member of the public called police to report that JG was wandering on Goldsdown Road, Enfield in a confused state. Police officers attended and spoke to JG who was only able to provide his name. Officers to confirm an address of 21 Norton Close, EN1 3PX and returned him to his home. The officers spoke to the warden AW who detailed JG's medical condition (Dementia, Arthritis and 'Racing Heart'). She detailed that CS, a family friend cooked and cleaned for him and also that ER of Enfield Social Services was aware. On 07.04.2016 YE PPD passed the MERLIN to Adult MASH.	
07.04.2016	LB Enfield	Electrical Engineer	No access to 21 Norton Close to fit the second smoke detector. The Sheltered Housing Officer to arrange access, the second smoke detector was installed and has been regularly tested.	
11.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: from referrer to Access	AW called reiterating JG's need for a face to face assessment. JG has wandered away from the property and was brought back by the police. AW also concerned that he may be taken advantage of by his friend and carer (no evidence of this). She will send in referral with her concerns.	
12.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Referral: Access	Received from AW: Scanned to Wisdom. Information gathered – past hospital OT report indicates diagnosed dementia and limited insight. Information from the respite stay stated that JG climbed a 6ft fence at the home – there has been no follow up to ascertain any issues in the community after the agreement for JG to return home. Advice to get clarification from referrer re concerns over friend – as there is no further information in the referral. Background information required – comprehensive assessment of needs may be required.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
12.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Information Gathering: Access	Screening Officer called referrer to gather more information. Regarding the carer, CS, AW said she had no proof that anything was wrong, only that she worries when people are involved and have nothing down officially such as the POA (Power of Attorney). CS always appeared to have done nothing but look out for his best interest and assists with his housework, shopping and sees that he has his medication. She drops him a meal when she can and she buys him easy to eat foods. For his personal care, AW stated that he appears ok, looks reasonably clean and tidy although showering is not his main priority. AW advised she has concerns as he has gone out and become lost so she feels with his dementia this can only continue to worsen. AW feels he requires comprehensive assessment completed to determine his needs and a long-term plan. Worker advised AW that information will be passed back to the manager.	
13.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Management Instruction: Access	Contact to be made with friend – CS to ascertain if she is in agreement and willing to support JG through the assessment process. Indication is case will need to be transferred to CMS (Case Management Service) for a comprehensive assessment of needs – this is based on past assessments and information.	
13.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Access	To CS, to enquire if she will support with the assessment process. CS advised that this is not a problem. She stated that JG is not a problem and she is happy to continue to care for him. She stated she visits daily and ensures that he is changing his clothes; she said he eats well and she ensures he has his meds; she advised that he got lost on that day because a friend took him to a different shop and when he came out, he turned the wrong way and lost his bearings. She advised that this has not happened before and does not think that he needs intervention because of this. She advised he functions well when in his own routine; he goes to the local pub each day and has half a pint of beer and pop into the shops and comes home.	
15.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Decision: Access Assistant Team Manager	JG appears well supported by CS, who will contact Adult Social Care if required. JG would need support at a face to face assessment due to anxiety. AW (referrer) has no evidence regarding financial issues and this appears to be personal unsubstantiated belief of AW. No further action required. AW to be advised.	
15.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone to referrer	AW contacted. Message left informed of above.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
19.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call from referrer: Access	Aw returned call – explained information gathered and that a comprehensive assessment is not required. Advised CS is fully aware of needs, happy to continue to provide support and has Access contact details if JG's needs change. AW advised she is 'worried' as she feels JG is 'vulnerable' due to his dementia. AW was asked how he could be made safe – AW was unable to advise. Residential care is not required; JG would not interact with carers due to anxiety and has support from CS. Day care would not be an option either. Advised AW that ASC agreed with his present support network and that if assessment were required either CS or AW could contact again. AW informed referral would be closed.	
19.04.2016	LBE SW Discharge Team at North Middlesex Hospital	Referral closed: Access	N/A	
19.04.2016	LB Enfield	Adult Social Care	Telephoned the Sheltered Housing Officer stating they have discussed with CS (the carer), and ASC currently feel they do not have the role to play as CS is able to continue supporting JG. The Sheltered Housing Officer raised concerns regarding JG's vulnerability and ASC pointed out that he has only got lost once before and to continue with CS's support.	
11.05.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records and RiO records	Requires a blood test but refusing to see GP. Going out every day. Reported to be keeping well (6 months between visits)	
24.05.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records and RiO records	Home visit to take bloods, unsuccessful.	
27.05.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Nurse	Unable to obtain blood sample – plan to inform community matron.	
14.07.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron	CM spoke to CS as male nurse was available to take blood. CS stated that JG would not agree to a male nurse attending.	
24.07.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records RiO records	Home visit to take bloods with female colleague. CS present. JG described as pleasant and co-operative. Clean and well dressed, memory described as poor. Still going to the pub daily to meet friend. Continues to smoke. Medical check completed.	
12.10.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records		
	Care plan reviewed – signed by CM.			

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
17.10.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron	Home visit. CS present. JG appeared well and claims he is not drinking alcohol anymore. Goes out walking daily. Refuses to cut down on smoking and gets upsets if this is discussed. Flu vacation is given. RiO entry states that CS reports that JG's memory is very poor and he forgets who she is.	
31.10.2016	LB Enfield	Sheltered Housing Officer	The Sheltered Housing Officer phoned CS to check that JG was warm enough in the current cold weather. CS informed the Sheltered Housing Officer that the community matron had visited JG the day before, as he has deteriorated and had been wondering on a number of occasions where the police had called CS to pick him up. He was being referred to Adult Social Care for an assessment of his needs. The Adult Social Care team rang the SHO and said they didn't have the role to play at this time, however they speak to JG's carer CS.	

APPENDIX 5: Chronology 5 (05/11/16 – 01.12.2016)

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
05.11.2016	Metropolitan Police	Metropolitan Police	On 05.11.2015, a member of the public called police to report that JG was stood on the door step of 38 Hillcrest, N21 and was frail and confused. Police officers attended and spoke with JG who provided his name as 'Sean', he could not recall any other details. The details of CS were found in his wallet. Officers contacted CS who advised she provided care for JG and she agreed to meet them at his home. On returning JG home, they met with CS. She provided the details of JG's social worker ER and stated she would ring to inform her of the incident. On 21.11.2016 YE PPD passed the MERLIN to Adult MASH.	
19.11.2016	Metropolitan Police	Metropolitan Police	On 19.11.2016, a member of the public flagged down police officers having found JG in a dishevelled state stood next to the A10. JG was unable to provide any details of his home address. Officers found details of CS within his wallet and as a consequence contacted her. The officers took JG back to 21 Norton Close, EN1 3PX where they were met by CS. CS informed officers that she would contact health care professionals due to the increase in JG leaving his home and getting lost. On 21.11.2016 YE PPD passed the MERLIN to Adult MASH.	
24.11.2016	Metropolitan Police	Metropolitan Police	On 24.11.2016, a member of the public called police to report that JG was on Bullsmoor Lane, Enfield seemingly suffering from Dementia. Police officers attended the location and found JG. Officers found details of CS within his wallet and as a consequence, contacted her. The officers took JG back to 21 Norton Close, EN1 3PX where they met CS, informed officers that she had been trying to arrange extra care for JG. On 02.12.2016 YE PPD passed the MERLIN for Adult MASH.	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
28.11.2016	Metropolitan Police	Metropolitan Police	At 14:57 on 28.11.2016, a member of the public called police to report that JG had walked onto his building site at 67 High Street, Enfield in a disorientated state. Police officers attended and spoke with JG who provided his name as 'Sean', he could not recall any other details. The details of CS were found within his wallet. The officers took JG back to his home, where they met CS. This incident was not forwarded to Adult MASH. (This will have been reviewed by Misper Unit)	
28.11.2016	Metropolitan Police	Metropolitan Police	At 22:15 on 28.11.2016, a member of the public found JG in the road at the junction of Church Street and Great Cambridge Road, N21. The member of the public then took JG to Edmonton Police Station Front Office. CS was contacted and she collected him. The information was added to the previous incident. No separate report was created.	
29.11.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Community Matron to Access	TC from Community Matron – JG's dementia is worsening and he's started wandering several times a week; picked up by police and CS, his friend, has put a card in his wallet 'If found please call' and her number is on the card. Advised by manager XXX should contact Safeguarding, XXX confirmed she had tried calling but no one has got back to her. XXX has been calling 020 8379 3169, I said it's 379 3196. Call ended abruptly.	
29.11.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Community Matron to MASH	The Community Matron expressed same concerns as above.	
29.11.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: MASH to CS	The MASH worker said that she would request a full needs assessment for JG and suggested that it might be useful to install telecare equipment etc.	
29.11.2016	LBE SW Discharge Team at North Middlesex Hospital	CareFirst message: MASH to Access	MASH worker alerted Access 'contact friend CS – see observations'	

Timeline	Source of Evidence	Contact with	Communication/Reason/Incident/ Location	Action taken
29.11.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	Community Matron paper records	Telephone call to Community Matron from CS. States that JG has been wandering and was picked up by the police by the A10. Community Matron visited JG at home that afternoon. CS and her grandson were present. CS reports that at times JG becomes very confused. CM spoke to social services (SS), Access and MASH and asked for an assessment. ER spoke to Dr C in Brick Lane who is reported to have agreed that the best course of action was to get SS involved. CM indicates that building work is underway at the flats and this appears to be confusing JG when he walks past. RiO records states that CS reports JG does not always remember who she is, often puts his shoes on the wrong feet and will get his clothes wrong and needs reminding to wash and dress.	
30.11.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	RiO Entry	ER spoke to CS who confirmed she had not heard anything from SS.	
01.12.2016	LBE SW Discharge Team at North Middlesex Hospital	Telephone call: Community Matron to MASH	Message left asking to speak with someone as JG had again gone wandering.	
01.12.2016	Barnet, Enfield & Haringey Mental Health NHS Trust	RiO Entry	ER spoke to CS. CS reported that JG got lost and was found at London Bridge by his friend. RiO entry indicates that ER made a further call to MASH at 09:15AM who promised to get back to her. Further call made at 14:00 – message left for MASH answer phone.	

Strategic Safeguarding Adults Service
Health, Housing and Adult Social Care

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ENFIELD Council