SAR Elvis

Statutory Safeguarding Adults Review (SAR) Report and Findings in respect of an individual to be known as Elvis

This report has been prepared under the statutory requirements of the Care Act 2014 by Statutory Partner Philippa Uren, SAR Reviewer for the Bexley Safeguarding Adults Board

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Preface

The subject of the SAR has been referred to as Elvis to provide some measure of protection to the subject and their family's right to confidentiality and privacy.

The Independent Chair and SAR panel members offer their deepest sympathy to Elvis's family and all those affected by his death. It was clear during the review and from the findings that Elvis was a much-loved brother.

The Independent Chair wishes to thank the SAR panel members for the professional way in which they conducted the review. This review commenced during the Covid-19 pandemic and required an online approach consistent with public health measures taken by UK Government, the SAR chair greatly appreciated the full engagement, sensitivity, and time of the SAR panel throughout the process.

Introduction

The subject of this review is a white British Male who was in his fifties at the time of his death in May 2020. Elvis died in hospital following an emergency admission. He had a learning disability and had a diagnosis of asthma.

He had lived with his long-standing friend (who will referred to as Anne (a pseudonym) throughout this report). Anne also has a learning disability. They lived together for many years and had limited contact with social care. There were concerns of self-neglect and domestic abuse prior to his death. Although concerns were raised by Housing and keyring regarding domestic abuse it has become clear during this review that Elvis and Anne friend would not want to be seen as partners. However, many professionals described their relationships as such, and the concerns of domestic abuse were taken forward in that context.

A concern was raised by the day centre that Elvis was putting himself at risk by attending the shops during the first wave of lockdown. A support service of a meals service was put in place as support and to mitigate this concern.

A Safeguarding Adult Review (SAR) is carried out so that the agencies involved in providing services can learn lessons and improve practice. This SAR follows an earlier review undertaken as part of the national Learning Disability Mortality (death) Review programme. People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented. The learning from deaths of people with a learning disability (Leeder) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

In a LeDeR review someone who is trained to carry out reviews, usually someone who is clinical or has a social work background, looks at the person's life and the circumstances that led up to their death and from the information they have, make recommendations to the local commissioning system about changes that could be made locally to help improve services for other people with a learning disability locally. They look at the GPs records and social care and hospital records (if relevant) and speak to family members about the person who has died to find out more about them and their life experiences.

In Bexley the findings of the LeDeR are reported to the LeDeR sub-group. In this case the group considered that a further review of the circumstances leading to the death of Elvis should be undertaken under the Safeguarding Adults Review process to focus on any safeguarding issues and lessons. The purpose of this review is to identify the learning, and to consider the extent to which there are similar or additional themes to those identified in previous reviews. The aim of this work is to provide information, understanding and insight and importantly, to improve services as a result of that learning. In view of the LeDeR and the relatively limited range of issues, it was agreed that the SAR should be led by the Independent Chair of the Safeguarding Adult Board, to consider the findings of that review, to identify if there is any additional relevant information and to determine any wider safeguarding lessons. It was agreed that the SAR would be conducted as learning process, with the information brought together and considered at several joint meetings.

Criteria for undertaking a SAR

A Local Safeguarding Adults Board must undertake reviews of serious cases in specified circumstances under Section 44 of the Care Act 2014 which sets out the criteria for a Safeguarding Adults Review (SAR). This includes circumstances involving an adult in its area 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 Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died.

The purpose of the review is primarily to:

a) establish lessons to be learned from the case of C, in terms of how professionals and organizations worked, both individually and together, to safeguard the adult at risk and prevent harm
b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems
c) deploy a mechanism for the BSAB to apply lessons learned to service responses for adults at risk across Bexley and to share these lessons at a national level

Information considered

In addition to the LeDeR review, individual management reviews (IMR) and summaries of involvement were received from:

1. Oxleas NHS Foundation Trust – Adult Community Learning Disability Team (CLDT)
2. GP Practice – in Bexley
3. Lewisham and Greenwich NHS Trust – Queen Elizabeth Hospital
4. Adult Social Care – Bexley
5. Housing – Bexley

Scope

The following concerns were raised via the LeDeR review and were to be used as the terms of reference for this review:

1. The lack of investigation of gastric and liver symptoms and failure to follow NICE guidance and failure to investigate and adequately follow up his increasing anaemia.

2. The lack of capture of his LD and literacy skills in his GP medical records and no evidence that reasonable adjustments were made to ensure that all his specific needs were understood and met to ensure safe and appropriate management of his health.

3. The lack of clarity around social care engagement and the apparent lack of an appropriate response to concerns raised by his next of kin in January 2020 about his and his long standing-friend's vulnerability and their obvious difficulties in keeping themselves safe in their home environment.

4. Elvis making himself vulnerable to financial abuse as he was struggling to manage his finances and pay his bills. It was clear to the attending LAS crew

on 5 May 2020 that they were in extreme difficulties. It is unclear how social services were not aware of the state of the house and how dangerous an environment it was to their health and safety.

5. It is unclear what arrangements were in place at the time of Covid 19 lockdown to monitor them, at a time when they would have been even more vulnerable due to increased isolation, as they were not able to go out into the community where they were well known. His [Elvis's] sister believes that her brother was going out in lockdown and therefore potentially putting him, as well as others, at risk.

The reviewer acknowledges that there were complaints made by his sister to both the GP and social care regarding their care and support of Elvis. These are separate processes and not part of this review.

Background

Elvis was a man in his 50's with a mild learning disability who lived for many years with Anne in the community. At the time of his death, he was only in receipt of a hot meals service.

Elvis did not have support for personal care and would visit the local shops to purchase what was needed. He would cycle there. He attended his GP surgery independently too.

Elvis had literacy problems – difficulty with reading and writing.

He was known to Oxleas CLDT team between May 2008 and July 2010. During this period of time, he was known to Oxleas Psychology and Nursing teams along with Bexley Local Authority Social Care and Shared Lives scheme. At this time this was a joint service where health and social care staff were based together and worked closely to provide a unified model of care.

He was not re-referred to the team following his discharge from the Psychology team in 2008.

In 2014 he was also seen by the Oxleas MSK Physiotherapy Service following a referral by his GP for right sided lumbar back pain. This is a mainstream service.

He was also open to Oxleas mainstream Adult Mental Health services in 2016 during a time of severe distress following a breakdown in his relationship.

Elvis was known to his GP surgery and would attend independently for advice and support. He attended for his asthma appointments, 'flu vaccinations, medication reviews and whenever he needed advice. He was invited for his LD annual health check in December 2019 but he did not attend.

Elvis had regular needs assessment from Adult Social Care and they worked alongside Housing when concerns were identified.

In the weeks prior to his death, he attended his GP surgery with heartburn and chest pain. He also attended the Urgent Care Centre for this problem. At his GP request Elvis attended the Emergency Department (ED) at QEW where he was assessed and treated and discharged back into the care of his GP with advice.

In May 2020 he was admitted as an emergency patient to QEW via London Ambulance Service where he received emergency surgery and treatment. Elvis' subsequent treatment was unsuccessful, and he died in QEW on 16 May 2021.

Family Involvement

Elvis had a sister that supported him and his Anne. Contact with the sister was attempted via telephone as this was during the first national lockdown for COVID. The reviewer discussed the purpose of the review and the sister was happy for this to proceed.

The reviewer asked if she would like meet via zoom and/or Microsoft teams but Elvis's sister did not wish to do this as she preferred to meet in person. The reviewer explained that this was not possible at this time due to the Pandemic. At this point Elvis's sister decided she didn't want to be part of the review.

Elvis's sister explained how she had made complaints regarding the GP and Adult Social Care and the reviewer explained how these were separate from the review and would be investigated independently of the review.

The reviewer asked Elvis's sister to contact her if she had any questions or queries and to date no contact has been received.

The SAR panel discussed whether it would be of benefit to contact Anne regarding the review and following feedback from the psychology team supporting her following Elvis's death it was felt this would cause her too much distress and so no contact has been made.

Following completion if this report the reviewer will contact Elvis's sister again to explain the recommendations and whether she would like to comment on the report before publication.

Summary of known events prior to episode of being unwell leading to death
2008- Dec 2018

Between 2008 and 2010 Elvis had been supported by the Integrated team for LD where he was supported with psychological input. His referral was for psychological support and there is evidence supporting good practice for Elvis to attend these appointments:

- Easy read leaflets to support his literacy
- Communications over the phone with details of the appointments
- Support in meeting Elvis at the bus stop to ensure appointment was kept.

Despite this Elvis did not respond to the appointment for this service.

Elvis was further offered support by the CLDT when attending a dentist appointment to support his understanding of the procedure and any necessary decision making/capacity issues. There was no further support from the nursing team within the CLDT following this.

In 2014 Elvis was referred to and seen by the Oxleas musculoskeletal service for back pain. This is a mainstream service commissioned by Oxleas.

From 2015 Elvis received prevention support from Adult Social Care (ASC).

In 2016 Elvis became distressed following a breakdown in his relationship and attended the CLDT base to access support from his social worker. He was taken to Queen Elizabeth's hospital (Woolwich) and assessed in the 136 suite. Elvis was assessed regarding his mental health and was seen by an AMHP who knew him from previous involvement and was experienced in supporting people with LD. The AMHP was able to make appropriate adjustments to the process and information given so that Elvis could understand. Following this assessment Elvis was referred back to his GP for management of low mood, to the Complex Care team and also referred back to LD Psychology for support around a computer game addiction. There is, unfortunately, no further report of the outcome of these assessments in Health notes.

In 2016 Adult Social Care (ASC) completed a needs assessment for Elvis. The needs assessment identified that Elvis had support when he first attended Smerdon, this was to help him to get to the day centre and then settle into the new environment. Once he settled into this routine and environment, he was happy to be involved with this community. Due to Elvis' tendency to not like change he stopped going when one of Smerdon's employees moved to another company.

This assessment also identified that Elvis was at risk of becoming socially isolated as he would go out to get shopping but otherwise he didn't go to new places or make new relationships. Elvis was able to access the community on his own and would go into the town centre to do shopping and he would attend the day centre on his own by public transport or taxi.

In 2018 ASC received a concern from a member of the public, via email, regarding self-neglect due to the state of the property and the number of animals within the property. The email detailed that there was animal excrement over the floor of the property. This concern from the member of the public was not put on the ASC system as a concern but forwarded by the screeners to the triage team who passed it onto the reviewing team. It was suggested that a review for Elvis an Anne was brought forward. This review was completed by the social worker and Frank House but there is no recorded outcome.

Elvis had contact with his GP throughout this year for both medication and asthma reviews and he also received his annual 'flu' vaccination. During this time his clinical observations were completed and there were no abnormalities identified.

On the 4th December 2018 ASC received a referral as the couple were in arrears for the Bexley emergency link service. This was passed to the Telecare assessor for assessment and support with resolving this matter.

In December 2018 a safeguarding concern was identified by the prevention support service (Keyring). These safeguarding concerns were in relation to potential financial abuse from Elvis towards Anne. It was identified that Elvis and Anne had a joint bank account where all their benefits were paid into. Keyring supported Anne to transfer some funds regularly to her own bank account as Elvis was withdrawing all the funds and not giving any to her. The report also identified that Elvis was verbally aggressive and intimidating towards support workers from Keyring and refused them entry into their home. Anne had contacted the prevention service on more than one occasion stating she has no funds and that she welcomes the support but will not let Support Workers in as says they will need to be mindful of Elvis' temper. A section 42 enquiry was opened but closed at the request of Anne and lack of evidence. There was an action for the social worker to support Anne to access her account regularly.

2019

In 2019 Elvis was invited to his GP surgery for his annual health check but he did not attend. There is no evidence of any follow up for this to be completed. However, Elvis did attend his GP surgery later that year where a general health check was carried out.

In January 2019 Elvis attended his GP surgery due to a sore throat. Following assessment Elvis was prescribed a Ventolin inhaler and diagnosed with a viral infection. Elvis was informed to take over the counter medication for his sore throat.

In March 2019 Elvis attended his GP surgery due to heartburn for a few weeks. Following examination his GP prescribed ranitidine medication.

In April 2019 Elvis' prevention support ended at his request with the provider. Keyring notified ASC via email of this. There is no evidence of ASC contacting Elvis to discuss this prior to closure of this service.

In May 2019 a safeguarding referral was emailed to ASC from housing. Housing had attended the property as they had received a request for rehousing. During this assessment the housing professional identified the following concerns:

- The property was in poor condition:
    - Numerous cats with numerous dirty litter trays
    - bowls of food and rancid water
    - the house obviously smells very bad.
    - The cats have fleas
    - The couple are in debt due to previous vet's fees.
    - The number of pets will be breaking their tenancy agreement.
- Fire risk due to numerous extension leads and over loading of sockets

- Allegation by Anne of Elvis shouting at her and her being scared he may push her down the stairs.

These concerns were not shared with his GP.

Also in May 2019 Elvis underwent a medication review with his GP.

In June 2019 there is evidence of joint working between housing and ASC in assessing the concerns identified regarding domestic abuse. A coordinated visit was identified as being needed. This coordinated meeting also had a worker from Smerdon who knew them both well. Housing also supported the couple by arranging for a pet charity to support with de-fleaing the animals, neutering them and possibly re housing some of them.

During July 2019 housing continued to work with both individuals in regard to rehousing them and shared concerns that Elvis may convince Anne that they need to move together.

September 2019 ASC received a referral from the sister of Elvis. This referral identified the following:

- Elvis does not have any care support and is struggling to cope
- Support needed to complete forms for ESA for DWP.
- Elvis isn't looking after his personal care and appears dirty and unkempt
- The property is in the same state.
- Elvis needs urgent help to improve his personal care and support with his finances.

Following this the triage Hub contacted the social worker allocated to his Anne who stated that they *"Spoke with Elvis following the referral. I also spoke with his Anne's social worker for further information on his situation. He confirmed that Elvis was independent with his own personal care, meals and goes out independently and can use buses to get about. Elvis can manage finances and is able to use a computer proficiently. Triage also spoke directly to Elvis who was more concerned with the letter he has received from the DWP*." Triage advised him to speak directly with the DWP about any concerns he had. Elvis also agreed he would get his sister to support him with this.

There is no evidence of any triangulation of the above concerns and no further action was taken to support.

His sister called ASC later in the month to request an update on her referral. Although ASC called her back and left a message no further contact was made or received at this time.

Elvis attended his GP surgery in September 2019 and admitted to drinking a lot whilst watching football. On examination his clinical observations were stable and the GP advised Elvis about drinking and arranged for blood tests to be competed. There is no evidence of any signposting or referral to specialist support for his use of alcohol.

November 2019 both Elvis and Anne contacted ASC to ask if they could go back to Frank House (a previous provider of 1 to 1 support for bills and finance). This support remained with Keyring

In December 2019 Elvis attended his GP surgery for his annual flu vaccination.

2020

In February 2020 Elvis attended his GP surgery with 'atypical chest pain'. Following review of his medical records it was identified that Elvis had attended UCC in the last 7 days with the same problem. Elvis was examined by his GP and his clinical observation were normal. Elvis stated that his pain is in the left side of his chest, and it worsens with movement. He was referred for blood test, an ECG and an x-ray. The GP identified the pain to be musculoskeletal in origin and prescribed a non-steroidal inflammatory gel for topical use. The GP also advised that if the pain became worse to call 999 and attend hospital. There is no evidence that Elvis was assessed to check his understanding this or whether any reasonable adjustments were used to support the information given to him.

Further communication from the housing provider to ASC identified that the property for Elvis and Anne had deteriorated again and that contractors were refusing to enter the property. A section 42 enquiry was not opened at this time. Instead, advice was given to housing to contact the Screeners with this information.

There is no evidence that this happened.

On 3rd March 2020 Elvis returned to his GP with further chest pain. Examination by his GP resulted in co-codamol analgesia being prescribed.

Elvis returned on the 11th March 2020 as his symptoms of chest pain had not resolved and he felt the analgesia prescribed in the prior appointment hadn't helped. Chest x-ray result was normal and GP identified that Elvis had not had his ECG or bloods as requested. GP identified that Elvis described epigastric pain and his GP requested further tests:

- Helicobacter Ag test
- Faecal Immunochemical test
- ECG (as previous request)
- Blood test (as previous test)

Elvis' GP prescribed Omeprazole 20 mgs tablets for possible gastritis and Elvis was given further advice to attend hospital or call 999 if pain worsened. GP planned to review following test results in 2 weeks or sooner if symptoms worsen. Elvis then stated he had passed black stool but no blood.

On 20th March 2020 the GP called Elvis as the surgery had received blood test result which were of concern as there was a drop in haemoglobin from 150g/L to 90g/L. Elvis confirmed to his GP that he had had no change in his bowel action. Elvis' GP informed him that he could possibly have an upper gastrointestinal bleed and that he must attend hospital emergency department urgently.

There is no evidence that the GP communicated their concerns with the emergency department or that he was known to have a learning disability.

The following day (21st March 2020) Elvis attended the emergency department at Queen Elisabeth Hospital (Woolwich). He reported that his GP had contacted him and advised for him to attend the emergency department as he had a low haemoglobin. Elvis was assessed and his records show he was alert, stated that he felt better and denied any pain. He had no cough, fever, of shortness of breath. There is a note that he may have been tachycardic.

Elvis was diagnosed with anaemia. The medical team stated *that "patient advised he had diarrhoea and vomiting last week which had resolved and noted one episode of black stools last week."* They further stated 'No guarding no peritonitis. No epigastric tenderness' (guarding is a sign that your body is trying to protect itself from pain). A rectal examination showed no evidence of melaena, no rectal bleeding. There is no evidence to suggest an urgent Oesophago-Gastro-Duodenoscopy (camera into the stomach) was requested to investigate his anaemia.

On completion of assessment the medical team diagnosed Elvis with anaemia stating it was a low threshold and for him to return if he was having black stools, vomiting and rectal bleeding. They further advised that the GP was to monitor his HB in the community.

There is no evidence to show that any reasonable adjustments were made by the department at this time to support his understanding of safety netting advice. There is also no evidence that they informed him not to take any analgesia that was a non-steroidal anti-inflammatory drug.

A discharge summary was sent to the GP requesting repeat blood test for Haemoglobin in 5 days and to continue ferrous sulphate.

23rd March 2020 – National Lockdown for the pandemic was declared. During the preceding days and following this announcement there was exceptional pressure on the NHS services that were working in unprecedented pressures. It is not known if this pressure had a detrimental effect on the outcome of his attendance at QEW.

In response to the discharge summary Elvis' GP wrote to him on 24th March 2021 requesting him to contact them. No contact was made by Elvis and this was not followed up. A repeat prescription was dispensed for 2 further weeks of ferrous sulphate tablets.

There is no evidence to show that the GP made reasonable adjustments or further attempts to contact Elvis in this matter.

On 14th April 2020 contact was made to ASC from Smerdon day centre. The service were concerned that both Elvis and Anne were going out to do shopping within the local community. This resulted in a hot meal service commencing to support the couple with meals. This service was a support service to prevent them from having to go into the community to shop unnecessarily during the national lockdown.

1st May 2020 the hot meal service provider contacted ASC triage with concerns that Elvis was not well. The triage nurse called and spoke with Elvis by phone. Elvis advised the nurse that he had an upset stomach the day before but was now feeling better and that he would contact his GP if he needed.

On the 5th May 2020 Smerdon day service raised a safeguarding concern with ASC as they had received a concern from Anne who stated she was worried for Elvis as he was not well. Her concerns were that Elvis had not got out of bed by 10.30 am and that this was unusual for him. Elvis was in bed as he was unwell.

Following this concern the triage nurse called to speak with Elvis and explored what was wrong. Elvis stated he had a stomach pain and other symptoms. The nurse offered to visit but Elvis declined this but accepted that she contacts his GP for him. Elvis stated that he was scared to go to hospital.

Following contact by the triage nurse the GP contacted Elvis at 14.35 hours via telephone. Following a telephone assessment, the GP identified that Elvis was unwell and advised to go to hospital. Elvis did not want this and therefore the GP contacted the London Ambulance Service (LAS) for further assessment. This was completed by the GP in his best interest as he felt that Elvis did not have mental capacity for this decision.

The LAS attended and following assessment conveyed Elvis to hospital. During their assessment with Elvis they identified safeguarding concerns and raised these with ASC:

- Need for needs assessment
- Socially isolated
- Neglect of selves
- Numerous pets and unhygienic environment.

At QEW he was assessed and had emergency surgery the same day. During the operation the following was identified:

- 2cm hole in the anterior aspect of the prepyloric region with 5-6 seed food debris around
- 2lt of free pus
- Cirrhotic liver
- Big varicosities in the abdomen as described in the CT

Following his surgery Elvis was admitted to critical care where he was intubated and supported with medication. He was reviewed by the multidisciplinary team and all relevant care and support was given. A Do Not Attempt Cardio Pulmonary Resuscitation form was completed

The hospital safeguarding adults team contacted both the GP to request relevant history and also made contact with the CLDT due to his diagnosis of LD.

During the next 15 days Elvis remained under the care of the critical care unit where his condition was monitored, and all relevant and supportive care given.

On 15th May 2020 it was identified by his care team that Elvis was not improving and

that his condition was deteriorating further. After a discussion with the surgeons and gastro team it was felt there was nothing to add that might benefit him. The surgical team also felt there was nothing to be done from a surgical point of view and felt an abdominal CT scan was not at the time indicated. Elvis's HB was also noted to be low, bloods and a transfusion was requested. His HB was 66 after 1 unit of transfusion. His sister was his next of kin and she was updated that he was developing multi-organ failure and that he was unlikely to survive this admission. There was no contact with Anne regarding his condition.

On the 16th May 2020 Elvis died. His cause of death was identified as:

1a. upper gastro intestinal bleed
1b. Chronic peptic ulcer and oesophageal varices
2. Liver cirrhosis and aspiration of blood

Following his death on 29th May 2020 Queen Elizabeth's Hospital spoke with Elvis's sister. During this telephone discussion his sister informed them that there were numerous packets of Ibuprofen in the house. At this time it is not known if Elvis had been self-medicating with this medication to try to control his pain. Ibuprofen is known to cause bleeding in the stomach.

Analysis

Elvis was a man in his 50s who had a mild learning disability and difficulty with reading and writing. He lived with a long-standing female friend who also had a learning difficulty. They lived independently in the community with intermittent support from GP, day centre and key ring. Their circumstances deteriorated from time to time and particularly after March 2020 and the start of Covid restrictions. A multi-agency assessment might have benefitted them by co-ordinating the support needed and improved their overall quality of life.

<u>Oxleas</u>

Elvis had a learning disability and was supported by the CLDT to attend psychological support and dental treatment with reasonable adjustments during 2008 to 2010.

Elvis received relevant support with reasonable adjustments during his mental health assessment in 2016.

<u>GP</u>

Elvis was known to have LD and this was identified on his medical records with his GP. He was invited for annual health checks by the surgery but did not attend in 2019. His surgery had not identified that he had problems with literacy and did not make reasonable adjustments to support this.

Elvis accessed support form his GP often when he had health problems and adequate rapport and verbal communication was established with him. Relevant investigations were requested when it was identified that Elvis was having chest pain. However, there is no identified reasonable adjustments identified to ensure

that Elvis was aware of the urgency of these or that he understood what medication he was prescribed.

Elvis' addiction habits were supported in a non-threatening and supportive manner.

The GP did complete regular monitoring of his blood test and these have been reported as improving. A camera test to look into the stomach due to persistent dyspepsia and drop in his Hb could have been beneficial and aid in diagnosis of cause of the symptoms – in line with NICE guidelines Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management (nice.org.uk)

Due to the significant drop in Hb over the past 6 months an urgent OGD could have been considered (2WW) either by GP or acute provider.

Although the GP advised Elvis to attend the emergency department when it was identified he had a drop in his haemoglobin, there was no onward communication with the department informing them of the GPs concerns or that Elvis had LD.

There was no follow up from the GP following their letter to him after attending the emergency department.

When acutely unwell the GP reviewed him via telephone (national guidance during pandemic) and called for support with LAS as his mental capacity was identified as lacking at this time.

LBB Housing

Elvis and Anne were assessed and supported to apply for new housing. Safeguarding concerns were correctly identified by housing and communicated to ASC appropriately. There is evidence of good partnership working.

The complex nature of their relationship was not explored by housing and they believed them to be partners. As such a relationship was believed by the professional working with them and subsequently identified that domestic abuse was occurring within this relationship. This was communicated with ASC but no support offered from housing or ASC in contacting specialist services. In 2019 there was a specialist housing Independent Domestic Violence Advisor (IDVA) that was available for support to the housing team and also to the victim, however no contact was made and the specialist support the IDVA could have offered was not utilised. This lack of referral was a missed opportunity for specialist service to further enquire about their relationship.

Support to Elvis and Anne was offered in caring for their pets and a referral to an animal charity was also completed.

However, both Elvis and Anne continued to keep numerous pets and repeatedly were unable to manage them safely and hygienically. Consideration of their executive capacity to comply with their tenancy agreement and the ability to look after their pets safely would have allowed the professionals working with them to

understand what the areas of support were in regards to these concerns could have been.

ASC

ASC responded to the concerns of domestic abuse and worked with housing to support this. No offer of specialist domestic abuse service was made.

During the national lockdown additional service of hot meals was provided as soon as a concern was identified but this was a response to a concern and no evidence of proactive assessment regarding vulnerabilities prior to this. There has been no identification that Elvis and his Anne were classified as requiring 'shielding' however, Elvis did suffer from Asthma and was invited for a 'flu vaccination each year. This demonstrates his increased vulnerability to the risk of COVID and the hot meal service supported them to adhere to the guidance of staying at home and only shopping for necessities as infrequently as possible.
There is no evidence to suggest that Elvis and Anne were involved in a discussion with ASC regarding any reasonable adjustments needed at this time to support their understanding of the lockdown measures and their increased risk of becoming socially isolated.

Prompt response from the triage nurse to assess Elvis when it was identified that he was not well was made and onward referral to his GP for assessment.

ASC received several concerns regarding self-neglect and neglect of property. There is no evidence to identify how these concerns were managed or support offered to Elvis and Anne.

QEW

On his first attendance Elvis was assessed and discharged. There is no evidence that they were aware that Elvis had an LD and no evidence of any reasonable adjustment being made.

23rd March 2020 – National Lockdown for pandemic announced. During the preceding days and following this announcement there was exceptional pressure on the NHS services that were working in unprecedented pressures. It is not known if this pressure had a detrimental effect on the outcome of this attendance at QEW.

On his second attendance prompt identification of the need for surgery and this was carried out without delay. All relevant treatment and care was provided to Elvis up to his death in May 2020.

During this period of care there was no LD Liaison nurse within QEW. However, a referral was made by QEW to the CLDT for support. Unfortunately, due to the pandemic the CLDT were unable to offer face to face support due to national guidelines.

Recommendations
Each agency involved in this SAR has submitted an IMR and the recommendations identified from each service as listed below.
Oxleas

1. CLDT nurses will be allocated to specific GP surgeries to support LD care in this service
2. Promotion of the Personal Health profiles (PHPs/Black books)

GP

The surgery has completed a significant learning event. The recommendations from this are:

1. Early and prompt involvement of patients' relatives or advocate, especially in patient with disabilities to ensure adequate medical interventions are effected.
2. The practice is now contacting all LD patients in a more appropriate manner, usually with telephone calls, to patient and carer, but also using the template letter specially designed for the purpose.
3. When patients are contacted or attend surgery, note on record if they have a carer or advocate.
4. Audit LD and similar patients who are living alone to understand level of social input

LBB Housing
Nil identified

ASC

1. Managers/ Seniors to discuss robust recording in team meetings
2. Opportunities for learning around unexpected deaths and the Board's role.
3. Ensuring staff are aware of the importance of follow up calls, robust recording, and triangulation of information to inform decision making. Seniors to discuss in team meetings for reflective learning.

QEW
Nil identified

The SAR panel met and discussed any further recommendations, and these are identified below:

1. Professional curiosity training for professionals to support understanding of complex relationships.
2. BASAB to identify and publish tools for healthy relationships in easy read formats
3. Improved reasonable adjustments for individuals with an LD diagnosis to include (but not exhaustive):

a. Acute provider and GP to share information regarding lists of individuals known to have an LD diagnosis and these to be flagged on the electronic system of the acute hospital.
b. Black book relaunch to support reasonable adjusted care for people with a learning disability
c. Recruitment of LD liaison nurse to QEW
d. Checking of understanding when with health professionals
e. Involvement of family/long standing friend /carers for best interest decisions.
f. Increased awareness of literacy problems and how this impacts on the individual
g. Use of easy read leaflets

4. Single point of contact for CLDT for professionals to use

5. Self-neglect
    a. Relaunch of the self-neglect toolkit
    b. Training for professionals on self-neglect to include escalations of concerns when nothing changes
    c. Use of a complex case pathway within Bexley
    d. Review of both the Mental Capacity Toolkit and Self- neglect toolkit used within Bexley to include a section on the importance of staff assessing executive capacity.

6. For professionals within Bexley to raise any safeguarding concerns directly with screeners rather than individual members of staff/teams.

7. For professionals within Bexley to raise concerns directly with the London Fire Brigade when there are concerns re hoarding and overloading of electrical sockets.

8. Domestic Abuse
    a. Continued training for DA awareness – to include hard to reach groups
    b. Champions from each service to be identified
    c. Development and launch of easy read LD leaflet
    d. Housing to utilise the skills of the specialist housing IDVA

9. Role of the carer explored by health and social care services when there is a co-dependant relationship using the Think Family process.