Safeguarding Adults Review

Learning from the circumstances of the death of 'Samuel'

1965 – 2018

Kate Spreadbury

Lead Reviewer

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1. Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Herefordshire Safeguarding Adults Board (HSAB) in response to the circumstances surrounding the death of 'Samuel', an assumed name for the purpose of this SAR. Samuel's body was found by police officers at his home on the **23 February 2019**, he had died some months previously. Samuel was 53 years old; the cause of his death was heart disease.

1.2 At the time of his death Samuel lived alone in the house he had lived in since childhood. Samuel was adopted, his parents are described as older when they adopted him and he was their only child. Samuel was White British. Both parents died, his mother when he was 17 years old, and his father nine years later when Samuel was 26. At the time considered by the SAR Samuel was isolated, he was unemployed and had no contact with family or friends. He loved the radio and reading books, he was an intelligent man who took an interest in world affairs. Samuel neglected many aspects of his own wellbeing, he only ventured out at night, had blocked up his own letter box and had not been seen by any agency since December 2018, fourteen months before his body was found. His neighbour, who alerted the police, said that he had not been seen for twelve months whilst other neighbours did not think that anyone lived at the address. Samuel had the support of mental health services for many years, his mental health issues were described in a number of ways, as a 'major' depressive illness, severe anxiety, obsessive compulsive disorder, social phobia, or agoraphobia.

1.3 This review is conducted in accordance with section 44 of the Care Act 2014 and the Herefordshire Safeguarding Adults Board Procedures. Section 44 (i-v) of the Care Act 2014 stipulates that a SAB must arrange for there to be a review of a case 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:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and (b)condition 1 or 2 is met.

(2) Condition 1 is met if— (a) the adult has died, and (b) 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).

(3) Condition 2 is met if— (a)the adult is still alive, and (b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.

*(4) An (*sic*) SAB may arrange for there to be a review of any other case 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).*

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— (a)identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases.

On the 27th March 2019 the Herefordshire Safeguarding Adults Board Chair decided to commission a SAR to learn from the circumstances of Samuel's death, based on the recommendation of the Herefordshire Joint Case Review subgroup.

The SAR lead reviewer was commissioned in April 2019 and the SAR activities commenced on this date.

2. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 Timeframe: The SAR covers the time period **July 2017 to the 23 February 2019** (the date that Samuel's body was found)

2.2 The **specific areas of focus** for the SAR are to:

- *explore whether agencies should have considered safeguarding and self-neglect more robustly. Enquiries should incorporate utility providers and the postal service to explore when they might raise "Welfare Concerns" when visiting a property/resident in these circumstances*

- *explore the degree to which Samuel's capacity may have been compromised, given his health condition;*

- *and his financial resilience from the perspective of his "ability to live". Reference is made to welfare and benefits intervention.*

Health specific terms of reference

- *Explore whether the issuing of repeat prescriptions was a factor in there being missed opportunities for professionals to have met with Samuel more frequently.*

- *What processes are in place in the GP practice around medication review?*

3. Methodology

3.1 The methodology used in this review seeks to promote a thorough exploration of the events prior to Samuel's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. All agencies considered within the SAR work in complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

3.2 Activities undertaken during the Review process have included: submission and collation of chronologies from the agencies involved, examination of documentation as appropriate, identification of key episodes and exploration of these episodes through a learning event with the agencies and personnel involved with the case, and follow up questions with specific agencies. A relative of Samuel's has contributed information to the review but had not seen Samuel since childhood.

3.3 The following agencies have contributed to the Review:

- Herefordshire Wye Valley NHS Trust
- Herefordshire Clinical Commissioning Group (representing GP services)
- Herefordshire Local Authority
- 2Gether NHS Foundation Trust
- West Mercia Police
- The Department of Work and Pensions (correspondence only)
- NHS Pharmaceutical Services (written information)
- Information is awaited from two utility companies and the Royal Mail.

4. Relevant history prior to the time in scope

4.1 Samuel's relative notes that Samuel was a pleasant but shy child who preferred the company of adults. He loved 'tinkering' with objects, he could take a clock apart and put it back together again. His GP wonders in retrospect if he had Asperger's' Syndrome, he did not, or was not allowed, to socialise with other children. Samuel is reported to have been at college in 1983, the year his mother died. Her death was followed by that of a close friend and later his dog. He became reclusive and appeared to be experiencing a depressive grief reaction. He did subsequently obtain employment with the Herefordshire Times. People who attended Samuel's funeral described him during this time as '*a smart young man* 'who dressed well in good quality shirts. In 1992 his father died and Samuel inherited the house. His behaviour and habit of withdrawing for weeks caused concern both to his employer and his GP. The police and a social worker followed up welfare concerns in 1994. In 1995 he appears to have gone travelling and stated future intentions to travel. However, his withdrawal was again causing concern, a further welfare visit from the police and a social

worker found Samuel shaking and pale, intimidated by their presence and refusing to let them into the house. Samuel was an in-patient at the local mental health hospital from November 1996 to January 1997, he had been prescribed Fluoxetine (Prozac) commonly used to treat depression or obsessional compulsive disorder. Records of the time indicate that he had a girlfriend but that he had struggled to cope with his father's death and had lost his job. After a short period in supported accommodation Samuel moved back to his house. He told his GP he felt anxious but really wanted to settle back into independence. His consultant psychiatrist of the time wrote to his GP; ''*I am afraid that everyone has patently failed to help this man and I really do not know where we go from here. My guess is that (Samuel) will return to being an eccentric, bizarre character and will remain this way for the rest of his life'.*

4.2 Between 2002 and 2015 Samuel supported by integrated mental health services, i.e. a team that was compromised of both mental health and social work professionals.

Samuel was seen by assertive outreach (AOT) services for over a decade, staff were refused entry to the house but were later able to help him with welfare benefits, bills and his garden, still with no access to the property. It was noted that the quality of his life 'was not great' but not so bad for action by statutory agencies to be taken. His window was broken in 2003 but Samuel refused to talk with attending police officers, it was recorded that it had taken two years for an assertive outreach worker to get him to collect his own money.

Samuel did very occasionally attend his GP surgery, for help with a recurrent minor medical matter, three times in 2005 and once in both 2007 and 2008. He had a 'mental health plan' and all his medication came via the mental health team. In 2009 his GP was made aware that he was on a different form of medication, Venlafaxine, prescribed for depression and anxiety. The mental health team asked the GP for Samuel's latest blood pressure and cholesterol tests, the GP requested that the community mental health team undertook these as the GP had no contact with Samuel.

AOT made an adult safeguarding referral regarding Samuel in November 2011. Samuel was described as 'extremely anxious' and depressed. He had engaged intermittently with the AOT but had recently refused to see the service, alleging that he was being harassed by an overly intrusive approach. The team were concerned about Samuel neglecting himself. He did not receive post, did not use a phone and had recently been threatened with court by his energy supplier who had to change his electricity meter for reasons unknown but exacerbated by Samuel's non communication via letter. In accordance with the agreed procedures at the time he was allocated to mental health services for further safeguarding action. AOT did manage to enter his house to assist with the electricity meter and noted that the doors were taped up. From this date Samuel's post appears to have gone through the local mental health team address, although it was noted in the strategy meeting minutes of December 12th 2011 that another service – 'Lifestyles'- could have supported him with this. With these arrangements in place the safeguarding action was closed.

In 2012 the AOT planned to discharge Samuel back to the care of his GP as he had been '*well and stable*' for a number of years. The discharge did not take place but the AOT continued to work with him, helping him to claim ESA, stating that Samuel had *'depression and social anxiety to extent cannot cope with everyday life'.* DWP was also asked to address all mail to the AOT as Samuel '*could not cope with mail'.*

At some point during 2013 Samuel transferred from the AOT to the Recovery team. His engagement with the AOT is reported to have been primarily with the social worker who doggedly followed up any opportunity for support that Samuel would allow. AOT felt generally that they had failed to engage him in any meaningful way. The Recovery team usually worked with a person for a maximum of two years with a set of agreed goals. The rationale for Samuel's transfer appears to be that the worker he had the strongest relationship with had transferred, there was no new agreement with Samuel about his goals or any plan for working with the Recovery team.

Samuel saw his GP regarding the same minor medical problem in 2014. His GP was invited to attend appointments with Samuel in 2015 but responded that Samuel did not attend the surgery and was not known. It is uncertain who, if anyone, was undertaking any physical health check-ups with Samuel.

From 2015 onward Mental Health services were no longer an integration of local authority and mental health workers. Mental Health support to Samuel continued via the 2gether Trust mental health nursing staff and support workers.

A Herefordshire Council Revenues and Benefits visiting officer contacted Adult Safeguarding in December 2015 concerned about the welfare of Samuel following an attempted visit to the property, he did not enter but saw that the property looked abandoned and neighbours said they had not seen Samuel for a few weeks. Adult Safeguarding contacted Samuel's allocated worker in the Recovery team. Samuel was reported as still living in the property but not engaging, post would be returned if it was not sent through the Recovery team, the Revenues and Benefits officer was accordingly given the contact number for Samuel's mental health worker.

Through 2015 to 2016 the Recovery team continued to work with welfare agencies to make sure that Samuel was able to complete a PIP application. Samuel's psychiatrist sent a list of Samuels' medications to his GP in March 2017 which the GP reviewed on paper, but Samuel was not discharged from Mental Health services to the care of his GP at this point.

On the 27th March 2017 Samuel's CPN and his support worker were both concerned that they had not seen him since February and could not contact him by phone. They reported concern for Samuel's safety to the police on the 12th April, explaining that Samuel was not using his medication and that on visiting they noted that all windows were blacked out with bin liners and got no response from knocking on the door. The police attended Samuel's address, noting that the letter box was sealed with tape and the property and garden in bad

repair. Samuel was coaxed out by officers, he looked physically ill, he seemed confused and distressed, he was unkempt and dirty. The police entered the property, '*no natural light and all door frames and window frames rotten*'. Samuel tried to lock the police officers out but did get into an ambulance, after then refusing to be conveyed to hospital he was detained under s136 of the Mental Health Act (MHA) and assessed at the local mental health unit. Samuel was not detainable under the Mental Health Act; he was returned home with medication but his '*severe self-neglect'* was noted by the assessing Approved Mental Health Professional (AMHP). Samuel agreed to meet with his CPN regularly to collect his medication. No referral was made to Adult Safeguarding, but Samuel was agreeing to take his medication and it was thought that the situation would improve once he did this.

Samuel did not attend medical appointments relating to his PIP benefit. The DWP appear clear that all his mail should go via the mental health team, recording on the 31st May 2017

'Good cause is accepted for non-attendance at the medical appointment 12/5/17. This is because when I rang (Samuel) on 31/5/17, he stated that he didn't receive his notification letter or his BF223. His mental health issues prevent him from dealing with his mail. The mental health team deal with all of his paperwork. (Samuel) was very anxious on the phone …. He stated that he would like all of his correspondence to go to the mental health team at (address). I have changed his care of address on (recording system)'

5. Time in scope – key episodes.

5.1 Introduction. At the beginning of the time considered by the SAR, Samuel's situation was as it had been for many years, he did not receive post and crucial letters were given to him by the Recovery team, he was reliant on their intervention to access benefits, he went out at night and did not let people into his house. Samuel's medication was given to him in person which allowed an opportunity for his wellbeing to be regularly observed. He had periods of disengagement from the Recovery team, by July 2017 he had begun to re-engage following his assessment under the MHA in April 2017.

5.2 July 2017 – November 2017

Samuel was recorded as seeing his support worker who was able to support him to walk to the local Cathedral. He was seen by a CPN monthly who would give him a month's supply of medication and use this opportunity to assess and monitor his mental state. The CPN was not permitted to enter his house. The CPN intervened on Samuel's behalf with DWP, explaining his mental health state and advising that he could not be assessed for PIP via a home visit as he did not permit anyone to enter his house. As he had boarded up his letter box the only way that he could get his post was via the Recovery team. Samuel was accepted as having a limited ability to work pending an assessment, his support worker agreed to do their best to get Samuel to attend an appointment.

In August 2017 Samuel had post from ESA, water and energy utility providers all sent to the local Mental Health office. His CPN recorded that a referral would be made to Adult Social Care (ASC) for social support but no referral was made.

In September 2017 Samuel did not attend the outpatient's appointment to pick up his medication but was given his meds the next day when he saw his support worker. In October 2017 the mental health Multi-disciplinary team (MDT) meeting discussed who would be best placed to give Samuel his medication and monitor his mental health, the GP was raised as a possibility, although this was not discussed with Samuel's GP. Samuel's social support needs were also not considered, no referral was made to ASC for an assessment of his care and support needs. When Samuel picked up his medication on the 19th October, he was advised by his CPN that he should collect future prescriptions from the GP. Samuel is recorded as saying that he was *'fine although anxious. No evidence of psychotic symptoms. Not wanting to engage in therapeutic interventions, including discussion'.*

Samuel did not want to pick up his medication from the GP and another appointment with the CPN was made for him for the 16th November.

5.3 November 2017 – February 2018

Samuel did not attend the appointment of the 16th November, the CPN went around to his house but could get no reply. On the 21st November the CPN and the responsible clinician discussed Samuel, planning that if he did not present within 'a few weeks', to seek medical review; discuss in MDT and consider a safe and well check from the police. The CPN was able to make telephone contact with Samuel in December, he said he was fine and did not want any contact but did attend an outpatient's appointment to pick up his medication on the 15th December. Samuel disclosed that he had not been taking medication for a few months and was feeling anxious. CPN 1 undertook a full assessment of Samuel's mental health and 'wellbeing' and made an appointment for him to see the psychiatrist to restart his medication, this had to be done carefully with the dosage built up over time. Samuel attended the appointment with the psychiatrist on the 22nd December, he talked about his severe agoraphobia and social phobia. A mental state examination was carried out, the psychiatrist recorded that they had no doubts about Samuel's capacity to make decisions about where he lived and what medication he took. Samuel agreed a plan of reinstating his medication and to continue the 'graded exposure' work he had begun with the support worker. A copy of this assessment was sent to and seen by the GP.

This was the last time that Samuel was seen by any agency.

Samuel last used his water payment card in a shop on the 16th December 2017. He had been paying for his water supply on a monthly basis until this point and his account was in credit. The Water Board attempted to telephone Samuel but the phone numbers were old, they wrote to him but letters were unanswered and presumably not delivered. Ultimately Samuel's debt was passed to a debt collection agency who were intending to try to make

contact with him. The Water Board had no information from statutory services with which to understand that Samuel was a vulnerable customer. Samuel's water was never disconnected, water companies are prohibited by law from disconnecting occupied domestic properties. However, they can disconnect the supply from households they believe to be unoccupied, a potential risk in for someone in Samuel's situation. Welsh Water have a range of schemes to assist 'vulnerable customers' including reduced tariffs and will also contact the local authority if a vulnerable customer appears to be experiencing difficulties. Samuel was not on any vulnerable customer register and Welsh Water were not aware of any concerns regarding his water use or ability to pay bills.

On the 19th January Samuel did not arrive to collect his medication and post, the CPN telephoned him and left a message. Samuel did not attend an appointment on the 2nd February and did not pick up his month's supply of medication. A CPA review was arranged for the 26th February to which he was invited.

Around the middle of February 2018 DWP made a decision that Samuel had been overpaid as his DLA had ended but this had not been factored into a previous decision regarding his benefits rate. His benefits were to be reduced by £60 per week from the 7th April 2018. The overpayment might need to be recovered. It is doubtful that Samuel received this letter as it was sent via the Recovery team office and he did not pick up his post.

On the 26th February Samuel was discussed at the mental health MDT meeting, it was agreed that he should be discharged from the secondary mental health team because of his long history of non-engagement. The arranged CPA review went ahead without Samuel or his GP present where it was agreed that a letter would be sent to inform the GP of Samuel's discharge, a letter would be left at Samuel's GP surgery at reception should he attend there, as he could not receive post no letters were sent to his address. No arrangements were made regarding Samuel's post or benefits, something that he relied on the mental health team to support him with. The letter sent to the GP on the 26th February explained Samuel's long-standing lack of engagement and his isolation, saying that he did not receive mail, answer his phone or allow anyone into his house. The Recovery team did not feel it could offer him a service. Samuel's medication was described with the caveat that he only picked it up intermittently from the mental health team and that they could not be sure what he was taking. There was no mention of his social situation, i.e. his difficulty in managing bills, benefits or utilities, or his long term 'self-neglect'. A letter was left at the GP surgery reception for Samuel, telling him of the new arrangements and of his discharge. He did not attend the surgery and never received the letter.

Samuel last used his payment card to pay for electricity on the 10th April 2018. The maximum value per transaction via a payment card is £49 and Samuel typically made multiple payments of £49 in a short period building up a credit balance, followed by a period with no payments being made as the credit covered his energy use. He would be able to see his credit status on his meter and when needed would top up his meter again and the cycle

repeated. His statements illustrated a minimum credit of around £300 typically held on his meter at any time, there was no debt on his account. Samuel was recorded as a 'vulnerable customer' with severe anxiety by the energy provider. The AOT was listed as his Delegate of Authority (DOA) with instructions that all contact was to go through them. The energy provider sent all communication through this mental health team address by letter for the five years prior to Samuel's death. They did not have a telephone number or email address for Samuel. The Energy company monitors patterns of payment, Samuel's pattern of making payments was consistent and 'well managed' up to the point of his last payment and the energy company had no contact with the DOA. No contact was received from the DOA highlighting '*any issues or concerns with this payment method, his ability to pay for his electricity and there were no reported issues with the energy supply or meter operation'.*

The energy provider wrote to Samuel, via the DOA, on 17th April 2018. No response was received from Samuel or his DOA. Recognising no contact or further payments had been received, the energy provider wrote to Samuel, via the mental health team in October 2018 highlighting this, and offering support options should Prepayment no longer be a suitable payment method and invited contact if there were any difficulties. No response was received from Samuel or his DOA. A further letter was sent to Samuel via his DOA, on 31st January 2019 asking for a meter reading. Where a Prepayment meter is in place a meter reading is received each time a payment is made, therefore meter reading agents did not visit Samuel' home. As no payments had been made since April 2018 no meter readings had been received which prompted the issuing of this correspondence. The letter was returned to the provider. On 8th February 2019 following the returned correspondence and still having received no payments or subsequent contact from the customer or DOA, a letter was issued addressed to "The Occupier" to confirm if a new person had moved into the property and was responsible for usage. Although the letter was address to the occupier, it was again sent to the DOA address. No response was received from the DOA. At no point was Samuel's electricity 'disconnected' but he had ceased to buy credit to keep the meter running.

5.4 February 2019. Police broke into Samuel's house on the 23rd February 2019, fourteen months after he was last seen by any agency. Samuel was lying on the upstairs landing and appeared to have died some time ago. The police found that there was no electricity in the house or running water, Samuel had been storing his faeces in bags. The last date on shopping receipts was the 18th July 2018. Boxes of medication were stacked up in the hall containing '*hundreds of packets'* of tablets, it may well be that Samuel had not taken his medication for a long period, he had none after December 2017 but had been picking up monthly supplies for years. It was hard to move around the kitchen for stacked rubbish, the doors to the downstairs lounge and dining room had been sealed with tape, the police entered, '*it was clear that these rooms have never been used'.* Samuel's bedroom contained a sleeping bag and piles of discarded cigarette butts. Bleach and other cleaning products were kept in the spare room whilst the third bedroom was again sealed with tape. Samuel

had a large amount of cash in the house, scattered in various places was £2100 in £20 notes and about £1100 scattered in various amounts of tins. A neighbour told the police that the electricity company had called on Samuel some months previously to check why his pre-payment card was not being used. It is unknown if they saw Samuel.

6. Themes from the Key Episodes

The difficulties Samuel had in coping with everyday life had not changed over the years he was known to mental health services. What perhaps had changed was the services themselves and the response that they could deliver to people who remained at risk of self-neglect but did not wish to engage with services.

6.1 Rights and involvement.

'*All members of staff dealing with adults at risk should be aware of their duty of care when dealing with cases of serious self-neglect, even when the individual has mental capacity…. All individuals have the right to take risks and to live their life as they choose. These rights, including the right to privacy must be respected and weighed when considering duties and responsibilities towards them. They will not be overridden other than where it is clear that the consequences would be seriously detrimental to their, or another person's health and well-being and where it is lawful to do so' HSAB (2108) p19.*

Samuel had been clear for many years before the SAR that he did not welcome the support of mental health services. Indeed in 2011 he told AOT that he felt they were overly intrusive and subjecting him to harassment. Samuel could not confide his thoughts and feelings easily; he did not benefit from psychological treatment. In addition, he found going out of his house stressful and reported that he had to undertake a number of rituals before leaving, and also took extreme measures to prevent anyone entering his house, meeting even his most familiar social worker in his garden or in the passageway outside the house.

Samuel's predicament illustrates the dilemmas agencies encounter when balancing a duty of care with the rights of any adult they work with. On one hand it was feared that Samuel's tendency to neglect the resources which enable wellbeing, i.e. utilities, benefits, would reach an extreme level and damage his life. Samuel had gone through periods of self-reporting an improvement in his anxieties and some weight was therefore placed on the hope that medication, and long-term attempts at desensitising him to his fears of being outside and with people, would ultimately help him. Mental health teams continued to enact a duty of care in the face of Samuel's objection at the loss of his right to privacy.

We can only reflect on why that duty of care was discounted when Samuel was discharged from mental health services to the care of his GP in February 2018. Mental health services did not appear to factor in the role played by the Recovery team in contributing to Samuel's ability to maintain his independence. The decision was enacted with no discussion about his tendency to self-neglect, or referrals to ASC or any agency who could support him with benefits etc, no discussion with his GP and no exploration with Samuel himself, but was

predicated on the role of the team in treating his mental health condition only. The team's approach is reported to have been that if Samuel was in trouble he would 'turn up', but as Samuel was so isolated and keen to remain that way it is hard to see how he would have come to anyone's attention.

Samuel did not have any formal assessment of his mental capacity either previously or during the time in scope of the SAR. An assessment was not undertaken as part of the MHA assessment in March 2017 as he was not being asked to make a decision about being admitted to hospital. He was felt to have capacity with regard to medication and accommodation by the psychiatrist who saw him in December 2018. However, Samuel does not appear to have been asked to make decisions about other significant aspects of his life, or about how he would decide to cope should he lose the support of the Recovery team in managing his post and affairs. We do not know if Samuel had made a capacitated decision to agree with and then rely on such support, or whether he would have preferred to have support from another agency without also having contact with mental health services, or what plans he could make to maintain his life independently. Such a conversation could have explored Samuel's capacity to make such decisions as well as his capability in the face of the challenging psychological barriers he experienced together with his preferred options for support.

6.2 Risk assessment.

'*Where the risks arise from the person neglecting their health needs, closer monitoring by the appropriate health professional is needed to continue to assess physical/mental health and consideration of further impact upon the person's capacity'* HSAB (2018) p.12

The facts that were known about Samuel and the way he lived his life led to an assessment of risk of '*severe self-neglect'* from 2005 – 2017, particularly should he disengage with services. He was extremely socially isolated. In the past it is reported that he had a relative nearby who would deliver a meal to him, Samuel would reach out from the porch and take the meal, or remove the meal from the door handle it was left on, this was how relatives knew he was alive. By the time considered by the SAR Samuel had no such visitors. His neighbours might see him on a night-time trip to the supermarket but apart from the Recovery team he had no one else.

Samuel was at risk of having vital services disconnected because he did not receive mail and could not cope with people being in his house. He could not attend medical appointments regarding his benefits and did not receive mail at home about this either. He found it very difficult to leave the house and rarely went out.

The true extent of Samuels living conditions and the impact of his mental health on this was not visible. Mental health staff had not been permitted entry to his house since 2011. The extent of his environmental neglect was not known by the Recovery team.

Mental health staff who last saw Samuel observed the same signs of self-neglect as they had for many years, he smelt a little unhygienic but was not underweight, he reported problems with sleep and a lack of appetite. He claimed that he used a washing machine and microwave. Staff who saw him at the time have commented that he did not present as a person who was severely self-neglecting, the risks seems low to them, he seemed '*as usual*'.

An assessment was not undertaken of the risks that should be considered at the point of discharge to his GP. Samuel had relied on the Recovery team to support him with his post and benefits. No referral was made to any other agency either in the year before he was discharged, despite the need for a referral to ASC for a care and support assessment being recorded in August 2017, or when discharge was being considered. No arrangements were made for another agency to continue in this vital role with Samuel. Samuel's benefits were reduced in the year of his death, it is as yet unknown what the impact of this was on him. He had a good deal of money in cash in the house, but whether he saw this as money he could spend is unknown. Samuel stopped paying for his water supply in December 2017 and his energy supply in April 2018. He had been placed on the energy companies' register of vulnerable customers but was not registered as such with the Water Board. Welsh Water reports that they struggle to identify particular groups of vulnerable customers, particularly those who self-neglect, and need the agencies working with this group to make sure the Water Board is aware of the customer's vulnerability. Although the energy company did have contact details for Samuel and knew he was vulnerable their letters to the mental health team office went unanswered, a chance for mental health practitioners to recognise that Samuel was not coping was missed and their previous agreement to be Samuel's 'Delegated Authority' not honoured. .

Samuel's physical health was not monitored during his mental health appointments or CPA reviews. He had no check-ups at his GP surgery. From the accounts given Samuel appeared to get little physical exercise, was often extremely stressed, having 'panic attacks' and smoked cigarettes. During the period in scope Samuel was prescribed Venlafaxine (also known as Alventa Xl) an SSRI used for anxiety /depression and Pregabalin (also known as Rodomel) for generalised anxiety disorder. He had in the recent past also been dispensed Aripriprazole, an anti – psychotic drug also used to treat people with 'major depression' or Obsessive-Compulsive Disorder. Large quantities of all these drugs were found at his house, mental health staff who knew him reported that they did not know whether he took the drugs or not but had to rely on Samuel's self-reports. It is likely that Samuel was feigning compliance with mental health services, transporting 28 days' worth of drugs home but not in fact taking them. This was not known at the time, and these drugs can have a number of long-term side effects which should be monitored. Samuel was no longer taking Aripiprazole in December 2017 but does not appear to have had his blood sugar, cardiovascular health etc monitored in accordance with NICE Guidelines (2014). He did not receive physical health checks to monitor his health whilst taking any other drug. The impact of his lifestyle

on his physical health, or any interaction between his lifestyle and the drugs he was given does not appear to have been considered.

The Kings Fund (2018 p.1) note that '*People with a severe mental illness die 15 to 20 years earlier than the general population, mainly from natural causes such as cardiovascular disease, endocrine disorder and respiratory failure. In the vast majority of cases, these early deaths could be avoided through timely diagnosis and treatment*'.

Naylor et al (2016) argued that insufficient attention has been paid to the integration of physical and mental health services. Service users who took part in the research asked that specialists across both mental health and physical health secondary services should have

- a foundation of basic common competencies in mental and physical health
- an openness to explore what a person's wider needs might be beyond the boundaries of their own specialism
- an understanding of other forms of support that are available and how to make a referral to relevant services. (P14)

The UK government (DH 2016) has published a resource for mental health nurses to improve the physical health of people living with mental health problems. Regular health checks are crucial, and nurse are urged '*to make sure that people's physical, social and psychological needs are assessed and responded to. They must also recognise and work within the limits of their competence'*. P14

Finally, NICE (2014) guidance recommends annual physical health checks for people with serious mental illness. Whilst this focuses on people with a diagnosis of psychosis, it also covers people who are taking the antipsychotic medications dispensed to Samuel during the year before his discharge from mental health services.

6.3 The importance of multiagency working.

'Often concerns around self-neglect are best approached by different services working together to find solutions. Co-ordinated actions by Housing Officers, mental health services, GPs and District Nurses, social work teams, the police and other public services and family members have led to improved outcomes for individuals'. HSAB 2018 p.11

During the period of the SAR Samuel was on a 'standard' care approach, i.e. he had a lead professional overseeing his care. He is described latterly as having a 'Care Pathway Approach' (CPA) review. CPA meetings are an opportunity to for a meeting of all agencies involved with the person and the person themselves to review and plan future care. Samuel does not appear to have had any CPA meetings during the time in scope until the 26th February 2017, when his discharge was being considered. Samuel's GP was not invited to this review meeting, so missing a vital opportunity to discuss handover arrangements for Samuel's care, the GP did receive a copy of Samuel's assessment and plan on the 22nd

December. Participants at the learning review describe a historic non- attendance of GPs at CPA meetings, leading to a tendency to not invite them. The Recovery team had been intermittently contemplating discharging Samuel to his GP since March 2017 but had made no active attempts to engage with the GP. The GP surgery did not proactively attempt to engage Samuel after receiving his discharge letter although with the difficulties described in the letter in communicating with him it is hard to know how they would have done this. Samuel's self-neglect was not detailed, the GP surgery had no opportunity to know how vulnerable he was.

Throughout the time in scope of the SAR there were opportunities to refer Samuel to ASC for an assessment of his care and support needs, or to arrange for an alternative agency to support him with the elements of daily life that he could not deal with himself. Samuel's discharge back to his GP was considered in March 2017 and in October 2017 with no other consideration of developing a multi-agency plan to support the discharge of a man who was by this stage very dependent on the Mental Health Trust to support aspects of his independence. Samuel's detention under s136 of the MHA and subsequent assessment in March 2017 noted that he had a history of 'severe self-neglect' and was presenting as self-neglecting, but the response appears to be single agency only, a return to medication and therapeutic approaches to resolve his fear of going outside etc. and not in a referral to adult safeguarding regarding his self-neglect, a missed opportunity for a multi-agency response. A referral to ASC was considered in August 2017 but appears not to have been progressed. Such a referral would have necessitated mental health and ASC working together to assess Samuel's care and support needs, Samuel would have undoubtedly rejected the intervention of ASC as a new and potentially intrusive agency, but his capacity to make decisions about his own future financial and utility support would have potentially been questioned together with an exploration of the support options available to him. The arrangements the mental health trust had made for supporting Samuel to maintain his independence may then have been formalised, with a support plan in place or the use of appointeeship or deputyship should he lack capacity to make decisions about payment and use of utilities. Agencies who took part in the Learning Event thought that a formal risk enablement process, similar to the 'Creative Solutions' forum in Plymouth, would be helpful in situations when people are severely self-neglecting but unwilling to accept support. Participants reported that agencies in Herefordshire struggle to work with people who self-neglect and refuse support, and it is uncertain that adult safeguarding concerns are being raised regarding people who self-neglect. It should be noted that these forums are used where all other solutions have been tried and exhausted and the person is still at risk. Samuel received a single agency response during the time of the SAR, referrals and joint work with ASC and his GP would need to be tried before such a process was contemplated. The Plymouth Creative Solutions Forum has been operational for three years and has been emulated by similar forums across the South West and latterly London. The idea is that agencies work together with a small budget to create bespoke person-centred plans. '*Eligibility for the Forum is based on presenting need not on diagnosis or primary label, so*

any adult over 18 years that meets the criteria of a complex presentation that cannot be managed with a single agency response or the standard multi-agency response. It is not intended to replace "business as usual" social work or healthcare delivery; but is reserved for cases with high complexity and high risk where a single agency approach is not adequate to meet need'. (Plymouth 2019 p3) It may well be that such a Forum is felt to be useful in Herefordshire, but it would have been used in this case until all other multi- agency processes had been explored.

Lastly, no 'safe and well' welfare check was undertaken prior to Samuel's discharge from mental health services. When Samuel disengaged from mental health services in March 2017 a police welfare check found him very unwell, when Samuel disengaged again in November 2017 a plan was made to consider a safe and well check should he not re engage. No such consideration appears to have taken place in February 2018. We cannot be sure of Samuel's health status after the 22nd December 2017, the last time he was seen by any agency.

7. What has changed since February 2018 (the date of Samuel's discharge)

2gether NHS Foundation Trust Report that since the end of February 2018:

- GP's are now routinely invited to attend CPA reviews, if they are not able to attend the Trust requests that they send information using the CPA review letter which includes a section for them to complete.
- Primary care networks (multi agency) have been set up as part of long-term plans.
- For all current service users a check is undertaken on the caseload recording systems to see if an annual health check has been completed, if it has not then this is offered through the relevant Mental Health team or liaison takes place with the GP to arrange a health check. This is documented on the electronic recording (RiO) system.

8.Findings and Learning Points

8.1 The SAR was asked to focus on the following **specific areas of focus**:

- *explore whether agencies should have considered safeguarding and self-neglect more robustly. Enquiries should incorporate utility providers and the postal service to explore when they might raise "Welfare Concerns" when visiting a property/resident in these circumstances*
- *explore the degree to which Samuel's capacity may have been compromised, given his health condition;*
- *and his financial resilience from the perspective of his "ability to live". Reference is made to welfare and benefits intervention.*

Health specific terms of reference were also developed:

- *Explore whether the issuing of repeat prescriptions was a factor in there being missed opportunities for professionals to have met with Samuel more frequently.*
- *What processes are in place in the GP practice around medication review?*

These health specific areas have not been explored. Samuel did not have 'repeat prescriptions' and, whilst his medication was reviewed once by a GP on paper in March 2017 had no contact with the GP surgery during the time on scope of the SAR. Mental Health professionals did attempt to meet with Samuel on at least a monthly basis and used this opportunity to ascertain his wellbeing, including his mental health.

8.2 The SAR findings are detailed under the three specific areas of focus below; areas of focus are also extended in accordance with the actual findings of the SAR:

8.2.1 This area of focus is broken into two parts:
Firstly *'Explore whether agencies should have considered safeguarding and self-neglect more robustly* and secondly *'Enquiries should incorporate utility providers and the postal service to explore when they might raise "welfare concerns" when visiting a property/resident in these circumstances'*

Regarding *whether agencies should have considered safeguarding and self-neglect more robustly,* our finding is that there were several opportunities within the time in scope to do so. At the point of Samuel's discharge in February 2018 mental health services should have made efforts to see Samuel and, if unsuccessful, requested a 'safe and well' check from the police. The police found Samuel in a poor physical and mental state sufficient to use their powers under s136 of the MHA to detain him in April 2017. There was no reason to think that he may not be experiencing a similar period of vulnerability and self-neglect. Indeed, between December 2017 and April 2018 evidence from utility suppliers would suggest that Samuel was struggling to cope with managing his everyday life.

Mental health services should have referred Samuel to ASC for an assessment of his care and support needs and worked jointly with ASC to determine with Samuel how he would maintain his independence after his discharge from mental health services.

A referral should have been made to Adult Safeguarding regarding concern about Samuel's non engagement with services and self-neglect when he was assessed under the Mental Health Act in April 2017. Adult Safeguarding would have provided a multi-agency forum with which to explore options with Samuel and assess both his capacity and capability to maintain his own wellbeing. An exploration of his mental capacity would have opened up a pathway for professionals to provide further support.

Mental health services should have made efforts to ensure that the CPA meeting held prior to Samuel's discharge was multi-agency in nature and not single agency only. The GP was not invited, or any prior contact made with ASC or any other helpful agency. The CPA could have been used for meaningful planning regarding Samuel's isolation and the prevention of increasing self-neglect.

Mental health services should have worked closely with Samuel's GP in order to a) determine how Samuel's physical health would be monitored and share information about this, and b) to plan his discharge to the GP's care, making his specific vulnerabilities well known.

During the time considered by the SAR Mental Health services appear to work in isolation. This may reflect an approach taken in this case only, or a wider trend within the Trust.

Learning Point 1 Mental health services cannot work with people with complex needs in isolation. All agencies must know and act upon the requirements of the Care Act 2014 to refer concerns about abuse or neglect, including self-neglect, to the local authority. Practitioners must consider and use agreed referral processes for people who may have care and support needs.

Learning Point 2 It is vital that opportunities for mental health services and GPs to work together are identified. Participants at the Learning Review discussed a range of strategies, including holding CPA meetings at GP surgeries, mental health workers visiting GP surgeries or having a named contact in the mental health teams for GPs in the local area. The appointment at one surgery of a Safeguarding nurse who can ensure liaison and communication with other agencies regarding vulnerable patients has proven a useful approach.

Learning Point 3 Mental Health services must also focus on the person's physical health. A different approach to assessing and monitoring physical health may be needed for each patient. Mental Health nurses and GPs will each be able to contribute to this approach, use must be made of a wide range of available resources and guidance in agreeing a Herefordshire wide approach.

Learning Point 4 If a person with previously known self-neglecting behaviour is being discharged from the Mental Health services their wellbeing at the point of discharge should be ascertained, by seeing them in person. In rare cases where people are very hard to engage and it is feared that they may be ill or their lives at risk police powers may need to be considered.

Learning Point 5 The discharge from services of people who are at risk of harm or self-neglect and who are isolated must be carefully considered and planned with colleagues from other potentially helpful agencies, i.e. need to be multi agency in approach. Options for less intrusive minimal support and monitoring must also be considered.

Enquiries should incorporate utility providers and the postal service to explore when they might raise "welfare concerns" when visiting a property/resident in these circumstances'

The energy company does have a register of vulnerable customers and believed that it was contacting the agency responsible for overseeing Samuel's wellbeing.
The water company, Welsh Water, also has a register of vulnerable customers but has identified that it cannot be satisfied that agencies are contacting them about people who self-neglect or have other vulnerabilities that may impede their ability to pay bills or manage their water supply.. Welsh Water would very much welcome an approach to develop protocols to address this gap in their support for vulnerable customers.
Royal Mail report that they received and attempted to deliver 'very few items' during the years that Samuel's letter box was sealed. An attempt was made to deliver each item by knocking on the door of the property but there was never an answer. Royal Mail cannot redirect mail unless a redirect request was in place and paid for. Samuel's mail would be returned to sender with the advice that the address was inaccessible.

Royal Mail does not appear to have an adult or children's safeguarding policy or 'vulnerable customers' policy with which to guide their staff to be alert and refer welfare concerns encountered in their daily work. The Royal Mail recognises its role as a socially responsible business and, for example, has engaged in research and devised approaches to tackle 'scam' mail. The only action taken if addresses cannot be delivered to for over 12 months is to report these anonymously to Ofcom as part of a detailed Exceptions Report each year (Royal Mail 2019a), in itself merely a regulatory obligation, no other actions regarding the individuals concerned are taken. Royal Mail acknowledges its role as *'the eyes and ears of the community'* (Royal Mail 2019b p 52) and has a partnership with the Charity 'Missing People,' issuing pictures of missing people to delivery staff. However, these initiatives need to be pulled together in a wider framework which supports postal service staff to be alert and curious regarding all potentially vulnerable customers, and to make children's and adult safeguarding concern referrals as needed.

Learning Point 6 When working with people who self-neglect agencies must consider seeking consent from a person who is self-neglecting to register them as a vulnerable customer with utility suppliers with an indication of who to contact should concerning issues or patterns be identified. The utility companies we have been in touch with have procedures in place to protect vulnerable customers but need the cooperation of agencies

to ensure they are aware of vulnerability and who to contact if further assistance is needed.

Learning Point 7 Organisations who regularly visit locations in communities are indeed the vital 'ears and eyes' as to the welfare of adults and children. The Royal Mail must address the gap in its arrangements to support staff to report any safeguarding concerns they may have regarding their customers.

8.2.2 *Explore the degree to which Samuel's capacity may have been compromised, given his health condition;*

As noted above, Samuel's mental capacity was never formally assessed. His capacity to make decisions about hospital admission, his accommodation or medication was not in doubt. His capacity to make decisions about receiving mail, attending interviews regarding his benefits, using electricity etc. was not assessed. Samuel's mental health issues can be considered as '*an impairment of, or a disturbance in the functioning of, the mind or the brain.' (*MCA 2005 s2.1*)* The Mental Capacity Act code of practice states that one of the reasons why people may question a person's capacity to make a specific decision is "*the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision*" (4.35, MCA code of practice, p52). Arguably, blocking up the letter box, taping up windows, being unable to interact with a range of agencies or arrange utilities and benefits could meet this criterion and an assessment of capacity should take place. The decisions could include making decisions about alternatives that for Samuel would be less threatening ways of maintaining independence or of accepting support.
It is impossible to say whether Samuel had the mental capacity to make these decisions or not given the absence of assessment, however we do know that Samuels mental health conditions made it impossible for him to manage these aspects of his life and that his decision making ability was affected by his mental health condition. Samuel may have been able to verbally acknowledge this, but how did he make decisions about dealing with the consequences of his decisions? The provisions of the Mental Capacity Act 2005 are often misunderstood or misused during assessment and decision making about risk in adult safeguarding. Assessments of capacity to make decisions about a specific risk are not conducted correctly, too much weight is put on what the adult is saying rather than what they are doing or able to do. An adult's *executive capacity*, i.e. their ability to implement or deal with the consequences of a decision, is not always explored. In addition, emphasis may be put on the individual verbally communicating that they understand and can retain information, but less on whether they can use the information to weigh up the alternative options and for see the potential consequences and the impact of these on their well-being. Preston Shoot (2017 p27) reminds us that '*practitioners need specifically to consider whether someone's executive capacity may have been impaired by their physical and mental*

ill-health, or the dynamics of their lived relationships ….and to weigh in the balance the relationship between a person's autonomy and a professional's duty of care'.

Options to support Samuel in managing his affairs may have emerged from consideration of his capacity and what he was able to do. Samuel had no appointee, or deputy for property and affairs if appropriate, and might have agreed to third party administration of his affairs. He may also have agreed to proportionate 'welfare checks' unconnected with mental health or other statutory services.

Feedback from participants at the learning event would indicate a lack of confidence across partner agencies in assessing mental capacity in situations where a person is self-neglecting and their decision-making ability or capability regarding the consequences of their current decision is of concern. This may well be an area of improvement for all agencies involved.

Learning Point 8

All agencies in Herefordshire, including mental health services must be confident and capable in using the provisions of the MCA 2005, where appropriate, in everyday practice.

8.2.3 *and his financial resilience from the perspective of his "ability to live". Reference is made to welfare and benefits intervention.*

Samuel was supported by mental health services regarding his benefit claims from 2012 – 2017. Samuel's benefits were reduced from April 2018, he may not have received any notification of this and we do not know how he reacted to the reduction in his benefit levels. In May 2017 the DWP recorded that *the mental health team deal with all of his paperwork…. I have changed his care of address on (recording system).'* The mental health team liaised with DWP to try to get Samuel to an assessment appointment. They liaised with utility companies historically which resulted in adjustments being made to how Samuel paid for his energy. All these supports ceased once Samuel had been discharged and his lack of response may well have resulted in the reduction of his benefits. The police found a great deal of cash in the house when Samuel's body was discovered, enough to support his ability to live for some time. We do not know whether Samuel intended to spend this money or why he was accumulating it in this way. His relative reports that he appeared to be in the habit of taking £50 from the bank cash machine and leaving any change from food shopping at home, taking another £50 when shopping again. Samuel made regularly payments into utility suppliers until suddenly ceasing to do so, often overpaying rather than waiting until all credit was exhausted. This possibly gives us some insight into the rituals and routines of Samuel's life.

Learning Point 9 A person's mental health can directly impact on their ability to manage their own finances and maintain 'financial resilience'. All agencies, including Mental Health

services need to be familiar with pathways that can be used to support and promote such resilience.

9.Recommendations to Herefordshire Safeguarding Adults Board

The SAB is recommended to

9.1 Request all SAB partners to audit and report back to HSAB how the agreed Adult Self Neglect best practice guidance is understood and implemented by staff in all agencies, whether statutory or non-statutory and particularly in light of the lessons from this SAR. One emphasis of the audit should be on how the welfare of the person is checked before discharge from a service or case closure. In situations where on-going risk to the person's wellbeing is identified, are monitoring arrangements in place?

9.2 Receive regular updates on the progress of action plans to address identified gaps or concerns regarding staff competence and confidence in using the Adult Self Neglect best practice guidance in Herefordshire.

Learning Points informing the above recommendations: 1,5,6, 8 and 9.

9.3 In common with the majority of Safeguarding Adult Reviews in England, this review demonstrates the inconsistent understanding and use of the provisions of the Mental Capacity Act 2005. This SAR highlights the lack of understanding of why the provisions are important, what the benefits are for adults of using the legislation to support their decision making, identifying areas of decisional and/or executive capacity that need support and person specific options for maintaining wellbeing. The HSAB is recommended to consider how it might promote the positive benefits to adults of using the provisions of the Mental Capacity Act, including the need to support both decisional and executive capacity.

Learning Points informing the above recommendation: 8, 9

10. Additional considerations for the HSAB:

10.1 Welsh Water are very keen to develop joint protocols to improve the identification and support of people who are self-neglecting and may experience difficulties in maintaining a water supply. Welsh Water covers parts of Gloucestershire, and Herefordshire, particularly Hereford, as well as locations in Wales. The company would welcome further communication with relevant Boards or agencies to develop a means by which local agencies will reliably notify them of people who self-neglect in relation to use of water, the SAB is invited to consider how such an initiative can be supported.

Learning point informing this consideration: 6

10. 2 At a national level steps need to be taken to engage Royal Mail to develop policies and procedures that will support staff to identify and report safeguarding concerns in the community. The SAB is invited to consider how such steps can be initiated.

Learning point informing this consideration: 7

11. Glossary of terms used

A and E - Accident and Emergency Department

AOT- Assertive Outreach Team

ASC – Adult Social Care and Health

CPN – Community Psychiatric Nurse

CPA – Care Programme Approach

DLA – Disability Living Allowance

DOA – Designation of Authority

DWP – Department of Work and Pensions

ESA – Employment and Support Allowance

GP – General Practitioner

HSAB – Herefordshire Safeguarding Adults Board

MCA – Mental Capacity Act

MDT – Multi Disciplinary Team

MHA – Mental Health Act

NICE – National Institute for Health and Care Excellence

Ofcom – The Office for Communications (regulates communications companies)

Ofgem- The Office of Gas and Electricity Markets (regulates the monopoly companies which run the gas and electricity networks).

PIP – Personal Independence Payment

SAB – Safeguarding Adults Board

SSRI - Selective serotonin reuptake inhibitor

SAR – Safeguarding Adults Review

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