Safeguarding Adult Review

Adult A

Commissioned by the Harrow Safeguarding Adults Board
and Supported by the Harrow Children Safeguarding Board

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Contents

1 Introduction

1.1 On 25th October 2019 the London Ambulance Service (LAS) were called to attend a 46-year-old woman (A) at her home. They found her dead. With her was her 21-year-old daughter (B). **A** was mal-nourished and her living accommodation was in a very poor state with significant evidence of hoarding and poor hygiene.

1.2 The LAS (along with the Metropolitan Police) had previously been called to the same address on three other occasions (once in 2017 and twice in 2019) by different officials, who in the course of their work had raised concerns about the health and welfare of **A** and **B**.

1.3 Throughout her adult life **A** had a long history of interactions with health professionals, although there were also some substantial gaps., when she might go some years without presenting herself to a health setting. She had a complicated medical history and some of her reported medical conditions were undiagnosed.

1.4 As well as **B , A** had another child **C,** who was seven years older than **B. B** and **C** both missed a lot of schooling and both received medical treatment for a variety of conditions, a significant proportion of which were never diagnosed. The large number of different and often undiagnosed medical conditions that they presented with (and this is particularly true of **B)** mirrored the situation of their mother.

1.5 **C** now lives an independent life. **B** lived with her mother up to the time of her death and it is understood she may have a number of care and support needs herself.

1.6 The records of the agencies that dealt with **A** and her two daughters raise a number of concerns about the way that information was shared between those agencies . They also highlight opportunities for joint working and planning that were not taken or followed through.

1.7 The Harrow Safeguarding Adult's Board along with the Safeguarding Children Partnership decided that they should conduct a safeguarding adults review into this case. Because **B** and **C** were children living with **A** when she had care and support needs this report also looks at what impact the work of the relevant agencies may have had on **B** and **C** (when they were younger**).**

1.8 The rationale for commissioning this review and the terms of reference for it are found at Appendix 2

2 Agencies involved and information obtained

2.1 The review has sought to obtain information from all of the agencies that are known to have worked with **A**, **B** and **C** during the period 1st May 2014 and 25th October 2019.

- Harrow Council services; adult social care, children social care, environmental services, and the Multi Agency Safeguarding Hub.
- Metropolitan Police Service
- The London Ambulance Service
- The London Fire Brigade
- London North West University Healthcare Trust (acute health services)
- The Social Housing provider
- Central & North West London NHS Foundation Trust (CNWL) (Child and Adolescent Mental Health Services)
- General Practice

2.2 These agencies each produced a chronology of their involvement with **A** and her daughters. Those chronologies led to the development of a number of key lines of enquiry. Each agency then commented on these in more detail in a report that analysed and reflected on the effectiveness of each agencies work with **A** and her family.

2.3 A representative panel comprising senior individuals (each having no personal involvement with the case) (the Panel) met on a number of occasions in the first instance to review the agency chronologies and then to scrutinise their follow reports, whose lines of enquiry had been established by the Panel. The Panel then oversaw a professional practice group discussion.

2.4 A professional practice group discussion comprises staff and managers who have worked with the person or family that is subject of a review. For this case it met on 20th April 2021 to provide more detailed information about their work with **A, B** and **C** and to reflect more widely on their experience and suggest ways in which services might be improved. Prior to their meeting they were provided with a briefing sheet which outlined the issues to be discussed which had been identified by analysis of the chronologies and reports. This can be found at Appendix 3.

3 Family involvement

3.1 Safeguarding adult reviews should seek the views and involvement of family members.

3.2 This review has sought the views and involvement of **B** and **C**. This can be difficult for families. This review has sought to involve B and C as much as they feel they want to be involved.

3.3 **C,** as a routine part of the enquiry into the death of **A** provided the police with some background information about her childhood and life with **A.** This information has been shared with the enquiry.

3.4 **B** has had some communication with the review and has indicated that she might wish to comment on it once it is complete.

4. A, B and C; A Brief Biography (Extracted from the Harrow Partner Records)

4.1. Brief Biography of A

4.1.1 **A** was 46 when she died. She was white British. She became a mother to **C** at the age of 17. Her second child **B** was born when **A** was 24.

4.1.2 **A** had a history of mental ill health issues going back to her childhood. There is a narrative in her records of suicide attempts, anorexia, self-harm and drug and alcohol dependency. At an assessment in 2006 she reported that, as a child, she had experienced a range of adverse childhood experiences which involved her leaving her parents to escape from a violent and abusive home.

4.1.3 She is reported as saying that she lost interest in school at the age of 14. From a relatively young age she had a series of relationships , some with violent and substance misusing partners. She married in 1995. That relationship lasted for about four years. Partner records contain very little information about the two different fathers of **B** and **C.**

4.1.4 In late 2000 (seemingly after her marriage had broken down) she suffered an act of domestic violence which occurred in the presence of her daughters. She sought help and the man responsible was charged. That is the only record of her seeking help for abuse.

4.1.5 **A's** hospital records date back to 1987, when she was 14. Between then and 2014 she had a lot of contact with a wide range of medical specialists. There was little contact with health professionals during the time that this review focuses on. However, her ill health must have remained a significant feature of a life to the extent that she reported to the LAS in June 2017 that she had 68 medical conditions.

4.1.6 **A** had mobility issues. In 2005 she attended a hospital appointment on crutches, the reason for which could not be ascertained by the consultant who saw her. At around this time she was provided with a mobility scooter. She fell off this in 2017. There are medical records of two other falls.

4.1.7 **A** by the time of her death had adopted an extreme diet, having progressed from vegetarianism, through veganism to frutarianism. This diet made her physically weak.

4.1.8 **A** had a history of refusing medical and social services help. She was suspicious of most formal medical interventions. In 2017 she went to hospital twice by ambulance but refused both medical treatment and the assistance of the Local Authority reablement service. In 2019 she twice refused even to be taken to hospital, following an ambulance attending her and recommending that she did so.

4.1.9 Her decision to refuse the treatment that could have helped her was accepted by the hospital in the first instance and the attending ambulance staff later on, on the basis of their professional judgement that she had capacity to make decisions about her own health.

4.1.10 In 2017 and 2019 The Metropolitan Police and the LAS reported A's living conditions to be unhygienic and highly cluttered (as a result of hoarding).

4.1.11 **A** was found dead by the LAS on 25th of October 2019.

4.2 Brief Biography of B

4.2.1 **B** was born in 1997, the younger daughter of **A.** Her father was part of the family till **B** was three**,** when he left**.** She lived with **A** and their live s were very closely aligned.

4.2.2 She had very little formal school education, starting primary school when she was nearly 9 and leaving to be home schooled when she was nearly 10. She never attended secondary school.

4.2.3 **B** has a long medical history. She was hospitalised in 2006 (aged 9) for a hypomobility condition. She later had a number of referrals for a variety of specialist health services.

4.2.4 In 2006 B and C were referred to the Child and Adolescent Mental Health Service (CAMHs)

4.2.5 **B and C** did not receive treatment from CAMHs because **A** refused to allow them to do so.

4.2.6 In June 2006 both **B and C** were placed on a child protection plan under the category of neglect. **C** was removed from the plan in August 2007 and **B** in June 2009

4.2.7 In 2006 **B** was identified as being a young carer but she refused to be referred to the local Young Carers' service.

4.2.8 **B** remained home schooled till she reached 16 years old. There are few partner records concerning her till 2017 , when she was taken to hospital with **A,** suffering from malnutrition and neglect.

4.2.9 In a clear echo of **A** she reported to the ambulance that attended her that she had 60 medical conditions and then refused treatment when at hospital.

4.2.10 The hospital staff offering her treatment judged that she had full capacity to decline even though that decision may have been to a detriment to her health.

4.2.11 She adopted the same diet as **A.** In 2019 she, in company with **A** refused to go to hospital (see 4.1.8)

4.2.12 She was with her mother when she died.

4.3 Brief Biography of C

4.3.1 **C,** the older daughter of **A,** was born in 1990. Her father who is a different person from the father of B played no part in her life.

4.3.2 Her schooling was more regular than that experienced by **B.** She was home schooled until she was 10. She completed her primary schooling and then won a scholarship to a selective academic private school. She stayed there till she finished her GCSEs.

4.3.3 She had a lengthy and complicated medical history as a child. She like **B** had a two week stay in hospital in 2006. In 2009 she was described as having a long list of medical conditions.

4.3.4 **C** was placed on a child protection plan in June 2006 (see 4.2.6) .

4.3.5 **C** was referred to CAMHs (see 4.2.4 an 4.2.6) and was identified as a young carer but refused to be referred to Young Carers (see 4.2.7)

4.3.6 **A's** highly restrictive diet and her determination to impose it on her children led C to leave home.

4.3.7 Following a university degree **C** embarked on a professional career and now lives a fully independent life.

4.3.8 **C** was informed of **A'**s death by her cousin.

5 Analysis of Key Issues

5.1 Elective Home Education (EHE)

5.1.1 Both **B** and **C** missed large sections of their schooling. This was the subject of discussions at a number of planning meetings and conferences. It impacted **B** more than **C. B** missed all of her secondary schooling and much of her primary schooling as well, while C attended for her secondary years.

5.1.2 Professionals from time to time and particularly in 2006 articulated concerns that their non-attendance at school was likely to impair their development.

5.1.3 At first **A's** mobility issues were considered to play a significant part in the children's non-attendance; with her finding it difficult to get them to school. Considerable efforts were made by children's social care to help A get them to school and funded a taxi for them.

5.1.4 This non-attendance , when combined with other concerns raised about them led to them both being on child protection plans. These lasted in B's case from 2006 to 2008 and in C's case from 2006 to 2007.

5.1.5 In 2008 A removed them from school to be electively home educated. By then they had been removed from their child protection plans and they effectively dropped out of sight.

5.1.6 One unsuccessful attempt to visit **B** by the home education officer was made in 2009. This was not followed up.

5.2 Reflection and learning on the elective home education of B and C

5.2.1 **B** and **C'**s lives seem to have turned out very differently. While **B** lived alongside her mother and at the same time appear to have developed a range of care and support needs **C** has able to establish a more independent life, which is away from London. There seems to be a correlation between these two states and the amount of schooling they received. It is also likely to be connected to the fact that **A's** mental ill health (according to **C**) began to deteriorate when she was about 30. At that time **C** was 13 and **B** six.

5.2.2 When they dropped out of school in 2008, they did so at a time when their mother's mental health was likely to be deteriorating , and when the oversight of a school would have been invaluable.

5.2.3 There is little that can be done legislatively to prevent parents removing their children from school. However, when there have been safeguarding concerns about a child, should they be removed from school they should become a case of concern.

5.2.4 These events predate the Harrow multi-agency safeguarding hub (MASH) , which was established in 2014. Now when a child is removed from school, they are referred to the MASH and any safeguarding concerns are assessed. Furthermore ,there is now an escalation system for those dealing with EHE. Where a home visit or some other request for evidence of the quality of EHE is refused or unsatisfactory the case is prioritised.

5.3 Recommendation 1

The Harrow Safeguarding Children Board (HSCB) reviews

- the effectiveness of the current system for assessing safeguarding risks for children who are EHE.
- how well the escalation system is known, understood and used by the children's workforce.
- how children with previous safeguarding concerns are tracked should they become EHE

5.4 B and C as Young Carers

5.4,1 "A young carer is someone under 18 who helps look after someone in their family, or a friend, who is ill, disabled, has a mental health condition or misuses drugs or alcohol".[1]

5.4.2 There are 166,000 young carers in the UK and their average age is 12[2]. This figure is taken from the 2011 census. Young Carers' data are not available on a Local authority basis but the national figure suggests there are likely to be about 700 in Harrow [3]. However, those who represent young carers claim the real figure in the UK (and by extension in Harrow) is more like 800.000[4], because so many are hidden from view.

5.4.3 "Young carers have significantly lower educational attainment and around one in 20 misses school because of caring responsibilities. ... Around 40% of carers have high levels of anxiety or depression, with young carers known to have a higher-than-average prevalence of self-harm."[5]

5.5. Reflection and Learning on B and C as Young Carers

5.5.1 Identifying and supporting young carers is vital for their health and welfare. **B and C** were identified in a range of case files as being in the role of a young carer for **A**. However insufficient action was taken to follow up this aspect of their lives. In 2006 (which coincided with the time at which they were being considered for a child protection plan) they were referred to a Young Carer's Service.

5.5.2 They refused to see a social worker to progress this. That ended that line of enquiry, when it should have raised a red flag. **B** was only eight when she "refused" . Considerations should have been given to the fact that **A** was influencing her decision making.

5.5.3 These events predate the Children and Families Act 2014, which place a duty on local authorities to conduct assessments of the support needs of young carers. Those conducting the assessments need to be properly trained and accredited . The way they operate and the information they impart is now covered by regulation.[6]

5.5.4 The way in which Harrow responds to the needs of identified young carers should be different from what it was in 2006. However, Harrow Carers[7] claim that there are still many young carers in Harrow unknown to the Local Authority.

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[1] Carer's Trust ; accessed at https://carers.org/about-caring/about-young-carers

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/498115/DFE-RR499_The_lives_of_young_carers_in_England.pdf

[3] https://webarchive.nationalarchives.gov.uk/20160107224205/http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/provision-of-unpaid-care-in-england-and-wales--2011/sty-unpaid-care.html

[4] https://www.carerssupportcentre.org.uk/new-research-reveals-hidden-young-carers/

[5] Wong 2017 , British Journal of general Practice

[6] Accessed at https://www.legislation.gov.uk/uksi/2015/527/made

[7] A voluntary organisation providing support, advice and training for unpaid carers in Harrow

5.5.5 A representative of Harrow Carers has recently joined the Harrow Safeguarding Children Board and will be able to work with the safeguarding partners to ensure that young carers are not missed by the system.

5.5.6 It was suggested by an attendee at the session described at 2.3 that liaison between children and adult services is not regularly considered as part of a young carer's assessment but should be. The care and support need of the adult should be considered as part of the assessment

5.6 Recommendation 2

- HSCB and HSAB develop a process to ensure that young carers' assessments are the product of joint working across children and adult services.
- HSCB work with Harrow Carers to close the gap between the number of Young Carers supported by the Local Authority and the number known to the local Harrow Carers' service.
- HSCB to satisfy itself that the young carers assessment process in Harrow is effective.

5.7 Perplexing Presentations, Fabricated or Induced Illness (FII)

5.7.1 FII is a rare form of child abuse. It happens when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child[8]. Its prevalence in the UK is difficult to determine as there has been little by way of authoritative research into it. However what literature there is all agree that it is complicated, difficult to deal with and serious. It often takes a considerable time and many medical consultations before it can be determined whether a child is genuinely ill or is in fact being subjected to medical interventions by a parent or carer for some reason that has nothing to do with the child's wellbeing.

5.7.2 A number of contemporaneous records mention suspicions that the many medical presentations of **B and C** were FII. Their multiple medical conditions were similar to the many conditions claimed by A. There is no record of any thorough investigation into the suspicion that B and C were victims of this particular child abuse.

5.8 Reflection and Learning on Perplexing Presentations and B and C being victims of FII

5.8.1 The London Child Protection Procedures[9] describe how professionals should approach the management of cases where FII is suspected. It is a painstaking process, which requires the support of a wide range of professionals. Many cases take a year or more to diagnose.

[8] https://www.nhs.uk/mental-health/conditions/fabricated-or-induced-illness/overview/
[9] https://www.londoncp.co.uk/fab_ind_ill.html?zoom_highlight=FII

5.8.2 In this case, the sort of careful review of the information with the involvement of the necessary range of professionals did not take place and so the suspicions were never explored or investigated.

5.8.3 In 2008, the fact that **B** was being taken to her medical appointments was cited as a reason for removing her from her CPP even though by this stage she had been taken out of school. In a case of FII the regular and frequent attendance at medical appointments may not be a protective factor. It could be seen as part of the abuse.

5.8.4 The author of the Harrow Children Services report (see 2.2) commented that **B**'s case lacked productive supervision, with too little direction as to how to progress what was a very complicated case.

5.8.5 The Harrow Council social work supervision system is different now. However, a case involving FII needs to be closely supervised as well as involving a multi-agency approach.

5.8.6 The Royal College of Paediatrics and Child Health[10] recently (Feb '21) updated their guidance for medical professionals on fabricated and induced illness, entitling the presentations to health as perplexing presentations. Most FII cases first give rise to suspicion in a medical setting and therefore health professionals should be familiar with how to access the latest guidance.

5.9 Recommendation 3

- Professionals need to recognise when confronted with perplexing presentations how to follow the RCPH pathway
- HSCB to work with the designated nurse to in reviewing the HSCB procedures that cover the management of perplexing presentations and FII to ensure that cases are manged at a multi - agency level and properly supervised.

5.10 Hoarding, Hygiene, Fire and Gas Safety

5.10.1 **A's** premises in 2019 were the subject of a number of referrals and complaints , which various agencies sought to deal with. At the same time , **A** was an open case to Harrow Adult Services, who were trying to assess her need for care and support, her mental health and her capacity to make decisions.

5.10.2 "A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner, usually resulting in unmanageable amounts of clutter. The items can be of little or no monetary value"[11]

[10] https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/
[11] https://www.nhs.uk/mental-health/conditions/hoarding-disorder/

5.10.3 In June 2018 the World Health Organisation classified hoarding as a medical condition. Compulsive hoarding is now recognised by the NHS as a mental disorder.

5.10.4 Hoarding is (or can be) part of a group of behaviours that are described as self-neglect and which now features in the statutory Care and Support Guidance[12]. This was refreshed in April 2021. The tensions that exist for professionals in allowing an adult to live independently while seeking to safeguard them from harm (even self-inflicted harm) are well described in The Guidance and below at 5.11.1

5.10.5 **A** moved into her accommodation in 2008. By the time of her death, she had become a compulsive hoarder. Her's was clearly a progressive condition[13]. In 2015 her landlord successfully carried out a gas safety check at her premises and there was no mention of hoarding then.

5.10.6 In 2017 the LAS reported that **A**'s accommodation was very untidy and unclean, but hoarding was not referred to. However, by 2019 two safeguarding referrals (August and October) were made on her behalf following the LAS and the Metropolitan Police going to her address. On these occasions hoarding was identified with the LAS rating it level 7. (Figure 1 is an example of what level 7 looks like). Clutter levels are graded from 1 – 9 (with 9 being the most cluttered). So, between 2017 and 2019 hoarding had developed into a significant problem for A.

5.10.7 In addition to hoarding **A's** premises were also described to Harrow Council's Environmental Health Service (EHS) as being verminous by a concerned neighbour (sometime in 2019) and being contaminated with faecal matter (Police report October 2019)

5.10.8 Hoarding is also a fire risk. The LAS following their assessment of **A'**s hoarding at level 7[14] (August 2019) notified the fire brigade (LFB), so that they could conduct a fire safety check.

5.10.9 Her landlord ,as he was required to do, wanted access to carry out an annual gas safety check.

5.10.10 Various attempts were made in 2019 by the Landlord, the LFB and EHS to access **A's** accommodation to carry out their premises -inspection functions but without success

- 19th August ; landlord (accompanied by LFB) and Harrow Council social work team refused entry,
- 23rd August EHS refused entry
- Some pre-arranged appointments to attend **A's premises** were then cancelled, refused or rescheduled between August and October.

[12] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Found at Para 14.17

[13] Hoarding is known to get worse with age ; https://www.agingcare.com/articles/hoarding-behavior-becomes-more-severe-with-age-146409.htm

[14] Illustrated at Appendix 7

5.10.11 Between August 2019 and October 2019 attempts were made to coordinate the approach of the various agencies who wanted to inspect A's premises for their various reasons and adult services who wanted to check A's mental capacity all to no avail.

5.10.12 There are a number of powers available to enable the sort of premises inspection required in this case.

- Power to enter premises to conduct a gas inspection[15]
- Power to enter premises to take public health cleansing action[16]
- Duty to give advice[17] on how to prevent fires[18]

5.10 13 A fire safety inspection is likely to be received relatively willingly as it only comprises advice that can be rejected. The other powers were not likely to be received favourably given **A's** known history of non-engagement with a variety of services.

5.10.14 On 2nd October 2019 the Landlord gained entry and carried out the gas check without any of the other agencies present. This was a missed opportunity for all the relevant agencies to work effectively together.

5.11. <u>Reflection and Learning on issues concerning hoarding, hygiene fire and gas safety</u>

5.11.1 Hoarding is a subject that professionals often find hard to deal with. That was reflected in the observations of the Harrow professionals meeting (2.3) There are tensions between respect for the autonomy of an individual to make unwise and life limiting choices, provided they have capacity and what they are doing does not negatively impact others and a perceived duty on behalf of professionals who want to preserve health and wellbeing of those they care for.

5.11.2 These tensions are well reported on by the agencies contributing to this review.

5.11.3 The Cochrane Collection[19] contains 21 studies concerning the treatment for Hoarding Disorder. These studies and the Therapists' Guide[20] for treating Hoarding Disorder (reissued in 2014) all describe treatment of Hoarding as a long term process. Time, constancy of approach and developing trusted relationships with those who want to help can allow those who hoard to make progress towards having less cluttered lives.

5.11.4 While hoarding on its own generally does not negatively impact others and could be susceptible to a long term approach, infestation, posing a fire risk to others

[15] Gas Safety (Installation and Use) Regulations 1998
[16] Sec 287 Public Health Act 1936
[17] This is a duty and not a power. The householder is free to resist any offer made under this section.
[18] Sec Fire and Rescue Services Act 2004
[19] Accessed at www.cochrane.org
[20] Oxford University Press 2014 ; Stekete and Frost.

and having unsafe gas fittings might pose an unacceptable risk and requires an approach that does not fit with a long term gradual solution.

5.11.5 Each of the agencies responsible for dealing with the hygiene, infestation and gas safety issues needed to take action to protect others. They appeared keen to work in partnership with those who had a different but linked function.

5.11.6 At the same time that Harrow Adult Services wanted to assess **A'**s mental capacity but were finding it difficult to get access to her, a number of other agencies wanted social care expertise to accompany them should they take enforcement action.

5.11.7 While a lot of multi-agency good intentions are described in agency reports there was a lack of effective coordination.

- On 2nd October Adult social care closed **A's** safeguarding case without there having been any multi- agency meeting as follow up to the August referral. (5.10.4)
- On 4th October EHS sought information from the Landlord and only received a reply on 24th October.
- On 8th October EHS stated that they would like to see the case raised at the next risk enablement panel on 6th November to seek agreement to the proposition that they obtain a warrant to enter **A's** premises. It is not clear if the relevant council managerial staff knew that there was a process for having an emergency meeting, or, even if they did ,whether this would have been considered an emergency case.
- On 22nd October the landlord asked adult services to clear household waste from A's premises, not knowing apparently that this was not a function of adult services and had not been agreed.
- On 21st August LFB closed their home fire safety visit file in accordance with their closure policy. This requires closure after three unsuccessful visits. In fact, two of those attempts were called off by LFB because they did not have any staff.

5.11.8 This situation required a multi-agency panel to work out the complexities of the case, to decide which agency was going to lead and a proposed timetable for action. This needed to include whether and which powers were to be used to access **A's** premises and **A** herself.

5.11.9 The Risk Enablement panel,[21] which meets every six weeks would have been a good place to have to have worked out the multi-agency plan. However, a meeting every six weeks may not capture cases which contain escalating risk. A process for having

[21] The Risk Enablement Panel is a multi-agency process managed by Harrow Council Adult Services. Referrals to it are made by managers from within adult services , although referrals can be (and are encouraged to be) passed to managers by other agencies.

an emergency panel existed but was not activated even though activity was being planned by various agencies.

5.11.10 Harrow Council has significantly revised its Self-Neglect (including hoarding) Protocol since 2019. It describes a multi-agency approach to cases that involve hoarding. Had this been in place in 2019 and had it been followed some of the difficulties in managing this case may not have occurred.

5.11.11 Of particular note are the powers that are available to partners. These are described in Appendix 3 of the revised protocol (Reproduced at Appendix 4 of this report) . This is a useful template for ensuring that each option (for the use of a power) is considered and its rationale explained.

5.11.12 There was a lack of confidence about the right approach to **A's** hoarding and the hygiene issues at her premises There are a number of organisations that specialise in helping organisations deal with these difficulties. Harrow's Safeguarding Adults Board has a strong record of engaging the voluntary sector . They should develop links with an appropriate hoarding expert organisation with a view to building up partner capability in this area.

5.12 Recommendation 4

- HSAB seeks a third sector partner with expertise in hoarding to complement the work of the board and enhance the skills and confidence of the workforce.
- Harrow Council to ensure that their managers are aware that the Risk Enablement Panel can hold urgent meetings in appropriate cases.
- The LFB amend their policy in closing fire safety cases, so that an inability to provide staff for a visit is not recorded as an unsuccessful visit.
- The Landlord ensures that in cases where there are known safeguarding concerns at an address, they do not exercise a gas inspection injunction with a power of entry without providing Harrow Council with prior adequate notice enabling them to provide a response and assistance.

5.13 The Safeguarding Response

5.13.1 **A** was known to Harrow Adult Services for a relatively short amount of time; first coming to notice following the police and ambulance visit to her house in June 2017 (4.1.9). She refused medical treatment at the hospital and subsequently refused assistance from the Harrow Council Reablement team. There was no reason to doubt her capacity at that time.

5.13.2 She came to notice again in August 2018. In this instance Harrow Council set in motion a series of activities;

- A Care Act Assessment[22] of both **A's and B's** care and support needs

[22] Section 9 Care Act 2014

- A safeguarding enquiry[23] in response to **A's** reported self-neglect
- A referral to Central North West NHS Foundation trust for a mental health assessment.

5.13.3 A Care Act Assessment should be done by a local authority if an adult seems to be in need of care and support However, if an adult with capacity refuses, then no assessment needs to be done[24]

5.13.4 **A and B** could clearly be seen as candidates for care and support but they had refused treatment and help in 2017 in circumstances not dissimilar to those apparent in August 2019. The issue that needed clarifying following this referral was, did they still (and particularly **A)** have capacity to refuse assessment and help.

5.13.5 In order to assess someone, professionals need to meet with them. Someone who routinely refuses help is capable and indeed likely to refuse to meet a potential assessor. The social worker allocated the case anticipated **A and B** being difficult to engage.

5.14 Reflection and Learning; The Safeguarding Response

5.14.1 This was a complicated case and the allocated social worker sought to arrange a multi-agency meeting to move the case forward so that **A** could be assessed. However, no comprehensive multi agency meeting was arranged and nor, it seems, did the attempt to have a mental health assessment make progress.

5.14.2 It is not clear from the retained records of the relevant agencies why no assessment of A's mental health took place. Nor is not clear whether senior management support and oversight were sought or offered.

5.14.3 Since these events CNWL have introduced a Single Point of Access system that ensures better oversight of the sort of case that a request for assessment of **A** typifies.

5.14.4 There were however a series of prearranged attempts to engage **A and B** in their own home , during which social workers accompanied other agencies as they sought entry (5.10 – 5.12) . They were either cancelled or fruitless in that entry was refused.

5.14.5 On 2nd October, even though no assessment of **A or B's** capacity or needs had been carried out by social workers the safeguarding case was closed. Some staff disagreed with this decision. Additional management support and advice should have been available at this point and could have made a difference.

[23] Section 42 Care Act 2014
[24] Section 11 Care Act 2014

5.14.6 Adult Services relied the powers that other agencies had to gain entry to **A and B** to enable an assessment. No access to them was gained and so the only formal assessment of their capacity was completed by LAS on 2nd October 2019.

5.14.7 In relation to the Public Health power of entry, which EHS might have sought, the law specifically provides for the officer with the warrant of entry to be accompanied with any other person that is deemed necessary[25].

5.14.8 In relation to the Landlord's various powers of entry Harrow Council should clarify the legal status of social work staff accompanying a land lord so that the social work staff can carry out a capacity or needs assessment,

5.14.9 There are other ways in which social work professionals might seek access to adults in need of assessment.

5.14.10 Section 135 Mental Health Act 1983

5.14.11 This provision enables a magistrate , following a statement from an approved mental health professional to authorise a constable to gain entry to a premises where there is believed to be a person suffering mental disorder who is

- Being ill-treated or neglected ……or
- Is incapable of looking after themselves and is living alone.

So that the person can be taken to a place of safety and assessed.

5.14.12 While this power needs to be borne in mind by professionals seeking access to individuals whose mental health and capacity requires assessing , in this instance this power was not suitable for two reasons

- A's neglect was self-neglect and not neglect of her by another
- She was not living alone.

5.14.13 Inherent Jurisdiction

5.14.14 This legal power enables the high court to intervene in the lives of vulnerable adults who have capacity but who require protecting from undue influence. It seeks to facilitate the process of unencumbered decision-making by those who would otherwise be restrained by external pressure.

5.14.15 Re-establishing the individual's autonomy of decision-making by using the powers of the court under its inherent jurisdiction is deemed to enhance rather than breach a vulnerable adult's Article 8, ECHR right to privacy and family life

[25] Sec 237 (3) Public Health Act 1936

5.14.16 Harrow have been bold in using this "power" over the past 18 months or so and are getting skilled at applying it. In this instance it probably would not be applicable. It is a power to "rescue" someone from undue influence, who has capacity , but nonetheless is under some form of influence which needs to be taken off them.

5.14.17 There is no suggestion that there was an undue influence on **A** despite the fact that **B** was often the person who cancelled appointments and refused access. Professionals did not record any evidence or information to the effect that **A** was under any undue influence. That being so there would be nothing for the court to adjudicate on.

5.14.18 In **A's** case the options for Adult Services to access **A** for assessment purposes given her resistance were limited. The best legal means, given the situation was to try to gain entry alongside EHS colleagues (5.14.5) **A's** is unlikely to be a rare case and so it would make sense to develop a joint way of working between EHS and adult services.

5.15 Recommendation 5

- HSAB should review the impact of the self-neglect (and hoarding) protocol and assure itself that cases such as these are properly allocated to experienced staff, and supervised.
- The Harrow Council escalation policy should be reviewed and re publicised to adult services staff.
- Harrow Council should establish the legality of social workers accompanying landlords when forcibly entering premises to exercise a power of injunction.
- HSAB should assure itself that the process for closing multi-agency cases due to or following non-engagement is safe.
- Harrow Council, EHS and Adult Services should develop a protocol for the use of public health entry warrants to enable social workers to carry out capacity assessments where such an assessment is needed by either service
- HSAB should seek reassurance of the effectiveness of the single point of access system for seeking mental health assessments.

5.16 Resistant service users and mental capacity assessment

5.16.1 **C** told the police that **A** had a deep distrust of medical professionals and social services (both adult and children).

5.16.2 A pattern is visible in **A's** dealings with the authorities. She refused help for herself and her children (4.2.5 and 5.5.2) and from time to time she and an accompanying child or children seemed to "operate as a single unit"and were treated as such when they presented with similar symptoms. In 2017 and 2019 **A and B** were both offered medical and social services help on three occasions and they both turned it down.

5.16.3 **A** was an articulate person who resisted help which she may well have interpreted as interference. She is noted in the report of her attendance at hospital in 2017 with **B (**where she was taken by ambulance) that she appeared to be speaking for her adult daughter in refusing care.

5.16.4 Although **A's** GP had not had contact with her for four years , they were a source of information and support which was not used in trying to manage **A's** situation. They were not asked to support the safeguarding enquiry in August 2019 nor in October, even though the LAS had spoken to them about **A's** capacity.

5.17 Reflection and Learning on Resistant Service Users and capacity assessments

5.17.1 Resistant service users provide health and social care professionals with difficult challenges. At the practitioners meeting (2.3) a number of attendees expressed this.

5.17.2 In this case the inability of staff to meet with **A** meant that it could not be determined that the decisions she was taking about her own care were ones she fully understood. Offering appropriate help was impossible.

5.17.3 While this review is about **A,** there are concerns about the way **B's** needs were addressed. In partner records between 2017 and 2019 (with the exception of one hospital visit by A in early 2017) **A and B** were seen together and received the same result. That may be because they appeared to speak as one voice.

5.17.4 Various partner records are clear that **A** dominated **B.** A number of professionals who encountered them both did identify this but did not decisively act on what they had observed.

5.17.5 Cases such as this need close supervision, and good decision making informed by multi agency decision making (see 5.11.7). Supervisors should be aware of the need to support staff dealing with resistant service users. They should also ensure that adults presenting together are seen as separate individuals. They should not be seen as a single case.

5.18 Recommendation 6

- HSAB should ensure that cases of resistant service users should involve multi agency decision making.
- Harrow Council should ensure that staff dealing with resistant service users have support and advice from senior colleagues.
- Harrow Council should ensure that there is appropriate level of management oversight of cases that display this degree of complexity.
- Harrow Council should ensure that there is system in place for cases where two people are subject to a linked assessment or safeguarding enquiry. The system should require both to be dealt with separately.

6. Conclusion

6.1 Reviews are about learning and improving practice. Some time has elapsed since **A's** death. Some of the recommendations in this report have already been enacted and procedures have already improved.

6.2 The HSAB will ensure through its case review group and its quality assurance process that the lessons that have been learned will lead to different and improved practice.

6.3 This review would not have been possible without the open reporting and reflection of the agencies that have contributed to it. Thanks is due to all the staff who put time and attention into assembling their reports as a result of which the safeguarding system in Harrow will be improved

Appendix 1 - Schedule of Recommendations

Recommendation 1

The Harrow Safeguarding Children Board (HSCB) reviews

- the effectiveness of the current system for assessing safeguarding risks for children who are EHE.
- how well the escalation system is known, understood and used by the children's workforce.
- how children with previous safeguarding concerns are tracked should they become EHE

Recommendation 2

- HSCB and HSAB develop a process to ensure that young carers' assessments are the product of joint working across children and adult services.
- HSCB work with Harrow Carers to close the gap between the number of Young Carers supported by the Local Authority and the number known to Harrow Carers.
- HSCB to satisfy itself that the young carers assessment process in Harrow is effective.

Recommendation 3

- Professionals need to recognise when confronted with perplexing presentations how to follow the RCPH pathway
- HSCB to work with the designated nurse to in reviewing the HSCB procedures that cover the management of perplexing presentations and FII to ensure that cases are manged at a multi - agency level and properly supervised.

Recommendation 4

- HSAB seeks a third sector partner with expertise in hoarding to complement the work of the board and enhance the skills and confidence of the workforce.
- Harrow Council to ensure that their managers are aware that the Risk Enablement Panel can hold urgent meetings in appropriate cases.
- The LFB amend their policy in closing fire safety cases, so that an inability to provide staff for a visit is not recorded as an unsuccessful visit.
- The Landlord ensures that in cases where there are known safeguarding concerns at an address, they do not exercise a gas inspection injunction with a power of entry without providing Harrow Council with prior adequate notice enabling them to provide a response and assistance.

Recommendation 5

- HSAB should review the impact of the self-neglect (and hoarding) protocol and assure itself that cases such as these are properly allocated to experienced staff, and supervised.
- The Harrow Council escalation policy should be reviewed and re publicised to adult services staff.
- Harrow Council should establish the legality of social workers accompanying landlords when forcibly entering premises to exercise a power of injunction.
- HSAB should assure itself that the process for closing multi-agency cases due to or following non-engagement is safe.
- Harrow Council, EHS and Adult Services should develop a protocol for the use of public health entry warrants to enable social workers to carry out capacity assessments where such an assessment is needed by either service
- HSAB should seek reassurance of the effectiveness of the single point of access system for seeking mental health assessments.

Recommendation 6

- HSAB should ensure that cases of resistant service users should involve multi agency decision making.
- Harrow Council should ensure that staff dealing with resistant service users have support and advice from senior colleagues.
- Harrow Council should ensure that there is system in place for cases where two people are subject to a linked assessment or safeguarding enquiry. The system should require both to be dealt with separately.

Appendix 2

TERMS OF REFERENCE
SAFEGUARDING ADULT REVIEW: Adult/Family (insert code name/initial)

1.INTRODUCTION

The 2014 Care Act requires Safeguarding Adults Boards (SABs) to conduct a Safeguarding Adults Review (SAR) when certain criteria are met*. A SAR is a multi-agency process which identifies any learning that will enable the partnership to improve services and prevent abuse and neglect in the future.

A decision to hold a Safeguarding Adult Review was agreed by the joint Safeguarding Board's Case Review Sub Group on 21st November 2019. This was in response to the death of a 46 year old woman known to local services and it was felt that significant learning could be extracted from a SAR to inform future practice and service arrangements.

2. CRITERIA

** (i). The Safeguarding Adult Board must arrange for such a review in cases where an adult with care and support needs (whether or not the local authority has been involved in providing services) 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) either of the following conditions are met:

*(ii) 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)

(iii) 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

In this case, it was agreed that the criteria were met because an adult with care and support needs died and abuse or neglect was suspected and initial information presented to the Case Review Sub Group suggested that provider and other statutory services may have lacked coordination in the way that they operated. The case also raises questions about the service response to the adult's own children and consequently the lines of enquiry were expanded to issues relevant to the Harrow Safeguarding Children Board too.

3 PERIOD UNDER REVIEW AND METHODOLOGY

a) All member agencies of the HSAB and HSCB are required to confirm whether they had any involvement with the family under review.

b) The review will seek a **summary of background information** from all involved agencies covering their knowledge and history of involvement with the family.

c) The summary from each involved agency will be accompanied by an analysis of practice where it relates to the lines of enquiry (listed below).

d) All involved agencies will also produce a **detailed chronology** of their involvement from **0l.05.14** until the date of the adult's death **25.10.19.** The start date for the detailed chronology was set to include a period before the youngest child in the family became an adult.

e) The Case Review Panel will analyse the summaries and a combined chronology – and where necessary address any quality assurance issues.

f) The Case Review Panel will design and run a case discussion event with relevant front line practitioners and their managers to draw learning from the key lines of enquiry

g) The views and experiences of key family members will also be sought to inform learning for the review

h) An overview report will be produced and presented to both the HSAB and HSCB

i) The Case Review Panel will produce and deliver a programme to disseminate the learning across the partnership

3. LINES OF ENQUIRY

a) How did current procedures for assessing mental capacity work in this case?

b) What else might Harrow partners do to enable a capacity assessment in complex cases where there is resistance to statutory services.

c) Were there other options in terms of legislation (outside the Mental Capacity Act and Care Act) that might have assisted in this case?

d) The children of JL, who are now adults, were subject of child protection procedures and were home schooled. One of JL's children now has considerable support and care needs. Have the current Harrow child protection procedures and practice developed since JL's children were known to statutory services in relation to thresholds and the quality of assessments – and if so, how?

e) Was practice adequately informed by the voice of the child/service user?

f) Was practice adequately responsive to the cultural identity of the family?

g) How effective were supervision and management oversight in this case?

h) How was the health and education outcomes for both young people monitored during the period of being educated at home from 2008?

4. List of agencies and services participating in the review

- Adult Social Care
- Children's Social Care
- Primary Care
- Education services
- Housing Association
- Environmental Services
- Central North West London Mental Health Services (CNWL)
- London North West University Hospital Trust
- The Metropolitan Police
- The London Fire Brigade
- The London Ambulance Service

Appendix 3 (Briefing Note for Professionals Meeting)

Safeguarding Adult Review (SAR) Adult A; Practitioners' Event – 20th April 2021

1 Background – Why is Harrow Safeguarding Adults Board conducting a SAR?

1.1 When an adult who is need of care or support (whether or not care and support was actually being provided) dies or is seriously harmed and

- there is a reasonable cause for concern about the way that SAB members worked together to safeguard the adult and
- the SAB knows or suspects that the death resulted from abuse or neglect (whether or not the abuse or neglect was known about before death) then

the SAB must arrange for a review of the case.

1.2 In the case of A,

- She died on 25th October 2019
- A number of different agencies had had a lot of involvement with A over a number of years; some close to her death
- The records reveal that there were some actions that could have been taken to safeguard her which were not followed through.
- Her living accommodation was in a very poor state, with considerable evidence of clutter and poor levels of hygiene.
- At the time of her death, she was emaciated.

1.3 Taking all these factors into consideration the Harrow SAB case review group considered that this case met the threshold for an SAR and recommended to the full SAB that a SAR should be commissioned.

1.4 In addition to issues relevant to the death of A, partner records reveal that she had two children (B and C) who for much of their childhood missed significant periods of school. B and C also had a lot of dealings with the Health Service where they presented with a large range of unidentified symptoms and conditions that mirrored those expressed by their mother, many (most) of which could not be explained.

1.5 In the light of the issues concerning B and C the SAR will also examine how agencies worked to protect them when they were children and so this is a review that is fully supported by the Harrow Safeguarding Children Board.

1.6 This practitioners' event is being held so that those who were involved with A and her family can contribute their thoughts, ideas and experiences. These will be used to amplify our understanding of what happened and why. In due course our final

report will provide us with learning which will help us to deal better with incidents such these in the future.

2 Introduction

2.1 When A died on 25th October 2019, she was 46 years old and living in social housing with her adult daughter (B), who was then 21 years old. A and B had a high degree of mutual dependence. There is another daughter (C) who lives away from London and has a professional career.

2.2 The Harrow Case Review Group having considered that the death of A met the threshold of a SAR asked agencies who had had dealings with A to submit a chronology of those dealings along with comment where appropriate and a detailed report on the impact and importance of those dealings and whether more could or should have been done.

2.3 Agencies were asked to provide a chronology and a detailed report of their involvement with A and her family from 1st May 2014 until her death.

2.4 The timespan was designed to include a period when B was still a child.

3 Agencies Involvement

3.1 Ten agencies[26] submitted chronologies and follow up summary reports covering the period described at 2.3. Additionally , separate reports were submitted by the Harrow Multi Agency Safeguarding Hub concerning the schooling of B and C (2000-2008) and by the CAMHs[27] service that was involved with B and C in the years 2001 – 2007

3.2 Some themes reoccur in these agency reports. They include that it was not always easy to communicate with A . She seemed not to welcome much of the help offered. She seemed to keep her children very close and was determined to follow what eventually became a narrow and horizon limiting lifestyle. There were concerns expressed by various agencies as to A's mental capacity. Except for one occasion when the LAS conducted one "on the spot", the various agencies' concerns did not lead to a full capacity assessment.

3.3 Another issue that on a number of occasions when A and B came to attention together, they seemed to be treated as a single unit, even though B was herself an adult with her own life issues.

4. A, B and C's Early Involvement with Services

[26] Harrow Council, Adult Social Care; Harrow Council , Children Social Care; Harrow Council, Environmental Services; The Metropolitan Police Service; The London Ambulance Service; The London Fire Brigade; London North West Healthcare NHS Trust (Northwick Park Hospital);, Primary Care (A'S GP) and A2 Dominion Housing Association.

[27] Provided by Central North West London NHS Healthcare Trust

4.1 Records that precede the review period contain the following important background details

- A was once addicted to cocaine and had been alcohol dependent
- She had a long medical history with many reported conditions and symptoms, a proportion of which could not be explained.
- She reported during a mental health assessment in 2000 that as a child she had been abused
- In the same assessment she reported that she had also been abused by her husband.
- C was twice referred to CAMHs (2001 and 2005) and B along with C in 2005
- In 2005 A refused to allow B and C to engage with CAMHs help.
- B was home educated for all of her secondary years and some of her primary years
- C attended a selective private school on a bursary for her secondary years and was home educated for some of her other school years.
- B and C both had complicated medical histories which mirrored some of their mother's symptoms. In records in 2006 there were concerns raised about the many illnesses that B and C reported, which seemed to have no known cause.
- There are records of B and C being identified as their mother's carers.

5. Hoarding and Other Issues relating to A's living conditions

5.1 In June 2017 the Metropolitan Police and the London Ambulance Service[28] attended A's home address where they found A and B in need of help. Both were taken to hospital. Hoarding, squalor and faecal matter were noticed and safeguarding alerts through both LAS and MPS were raised.

5.2 In August 2019[29] and early October 2019[30] the MPS and LAS went to A's house. On both of these occasions A and B were present and although seemingly in need of medical care both refused to go to hospital. The LAS deemed both to have capacity , noticed level 7 hoarding and squalor and both agencies submitted safeguarding alerts.

5.3 Following on from the events of August 2019 the LAS made a referral to the LFB for a fire safety check. This did not take place.

[28] They were called by the DWP following a complaint by A about of having had her benefits cut off, rendering her and her daughter penniless and unable to feed themselves.
[29] The landlord had an appointment with A, could not get access and called the police because he was concerned. The Police forced entry to establish the welfare of A
[30] A gas safety engineer gaining entry with an injunction called the police because he was concerned at the squalor he found.

6 Mental Capacity Assessments

6.1 In June 2017 and again in the period August 2019 – October 2019 (which were occasions when A came to the attention of Harrow agencies) A made a number of decisions about treatment for herself that professionals identified as being likely to be life limiting and professionals in a number of agencies recommended or sought to have A's capacity assessed.

6.2 A did not accept the offer of treatment in June 2017, nor in 2019. On this latter occasion social care professionals would have liked to contact A alongside A2 Dominion housing colleagues who were seeking entry for gas inspection purposes.

6.3 In parallel with A2 Dominion seeking entry for gas inspection purposes Environmental Health Services were pursuing issues concerning the property's state of hygiene.

6.4 The records suggest that professionals wishing to carry out an assessment of A wanted to be able to work with other agencies who had power to enter A's home so they could make contact with her. This was based on the belief that A would not allow people into her home willingly to allow an assessment.

6.5 Although a gas engineer did gain access in October 2019, he was not accompanied by any staff capable of completing a thorough assessment because social care were unaware of the impending visit.

6.6 It is not clear from the records how comprehensive the multi-agency planning and information sharing was in this case.

7. What is expected of you?

7.1 You are attending this practitioners' event because you or your department had some involvement in this case. We want to know what you think went well, what didn't go well and what changes would be useful to make so that a case like this goes better in the future.

7.2 This is an event to help with learning and understanding. So, we need you to speak out. We will be looking at four themes as described below. Please come prepared to offer your thoughts on them.

8. Areas to be covered

8.1

Use of history – and professional curiosity regarding:

- history of abuse, neglect & domestic abuse
- history of mental health, self-harm and substance misuse
- illnesses, disabilities and concerns of FII

8.2

Multi-agency working and information sharing

- Need for multi-agency meetings
- Need for understanding each other's roles and legal powers to intervene
- Instigating new assessments – mental health
- Awareness of hoarding

8.3

Working with intelligent non-engaging/resistant service users

- Coercive control
- Seeking and hearing the voice of the child
- Communications led by one person – treating the family as a unit and not as separate individuals

8.4

(i) Closing or suspending cases in response to non-engagement

- Recognising escalating risk
- Using multi-agency meetings to address issues/differences

9. Conclusion

9.1 The nature of A's death and the impact that her lifestyle had on B constitute a rare event. However, there we need to learn from what happened so that we can equip ourselves better if we come across a similar set of events in the future.

9.2 Please reacquaint yourself with the part that you and your agency played in this case and be prepared to help us all learn.

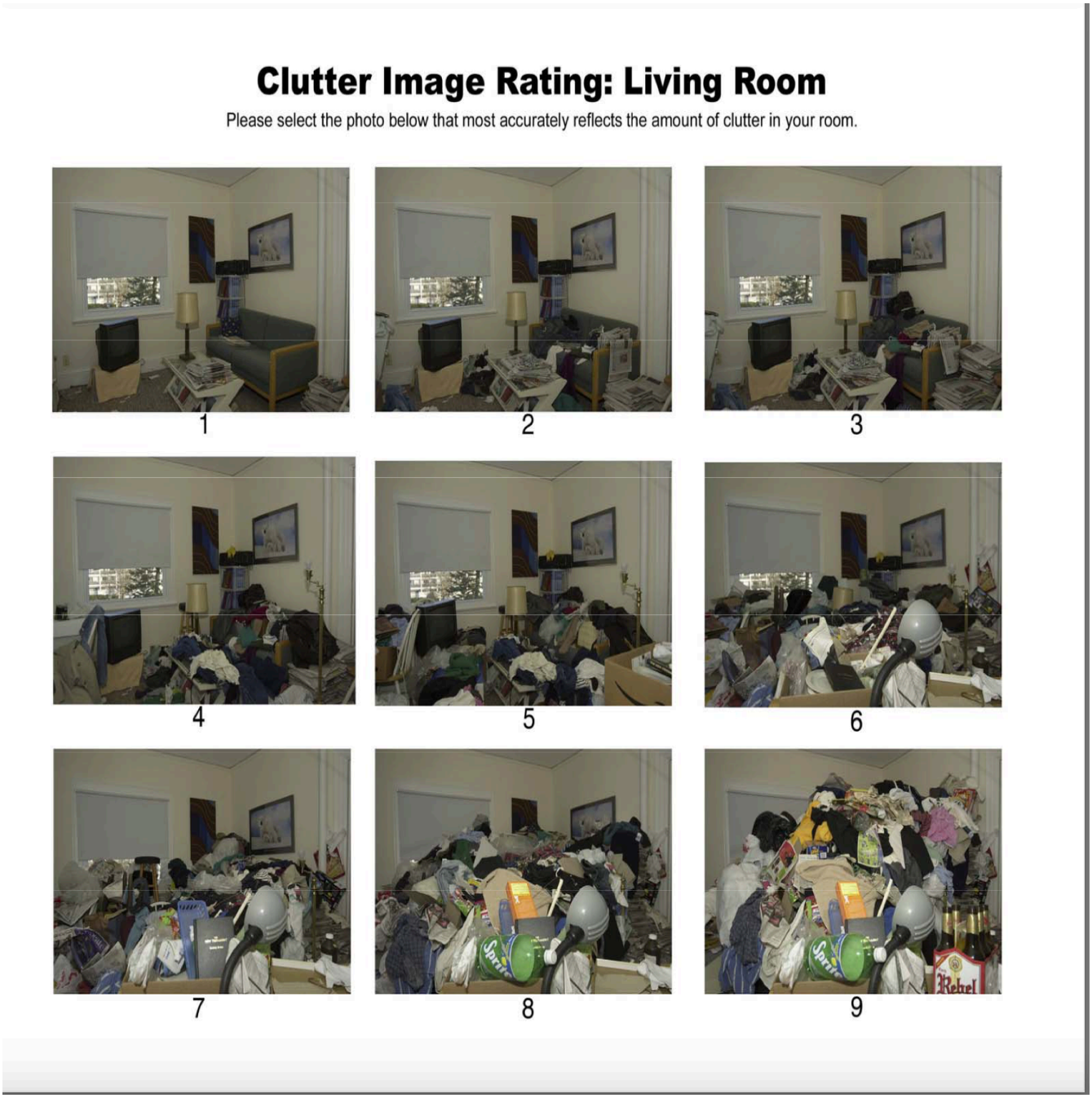
Chris Miller 08/04/2021
Independent Chair
Harrow Safeguarding Adult Board

Appendix 4 (Extract from Harrow's revised Self Neglect Protocol

Appendix 3 Consideration of the statutory options (benefits and burdens)

Possible interventions	Statutory grounds	Benefits	Burdens
Removal from home	Powers of entry under the Environmental Protection Act 1990 and the Public Health Act 1936 to address conditions prejudicial to health		
Eviction	Consider possible breach of the implied terms of a tenancy agreement i.e. not taking proper care of the property. Person may be declared intentionally homeless under the Homeless Persons Act 1977. Eviction may be disputed by reference to the Equality Act 2010		
Compulsory admission into hospital under the Mental Health Act 1983	The existence of defined forms of mental disorder, and for the individual's own health or safety or to protect other persons		
Guardianship	Under s.7 of the Mental Health Act 1983 What short term or long term solutions would result, given the limited powers under guardianship provisions?		
Declaration of Mental Incapacity	The Mental Capacity Act 2005 enshrines the presumption of capacity. Incapacity must therefore be proved. Decisions and interventions in respect of people lacking capacity must be in their 'best interests' Ensure "executive capacity" is fully considered through "carefrontational questions"		
Any other possible intervention?			

Appendix 5[31]



[31] Accessed at https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf