Safeguarding Adult Review

Adult B

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

Chris Miller
Independent Chair
Harrow Safeguarding Adults Board

December 2021

Contents

1. Introduction

1.1 On 11th April 2021 an adult woman **B** (aged 73) died in hospital three days after her admission for a gastrointestinal problem.

1.2 Prior to her death she had been living at home with two of her four adult children. She was in receipt of a package of care , which provided for her social care needs. The rest of her needs were the responsibility of her family.

1.3 Adult B had significant involvement with the Health Service , both through district nurses visiting her at home, general practice and because of a series of hospitalisations.

1.4 In the two years prior to her death, she frequently but not consistently declined both medical and social care help.

1.5 The adult children with whom she lived and who had a role caring for her had themselves been in care as children. They were described in partner records as having learning difficulties.

1.6 The records of the agencies that dealt with **B** and her children raise a number of concerns about the way that they cooperated to provide for **B.** They also highlight opportunities for joint working and planning that were not taken or followed through.

1.7 The Harrow Safeguarding Adult's Board (HSAB) decided that they should conduct a safeguarding adults review into this case.

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

1.9 This review identifies five significant learning points and makes some recommendations in relation to them, which have been agreed by the partner agencies in Harrow to improve the future understanding and approach to cases that are similar to this.

a. The relationship between learning difficulties and a learning disability and how that affects service users.
b. The role of proper assessment in helping carers to care.
c. How adverse childhood experiences impact adults
d. The timing for multi-agency decision making meetings
e. The difference between formal and informal mental capacity assessments

1.10 In June 2021 the HSAB in conjunction with the Harrow Safeguarding Children's Partnership produced a safeguarding adult review[1] (known as SAR A) which bore some similarities to this case. Some of the issues addressed in that review apply to this case.

[1] This has not yet been widely published as the partners are still working to ensure that the family have an opportunity to comment on and better understand its contents.

Improvements have already been put in place to fulfil the recommendations from SAR A. The work that has been undertaken by the partnership since then has reduced the number of recommendations in this report.

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 or had involvement with **B** and her children during the period 1st January 2019 and 11th April 2021. Throughout this review these agencies are called the Partners and are only identified specifically when the sense of the Review requires it.

- Harrow Council adult social care.
- The Metropolitan Police Service.
- The London Ambulance Service.
- London North West University Healthcare Trust (acute health services)
- The Social Care Provider
- The Central North West London NHS Foundation Trust
- General Practice

2.2 These agencies each produced a chronology of their involvement with **B** and her children. 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 their work.

2.3 A group of staff and managers who had worked with the family met as a professional practice group on 29th November 2021 to provide more detailed information. During this session the professionals reflected on their experience and suggested ways in which services might be improved.

2.4 Prior to their meeting they were provided with a briefing sheet which outlined the issues to be discussed. 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 not yet sought the views of **B's** family but will do so before publication.

4. A Summary of Key Issues and Events concerning B

4.1 **B** was known to services for many years before the period covered by this review including a series of hospital visits immediately prior to January 2019.

4.2 In December 2018 she was due to be discharged from hospital but was unable to return home because her house had not been cleared by her children and made ready for the micro environment[2] that she needed to make home care possible.

4.3 She remained in hospital till 15th February 2019. When she returned home her care package consisted of four daily visits (later reduced to three) from two carers, who provided physical care. Her meal and shopping needs were met by her children.

4.4 From 15th February 2019 until her death she remained at home, where she received frequent visits from district nurses, a nurse practitioner and her General Practitioner.

4.5 She was bed bound partly because she refused to make use of a hoist which would have allowed her to leave her bed and use a chair. Her refusal is probably related to an earlier incident when she fell while being moved with a hoist. She was doubly incontinent and from time to time had skin lesions, foot problems and ulcers.

4.6 She was diabetic and on two occasions the analysis of various samples provided by her suggested that she was consuming sufficient alcohol to affect the sample readings. She denied using alcohol on both of those occasions.

4.7 Her carers, the district nurses, her GP doctor and the GP nurse practitioner all report occasions when she refused treatment , examination or help. She was inconsistent in the way she responded to offers of treatment, although towards the end of the two years that make up this review, she refused a lot of interventions. In one particular instance she refused to be referred to a haematologist.

4.8 She was described on occasions as having low mood, low motivation and being confused. On most occasions when she refused treatment or support, her notes had an accompanying report to the effect that she had the capacity to refuse what was offered.

4.9 She was not subject of a formal mental capacity assessment during this period.

4.10 Her living accommodation was described as being cluttered, unhygienic and on at least one occasion as being “hoarded”

4.11 In 2015 (prior to the period covered by the detailed contents of this review), because of her son (**M**)’s behaviour towards her **B** was the subject of a safeguarding enquiry**.** She was made the subject of a further safeguarding enquiry in February 2019 , following the failed discharge from hospital.

[2] A micro environment is the means whereby hospital equipment is placed in a person’s home to enable high level community health care without the need for an inpatient stay.

5. Other Key Issues

5.1 **B** had four adult children, **T,M P** and **N. M** lived with **B** throughout this period. **N** lived with her until she had a baby in May 2020. **M** and **N** had both , as children, been in care

5.2 **M** was known to the partners to live with **B**. Her carers and the district nurses report him as being rarely seen. On some occasions he could appear uncooperative. In 2015 he was heard using abusive language towards **B** and that led to a safeguarding referral (4.11)

5.3 On other occasions **M** communicated reasonably with care professionals, reporting concerns he had and being cooperative with what was required of him as a carer.

5.4 **N** was described as being more willing than M to engage with care professionals. She had been in foster care as a child and while in care had been reported frequently as a missing person.

5.5 In April 2020, **N** gave birth to a baby following a concealed (or possibly) an unknown pregnancy. Fairly shortly after the birth she went into a mother and baby foster placement and does not appear to have returned to live with **B.**

6 Analysis of Key Issues

6.1 <u>Reflection and learning on the learning difficulties of B's children</u>

6.1.1 **M** and **N** took on an enhanced caring role when their mother was discharged from hospital in February 2019. They were described by various of the partners as having learning difficulties[3].

6.1.2 The range of issues that comprise a learning difficulty is wide and a learning difficulty is not the same as a learning disability[4].

6.1.3 "*In general, a learning disability constitutes a condition which affects learning and intelligence across all areas of life, whereas a learning difficulty constitutes a condition which creates an obstacle to a specific form of learning, but does not affect the overall IQ of an individual. For example, Down's syndrome is classed as a learning disability, whereas dyslexia is classed as a learning difficulty, in that it only affects an individual's relationship to the processing of information, usually manifested in problems with reading, writing, and spelling".*[5]

[3] This was expressed in various case review meetings and at the practitioners' event but the phrase ***learning difficulties*** appears only once and that is in the detailed police report. However , that M and N had some learning difficulties can be further implied from much of the commentary in the other agency reports.

[4] While there are a number of ways in which learning disability is assessed one of the more common is the use of the IQ score. Those with an IQ of 70 or less are usually deemed to have a learning disability; (https://patient.info/doctor/general-learning-disability#ref-3)

[5] https://www.mentalhealth.org.uk/cy/node/1955

6.1.4 Those with a learning disability receive statutory help, while those with a learning difficulty may not.

6.1.5 **M** and **N** were significant caring factor for **B**. Those who had to deal with **M** and **N** directly or who needed them to help with **B's** care would have benefited from a better understanding of what learning difficulties they may have had.

6.1.6 No formal carers' assessment was completed in the case of **M** and **N** (of which more later). An assessment should have been done and it should have assessed the extent of **M** and **N's** learning difficulties.

6.1.7 The legislation[6] covering the requirements of a carer's assessment is fairly widely drawn and could certainly cover the issue of a carer's learning difficulty although it is not explicit in that regard.

6.1.8 The current carers assessment template available on Mosaic[7] for Harrow's adult social care staff does not cover the needs of the carer. This has already been identified by Council and a revised template covering this issue has been produced but is not yet published on Mosaic.

Recommendation 1

- Harrow Council Adult Services assess the extent to which their Carers' Assessment Process takes account of the learning difficulties of potential carers.

- Harrow Council Adult Services updates the Carers' template on Mosaic so that it encompasses the necessary investigation into a Carers' needs as well as their abilities.

6.2 Reflection and Learning on Carers' Assessments

6.2.1 "*A carer is someone who provides support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. All the care they give is unpaid.*

A carer could be a spouse, partner, parent, sibling, child, friend or any other relation. Anybody from any background and of any age can be a carer and each carer's experience is unique to their own circumstances"[8]

[6] Accessed at https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted
[7] Mosaic is the electronic case management system used by Harrow adult social care
[8] https://www.carerssupportcentre.org.uk/about-us/what-is-a-carer/

6.2.2 Because **M** and **N** did not provide physical care for **B** it seems that they were not formally identified as requiring a Carer's assessment. Harrow Council, as is common in the profession, uses the term ***informal carer*** , for those who are unpaid. The use of this term may have inadvertently caused the need for a carer's assessment to get overlooked.

6.2.3 Irrespective of what they were called, their role in providing food, shopping, company and being someone available and required to summon help in the event of **B** suffering a medical need made them an important factor in **B's** life. Indeed they were carers. Without them it seems unlikely that **B** could continue living in her own home.

6.2.4 In 2006 the Kings Fund published a report into informal care provision in the UK. It identified informal carers as being people who were not paid[9]. It also explored Carers' objections to the term "informal" as suggesting that the care they provided was less important than that provided by formal carers.

6.2.5 However, because **M** and **N** were identified as informal carers it seems that the need to conduct a Carer's assessment (as required by the Care Act 2014) was not considered

6.2.6 The Care Act does not distinguish informal from formal carers. It describes a carer as *"an adult, who provides or intends to provide care for another adult"*[10] This description perfectly adequately describes what **M** and **N** were expected to do.

6.2.7 M and N should have been identified as carers requiring a formal assessment. Once completed greater support could have been provided to them to support them in their caring role.

Recommendation 2

That Harrow Council

- Considers whether the use of the term informal carer helps its staff operate consistently in accordance with the requirements of Care Act.
- Reassures itself that its process for conducting carers' assessments is effective in identifying those who are entitled to an assessment.

6.3 Reflection and Learning on the Impact of adverse childhood experiences in adulthood

6.3.1 "*Adverse childhood experiences (ACEs) are traumatic events that occur during childhood. ACEs can have a significant impact on a person's physical, emotional, and mental health throughout their life."* [11]

[9] Accessed at https://www.kingsfund.org.uk/sites/default/files/Securing_Good_Care_background_paper_6_.pdf
[10] Section 10 (3) Care Act 2014
[11] Medical News Today https://www.medicalnewstoday.com/articles/adverse-childhood-experiences

6.2.2 *"ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood."*[12]

6.3.2 The understanding of ACEs has grown since the 1998 publication of a US study of 17,000 adults whose lives had been affected by adverse events in childhood.[13] **M** and **N** suffered a range of adverse childhood experiences. These will have had an impact on how they managed their lives as adults and , of course, how they coped as carers for **B**

6.3.3 The Professionals at their meeting (29th November) were consistent in their view that those working in adult services require a good understanding of what impact ACEs may have on those with care and support needs or their carers.

6.3.4 **M** and **N's** childhood experiences were documented in some of the partner records. It is not clear that this knowledge challenged or changed the way that **M** and **N** were viewed as carers for **B**

6.3.5 There was no consistent view of **M** in particular. Sometimes he was seen as a protective factor for B and at others unhelpful and even a safeguarding risk.

6.3.6 The Professionals meeting agreed that further training for adult safeguarding practitioners in ACEs would improve practice and that it would be particularly effective if it was organised across both the Children and Adults Domains

Recommendation 3

- Harrow Council reviews its various assessment processes in relation to adults to see whether they reflect current understanding on ACEs.

- HSAB and HSCB arrange for a multi-disciplinary event that explores how ACEs go on to affect adults , whether as service users or their carers

6.4 Reflection and Learning on the Need for Multi-Agency Meetings

6.4.1 The review referred to at 1.10 explored issues concerning multi agency meetings in self neglect cases in some depth and many of the issues explored in that report (para 5.11.1 ff) are relevant to the issues contained in this review.

6.4.2 Generally speaking the most intractable cases are those which involve a variety of agencies. In this case The Local Authority, the Community Health Care Trust, General Practice, and the Care Provider were having interactions on an almost daily basis with

[12] Centre for Disease Control USA

[13] Relationship of childhood abuse and household dysfunction to manyof the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study accessed at https://pubmed.ncbi.nlm.nih.gov/9635069/

B, which each agency found difficult. In addition, later on **N,** with her baby were being worked with by Children's Social Care.

6.4.2 This case would have benefited from a multi-agency approach such is now described in the Harrow Self Neglect Protocol[14] This relatively new protocol was not published till March 2021, after the date of **B's** death. Its focus on multi agency working, resilience, experienced leadership and management offers good support for staff dealing with these cases and injects purpose and positivity into cases that can have a tendency to drift and suffer delay.

6.4.3 The follow up work from SAR A, which has seen progress against the recommendations has placed the Partners in a stronger position than they were beforehand. The HSAB should now reassure itself that progress is real and sustained.

Recommendation 4

The HSAB should review the effectiveness of the self-neglect policy to establish

- the quality and outcomes for service users of Harrow's multi-agency risk enablement panels.
- Its acceptance, understanding and adoption by the adults' workforce

6.5 Reflection and Learning on the use of mental capacity assessments

6.5.1 When service users refuse medical aid, physical assistance or other help, professionals are presented with a dilemma. Their instincts to safeguard and protect those who are vulnerable are challenged by their understanding of the importance for service users of self-determination and autonomy.

6.5.2 In the case of **B** she frequently refused services and care in ways that were to the detriment of her health and comfort. However, she was not consistent in her refusal of care; accepting some and objecting to others.

6.5.3 The Partner records make frequent references to **B** having the capacity to refuse care or treatment on the many occasions that she does so. However, she is never subject to a formal mental capacity assessment.

6.5.4 She was described from time to time as having a low mood. On more than one occasion she was described as being confused (possibly because of an infection) and she also engaged briefly with psychiatric service.

[14] https://www.harrow.gov.uk/downloads/file/23878/harrow-s-safeguarding-adults-board-hsab-protocol-for-self-neglect

6.5.5 In January 2019 she registered a score of 15 on the Montreal Cognitive Assessment Test for Dementia. A score of 22 indicates cognitive impairment and 16.5 indicates dementia.[15]

6.5.6 Cognitive scores can change over time according to circumstances. However, there were sufficient indications about B's mental functioning that meant that the assumption of capacity was at least worth testing with a formal capacity assessment.

6.5.7 This is a difficult area for professionals to operate in, with much being left to their judgement. Difficult cases are the ones that require the most partner input. Just as the issues of her self-neglect would have benefited from a multi-agency meeting , pulling together information and expertise from across agencies, so would the issue of her refusing help and treatment.

6.5.8 The Harrow self-neglect policy (the Policy) demonstrates admirable clarity in this respect. Each case that proceeds to the risk enablement panel is required to have a current formal mental capacity assessment. The Professionals meeting suggested that any service user that makes more than one decision to reject care against clinical advice should be the subject of a mental capacity assessment.

6.5.9 The Policy which post dates **B**'s death enables this approach, provided that the care and medical refusal poses a significant risk to health.

6.5.9 The effectiveness of the Policy depends on staff knowing about it and making appropriate referrals. Recommendation 4 , if accepted will establish the extent to which professional practice has changed since SAR A and since **B**'s death.

6.5.10 There are a lot of references in partner records to **B** refusing care and medical help, with no corresponding references to her being subject to a formal mental capacity assessment. This needs to be explored further by the HSAB.

Recommendation 5

> The HSAB to explore the feasibility of auditing partner records to establish their use of formal mental capacity assessments in cases where service users to the significant detriment to their health and wellbeing refuse care or medical treatment.

7. The Impact of the Pandemic on this case

7.1 Each agency was required to assess the extent to which the restrictions of the pandemic affected the services offered to **B** and her family.

[15] Described at https://www.verywellhealth.com/alzheimers-and-montreal-cognitive-assessment-moca-98617

7.2 It was apparent from the chronologies and reports supplied by the agencies that **B's** case was affected very little by the pandemic. She received frequent face to face visits and care. Her social care service was delivered uninterrupted and she was visited frequently by district nurses, General Practice and the nurse practitioner.

8. The failure of medical equipment

8.1 An early line of enquiry suggested that her air bed (supplied to help with pressure sore management) partially malfunctioned and took too long to replace.

8.2 While her bed did malfunction and it did take too long to replace, it transpired that the bed was supplied to a specification in excess of her needs. Even in its malfunctioning state it was both safe and medically satisfactory. So that issue had no impact on this case at all.

9. Conclusion

9.1 Reviews are about learning and improving practice. This review should be read in conjunction with SAR A. Much of what might have been recommended in this review was recommended in SAR A and some of the recommendations in that earlier report have already been enacted and procedures have already improved.

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

9.3 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 and also to those who took part in professionals engagement session on 29th November. Their candour, expertise and curiosity has added to what we have been able to learn from this process.

Appendix 1 - Schedule of Recommendations

Recommendation 1

- Harrow Council Adult Services assess the extent to which their Carers' Assessment Process takes account of the learning difficulties of potential carers.
- Harrow Council Adult Services updates the Carers' template on Mosaic so that it encompasses the necessary investigation into a Carers need as well as their abilities.

Recommendation 2

That Harrow Council

- Considers whether its use of the term informal carer helps its staff operate consistently in accordance with the requirements of Care Act.
- Reassures itself that its process for conducting carers' assessments is effective in identifying those who are entitled to an assessment.

Recommendation 3

- Harrow Council reviews its various assessment processes in relation to adults to see whether they reflect current understanding on ACEs.
- HSAB and HSCB arrange for a multi-disciplinary event that explores how ACEs go on to affect adults , whether as service users or their carers.

Recommendation 4

The HSAB should review the effectiveness of the self-neglect policy to establish

- the quality and outcomes for service users of Harrow's multi-agency risk enablement panels.
- Its acceptance, understanding and adoption by the adults' workforce

Recommendation 5

The HSAB to explore the feasibility of auditing partner records to establish their use of formal mental capacity assessments in cases where service users to the significant detriment to their health and wellbeing they refuse care or medical treatment.

Appendix 2

TERMS OF REFERENCE
SAFEGUARDING ADULT REVIEW: Adult/Family (Adult B)

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 11.05.21 and agreed by the Independent Chair of HSAB. This was in response to the death of a 72 year old woman (Adult B). There were concerns of self-neglect and possible neglect by her adult children who lived with her. She died in April 2021 after being admitted to hospital with severe bedsores.

B was known to a number of local services, but they experienced difficulties in engaging with her and it was unclear whether B had mental capacity when she refused their support. Her own children had been taken into care when young due to parental neglect. Subsequent discussion by the Case Review Sub Group revealed that B's children may have learning difficulties and therefore the issue of their ability to care for their mother also needed to be explored.

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 SAR 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 neglect was suspected. In addition, there were initial indications that agencies might not have carried out appropriate assessments of B and her carer's needs, nor of the safeguarding concerns that were suspected.
NB – The Panel noted some similar themes to another SAR that was coming to its conclusion. To avoid any unnecessary duplication of focus, it was agreed that this review should examine additional lines of enquiry, but ensure that the overall analysis is informed by learning from the other SAR.

2. METHODOLOGY

(i) The SAR will be overseen and managed by a Case Review Panel made up of the following professionals:

- Chair of the Case Review Sub Group
- Team Manager - Adult Social Care
- Designated Nurse – Adults
- Designated Nurse – Children
- Named Nurse – LNWUHT
- Head of Service – Quality Assurance – Children's Social Care
- Representative – Harrow Carers
- Business Manager – HSCB

(ii) The Panel will assisrws by an **Independent Overview Author** who will produce the final report for publication and will be supported by the HSCB's Administrative Officer.
(iii) Specified agencies will be requested to:

a) produce a detailed chronology of their involvement with Adult B and her family from **01.01.19** to the date of Adult B's last admission to hospital on **07.04.21.**
b) provide a report providing a **brief summary of background information** from all specified agencies covering their knowledge and history of involvement with the family prior to **01.01.19**

c) follow the above summary with an analysis of information contained within their agency's chronology where it relates to the lines of enquiry (listed below). A report template will be provided.

(iv)The Case Review Panel will analyse the summaries and chronologies – and where necessary address any quality assurance issues.
(v)The Case Review Panel will run a case discussion event for relevant front line practitioners and their managers to draw out additional learning.
(vi)Where appropriate, the views and experiences of key family members will also be sought to inform learning for the review. Advice will be sought about the best way of engaging Adult B's children.
(vi)An overview report will be produced and presented to both the HSAB and HSCB
(vii)The Case Review Sub Group will produce and deliver a programme to disseminate the learning across the partnership

4. LINES OF ENQUIRY

a) Was the response to this case impacted upon by the Pandemic and its associated restrictions? In particular, did this impact on the assessment of risks?

b) With regard to the medical equipment required, were faults addressed in a timely way and by the right agencies?

c) How well were the safeguarding issues managed in general? and specifically:

- Was the impact of the children's experience of neglect in their childhood considered in terms of their ability to be carers?
- What was the quality of response to the concerns of financial abuse?

d) How well was neglect and self-neglect understood by the agency? – and specifically:

- how well was Adult B's Mental Capacity assessed in this context?
- how well understood was the impact of B not being hydrated and suffering possible infection on her ability to make informed decisions?
- how well did partners manage the issue of B's pressure sores?

e) What was the quality of information sharing in general? – and specifically:

- Were there any complications presented by some services being provided out of borough?

f) How well were B's adult children assessed as carers:

- in terms of their ability to provide care?
- in terms of their own needs?

5. List of agencies and services participating in the review:

- **GP**
- **District Nursing – CLCH**
- **District Nursing - CNWL**
- **Adult Social Care**
- **Local Authority Occupational Therapy Service**
- **LNWUHT**
- **Care Agency – Capital Home Care**
- **Housing**

As the review progresses it is likely that specific information, queries and advice will be sought from:

- **MPS**
- **Legal Services (Local Authority)**
- **Medical Equipment Service**

6. **PUBLICATION**The final report will be anonymised and published on the HSP's website.

Appendix 3

Safeguarding Adult Review (SAR) Adult B; Practitioners' Event – 29th November 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 B,

- She died on 11th April 2021 aged 73
- A number of different agencies had had a lot of involvement with B over a number of years right up to her death
- The records reveal that there were some actions that could have been taken to safeguard her which were not followed through.
- She had four adult children two sons and two daughters and lived with the older son (M) and the younger daughter (N)
    - M (now aged 41) had learning difficulties.
    - N also had learning difficulties and in May 2020 gave birth at home to a baby following either a disguised or more likely an unknown (to her) pregnancy.
- From time-to-time concerns were expressed that M was financially abusing his mother.
- Her living accommodation was in a poor state, with evidence of clutter and poor levels of hygiene.
- She was obese and often refused care and help.
- Agencies were always clear that she had capacity to refuse care , but no formal assessment was done of her.
- She died in hospital following her admission 3 days previously for a gastrointestinal problem.

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 B, partner records reveal that of her four children, M had been known to be physically and verbally abusive towards her causing a safeguarding referral in 2015, N had been in foster care for periods of her child hood and P (the younger son) had an extensive criminal record. The older daughter T has few partner records .

1.5 M in particular and N to a lesser extent were often identified as being a protective factor for B, probably because the full family history and dynamics were not known.

1.6 This practitioners' event is being held so that those who were involved with B 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 B died on 11th April 2021, she was 73 years old and living in social housing with her adult son (M), who was then 41 years old.

2.2 The Harrow Case Review Group having considered that the death of B met the threshold of a SAR asked agencies who had had dealings with her 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 The chronology and detailed report covered agency involvement with B and her family from 1st January 2019 until her death.

2.4 The timespan was designed to include the period when B had most dealings with a large number of agencies and during which time her health deteriorated.

3 Agencies Involvement

3.1 Eight agencies[16] submitted chronologies and follow up summary reports covering the period described at 2.3.

3.2 Some themes reoccur in these agency reports. They include that B frequently refused treatment , advice and help. There were concerns expressed by various

[16] Harrow Council, Adult Social Care; Harrow Council, Housing Services; The Metropolitan Police Service; The London Ambulance Service; London North West Healthcare NHS Trust (Northwick Park Hospital);, Primary Care (B's GP), Capital Home Care Ltd and Central North West London NHS Foundation Trust.

agencies as to B's mental capacity. The agencies had an inconsistent view of the extent to which M was a protective factor in B's life.

4 Refusal of Care and Mental Capacity Assessments

4.1 Between 2019 and 2021 B made a number of decisions about treatment for herself that professionals identified as being detrimental to her comfort and well-being. No formal assessment of her capacity was undertaken even though the fact that she was deemed to have capacity was documented.

5. Family members as carers.

5.1 M lived with B throughout the period of B's greatest medical and social care need. Some agencies found him hard to engage , while other agencies assumed that because they lived together and he was her son he was a protective factor in her life.

5.2 Previously M had been suspected to be a safeguarding risk to B but that detail became obscured from professionals dealing with them later on.

6. What is expected of you?

6.1 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.

6.2 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.

7. Areas to be covered

7.1

Multi-agency working and information sharing
- Need for multi-agency meetings
- When to complete a formal mental capacity assessment.

7.2

Use of history – and professional curiosity regarding:
- history of abuse, neglect and family dynamics

7.3

Working with service users who refuse some care but not all.
- Financial and emotional manipulation by family members
- Assessing carers' suitability.

8. Conclusion

8.1 The nature of B's death and the conditions she lived in bears some similarities with another case that we have recently reviewed. We want to build on the learning from our earlier case so that we can equip ourselves better if we come across a similar set of events in the future.

8.2 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
Independent Chair
Harrow Safeguarding Adult Board

November 2021