Safeguarding Adult Review

RE: Gaynor

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1. Introduction

Section 44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adults Review (SAR). A review is required to be undertaken if the Board considers that there is significant learning to be gained across partner agencies.

Gaynor was taken to the Emergency Department in December 2021 requiring a critical level of health care. This was believed to be due to severe injuries to her body, thought to have been caused through self-neglect and a preliminary diagnosis of stroke. Gaynor later died. Cause of death has not yet been ascertained. Concerns were raised about the level of support afforded to Gaynor and her family in the 2 years prior to her death.

2. Process

This review considered a comprehensive multi-agency chronology and relevant records.

Written chronologies were requested from all services who were identified as being involved in the care of Gaynor. These were the following: Greater Manchester Police, Tameside Adult Social Care, Tameside Children's Social Care, Tameside Families Together, GP service for Gaynor and her son Tim, Tameside Integrated NHS Foundation Trust, North West Ambulance Service.

A learning review panel contributed to the findings and recommendations to ensure that actions resulting from this review complemented the improvement activities of the safeguarding partnership. Practitioners who were directly involved in the care of Gaynor also contributed to the review through a practitioner event held.

Contribution to the review was also received from Gaynor's son and her two daughters. An offer was made to Gaynor's brother who also lived at her property but this was declined.

The contribution of all those involved enabled a greater understanding of the context in which practitioners and managers worked at the time and maximised opportunities for organisational learning. It was also an opportunity for services to understand the difficulties faced by family members in working together to support each other when individuals within the family have a diversity of complexities within their lives

It was agreed that the review would consider the involvement of agencies with Gaynor from July 2020 to her death in December 2021. This date covered a period

of care when Gaynor was asked to become the main carer for her granddaughter, a child. Relevant information outside of these dates was also considered.

3. Terms of Reference of the Review

The review explored the following elements of learning:

- The interface between adult and children's multi-agency services.
- Issue around self –neglect
- Missed opportunities to raise a safeguarding
- Professional Curiosity
- Think Family Approach
- Referral Pathways and case closure
- Oversight of safeguarding concerns
- Organisations working in Partnership and Accountability
- Cause or allow a vulnerable person to come to serious harm

In this context consideration was given to:-

- Supportive decision making with people with capacity
- Professional approach to explore power and balance
- Roles of professionals when clients resist support with care
- Practitioner perception of the role of family as carers and the impact on care delivery

The review also promoted opportunities to explore examples of good practice and identify lessons to apply to current and future practice

The following six safeguarding principles are defined in the Care Act 2014 and the review will reflect these:

- **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** The least intrusive response appropriate to the risk presented
- **Protection** – Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding.

4. Membership of Learning Review Panel

Agency
Deputy Designated Nurse Safeguarding CCG (Reviewer)
TASPB Business Manager
DCI, Greater Manchester Police
Principal Social Worker, Adults, TMBC
Senior Nurse Safeguarding Tameside and Glossop Integrated Foundation NHS Trust
GMP, SCR Team
Head of Safeguarding, Pennine Care NHS Foundation Trust
Head of Quality and Safeguarding, Children's Social Care
TASPB Administrator (minutes)

The review panel members have not been directly involved in the case but have knowledge of the services and practices within the organisations which they represent. These members are, therefore, best placed to review the circumstances resulting in the SAR referral.

Practitioners from the organisations involved were invited to attend a practitioner event and contributed their perspectives as necessary. They were encouraged to be fully engaged in the review.

The Learning Review Panel met following the collation of the chronologies. Separate meetings were held so that there was a collaborative opportunity for reflection and confirmation of the learning points.

5. Accountability

The Learning and Accountability Principle, a sub group of the TASPB met to agree:-

- The conclusion of the Review

- Recommendations to TASPB
- Action Plan

6. The Family and Background Information

Gaynor lived in her own property. It had been the family home for many years and her children reported that they had lived there for most of their lives. Gaynor had been divorced from her husband, the father of her children, who had since died. She had worked as a registered nurse at a hospital. Gaynor had four children. Her son (Tim) and her two daughters reported to the author that Gaynor had become depressed after the death of her eldest son in 2010 and living at the home had become more difficult. All the children described the relationships between them all as being very fraught and believed that Gaynor was controlling. The family believed that it would have been difficult for Gaynor to accept help and support.

Gaynor's brother also lived at the family home at the time of her death. The family informed the author that this was because he had separated from his family and Gaynor had offered him some accommodation. He has declined the offer to contribute to the review.

7. Agency involvement

The Learning Review Panel requested chronologies from agencies who had provided care to Gaynor and analysis was undertaken so that learning could be identified. During the learning review panel meetings further information was sought from practitioners. A practitioner's event took place with the purpose of ensuring that practitioners who had been involved in the care of Gaynor were able to share their perspective of events. Relevant practitioners were also invited to participate in Learning Review Panel discussions as necessary.

8. Why were we worried?

Little of the information presented to the Panel identified worries about Gaynor. She was on the periphery of the information provided. Issues that were identified for family members had an impact on Gaynor's life and there were expectations from practitioners that Gaynor would be the main care provider to her family.

In March 2020, Tim (adult son of Gaynor) made a request directly to Tameside Adult Social Care (ASC). Tim said that he had needed to return home to live with Gaynor. He stated that their relationship was strained and needed help to secure alternative accommodation. Tim told ASC that he had a diagnosis of a number of health issues, including Autism and Asperger's syndrome. He was unemployed but working with an agency to secure work. Tim wished to receive help to identify some support networks

as he was no longer able to meet with his friends due to the Covid restrictions which were in place at that time.

Tim was referred to Tameside Families Together (TFT) who identified that they were already working with Tim. They identified that Tim was potentially being financially abused by his mother. Home conditions were described by practitioners as being "tense between all members". Tim told the practitioner that Gaynor had asked him to seek alternative accommodation. There is no evidence that practitioners undertook more formal action to ascertain more formal steps to understand the full nature of what may have been happening within the home. During this time period there is also evidence of physical abuse occurring between Tim, Gaynor and Gaynor's granddaughter (Ingrid).

A Child Protection Strategy Meeting was held in November 2020 after Ingrid made disclosure of physical abuse by Gaynor and Tim. The meeting identified unsuitable living conditions within the home but no further action was taken by Children's Social Care and there is no evidence that any information was gained from services working with the adults in the family. Adult services involved were aware of the allegations of physical harm being made by Ingrid but did not appear to offer any contribution to the strategy discussion. These enquiries continued until February 2021 and consideration was given as to whether there was a need for agencies to pursue criminal proceedings. Tim and Gaynor were asked to attend a police station but Tim said that Gaynor was now unable to mobilise and spent much of her time in bed. In addition practitioners were asked to provide an appropriate adult to help Tim in his interview with the Police. This investigation was not pursued as Ingrid did not wish to pursue criminal proceedings. A child protection case conference was convened and Ingrid was accommodated by the local authority.

In December 2020 TFT discussed the need to escalate helping Tim to find alternative accommodation. Tim had said that his mother had care and support needs and that he was required to help her meet her needs which he was reluctant to do. Practitioners discussed the skills which Tim possessed to live independently and believed that he would be able to do so. Concerns were raised about the health needs of Gaynor. It was documented that the Family Intervention Team described the condition of the physical environment of the home to be "*terrible*". There is no evidence that any practitioner followed up their concerns with any relevant agency and no action seems to have been taken.

In March 2021 an initial child protection case conference took place with respect to Ingrid. It was attended by Gaynor. In the meeting it was discussed that Gaynor was having problems with her mobility and concerns were raised about the standard of hygiene within the home. Gaynor said that she was struggling to do housework but there had been an improvement since her son had moved back to the family home. Gaynor said that she did not have a problem with getting up and down stairs. This was contrary to the assessment of the social worker for Ingrid. Decision was made at the conference for referral to be made to Adult Social Care so that some support could be identified for Gaynor. This referral was made.

In May 2021 a family intervention worker undertook a home visit after the referral from the Case Conference Chair. Discussion took place between the worker and Tim's worker that the home environment felt "toxic". Relationships within the household were described as being tense. An argument had ensued between Tim and Gaynor in which issues of alleged financial abuse were discussed. Practitioners believed that Tim was being financially abused although this is unclear. A number of family members had become involved in the argument and there was significant conflict. There is no evidence that practitioners undertook any further action with respect to allegations of financial abuse.

In June 2021 an incident occurred at the home in which both Ingrid and Tim sustained injury. Both alleged that they had been assaulted by the other. This incident resulted in Ingrid being placed into local authority care. Ingrid's social worker and Tim's GP made referral to Adult Social Care but as Tim's case was already open to the social prescribing team it was considered that this was a sufficient level of support to meet his needs. Decision was made to escalate to housing the need for Tim to be in his own tenancy.

In July 2021 police investigated a phone call made to Tim from a friend of his sister. In this call threats were made to Tim. Tim contacted his worker to let her know that he had needed to change his mobile number. The reason given was "to protect his mum from nuisance calls". The outcome of this investigation is not known.

In November 2021 Tim made a phone call to his worker. He said that his mother had fallen out of bed but he had been unable to lift her as she was too heavy. Gaynor was refusing any help and did not wish for him to call an ambulance. The worker advised him to call the ambulance service anyway.

North West Ambulance Service attended the incident. They returned Gaynor to her bed. Gaynor refused any treatment and signed a refusal of treatment form. Tim again reiterated to his worker that he felt unable to care for his mother.

North West Ambulance Service reported that Gaynor had fallen on the previous evening. They described the bedroom as being severely cluttered and that there was an excess of faeces on the floors of the household. The service noted that Gaynor was having great difficulty in mobilising due to the clutter and size of the room. Gaynor was said to be morbidly obese and this was contributing to her mobility problems. Gaynor refused to go to hospital and her mental capacity was assessed as being capable of making this decision. Gaynor did agree to a referral to Adult Social Care from the Ambulance Service.

Adult Social Care received a referral for Gaynor on the same day as the incident. A physiotherapist from the IUCT team attended the property on the following day. There was no response when the physiotherapist attended the property and the referral was closed.

On 06 December 2021 Tim made a phone call to his worker. He informed her that both Tim and his mother had been asked to attend the Police station to speak to the Police about the incident of assault which had occurred in July between Tim and Ingrid. Tim was described as being very anxious as he was unable to pay for a

solicitor, his mother had still not got out of bed and was now refusing to eat and drink. Tim felt that he was the only one caring for his mum and said that although his uncle lived in the house he was working for most of the day and night so Tim had become responsible for the care of his mother.

The worker made a referral to Adult Social Care. An IUCT worker contacted the family by telephone and made decision to call for an ambulance.

North West Ambulance Service attended. They described Gaynor as being unresponsive and considered whether Gaynor may have suffered a stroke. They found home conditions to be in a severe state of neglect and documented that there was an infestation of flies in the room where Gaynor had been found. There was evidence that Gaynor had been incontinent over a long period of time and her skin was described as necrotic. Due to her weight, excess clutter in the environment, size of the room and her clinical condition, a further ambulance crew was called to help Gaynor be transferred to hospital. There is some evidence that Gaynor had changed her sleeping arrangements to be downstairs between the crew's previous attendance at the property in November 2021.

Gaynor died on 10 December 2021. The Emergency Department at Tameside Hospital made a full referral to Police and Adult Social Care.

9. Analysis

Guided by the terms of reference for this review, specific themes emerged following a systematic analysis of all the available information, both from agency records and from the practitioner event, as well as discussion with the review steering group. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve multi-agency adult safeguarding practice in Tameside.

10. Overall quality of support offered to Gaynor and family by agencies

Much of the support which was received from the family was directed at other family members. This was specifically for Tim and Gaynor's grand-daughter Ingrid. Whilst it was clear that concerns were raised about Gaynor's physical and mental health, there was little regard made to considering that Gaynor was a vulnerable adult herself or the impact which any health difficulties identified would have on her ability to care for others.

Despite clear evidence, prompted by disclosures being made by both Tim and Ingrid, safeguarding of the family was fragmented and opportunities were missed in ensuring that the family was safe. There were a number of teams involved in the care of family members and although there was some evidence that they spoke with one another this was informally rather than a team round the family approach to care. Other key lines of enquiry have been identified in this review.

- The interface between adult and children's multi-agency services.
- Issue around self –neglect
- Missed opportunities to raise a safeguarding

- Professional Curiosity
- Think Family Approach
- Referral Pathways and case closure
- Oversight of safeguarding concerns
- Organisations working in Partnership and Accountability

11. Think Family Approach between adult and children's multi-agency services

It was evident from the information provided to the Panel that agencies involved in the care of family members responded appropriately to support meeting the needs of the individual who was the focus for their intervention. There was less evidence, however, identifying that practitioners were making assessments of how behaviours of one person within the home was impacting on others who were living there.

There were a number of assessments made by practitioners from services involved with each individual for whom assessment was required but these were not married up to ensure that all elements of care which were required could be carried out effectively and be of benefit to the whole family.

Whilst assessments identified the roles which others were expected to play in meeting the needs of an individual, there was not always more formal assessment undertaken to ensure that individuals were able to meet those needs or had a willingness to meet the expectations of practitioners to provide care and support. There is some evidence to suggest that practitioners made assumptions of Gaynor with expectations that she was willing to support family members within her home when this may not have been the case and when practitioners were already identifying that she had begun to have some physical health problems of her own. Whether this was because Gaynor denied some of her physical health problems or the possibility that there was an automatic expectation that she would care for others is unclear.

A think family approach to the care of families in Tameside has been identified in previous safeguarding reviews for both adults and children. The difference in this case is that those reviews have been focused on ensuring that the needs of adult carers were identified. In this case Gaynor was being expected to parent a child as well as care for adults. Her own ability and/or willingness to take on this role was not always evident.

Whilst there is some evidence that practitioners from services involved with the family had informal conversations with each other about their concerns, there is no evidence that there were more formal arrangements in place for discussion to jointly evaluate interventions, effectiveness of care and impact for all family members at the household. This was a missed opportunity which may have possibly identified the extent of Gaynor's physical health problems and the impact which this was having on others. An example of this was that Tim had told practitioners that he had become his Mum's carer. There is no evidence that Tim was challenged when he made this disclosure. There was no professional curiosity as to why he believed this to be so.

There was no attempt to ensure that a formal carer's assessment was planned or undertaken.

12. Response to Neglect and Self neglect

All agencies involved in the care of the family discussed concerns about the standards of hygiene in the property and the impact which this was having on the day to day living on all family members. Ingrid, as a child, raised concerns to her social worker about the living conditions. Although immediate measures were put into place to clean the property, there appears to have been no ongoing follow up as to whether a satisfactory standard had been maintained within the home or the sustainability of hygiene being maintained. When the author of the review spoke with Gaynor's family they reported that the hygiene within the home had been a long term problem and as children they had been expected to carry out housework routines and prepare food. They had not been shocked by the poor standard of hygiene which NWAS reported on their two visits to the home.

At the practitioner event it became clear that there was no assessment tool used to measure neglect used in adult services and so various agencies believed that the standard of hygiene within the home was either bad or good enough. There was not a shared understanding and so no clear plan to address the issues. In addition although the suitability of the home environment would have been assessed for a child to live there, there had been no use of the graded care profile. This is a tool used by multi agency services to assess level of neglect within a family home. This was a missed opportunity.

Recommendation 1: There is a need for a multi-agency assessment tool to be developed to assess the risk of harm from neglect within adult services.

13. Oversight of Safeguarding Concerns.

Whilst Gaynor is the subject of this review there was very little multi agency focus on safeguarding concerns being raised about Gaynor as a vulnerable adult. This mainly appears to be because Gaynor was believed to have the capacity to make decisions and because she was seen as a carer of others who were more vulnerable. There was evidence that practitioners had an expectation of the input required by Gaynor as a mother and grandmother.

There is evidence that Gaynor refused to identify that she was having deteriorating difficulties with her health and mobility. She had not accessed her GP for help and support. Although there were referrals made to Adult Social Care for help and support, Gaynor was reluctant to take these. Once Gaynor had declined care offered to her there was unilateral agency decision made to close the case. There was no opportunity for discussion between the referring agency and the receiving one which may have resulted in agencies either persisting with the referral or identifying alternative ways to support Gaynor.

Gaynor had expressed a wish that she wished to care for Ingrid. There is no information available from professionals as to why Ingrid was not cared for by her

parents. It is unclear why Tim had returned to the family home, as an adult, who had previously received his own tenancy due to the difficulties in his relationship with his mother. There was a lack of professional curiosity to understand what it was like to live within this household from the perspective of any of the residents living there including Gaynor. This meant that any safeguarding plans made would not be effective as alternative approaches would have been required to meet the needs of the whole family.

Safeguarding focus was, therefore, based upon the needs of Tim and Ingrid, who clearly had safeguarding needs but who also had workers identified to work directly with them. The focus therefore, remained directly on those individuals with Gaynor being required to be the in the role of carer.

There was no evidence that services were working together to look at the impact of adult and child safeguarding issues were having on Gaynor and her capacity to address this.

Even though services involved in the care of Tim and Ingrid were aware of ongoing conflict within the family and new allegations of abuse, there was no formal and agreed plan of next steps to take. Practitioners discussed the concerns between themselves but there was no formal escalation to prompt a multi-agency response to those concerns. Those discussions also appear to have seen Gaynor as a perpetrator of abuse rather than being a vulnerable person in her own right. Was there an assumption made that because Gaynor was a grandmother and a mother then there was an expectation that she should was an able care giver even when it was evident that her own physical health was deteriorating?

Recommendation 2: There is a need for Children's and Adult Social Care to jointly develop the team around the family approach to their care offers and take a shared approach to the accountability and responsibility of practitioners to recognise and respond to safeguarding concerns for all family members

14. Good Practice

The Children's Independent Reviewing officer at the initial case conference made prompt and appropriate referral to Adult Social Care to support Gaynor with issues about decline in her physical health.

North West Ambulance Service also made prompt and appropriate referral to services in the last month.

15. Conclusion

This review has identified that professionals from a number of agencies were working and providing support to the family. However there is a lack of evidence to demonstrate that services take time to reflect on the impact of their work. This is both with respect to impact on an individual who may be the focus of intervention and/or on those family members who are living alongside or contributing to the caring of the individual.

On reflection Gaynor was a vulnerable person. She did not regard herself to be so and was reluctant to take help. Practitioners did not consider her to be a vulnerable adult. There is some evidence to suggest that there was an expectation that Gaynor as a mother and grandmother ought to be providing care to others. Her family reported to the author that Gaynor had always been in control of trying to meet her own needs and those of her family. She had always refused the help of external agencies. They highlighted key events in the family history when this point was illustrated. These included Gaynor caring for her eldest son until his death and the care of their father. When services were offered to support and they were not accepted by Gaynor, there was no consideration to persist with the offer or help her to find alternative options which she may have considered as acceptable. In addition there was no consideration that perhaps she was unable to meet the needs of others if she was unable to care for herself. There was a lack of professional curiosity in caring for the family. When it appeared that Gaynor was refusing help there was a unilateral decision made to close the case even though this left issues raised as being unaddressed. The recommendation about practitioners from all agencies having formal protocols about case closure has been made in other children and adult reviews in Tameside and so further recommendation will not be made in this review.

Because Tim was seen as being able to meet his own needs independently, the impact on Gaynor and other family members was not undertaken. In addition there was no consideration that once he returned home that there would be expectations of a role which he would need to undertake there. This included helping his mother with household tasks and later providing some care to her. Tim told the author that he had left home previously as his relationship with his mother had been tense and he knew that when he returned that he would be unable to meet her expectations.

When her daughter left the family home, her daughter (Ingrid) was placed with her grandmother. Her daughter informed the author that Gaynor had requested this. However, it was evident that concerns were raised by professionals about Gaynor's physical health and about the home environment. Ingrid later made complaints herself about this. The views of Tim, which did not support Ingrid living with her grandmother were not sought. There is little information available to suggest that multi-agency children's services considered the whole picture when decision was made to place a child in that environment. There is evidence that practitioners spoke informally together and expressed their concerns but these were never escalated further or taken through formal adult or child safeguarding procedures.

A significant number of professionals who accessed the family home had been concerned about the standard of hygiene in the home and the inappropriate diet. Ingrid told her social worker that she had been expected to cook her own food and clean the house. At the practitioner event there was conflict evident between professionals who disputed the account given by North West Ambulance Service about the hygiene at the property and how this had directly impacted on Gaynor's physical health. Practitioners did not share the same views about good/ bad hygiene and its impact on the mental and physical help of an individual.

There is no assessment tool used in adult services, aligned to the graded care profile as is used in children's services for practitioners working with family to acknowledge risk of harm from neglect. Despite neglect being considered as a risk of harm to Ingrid, this tool was not used in the assessment for Ingrid.

The information provided for this review from both practitioners and Gaynor's family has identified that Gaynor did not consider herself to be vulnerable and practitioners did not consider the impact of the expectations placed upon her to provide care to others was unreasonable. Even though Gaynor expressed the wish to care for others on occasion, this offer ought to have been considered further from both the perspective of Gaynor's ability to care and the impact that this may have on others if Gaynor was unable to provide care to a good enough standard. Although there is evidence that Gaynor would have been unlikely to have accepted help and support offered, there is little evidence that she was offered such support and there was no consideration of alternative ways to help Gaynor.

16. Recommendations

Recommendation 1: There is a need for a multi-agency assessment tool to be developed to assess the risk of harm from neglect within adult services.

Recommendation 2: There is a need for Children's and Adult Social Care to jointly develop the team around the family approach to their care offers and take a shared approach to the accountability and responsibility of practitioners to recognise and respond to safeguarding concerns for all family members.

Recommendation 3: Practitioners who work predominantly within children's Services need to undertake at least Level 1 adult safeguarding training

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