SAFEGUARDING ADULTS REVIEW (SAR)

Elsie Wake (Jnr)
SAR Report

Independent Reviewer and Report Author: **Annie Ho**

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Prepared for: **Northumberland Children and Adults Safeguarding Partnership**

This review is

> '*talking about ordinary people – carers and cared for – who find themselves in potentially extremely difficult situations that they didn't choose, with immense emotional and practical implications for their lives*.'[1]

(a quote from a carer who contributed to the LGA/ADASS briefing note on 'carers and safeguarding', 17/02/2022)

'*Safeguarding is complex*'.
'*Sometimes there are no perfect answers: there are usually risks as well as benefits associated with all decisions. Adult carers are not a homogenous group. Their needs and circumstances are very diverse.*'[2]

'*Carers… may come to feel that it is "OK not being OK" when it is not and be left to get on with life.*'[3]

'There are dark days… feeling no one understands me, feeling very alone, feeling just on my own… It's a hard topic. It's time to talk about caring.'
(video 'Two sides of the story: Share that you care'[4])

[1] https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers
[2] ADASS Advice Note, *Safeguarding Adults 2011*, ADASS Safeguarding Policy Network April 2011
[3] ADASS Advice Note, *Safeguarding Adults 2011*, ADASS Safeguarding Policy Network April 2011
[4] https://www.youtube.com/watch?v=gHQ6hQ3SQUM

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1. Introduction

1.1 Brief overview of the circumstances that led to this review

1.1.1 This Safeguarding Adults Review (SAR) is commissioned by the Northumberland Children and Adults Safeguarding Partnership (shortened hereafter to NCASP) on the case of Elsie, following her death on 30/04/2024.

1.1.2 Elsie was 64 years old at the time of her death. She had multiple physical health conditions, further complicated by what was recorded as 'morbid obesity' which impacted on her mobility. She had a diagnosis of endometrial cancer diagnosed in March 2023. She had heart disease, atrial fibrillation, COPD, liver disease, arthritis and a history of falls along with tremors in her arms and legs. There were also reports and referrals for sleep apnea, swallowing, vaginal bleeding and significant anaemia

1.1.3 Elsie died in the ICU of the Northumbria Specialist Emergency Care Hospital (NSECH).

1.1.4 There was an open safeguarding at the time of her death.

1.1.5 The Coroner advised that, following the police investigation into possible neglect, the inquest has been discontinued. A natural cause of death was given on post-mortem of multiple organ failure, sepsis of unknown origin and stage 3 endometrial cancer, morbid obesity, chronic kidney disease and left ventricular hypertrophy.

1.2 Statutory duty to conduct a Safeguarding Adults Review

1.2.1 The Care Act 2014 stipulates that a Safeguarding Adults Board (SAB) must arrange for a Safeguarding Adults Review (SAR)[5] where:

- an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect; and
- there is reasonable cause of concern about how the Board, its members or others worked together to safeguard the adult.

1.2.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt from the adult's case and applying those lessons to future cases[6].

1.2.3 A SAR is not an inquiry into how someone died or suffered injury, or to find out who is responsible. The purpose is not to allocate blame or responsibility[7].

[5] Sections 44(1)-(3), Care Act 2014
[6] Sections 44(5), Care Act 2014
[7] Para 14.168, Care and Support Statutory Guidance updated 18/02/2025

1.2.4 SARs should reflect the 6 safeguarding principles[8] - empowerment, prevention, proportionality, protection, partnership and accountability.

1.3 NCASP's decision to conduct a review

1.3.1 At the Rapid Review meeting of 24/05/2024, all partners agreed that this case met the criteria for a SAR.

1.3.2 It is acknowledged that there is overlapping learning for both adults and children's safeguarding, and a whole family review approach should be adopted.

1.3.3 At the Safeguarding Adults Review Group (SARG) meeting of 8/11/2024, it was agreed that the membership of the SAR panel will include relevant representatives from adults and children's services.

1.4 The lead reviewer

1.4.1 Annie Ho is a registered social worker and is the independent lead reviewer of this SAR.

1.4.2 Annie has had many years of practice and senior management experience in local authority safeguarding adults and mental capacity work. She provides expert reports to the court in her role as an independent social worker, alongside her SAR work. Her direct engagement with vulnerable adults and their families continues to inform her work as an independent reviewer.

1.5 SAR Review Group membership and Terms of Reference for this review

1.5.1 At the first SAR panel meeting of 12/02/2025, membership of the SAR panel and the ToR of this SAR were agreed. The ToR was reviewed throughout the SAR process.

1.5.2 The membership of the SAR panel includes representation from relevant agencies relating to their senior management responsibility in decision making and oversight of quality assurance of the review, independent of operational responsibility in the case.

1.5.2.1 Northumberland County Council (NCC) Adult Social Care (ASC)

1.5.2.2 Northumberland County Council (NCC) Children's Social Care (CSC)

1.5.2.3 Northumberland County Council (NCC) Education: Schools Safeguarding Team

1.5.2.4 NHS North East and North Cumbria Integrated Care Board (ICB): on behalf of GP / Primary Care

1.5.2.5 Northumbria Healthcare NHS Foundation Trust (NHCFT)

1.5.2.6 North East Ambulance Service (NEAS)

[8] Para 14.166, Care and Support Statutory Guidance updated 18/02/2025

1.5.2.7 Northumbria Police: Strategic Innovation Partnership / Safeguarding

1.5.2.8 Bernicia: Housing Association

1.5.2.9 Carers Northumberland

2. Review Methodology

2.1 Communication with Elsie's family

2.1.1 Family engagement, if possible, is key to a Safeguarding Adults Review.

2.1.2 The SAB business manager and the reviewer made contact with Elsie's family by telephone calls, emails and remote meetings.

2.1.3 The reviewer was able to include the views of family members in this report, under relevant sections below.

2.1.4 The reviewer was unable to consult with Elsie's son as he has moved away and we have been able to obtain new contact details. The SAB business manager was able to visit him and give him a SAR leaflet shortly after Elsie died.

2.2 With the agreement of the ToR at the first SAR panel meeting of 12/02/2025, group members were asked to complete agency-specific Critical Analysis (CA) forms. This approach is aimed at promoting SAR panel members' ownership through their contribution to shared analysis and learning, adopting a peer challenge perspective without over-reliance on the expertise of the individual reviewer.

2.3 The CA forms are designed to aid proportionate and smart analysis by individual agencies of their involvement with Elsie. The important focus is on the context for practice at a single agency level, why particular actions were undertaken and decisions made.

2.4 The agency-specific CA form aligns with the SAR Quality Markers[9]. SAR Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what a good SAR looks like.

2.5 Three SAR Quality Markers are specifically referenced and highlighted for the attention of the SAR panel members and practitioners and managers. These include QM9 on assembling information, QM10 on practitioner's involvement and QM12 on analysis.

2.6 The reviewer offered one-to-one and group reflection meetings to key staff members of relevant agencies who were involved in the care of Elsie. These helped to provide insight to the reviewer of the challenges individuals / services faced in working on this complex case, and the learning they have taken to inform their continuing practice in safeguarding adults.

[9] https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers

2.7 An in-person practitioners learning workshop (stage 1 Learning Event[10]) was led by the reviewer on 3/4/2025, where practitioners of all agencies were invited to share with each other their reflection and learning from this case, and their analysis of what needs to change, what changes have already been put in place and what agencies can do to create further change. Participants were invited to adopt a peer challenge perspective and to share and extend their learning to a multi-agency level.

2.8 '*It is vital, if organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.*'[11]

2.9 Small group interactive exercises were used to gauge different agency representatives' level of understanding and knowledge of the SAR process, professional curiosity, legal literacy including mental capacity considerations and best interests decisions, the statutory safeguarding framework and partnership working.

2.10 The overall review methodology is aimed at developing a working relationship of trust with all partners and prompting an open learning culture.

2.11 To focus on learning, the review acknowledges that organisational and systemic factors can cause incidents.[12]

2.12 The alignment of practice perspectives with a systems approach enables the identification of enablers and barriers to good practice as well as systemic risks in the wider partnership.[13][14]

3. Review Scope

3.1 The review focuses on events from January 2021 until Elsie's death in April 2024.

3.2 Elsie and her family moved to her last address in 2011. Housing concerns were brought to light, including animals, clutter and fire hazards.

3.3 The reviewer invited the SAR panel members to include in the completion of their agency-specific CA forms, pertinent information outside of this

[10] https://www.researchinpractice.org.uk/media/hpsba3z3/developing-effective-safeguarding-adult-review-learning-events_pt_web.pdf
[11] Para 14.140, Care and Support Statutory Guidance updated 18/02/2025
[12] Safeguarding Adults Reviews under the Care Act: implementation support, SCIE March 2015 https://www.scie.org.uk/files/safeguarding/adults/reviews/care-act/safeguarding-adults-reviews-under-the-care-act-implementation-support.pdf
[13] Animation for strategic leads participating in case reviews https://biteable.com/watch/3872657/7b11f70eb5409fcb5e681015575e7027
[14] Animation for practitioners participating in case reviews https://biteable.com/watch/3867279/1296334c0b8ddeda1e2c48c9f8dc6e05

timeframe, with particular consideration of the questions under Key Lines of Enquiry (section 6).

4. Elsie: the person

4.1 The reviewer gathered minimal information about Elsie from professionals. She was able to get different perspectives from her family members.

4.2 Elsie had multiple complex physical health conditions. The reviewer's conversations with her family indicated that Elsie's mother also had some similar medical conditions.

4.3 Elsie had three daughters – adult 1, adult 2 and adult 3 (adult 1 being the oldest), and one son – adult 4 (adult 4 being the youngest).

4.4 Before she died, she was living at home with adult 3 and adult 4, and her two grandchildren, adult 5 and child A.

4.5 What individual adult family members shared with the reviewer appeared to indicate each one of them had particular physical and mental health concerns. Elsie considered herself and was considered by her family to be holding everyone together.

4.6 '*Everyone in the family needed something to be fixed.*' (adult 5)

4.7 '*Mum was focused on her family. Everything she did was for the family and for her mum.*' (adult 3)

4.8 From the family background details adult 3 shared with the reviewer, Elsie had experienced significant trauma in her life.

4.9 Elsie was an only child and she wanted a big family. Her brother was still-born.

4.10 Elsie's father died in 1994 (on Father's Day) from a heart attack. Her mother '*broke down*'. Elsie (at the age of 35) arranged the funeral and sorted his belongings after his death.

4.11 Elsie had been involved in the lives of her grandchildren since their birth. She took over the care of her grandson in 2003 and her granddaughter in 2014. Elsie made the decision to take child A out of school and elected home schooling from September 2018 for 5 years.

4.12 Elsie had a very close relationship with her mother. She used to help her mother a lot with charity fund-raising work and enjoyed meeting with other people.

4.13 The reviewer was unable to get any details from her family what Elsie's hobbies and interests were. Adult 5 shared that she did not have many opportunities to do what she wanted to do.

4.14 Her family believed that '*church was important to her*'. Records noted that when the family moved to the North East in 2002, they relied on support

from the church. Her husband remained in Telford. There was no information about this relationship and how important it was to her.

4.15 Elsie's mother had complex health problems. As her health deteriorated and she was experiencing short-term memory loss, both Elsie and adult 3 supported her wish not to move to a care home. Adult 3 had been living with Elsie's mother for 2 ½ years until she died, and then moved to live with Elsie.

4.16 '*I took after mum and mum took after gran.*' (adult 3)

4.17 Elsie was worried about her mother. Adult 3 said she was '*not allowed to go back home*' to see Elsie as she was told to '*put gran first*'. Adult 3 explained she was unaware until much later when she moved to live with Elsie on 25/02/2024 (the day Elsie's mother died), how much Elsie was deteriorating and how much child A was doing for Elsie.

4.18 Professionals described Elsie as chatty and polite and not a complaining person. She was more concerned about looking after everyone at home and holding everything together than about her increasingly deteriorating health.

4.19 Her family shared that Elsie had been hoarding for a very long time. She was embarrassed about the state of the house.

4.20 Her family described Elsie as a stubborn person.

4.21 Adult 5 referred to the 'good stubborn' side and the 'bad stubborn' side of Elsie. She 'instantly knew something was wrong with me' when he was badly bullied at school, and kept him from school for two months.

4.22 The reviewer noted from the submitted chronology that Elsie reported an incident to the police in September 2023 and talked about the experience of child A of abuse and threats on the estate for 3 years. It was recorded that Elsie '*broke down in tears during the call*'. She loved and deeply cared for her family.

4.23 Adult 5 described his close relationship with Elsie, referring to the two of them as '*two home bodies*'. Child A was at the neighbour's place most of the time. Adult 4 worked shifts and spent time at his friends' places after work. In effect, Elsie spent a lot of time every day downstairs whilst adult 5 was in his bedroom upstairs.

4.24 Her family shared that Elsie withdrew herself after her mother died, about two months before Elsie died. Her health deteriorated very quickly after that and she didn't want to move '*because of her grief*'. Adult 5 shared that Elsie was depressed before her mother's death.

4.25 '*All the fight had come out of her.*' (adult 1)

4.26 The family shared that the diagnosis of cancer significantly affected Elsie. '*I'm going to die anyway.*'

4.27 Elsie appeared to have been consistently resistant to engagement with services, despite some initial reception to offers of care and support.

4.28 Her family shared that Elsie did not like strangers in her home. It was indicated that the challenge of taking over the care of her grandchildren resulted in her mistrust of social workers.

5. Review Focus

The specific areas of enquiry requiring critical analysis include the following.

5.1 The voice of the person – working with an adult at risk who is not engaging with services; appropriate representation including applying the statutory duty of advocacy

5.2 'Team around the family' approach – partnership work between professionals involved with the adult at risk and the whole family

5.3 Partnership work between adult and children's services, where there were concerns relating to safeguarding adults and child protection

5.4 The consistency of the care provided by all organisations and professionals, management oversight and quality assurance, in line with expected standards of expected standards of primary legislation, statutory guidance and codes of practice, and relevant policies and procedures including:

5.4.1 Care Act 2014 – consideration of wellbeing outcomes and holistic assessment connecting physical health and mental health

5.4.2 Mental Capacity Act (MCA) 2005 – mental capacity considerations and assessment, application of the statutory principles in practice and best interests decision-making, including advance care planning and substitute decision-making authority

5.4.3 Safeguarding Adults, application of statutory principles and Making Safeguarding Personal

5.5 The understanding and application of professional curiosity

5.6 The understanding and application of trauma-informed practice

5.7 The concept of 'safe care at home' and the complex issue of abuse/neglect/inadvertent harm in familial care relationships

5.8 Inter-agency communication and information sharing and escalation, and partnership work including identification and agreement on different roles and responsibilities, case coordination and lead informing a multi-agency strategy for shared risk management and shared decision making, with clear actions and time frames

6. Key Lines of Enquiry

The key lines of enquiry are determined by the most important issues to be addressed in identifying the learning from this specific case.

6.1 Focus on the adult at risk

How were different agencies and professionals able to focus on EW's wellbeing and vulnerabilities, within the complex family dynamics and the needs of different family members?

Was Elsie's voice sought directly from her and recorded by professionals? How was Elsie's identity in relation to her family background and personal history understood by professionals?

6.2 Intersectional approach to safeguarding

What did professionals from different agencies understand about the whole family, including complex power dynamics and relationship inter-dependencies?

Were there opportunities for bringing the complexities under the statutory safeguarding framework?

6.3 Contextual safeguarding

What was the context of harm and neglect within the home and in the wider socio-economic environment, outside the home, considering the person's comorbidities and vulnerabilities?

What was the impact of the Covid-19 pandemic on the isolation of EW and her family?

Were there opportunities for bringing the complexities under the statutory safeguarding framework?

6.4 The carer and the cared for relationship

What was the impact on each other and on the family of the alleged arrangements of the care of EW by JW and of home schooling of JW by EW?

How were the care and support needs of EW met, and how were the care and support needs of JW met, and what were the implications of one on the other?

6.5 Mental capacity

How much was EW's mental capacity considered as the situation deteriorated?

Were other statutory principles of the MCA applied in the case?

6.6 Professional curiosity and trauma-informed practice

What would Elsie have liked to tell professionals? What was Elsie not telling professionals?

Perhaps Elsie needed a professional to 'stand in her shoes'. What would it have looked like?

What curious questions did professionals not ask / could they have asked her (and her family)?

How did each partner understand the situation and communicate their understanding with each other?

7. Thematic Analysis

The key themes here are taken from section 5. The themes are grouped to provide a helpful critical analysis and to inform recommendations from this review.

7.1 **The voice of the person** – working with an adult at risk who is not engaging with services; appropriate representation including applying the statutory duty of advocacy

7.1.1 The known history of the changeable level of Elsie's engagement with services and latterly the increasing disconnection from professionals, should have raised questions long before her significant deterioration in 2024 about the 'real voice' of Elsie, hidden behind what she presented to professionals.

7.1.2 It does not appear to the reviewer that professionals were able to see beyond the presenting problem and find the person and her identity underneath.

7.1.3 Elsie appeared always to put on a front to her family and professionals that she was in control. She was perhaps unable to find the voice to say she was no longer holding everything together, to understand what was happening for her and to ask for help.

7.1.4 At the learning workshop, the reviewer shared that perhaps Elsie needed a professional to '*stand in her shoes*'. For someone like Elsie, professionals need to challenge their assumptions, as well as the person's own and their family's assumptions.

7.1.5 In order to keep communication channels open with Elsie, it appears that professionals maintained a less intrusive (though respectful) approach. She was not questioned about the continuing hoarding and clutter in the house. Her response was accepted at face value that adult 4 was the hoarder and he was clearing the clutter.

7.1.6 Elsie's disguised compliance and her reported compliance of adult 4 was not questioned by professionals.

7.1.7 If professionals had asked more direct questions without making assumptions of Elsie's predictable responses, they could have helped her understand that she was hanging onto '*things to do with the family*' (adult 3), including her deceased mother's. She was clearly unable to

move from the same physical and emotional space she had remained for a very long time, at significant risk to herself.

7.1.8 Over time, what professionals considered as a more balanced and more proportionate approach, resulted in less direct (hardly any face-to-face) contact with Elsie and direct observations of her living conditions and care arrangements at home.

7.1.9 This had perhaps resulted in repeating patterns of professional offers and Elsie's responses, reinforcing over time professionals' fixed ideas and over-pessimistic view of her potential and aspiration for change, which in turn allowed Elsie and her family to believe the same.

7.1.10 The brief professional contact and intervention appeared to promote Elsie's right to private and family life. The fine balance between allowing her choice and control and ensuring her safety continued to be managed in the same way, even when her physical and mental health was significantly deteriorating.

7.1.11 There was good practice of individual professionals treating her with respect and dignity. However, her progressive endometrial cancer was causing her continuing vaginal bleeding and issues with hormone treatment in the absence of the option of surgery. This and her multiple medical conditions were complicated by her 'morbid obesity' which increasingly impacted on her mobility.

7.1.12 The reviewer noted adult 5 was the only family member who brought up what Elsie must have felt about taking more pills and having '*trouble with bodily functions*'.

7.1.13 Child A shared she nagged Elsie to go to hospital about her bleeding and felt that Elsie 'blamed' her when she found out she had cancer.

7.1.14 It did not appear to the reviewer that individual professionals considered or understood about her serious health condition and the significant distress and inconveniences this was causing her. Elsie did not tell and she was not asked.

7.1.15 From April 2023 when she was informed of the diagnosis of endometrial cancer to being recommended against surgery, then admitted to hospital as an emergency in July 2023, informed of progression of cancer to grade 3 in February 2024 and died in April 2024, she would have been feeling pain and fear.

7.1.16 The consultant obstetrician and gynaecologist shared in his reflection meeting that Elsie appeared to be more concerned about other people in the family she cared for than about her own health. The anaesthetist recorded that they touched on her '*social circumstances and caring responsibilities*'. These significant encounters with Elsie could have provided opportunities for appropriate information sharing with relevant professionals, to ensure she received the necessary support.

7.1.17 The reviewer asked the consultant for his clinical view on Elsie's rapid decline and death. He explained that progression of her cancer could have been faster as it was not possible to treat her in the normal way. He reflected that she could have suffered from depression, stopped taking her medication and neglected herself.

7.1.18 The surgery operated a 'usual GP' system, which means they are able to promote good practice by maintaining continuity of care with patients as much as possible.

7.1.19 The GP records noted a 'long consultation' with Elsie in November 2023 when Elsie presented with unexplained weight loss, choking sensation and dysphagia, and shared about difficulties with coping at home. The GP made a referral to the Primary Care Network (PCN) for a community link worker but Elsie declined after a one-off telephone conversation.

7.1.20 This happened when Elsie's cancer was progressing and she was told that surgery would never be a solution for her. The 'long consultation' was not followed up or shared with ASC.

7.1.21 In December 2023, Elsie completed a patient online questionnaire about cancer care. The ICB noted that her symptoms were impacting on several areas of her daily living and her response identified issues she wanted to explore.

7.1.22 These were missed opportunities when Elsie unusually opened up and admitted she was no longer able to do it all.

7.1.23 Her family shared that Elsie knew her cancer was terminal and she '*gave up*'.

7.1.24 Elsie was never registered with the surgery as housebound. Her usual GP explained there was no reason for her case to be discussed at their monthly multi-disciplinary team (MDT) meetings. Appointments required Elsie to attend the surgery, so her home environment was not observed except one home visit a few days before she died when adult 3 and adult 4 reported that she was breathless.

7.1.25 Every time she was delivered 'bad news' at a hospital appointment, letters must have been sent to the surgery for information. If Elsie was not flagged in any way on the surgery's systems, these letters could have been filed away without consideration by the GP of her deteriorating medical condition.

7.1.26 Reflection and learning on the voice of the person

7.1.26.1 The NCASP 'Principles of Engagement' document highlights the importance of appropriate use of language in recording. '*Terms like "failed to attend" and "difficult to engage with" place the emphasis solely on the person, there may be external factors impacting on a person's ability to engage.*' This may also affect the way another professional may approach the case.

7.1.26.2 It emphasises that professionals should recognise the extent to which a person's vulnerability may impact on their ability to engage. There was lack of consideration by professionals to explore with Elsie how her vulnerability impacted on her ability to engage and ask what else could be happening. (see section 7.7 on professional curiosity)

7.1.26.3 This NCASP guidance also highlighted the importance of remembering that a person's engagement may fluctuate. '*Just because a person has not engaged with services in the past, it does not mean that this will always be the case. This time it might be different.*' It reminded professionals to be 'tenacious with clients'.

7.1.26.4 The NCASP 'Safeguarding Adults Plus Size Guidance' was not known to professionals who attended the learning workshop.

7.1.26.5 '*Living with overweight is linked to a wide range of physical health problems, and is also associated with poor psychological and emotional health and poor sleep… sedentary lifestyles and depression.*' '*Plus size individuals are at risk of malnutrition due to illness, resulting in lethargy and depression.*'

7.1.26.6 All of the above risks clearly applied to Elsie. It is unclear whether these risks were not visible to professionals, or whether they were too polite to have the necessary difficult conversations.

7.1.26.7 In the individual reflection meetings, some practitioners shared that Elsie indicated she was in low mood but this was not further followed up.

7.1.26.8 '*The key message for practitioners is not to walk away… due to non-engagement, but to remain persistent, patient and respectfully interested and professionally curious.*'

7.1.26.9 To be respectfully interested and professionally curious in this case, practitioners would have to be sensitive as well as courageous to support Elsie to talk about the inconveniences and discomfort and anxiety she was experiencing (and largely trying to ignore), to help her understand what was happening to her and then to explore with her what help she needed and wanted.

7.1.26.10 This informs recommendation 1.

7.1.26.11 There were complex relationship dynamics in the circle of support for Elsie. It appears she was supporting everyone when she had no meaningful support from anyone (except child A who was providing help with personal and domestic care).

7.1.26.12 The reviewer posed the question to professionals at the learning workshop how Elsie's identity in relation to her family background and personal history was understood. They shared they were not aware of a lot of the information which the reviewer

gathered. They acknowledged the importance of putting together a pen picture of the person, including their history, as part of any assessments.

7.1.26.13 Professionals shared their reflection that Elsie needed a 'trusted professional', someone who could have built a relationship with her and facilitated her understanding of her personal circumstances and her family situation.

7.1.26.14 Whilst professionals were limited in remaining persistent and patient, considering other work pressures, an independent advocate or befriender could have afforded Elsie the time to be listened to and for a trusting relationship to be developed.

7.1.26.15 The offer and introduction of an advocate who is completely independent of statutory services could have addressed the power imbalance between professionals with designated authority and Elsie, considering her mistrust from her previous experience of child protection. She could have been more open to advice and support from someone independent of statutory services. It may have provided an opportunity to shift the difficult family dynamics and helped to ease her increasing sense of isolation.

7.1.26.16 The reviewer noted that the young carers service coordinator of Carers Northumberland shared that Elsie always engaged with her as she was '*no threat to her*', and Elsie '*started agreeing things*' about the care of child A.

7.1.26.17 Carers Northumberland's chronology indicated that Elsie's engagement with them became inconsistent over time and then completely stopped when adult 3 moved to the family home after the death of Elsie's mother.

7.1.26.18 When the Team around the Family (TAF) meetings started, it was agreed that the coordinator was to be the main point of contact with Elsie regarding child A's absence from school, so as to alleviate stress.

7.1.26.19 There could have been opportunities for an advocate to give Elsie time and propose creative options of supporting her alongside the involvement of her family.

7.1.26.20 It is statutory duty under the Care Act for an adult at risk to have the support and representation of an appropriate person during care and support processes '*for the purpose of facilitating an individual's involvement*'[15] and in safeguarding processes. If appropriate representation by their family is limited, advocacy should be offered.

[15] Section 67-68, Care Act 2014

7.1.26.21 Independent Advocates support people to be fully involved in a local authority assessment, care and support planning, care review or safeguarding process. Professionals need to know the broader duty to provide independent advocacy under the Care Act.[16]

7.1.26.22 This informs recommendations 2 and 3.

7.2 **'Team around the family' approach** – partnership work between professionals involved with the adult at risk and the whole family

7.2.1 It was clear to all professionals that Elsie's family was important to her.

7.2.2 The telephone conversation and remote meetings the reviewer had with Elsie's family provided an insight into the complex power dynamics and relationship inter-dependencies within the family.

7.2.3 Elsie did not appear to acknowledge she was a 'carer' although she was carrying the burden of being the family '*matriarch*' (adult 4). It must have been frightening for her when she began to realise the burden was getting heavier and becoming unsustainable, and she could not go on any longer.

7.2.4 The understanding and acceptance of her family in Elsie's matriarch role could have resulted in their continuing assumption of her independence and therefore over-estimation of her ability to look after herself (and to look after child A).

7.2.5 It appears to the reviewer that Elsie did not consider herself as a carer or fully understand the responsibilities she had always taken on. She and her family did not question or evaluate their assumptions as her health deteriorated and the family situation changed.

7.2.6 As circumstances deteriorated, the focus of attention was on child A as a young carer and not on Elsie as a carer in her own right.

7.2.7 Carers Northumberland shared that most of their work as an organisation is with adult carers. Elsie was not registered as a carer with them.

7.2.8 It may have been possible for staff of the local carers organisation or an advocate, independent of social and health care, to open up conversations with Elsie about her relationships with different family members and the increasing impact these had on her mental and physical health.

7.2.9 The ASC social worker acknowledged in her reflection meeting with the reviewer that she was '*confident*' in Elsie's family and assumed the adults in her family were assisting her.

[16] Para 7.64, *Care and Support Statutory Guidance* updated 18/02/2025

7.2.10 Other professionals appeared to share in this rule of optimism and assumed that adults in her family were the protective factors for Elsie.

7.2.11 Elsie's downstairs living and sleeping (on the sofa) arrangements were not questioned. Clutter was '*not at a concerning level*'. Professionals who managed to see Elsie at home on a small number of occasions, seemed to have '*accepted that her living arrangements were good enough*'.

7.2.12 At the one home visit the social worker made, Elsie talked a lot about her mother and adult 3. After adult 3 moved to live with Elsie, she responded to calls and providing updates, often putting Elsie on the loudspeaker so there was a three-way conversation with the social worker. There were missed opportunities of taking advantage of adult 3's engagement and finding out directly from her what was happening to Elsie.

7.2.13 The social worker shared her reflection that her concern for Elsie was overshadowed by her concern for child A.

7.2.14 The police shared in their critical analysis that Child Concern Notification (CCN) was raised in August 2023 and April 2024 when they attended the property. The first concerned issues child A was experiencing with children in the local estate. The second was requested by CSC social worker when access to the property was not allowed.

7.2.15 No Adult Concern Notification (ACN) was raised on either occasion. The reporting of the second occasion indicated clear concerns about the living condition and health condition of Elsie and should have triggered an ACN to be made.

7.2.16 The police shared that officers tend to make submission about the more prevalent concern, i.e. the concern about the welfare of child A, although they can raise both CCN and ACN at the same time.

7.2.17 The additional complexity of consent and mental capacity of adults may explain the relative lack of ACNs. Officers are more likely to note that the adult is unable to care for themselves or chooses the way they live, instead of naming self-neglect.

7.2.18 Professionals acknowledged at the learning workshop that no meaningful attempt was made to involve or consult with the family in order to understand the whole family situation.

7.2.19 Adult 5 has a diagnosis of autism and was previously known to CSC and the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). He was consistently isolating himself in his bedroom upstairs. He often answered the door to professionals as he was always in and yet professionals did not think about having any conversations with him,

when he was the one who perhaps shared the most time at home with Elsie.

7.2.20 Adult 4 has a diagnosis of autism and dyslexia, and was registered with the same GP. He referred himself to the mental health crisis team in January 2023 as he had thoughts to end his life. He was diagnosed with depression and started medication in February 2023.

7.2.21 NEAS recorded a total of 7 calls adult 4 made to the Emergency Operations Centre for health-related matters for himself, most of which took place in 2022 although none of them resulted in an ambulance disposition.

7.2.22 Police records noted some involvement of adult 4 as a victim of low-level crimes.

7.2.23 If professionals had spoken directly to adult 4 at some point, we could have perhaps explored how he felt about calling emergency services for himself and for Elsie.

7.2.24 When Home Safe staff spoke with adult 4 on 30/04/2024 before Elsie died, adult 4 openly shared his views. He described the property as mouldy and never cleaned. He stated that Elsie was a hoarder and had given up since her diagnosis of cancer, and was further impacted by the death of her mother. Adult 4 said there was no family support or professional input.

7.2.25 Other family members shared that adult 4 had violent outbursts. Elsie explained this was '*just normal*' for him, although child A said Elsie were also scared of adult 4.

7.2.26 Adult 3 shared that she suffered from depression. She made contact with CNTW following a period of decline in her mental health after Elsie's death.

7.2.27 The palliative care nurse took time to speak with adult 3 to find out what she and the family knew and understood about Elsie's health. It appears to the reviewer that this was the first recorded formal discussion when the whole family was considered, on the day Elsie died.

7.2.28 Adult 3 also explained adult 4 does not like to be in hospital and therefore left after a short time. This could have been further explored if professionals involved both of them much earlier in looking at what Elsie needed help with, considering they were the two older adults living with her at home.

7.2.29 Adult 1, mother of adult 5 and child A, suffered with mental ill health when Elsie's grandchildren moved to live with her. Elsie stopped communication and contact with adult 1 until the date of the funeral of Elsie's mother. Adult 1 shared that she has a diagnosis of post-traumatic stress disorder (PTSD).

7.2.30 Adult 2 did not move with the rest of the family in 2002 and remained in Telford. She had physical health concerns.

7.2.31 Included in this complex network was Elsie's neighbour. Child A spent a lot of time in the neighbour's place and returned home only to cook for Elsie and to sleep.

7.2.32 The reviewer noted little reference to this neighbour. She could have been considered as someone important to Elsie or child A and the family. She could have been involved and consulted about Elsie's care and support, including contingency planning, and especially in relation to her concern for child A.

7.2.33 Reflection and learning on 'Team around the family' approach

7.2.33.1 It appears to the reviewer that professionals continued to respect (rightly) the right of Elsie to private and family life, although it should be highlighted that Article 8 right is qualified and not absolute.[17][18]

7.2.33.2 Article 2 right to life and Article 5 right to liberty and security are limited rights. They can only be restricted in explicit and finite circumstances.[19] These could have been further explored and applied in this case.

7.2.33.3 A Think Family approach needs to be embedded in safeguarding adults and safeguarding children work, including 'Think Safeguarding' and 'Think Relationships'.[20]

7.2.33.4 '*In order to safeguard vulnerable adults and children we have to support families to make changes that are helpful and long lasting and we need to work with all the members of the family. If we understand and recognise that the needs and desired outcomes of each person in the family affect each other, we are more likely to support and enable sustainable change.*'

7.2.33.5 It is important to understand that family means different things to different people, and to explore this with the whole family which may include significant others (the neighbour in this case).

7.2.33.6 Making a genogram helps to map and identify intergenerational patterns and their significance and impact on current problems.

[17] https://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/7
[18] https://www.equalityhumanrights.com/human-rights/human-rights-act/article-8-respect-your-private-and-family-life
[19] https://www.local.gov.uk/sites/default/files/documents/Practice_Tool_8_Providing information about the Human Rights Act WEB.pdf
[20] https://www.warringtonsafeguardingpartnerships.org.uk/p/i-work-or-volunteer-with-adults/think-family-think-relationships-1

7.2.33.7 A Think Family system has '*no wrong door*' – contact with any one service gives access to a wider system of support. '*Individual needs are looked at in the context of the whole family, so clients are seen not just as individuals but as parents or other family members.*' [21]

7.2.33.8 '*Systemic Practice is an approach to bringing about change with individuals and families through paying attention to and working with their relationships, past experiences and social circumstances. This way of thinking underlines the complex interactions which affect people's lives and ability to cope, and places the focus on the problem, rather than the person.*'[22]

7.2.33.9 '*Systemic practice recognises that these factors interact to create family dynamics and patterns which have a strong influence on children's* (and adults') *wellbeing and outcomes. Families can find themselves stuck in unhelpful patterns or scripts that make it difficult for them to meet their* (*children's*) *needs.*'[23]

7.2.33.10 This is addressed in 9.8 and 9.9.

7.2.33.11 Research by Carers UK highlighted the additional stress and risks the Covid pandemic posed for family carers, including deteriorating mental and physical health and increasing exhaustion and social isolation.[24]

7.2.33.12 The potential of Family Group Conferencing (FGC) and other options of mediation with the family could have been explored with Elsie as the person at the centre of decision making, supported by an experienced FGC coordinator and independent advocate.

7.2.33.13 FGC may be beneficial where someone has care and support needs and where families/support circles need to talk together about problems or concerns and find solutions.[25]

7.2.33.14 In this case, FGC could have been used to enable family-led decision-making[26], whilst focusing on the vulnerabilities of Elsie and also of child A.

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[21] https://data.parliament.uk/DepositedPapers/Files/DEP2008-0058/DEP2008-0058.pdf

[22] https://www.warringtonsafeguardingpartnerships.org.uk/assets/17da3096/think_family_think_safeguarding_think_relationships_strategy.pdf

[23] https://www.warringtonsafeguardingpartnerships.org.uk/assets/17da3096/think_family_think_safeguarding_think_relationships_strategy.pdf

[24] https://www.carersuk.org/news-and-campaigns/our-campaigns/our-previous-campaigns/caring-behind-closed-doors/

[25] https://www.researchinpractice.org.uk/adults/publications/2017/june/what-is-a-family-group-conference-for-adults-brief-guide-2017/

[26] https://www.researchinpractice.org.uk/children/content-pages/videos/using-family-group-conferences-to-enable-family-led-decision-making/

7.2.33.15 There are examples from other Councils of areas of good practice in the application of FGC in working with adults, which would provide learning for this case.[27] [28]

7.2.33.16 This is addressed in 9.10.

7.3 Partnership work between adult and children's services – concerns relating to safeguarding adults and child protection

The reviewer has shared concerns and learning separately with the Safeguarding Children Business Manager and the Chair of the Children's Review Group. These are to be followed up in a proportionate way, outside of this SAR. This section provides an overview summary and brief analysis of the key relevant issues.

7.3.1 Elsie's identity had to be understood within her family. Her role and responsibilities with regards to her children and her grandchildren must have been very important to her.

7.3.2 Adult 5 appreciated how much Elsie looked out and stood up for him when he was bullied.

7.3.3 Elsie reported to the police in September 2023 that child A had experienced abuse and threats on the estate for 3 years. The police recorded that Elsie shared during this call that '*she was struggling to walk and struggling to take care of everything*'. She said '*her granddaughter is her carer and her son and grandson have autism and do not help*'. This was a missed opportunity to share relevant information and raise alert with ASC and CSC.

7.3.4 Elsie cared deeply for her grandchildren and especially for child A, being the youngest in the family. Child A referred to the '*normal nan*' of her initial years in Elsie's care, but she was unable to share with the reviewer details of happy times due to the very difficult relationship they later had.

7.3.5 CSC records noted the view that child A should remain in the care of Elsie as her maternal grandmother '*who will safely meet her everyday needs*' and will also '*manage a high level of contact*' between child A and her mother. The reviewer noted that when the Residency Order was granted in 2014, the recommendation was made of the gradual return of child A to her mother's care.

7.3.6 Elsie must have felt it was important for her to be the protector of child A and found it very difficult when the role reversal came along with her deteriorating health. She found herself in a situation when adults in her family who had always expected her to be holding everything together,

[27] https://fgcforadults.org.uk/
[28] https://www.scie.org.uk/news/opinions/family-group-conferencing

were not able to think about what she needed from them instead. She was not used to asking for help and they were not used to offering help.

7.3.7 When Elsie attended the hospital appointments where she received bad news, no adults in her family were with her. Child A absorbed all the distress Elsie experienced.

7.3.8 Elsie initially saw herself as the carer for child A. Child A shared that she was caring for Elsie as well as for the rest of the family.

7.3.9 As Elsie's health continued to decline, child A increasingly struggled to care for Elsie and the rest of the family.

7.3.10 With the complete role reversal between the cared for and the carer, both Elsie and child A appeared to be trapped in that deteriorating situation.

7.3.11 Child A's self-referral to Carers Northumberland started a series of events which were completely out of Elsie's control.

7.3.12 Child A shared with me that getting help from Carers Northumberland '*normalised*' the situation for her. She was named as a '*young carer*' – she came to realise that it was normal for young carers to feel the way she did and other people were worse off. She felt guilty and questioned herself for complaining too much.

7.3.13 Elsie must have come to some kind of acceptance of the situation when she agreed with child A's return to school, at the request of Carers Northumberland. This would have been a critical time to explore who was going to provide Elsie with the care and support she needed.

7.3.14 Child A was spending more and more time at the neighbour's place. No one was able to care for Elsie behind the doors she had kept closed.

7.3.15 Perhaps if professionals had gone inside, they would have discovered a very different reality of the relationship between Elsie and child A.

7.3.16 Adult 3 explained that Elsie found attending the TAF meetings very hard. When child A stopped speaking to Elsie after the fourth (last) meeting, '*it tipped her over the edge*'.

7.3.17 Adult 3 believed that Elsie was waiting for the social worker's visit on 30/03/2024 to sign the S20 paperwork, perhaps to get the assurance that child A was going to be taken somewhere else to be looked after, before she agreed to hospital admission.

7.3.18 This may indicate Elsie's thinking that when she had to give up the care of child A, no one else in the family could have stepped into this role.

7.3.19 Adult 3 shared that Elsie did not want to let child A go but it was eventually a kind of relief for her.

7.3.20 Professionals shared at the learning workshop there is a need for formal systems to ensure robust connection and joined-up work between ASC and CSC.

7.3.21 It was noted at the time of the Residency Order in 2014 that child A '*has a positive relationship with all of her immediate family members*'.

7.3.22 In the absence of a Think Family approach, child A's relationship with her family and with Elsie in particular deteriorated. She was socially isolated and was a victim of anti-social behaviour on the estate. By the time she openly disclosed at TAF meetings her self-harming behaviour, she shared she was physically exhausted and at breaking point with her mental health.

7.3.23 It appears to the reviewer that child A felt let down and was removed in a traumatic way when Elsie was critically ill.

7.3.24 Child A shared in her one-to-one meeting with the reviewer her anger with her grandmother and the complete breakdown of her relationship with Elsie. Earlier interventions through joint working between ASC and CSC could have brought about different outcomes for both Elsie and child A.

7.3.25 Reflection and learning on partnership work between adult and children's social care

7.3.25.1 The risks of harm to Elsie and the risks of harm to child A appeared to have been assessed and addressed separately without joined up thinking.

7.3.25.2 Carers Northumberland shared from their internal review that there were different routes for raising safeguarding adults concerns (email submission of completed form) and safeguarding children concerns (telephone referral).

7.3.25.3 The referral process needs to be accessible for referrers. The pathways should inform joined up assessment and timely actions, including providing updates to the referrer.

7.3.25.4 Lack of communication between children's and adult social care has been identified as a key theme from the 'Learning into Practice Project', the analysis by NSPCC and SCIE of national themes from Serious Case Reviews. In this analysis, there were examples in which potentially useful information held by adult social care (ASC) was not shared with, or sought by, children's social care (CSC).[29]

7.3.25.5 This analysis highlights a lack of understanding in children's and adult social care of each other's roles and how to work together in order to attain a whole-family assessment to protect both children and vulnerable parents.

[29] https://www.scie.org.uk/safeguarding/children/case-reviews/learning-from-case-reviews/14.asp

7.3.25.6 There is an additional layer of complexity due to the issue of consent in the work with adults. There is a lack of shared understanding about when consent is needed. Professionals in ASC may be concerned that seeking consent from the adult to share information may have a potential risk of breaking down working relationships.

7.3.25.7 Effective joint working between ASC and CSC is also hampered by overall capacity pressures. The lack of resources and time makes professionals work in an insular way.

7.3.25.8 It is helpful to understand the particular circumstances of this case within the wider context of kinship care. Research shows that many kinship carers live in impoverished circumstances, and this impacts on the children. 3 out of 4 kinship carers experience financial hardship.[30]

7.3.25.9 Whilst kinship carers generally show a high level of commitment, children in kinship care and their carers receive much less support than those in the care system.[31]

7.3.25.10 The reviewer is curious about how much Elsie (and her family) understood what she was taking on when adult 5 and later child A were moved to be cared for by her, what significant impact this would have had on her and others in her family, and what support[32] she could have accessed.

7.3.25.11 This is addressed in 9.13 and 9.14.

7.4 Care Act 2014 – consideration of wellbeing outcomes and holistic assessment connecting physical health and wider wellbeing

7.4.1 There were good reasons for the focus of professional interventions on Elsie's physical health and complex medical conditions, especially in her later years.

7.4.2 There were missed opportunities of understanding what was really going on for Elsie and her family, at a much earlier point when her physical health started changing and declined significantly after the death of her mother. Holistic assessments including conversations about choices and options under advance care planning (including consideration of Lasting Power of Attorney for health and welfare decisions and financial decisions) and additional support for Elsie, could have been undertaken before the situation became unsustainable.

[30] https://frg.org.uk/policy-and-campaigns/kinship-care/
[31] https://frg.org.uk/policy-and-campaigns/kinship-care/
[32] https://kinship.org.uk/support-and-advice/advice-and-information/prepare-for-being-a-kinship-carer/

7.4.3 The assessment of need completed during Elsie's hospital stay in July 2023 recorded her neglect of personal hygiene needs and her family's concerns that she was not showering/bathing regularly, and her diet including convenience food (e.g. chicken nuggets; empty takeaway boxes were observed amongst the clutter in the living area).

7.4.4 Elsie agreed to Short Team Support Service (STSS) reablement support 3 times per week for showering and monitoring personal hygiene and skin integrity. When Elsie later declined support at home, it would mean that the concerns about her personal hygiene and skin integrity were no longer addressed or monitored.

7.4.5 There appears to be a clear link between the decline of Elsie's physical health and the deterioration of her mental health. Her medical conditions impacted on her mobility and depression, which her family noted had been present before she lost her mother.

7.4.6 Health and social care professionals largely worked in silos. There were no attempts of intelligence information sharing and pro-active communication, until very late before Elsie died.

7.4.7 Information should have been triangulated between Elsie's cancer progression, attendance of child A at hospital appointments, distress of child A during hospital admission, and signs of her withdrawal and resignation after Elsie lost her mother.

7.4.8 The assessment in July 2023 also noted that Elsie was independent with self-administration of medication. As her mental health declined, it could be questioned whether she also gave up on the many pills she was prescribed for and whether she was taking her medication.

7.4.9 There was a clear health and safety risk for Elsie in the event of a fire and other emergencies, as she was unable to mobilise quickly or be safely assisted for evacuation. Practitioners were aware of the potential risk and shared with the reviewer they had considered making a referral to the Fire service for assessment, but this remained to be unaddressed.

7.4.10 NEAS recorded when they moved Elsie on 29/04/2024, the downstairs of the property was cluttered and evacuation assistance was requested to support extraction.

7.4.11 Reflection and learning on holistic assessment connecting physical and wider wellbeing

7.4.11.1 The continuing separation of consideration, assessment and decision making between the physical health and the mental health of Elsie was questionable. This hampered consideration of essential information sharing and risk management.

7.4.11.2 It is clear for a long time that many of the wellbeing outcomes under section 1(2) Care Act were not being fully met for Elsie. These include:

(a)personal dignity (including treatment of the individual with respect);

(b)physical and mental health and emotional wellbeing;

(c)protection from abuse and neglect;

(d)control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);

(e)participation in work, education, training or recreation;

(f)social and economic wellbeing;

(g)domestic, family and personal relationships;

(h)suitability of living accommodation;

(i)the individual's contribution to society.[33]

7.4.11.3 Recommendations from the national SAR analysis highlight '*the importance of holistic assessments, including risk and mental capacity, followed by detailed care planning that… gives parity of esteem to mental health and physical health needs*'.[34]

7.4.11.4 This is analysed further in other relevant sections.

7.5 Mental Capacity considerations and best interests decision-making – mental capacity considerations and assessment, application of the statutory principles in practice and best interests decision-making, including advance care planning and substitute decision-making authority

7.5.1 '*The person making the determination must …so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*'[35]

7.5.2 Regardless of the determination of Elsie's mental capacity for different specific decisions, professionals had a statutory duty to follow Principle 2 of the MCA – supporting decision making. When Elsie continued to cancel appointments and services, it is questionable how much she was supported with her decision making, perhaps with the involvement of her family.

7.5.3 '*He must consider, so far as is reasonably ascertainable –*

(a)the person's past and present wishes and feelings…

[33] https://www.legislation.gov.uk/ukpga/2014/23/section/1/enacted
[34] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[35] Sec 4(4) MCA 2005

(b)the beliefs and values that would be likely to influence his decision if he had capacity, and

(c)the other factors that he would be likely to consider if he were able to do so.'[36]

7.5.4 It is reasonable to assume that Elsie had strong beliefs and values in family relationships and her role and responsibilities within her family.

7.5.5 It is also reasonable to assume that Elsie wished to feel safe, to be connected with her family, to feel free from pain and to live a long life.

7.5.6 Both adult 3 and adult 5 shared with the reviewer the importance of the church for Elsie. When adult 3 was asked by the palliative care nurse what would be important to Elsie shortly before she died, adult 3 referred to her family and her Morman faith. The church elders visited earlier and offered her a blessing.

7.5.7 It is more challenging and, perhaps, more important to consider her past and present wishes and feelings. This would not have been possible unless professionals invested the time to find out and understand from Elsie what she felt and why she felt the way she did at different times.

7.5.8 '*Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*'[37]

7.5.9 '*An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*'[38]

7.5.10 It appears to the reviewer that Elsie was considered by most professionals during their interventions to have mental capacity for relevant decisions. As direct contact was limited, it is not possible to conclude about her mental capacity although there were reasons to consider and question whether assessment was necessary.

7.5.11 During her hospital stay at NESECH in July 2023, the nurse delivering care to Elsie formally assessed her capacity and determined that she lacked capacity for relevant care and treatment decisions. An urgent authorisation for Deprivation of Liberty Safeguards (DoLS) was issued.

7.5.12 It was good practice that Elsie's mental capacity was reviewed three times during this short admission, and all the assessments concluded the same.

[36] Sec 4(6) MCA 2005
[37] Sec 1(6) MCA 2005
[38] Sec 1(5) MCA 2005

7.5.13 It was noted that Elsie later presented as very upset that she had experienced confusion whilst she was acutely unwell. It must have troubled Elsie in knowing she was confused and not in control.

7.5.14 Adult 3 believed that Elsie was '*still sound of mind*' when she called the ambulance. She explained that Elsie told her she had to be at home to sign the S20 paperwork.

7.5.15 The CSC social worker shared her doubt with the reviewer about Elsie's capacity when she signed the S20 paperwork.

7.5.16 NEAS records noted that when they moved Elsie on 29/04/2024, she consented to assessment by the paramedics and also consented to the crew making a safeguarding referral to the local authority.

7.5.17 Professionals shared in the learning workshop that Elsie's mental capacity for different relevant decisions should have been periodically considered and reviewed.

7.5.18 Reflection and learning on considerations of mental capacity and best interests decision-making

7.5.18.1 Consideration of supporting Elsie with decision making would have necessitated listening to and finding out the real voice of Elsie, her wishes and feelings, beliefs and values, providing her with relevant, accessible information and considering the additional support of someone independent of statutory services.

7.5.18.2 The continuing decline of her physical and mental health condition should have prompted professionals to start conversations in a timely way with her and her family about advance care planning, including consideration of Lasting Power of Attorney (LPA) for health and welfare decisions and financial decisions, and other relevant support services.

7.5.18.3 Whilst the case of Southend-on-Sea Borough Council v Meyers reveals a very different set of circumstances, the conclusion of Hayden J provides a clear reminder of necessary and proportionate intervention with human rights.

'The judgement is a stark reminder that reliance upon the presumption of capacity and the 'right' of individuals to make unwise decisions cannot, in and of itself, discharge public bodies of Article 2 ECHR to take practicable steps to secure that person's life.'[39]

7.5.18.4 This informs recommendation 4.

[39] https://www.39essex.com/cop_cases/southend-on-sea-borough-council-v-meyers/

7.6 Safeguarding Adults and Making Safeguarding Personal – applying the statutory principles and the statutory framework of Safeguarding

7.6.1 The home environment including the continuing clutter and Elsie's living arrangements, whilst her physical health and mobility were deteriorating, alongside declining interventions and not having support from other adults in the family, could have been brought at an earlier time under the statutory safeguarding framework with the local authority leading the decision and maintaining oversight.

7.6.2 It appears from the records that the review of potential risks was cursory and focused on face-value information without critically analysing the underlying concerns.

7.6.3 During her hospital admission in July 2023 when an occupational therapist completed an assessment with Elsie and gathered information about how she functioned at home, she herself brought up the fact that her home was cluttered but '*her son was in the process of decluttering and taking a trailer load of stuff to the tip today*'. This was not further explored with her.

7.6.4 In August 2023, a worker from the home visit team of the Department of Work and Pensions (DWP) reported to NCC's Enquiry and Referral Coordination (ERC) Team (front-of-house call service) their concerns about the state of Elsie's house and clutter, her sleeping arrangements in the living room and her care by child A. This was a missed opportunity for raising a safeguarding concern and for review and joint working between ASC and CSC.

7.6.5 It was good practice for the GP to agree to a joint visit at the request of the social worker, in February 2024, due to concerns about Elsie not engaging with services and professionals not being able to access the property. This did not take place as Elsie declined and adult 3 did not engage. This was a missed opportunity for consideration of safeguarding and consultation with the safeguarding team.

7.6.6 This appeared to be overtaken by the sudden turn of events when Elsie's mother died.

7.6.7 Elsie's cancellation of care arrangements in February 2024 later led to case closure by ASC in March 2024. It was recorded that child A had support from CSC and Carers Northumberland, but there appeared to be a lack of exploration and progression of the safeguarding concerns relating to Elsie (instead of child A). An unannounced home visit could have triggered a formal safeguarding response.

7.6.8 It was not until after the TAF meeting of 11/04/2024 that a joint visit between ASC and Bernicia was arranged, but this did not happen due to the rapid decline and death of Elsie.

7.6.9 Bringing the increasing concerns under the statutory safeguarding framework much earlier and in a consistent and robust manner would have brought about the formulation of a multi-agency strategy and protection plan.

7.6.10 It also appears from records and from reflection with professionals that there were assumptions of protective factors at home as there were other adults living in the same place, when in fact they were unable to look out for and attend to Elsie's increasing care and support needs.

7.6.11 Professionals acknowledged at the learning workshop that child A and the neighbour were also assumed to be protective factors for Elsie.

7.6.12 Practitioners were reminded at the learning workshop of the key criteria under the Care Act 2014 of determination by the partnership of undertaking a SAR.

'*… an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect*'[40]

7.6.13 The reviewer observes from her work in SAR that social and health care professionals often find it difficult to name the abuse / neglect when it comes to familial harm with the person's home, whether intentional or unintentional. (see 7.9)

7.6.14 The statutory safeguarding process provides a formal framework for addressing carers issues in this complex case. '*Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include – a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.*'[41]

7.6.15 '*When risk increases in relation to carers unintentionally or intentionally harming or neglecting the adult they support, often the carers are themselves vulnerable… feeling emotionally and socially isolated… and have no personal or private space, or life outside the caring environment.*'[42]

7.6.16 'Neglect' is stated in the Care Act as a form of abuse. The statutory definition of domestic abuse introduced by the Domestic Abuse Act 2021 includes different types of relationships, including familial relationships.[43]

[40] Sections 44(1)-(3), Care Act 2014
[41] Para 14.45, *Care and Support Statutory Guidance* updated 18/02/2025
[42] https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers
[43] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet

7.6.17 When Elsie attended Emergency Department and was admitted to hospital in July 2023, a nurse noted child A was presenting to be unkempt and crying on the ward.

7.6.18 Adult 3 and adult 4 were informed that a children's safeguarding referral was submitted since Elsie was child A's main carer and child A was stating she was Elsie's main carer. This should also have raised adult safeguarding concerns.

7.6.19 Making safeguarding personal and professional curiosity (see 7.7) should be central to practice to support safeguarding both carers and the person they care for. Timely and careful assessments should be provided for both the carer and the person they are caring for[44], including understanding the competing needs of each and having separate focus on each.

7.6.20 Safeguarding concerns relating to the complex dynamics between the cared for person and the carer do not discredit the importance of that close relationship to the cared for or the dedication of the carer, even when harm or neglect is unintentional.

7.6.21 Contextual safeguarding seeks to understand the context of harm and neglect within the home, in relation to the wider socio-economic environment, considering Elsie's comorbidities and her vulnerabilities (and her family's).

7.6.22 Practitioners shared with the reviewer the context of the area of deprivation where Elsie and her family lived. Elsie was protective of her grandchildren on the estate.

7.6.23 Adult 5 shared with the reviewer that the family discovered paperwork of loans after Elsie died. '*Her health and money problems piled up*', with increasing bills for five people in the house.

7.6.24 Although church was important to Elsie, she was having increasing mobility issues and suffering with pain and breathlessness due to asthma. Taxi fares were too expensive.

7.6.25 The contact form of the gynaecology clinical nurse specialist recorded a call from a Macmillan welfare benefits caseworker about Elsie's eligibility for SR1 (benefit claim under Special Rules for individuals who are expected to have a life expectancy of 12 months or less due to a terminal illness).

7.6.26 There was no evidence in the records of Elsie's financial circumstances. Adult 5 indicated to the reviewer that he gave his benefit money to Elsie. Adult 4 appeared to be the only person who was employed and earning an income. Elsie did not share and professionals did not ask questions.

[44] https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers

7.6.27 On 29/04/2024 when NEAS moved Elsie from her home to hospital, they made a safeguarding referral due to the level of neglect they observed.

7.6.28 Professionals shared at the learning workshop that if concerns were flagged under the safeguarding framework, a different outcome might have been achieved for Elsie.

7.6.29 Reflection and learning on applying the Safeguarding Adults framework and Making Safeguarding Personal

7.6.29.1 At the learning workshop, professionals were asked to consider how the application of the six statutory principles of safeguarding would have looked like for Elsie. This provides an important insight to the gaps in practice of the application of Making Safeguarding Personal in this case.

7.6.29.2 Professionals shared in their reflection that they were perhaps overly focused on the principle of proportionality without fully considering the importance of the other statutory principles.

7.6.29.3 The use of narrative and 'I statements' should be person-led and help 'meaning-making' for the person. Professionals need to be able to step out of institutionalised frameworks and procedures from time to time – '*be able to deconstruct any stereotypes or conditions that are preventing expression and engagement with the person's own voice*'.[45]

Elsie's 'I statements' may have looked like these.

Empowerment – '*I want to have choice and be able to choose what happens for me.*'
The MCA principle of supporting decision making further promotes a person's sense of agency and autonomy. Consider what information may help the person, and make sure it is clear and simple.

Prevention – '*I want to be safe. I want to live without being hurt.*'
People often don't know what is happening is neglect and is not safe, and they need that explaining to them.

Proportionality – '*My family is important to me. I want you to take time and only get involved as much as needed. I don't want you to change everything at once.*'
Professionals need to be persistent and tenacious, whilst respecting the pace the person chooses. Consider the least intrusive response appropriate to the presenting risks. It is not always possible to achieve the person's desired outcomes.

[45] https://www.local.gov.uk/sites/default/files/documents/Practice_Tool_5-six_core_principles FINAL WEB.pdf

Protection – '*I may not want safeguarding because I value connection with my family.*'
People often don't understand the purpose and value of safeguarding, and they need that explaining to them in a sensitive way. Consider support and representation for the person in the safeguarding process.

Partnership and Accountability – '*I need to know and trust the professionals, who is doing what.*'
People need to understand professionals share information and work together to keep them safe.

7.6.29.4 The definition of adult safeguarding refers to '*people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action*'.[46]

7.6.29.5 Effective safeguarding work comes from multi-agency working with a coordinated and planned approach. Partner agencies should have a clear understanding of each other's roles and responsibilities, and work together to develop applied knowledge of the necessary and proportionate use of legal powers in safeguarding adults, sharing risk assessment and sharing decision making.[47]

7.6.29.6 Multi-agency strategy and planning meetings should include legal advice as a core element of management of complex cases, and clear time frames for exhausting all less restrictive options before pursuing legal options. This requires careful planning under partnership arrangements for assessing and managing risks, instead of crisis management.

7.6.29.7 This is addressed in 9.6 and 9.7.

7.6.29.8 It may be helpful to consider wider cross-partnership dialogue and agreement on raising professional understanding of neglect and the application of this in practice with adults at risk.

7.6.29.9 The wider context of Covid and austerity needs to be considered. Research has evidenced the important link between social isolation and a person's vulnerability to harm and abuse, and the overall adverse impact on the person's wellbeing. Complex family dynamics could potentially further increase the risk of social isolation.

[46] Para 14.7, *Care and Support Statutory Guidance* updated 18/02/2025
[47] http://londonadass.org.uk/wp-content/uploads/2015/02/Pan-London-Updated-August-2016.pdf

7.6.29.10 Safeguarding work must include conscious analysis of equalities considerations and implications of intersectionality.

7.6.29.11 Intersectional approaches can help us '*ask hard questions about social inequalities*', centring the experiences of adults with marginalised and stigmatised identities within the wider socio-economic context. It offers a framework that can be used to foster a more nuanced understanding of how interlocking oppressions manifest in everyday experiences for the people who need adult services.[48]

7.6.29.12 This is addressed in 9.11-9.13 and also informs recommendations 6 and 7.

7.7 The understanding and application of professional curiosity

7.7.1 Practitioners shared at the learning workshop their over-optimism about the protection Elsie's family was assumed to provide, and their continuing reliance on the reported updates from Elsie in the absence of other concrete evidence.

7.7.2 What Elsie was willing to share could be very different from the daily reality at home, in complete isolation behind closed doors.

7.7.3 Professional curiosity means questioning assumptions including over-optimism, addressing professional anxiety about working with hostile or resistant individuals/families, being willing to have challenging conversations and holding respectful scepticism.[49]

7.7.4 The 'rule of optimism' could have been related to professional reliance on the outward appearance of resilience of Elsie, someone who had clearly overcome challenges of her family circumstances (although professionals only had minimum knowledge) and limitations of her health.

7.7.5 Research shows that 'normalisation' is a barrier to professional curiosity, where ideas and actions come to be seen over time as 'normal' for that person. Elsie was able to maintain and present the story she wanted professionals to hear; her privacy was respected and there was not enough challenge to her based on the clear recognition and assessment of potential risks.[50]

[48] https://socialworkwithadults.blog.gov.uk/2020/01/31/why-intersectionality-matters-for-social-work-practice-in-adult-services/
[49] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf
[50] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf

7.7.6 It appears that escalating risks should have warranted professional intervention before the crisis stage.

7.7.7 Professionals shared the importance of always having a 'plan B', and relying less on optimism. Contingency planning allows for '*thinking the unthinkable*' and '*believing the unbelievable*'[51].

7.7.8 Whilst risk enablement should involve working with the person in a strengths-based way, accumulating and escalating risks should have been treated seriously, when continuing engagement with the person became increasingly difficult.

7.7.9 Respect for privacy, in working with the complex family dynamics of this case, stifled professional curiosity.

7.7.10 It appears that the 'doing' a lot of the time was undertaken at a single agency level. What was missing was a clear lead on decision making and coordinated joint working in an increasingly complex situation.

7.7.11 Reflection and learning on professional curiosity

7.7.11.1 The first national analysis of SARs (April 2017 – March 2019) highlights the need for practitioners to 'exercise sufficient professional curiosity' and 'authoritative doubt'.[52]

7.7.11.2 *'Autonomy was valued and promoted without attention to risk mitigation… Poor recognition meant that sometimes practitioners were simply not worried enough to take action.'*[53]

7.7.11.3 The concept of 'relational autonomy' provides a holistic account of autonomy – '*individuals throughout their lives will require the support of others to facilitate their agency and autonomy skill*'.[54]

7.7.11.4 Some familial relationships could have promoted Elsie's agency and autonomy and other relationships did not appear to, although they were all important to her.

7.7.11.5 Relationships matter, but an adult at risk needs more than relationships. Practitioners at the learning workshop were asked to reflect on whether Elsie had a circle of support as her grip was weakened and eventually lost.

7.7.11.6 The rule of optimism may result in professionals' uncritical efforts to see the best, concerns about consequences of

[51] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf
[52] https://www.local.gov.uk/sites/default/files/documents/National SAR Analysis Final Report WEB.pdf
[53] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[54] Kong, Camilla and Ruck Keene, Alex (2019). *Overcoming challenges in the Mental Capacity Act 2005*. London: Jessica Kingsley Publishers.

intervention, minimising concerns, not seeing emerging patterns or not ensuring a consistent focus on the person at risk.[55]

7.7.11.7 Professional curiosity means questioning assumptions including over-optimism, addressing professional anxiety about working with individuals/families, being willing to have challenging conversations and holding respectful scepticism.[56]

7.7.11.8 '*Sometimes, professionals may place undue confidence in the capacity of families to care effectively and safely*.'[57]

7.7.11.9 This is '*a well-known dynamic in which professionals can tend to rationalise away new or escalating risks despite clear evidence to the contrary.*'[58]

7.7.11.10 'Safe certainty' is used to describe an approach which is focused on safety but takes into account changing information, different perspectives and acknowledges that certainty may not be achievable.[59]

7.7.11.11 Professional curiosity should be central to practice to support safeguarding both carers and the person they care for. Timely and careful assessments should be provided for both the carer and the person they are caring for[60], including understanding the competing needs of each and having separate focus on each.

7.7.11.12 Other barriers to professional curiosity include the lack of support and clear direction from supervision, complexity and pressure of work, which are directly linked to resourcing gaps across health and social care.

7.7.11.13 In the face of increasing risks of harm to the vulnerable adult and the absence of meaningful and concrete change, professionals need to ask '*so what*' and then '*so what*'.

7.7.11.14 This is addressed in 9.12.

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[55] ADASS Advice Note, *Safeguarding Adults 2011*, ADASS Safeguarding Policy Network April 2011

[56] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf

[57] *Carers and Safeguarding Adults – working together to improve outcomes*, ADASS Advice Note April 2011 https://www.adass.org.uk/adassmedia/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf

[58] https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-Professional-Curiosity-Aug-2022-Final-.pdf

[59] https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/

[60] ttps://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers

7.8 The understanding and application of trauma-informed practice

7.8.1 This focus theme was not included in the first version of the ToR of this SAR. Further analysis of records and reflection with practitioners revealed the significant trauma experiences of Elsie which perhaps explained her thinking and her relationships with her family and professionals.

7.8.2 Without spending time to listen to and find out directly from Elsie her story, the impact of trauma on her continuing deterioration in physical and mental health was left unexplained and unexplored.

7.8.3 There were missed opportunities of exploring directly with Elsie and helping her understand what had been going on for her.

7.8.4 During a hospital appointment in April 2023 when '*distressing information*' (unfit for hysterectomy due to multiple comorbidities, heart issues and weight) was shared with Elsie with the accompaniment of child A, it was documented how upset she became.

7.8.5 When the CSC social worker attempted visit on 12/04/2024, Elsie was heard saying through the opened door, '*I can't be bothered. I've just lost my mum.*'

7.8.6 Trauma informed practice was lacking in this case. It is unclear whether this was due to professionals' fear of asking 'concerned curiosity' type questions and having challenging conversations or the failure to see the whole picture.

7.8.7 Reflection and learning on trauma informed practice and professional curiosity

7.8.7.1 '*There needs to be a greater focus on loss and trauma. Adverse childhood and adult experiences, involving loss and other trauma, are known to lie behind many manifestations of self-neglect. They can impact on people's behaviour, such as disengagement, and on their physical and mental health… Developing a trauma lens in health and adult social care practice is required.*'[61]

7.8.7.2 What could have been helpful for Elsie was for professionals to move beyond a task-oriented approach to a more personalised, trauma-informed approach.

7.8.7.3 A trauma-informed approach includes '*the need to see beyond an individual's presenting behaviours*'[62]. It helps to explain the continuing and repeating pattern of the individual's responses.

[61] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[62] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

7.8.7.4 There is a direct link between trauma experiences and neurological changes, hence disabling the person from executive functioning.[63]

7.8.7.5 Executive functions are critical to goal-directed behaviour. Disruptions in executive functions have been consistently replicated in samples of adults exposed to trauma.[64]

7.8.7.6 This informs recommendations 4 and 5.

7.9 Safe Care at Home

7.9.1 It did not appear that professionals spent time to analyse critically and work together to get to the nub of the issue, what care at home was really like for Elsie, and the significant adverse impact of isolation on her as the carer of child A (and the rest of her family) and later as the cared for (by child A without support from the rest of the family).

7.9.2 Professionals appeared to look narrowly either at the care and support needs of Elsie or those of child A, without critically analysing the long-standing and complex co-dependencies of relationships within the family unit.

7.9.3 When professionals were asked to name the abuse or neglect Elsie's death resulted from, the majority put down self-neglect. Professionals' responses were focused on what Elsie did and not did, e.g. putting others' needs before her own, not engaging with services, grieving for the loss of her mother, hoarding, lack of education about medical care, poor hygiene and poor nutritional intake. There was little understanding of what was going on at home and therefore limited recognition of neglect outside of the label of self-neglect.

7.9.4 The CSC social worker requested police attendance in April 2024 when Elsie refused access. It was noted in the recording that the smell in the property made the social worker '*feel physically sick*'.

7.9.5 Another CSC social worker reported on 29/04/2024 when Elsie was removed, that '*the smell was overwhelming*'. She shared with the reviewer that what she saw was shocking, considering her many years of experience in CSC work.

7.9.6 Placing Elsie's vulnerabilities alongside the needs of the different family members is important for understanding what neglect was, i.e. safe care at home was not happening for her.

7.9.7 In the context of the family dynamics and relationship inter-dependencies, Elsie and her family around her were perhaps all

[63] M.D. Bessel van der Kolk (2015) The body keeps the score.
[64] El-Hage, W., Gaillard, P., Isingrini, M., & Belzung, C. (2006). Trauma-related deficits in working memory. *Cognitive Neuropsychiatry*, *11*, 33–46.

involved in some kind of controlling and coercive behaviours without fully understanding what was going on.

7.9.8 Professional intervention could have provided what was needed in that complex web, to bring the needs of Elsie to the forefront and to support the family to understand the increasingly difficult situation at home.

7.9.9 Reflection and learning on safe care at home

7.9.9.1 The Safe Care at Home Review (June 2023), jointly led by the Home Office and Department of Health and Social Care (DHSC), is an important reminder that some people may be '*particularly vulnerable to harm because of their dependence on others and the complexity of their care needs*'. '*They might rely on other people for physical, mental or financial support, and may face difficulties recognising or reporting harm.*'[65]

7.9.9.2 '*In care relationships, deciding what is deliberate abuse, neglect or inadvertent harm may not be clear-cut.*'

7.9.9.3 NHS Digital data on safeguarding adults shows that the most common location of the risk was the person's own home (48%). The most common type of risk in section 42 enquiries that concluded in March 2022 was neglect and acts of omission, which accounted for 31% of risks.

7.9.9.4 The Safe Care at Home Review acknowledges the excellent care and support vulnerable adults receive at home from unpaid carers. The human stories in this review highlight the complexities of identifying and responding to harm that may happen behind closed doors.

7.9.9.5 The Safe Care at Home Review concluded on key themed areas where improvements are required for government action. The recommendations should be taken up by local Safeguarding Adults Boards concerning leadership and accountability including learning from missed opportunities, reviewing local response to safe care at home including equipping staff to understand and navigate the complex legislative framework, and analysing local data and research.[66]

7.9.9.6 This informs recommendation 6.

7.10 Inter-agency communication and multi-agency partnership work – information sharing and escalation, and multi-agency partnership work including shared risk assessment, management of harm and shared decision making

[65] https://www.gov.uk/government/publications/safe-care-at-home-review
[66] https://www.scie.org.uk/safeguarding/evidence/safe-care-at-home/

7.10.1 The analysis of documentation and the learning conversations the reviewer had with individuals indicated different single-agency responses, without coordinated multi-agency working.

7.10.2 Better information sharing and closer partnership working between all services, including between ASC and CSC, could have provided triangulation and collated evidence of concerns to inform the bigger picture of the deteriorating situation.

7.10.3 Professionals highlighted to the reviewer that their observations were limited to the downstairs. No one asked about or saw the upstairs arrangements (except an early-help worker in May 2017 when referral was made due to concerns about adult 5's mental health, personal hygiene and home conditions) or initiated conversations about the isolation of adult 5 in his bedroom upstairs.

7.10.4 Although there was evidence of professionals observing the hoarding and cluttered home environment, and Elsie and adult 4 acknowledging it was an issue, professionals did not appear to have linked with Bernicia.

7.10.5 Including Bernicia in multi-agency collaborative working would have revealed to professionals the knowledge the housing provider had of the condition of the property. Bernicia's Intensive Housing Management (IHM) team was involved in May 2021 and relayed information to Elsie's housing team for monitoring when she declined to engage.

7.10.6 Elsie was offered help with her benefits but she refused for a needs assessment to be completed by IHM.

7.10.7 It was good practice for Bernicia to offer Elsie early help in support of decluttering the property, but she declined the offer of a skip.

7.10.8 When Elsie was discharged home from hospital in July 2023, she initially accepted offer of assistance with showering from STSS. This was a rare opportunity for them to observe within a period of time the home environment, but their recording was focused on the care provided and did not detail what the home was like.

7.10.9 Bernicia also shared that when they raised concerns in September to October 2023 on NCC's 'one call', return follow-up calls were not made and updates were not provided to them as agreed.

7.10.10 It was good practice that Carers Northumberland continued to flag concerns about Elsie with ASC.

7.10.11 Carers Northumberland made an urgent referral on 13/11/ 2023 via ERC for a care needs assessment for Elsie. The ASC chronology referred to concerns about Elsie's son as being '*controlling regarding money*' and issues with the home being '*very cluttered*'. This was not allocated until 22/11/2023.

7.10.12 The ASC social worker undertook an assessment visit with Elsie on 7/12/23. It appears that there were difficulties for ASC to follow up the potentially significant concerns due to Elsie's cancellation and hospital attendance.

7.10.13 In January 2024, Carers Northumberland alerted ASC social worker that Elsie had a fall and asked whether a pendant could be put in place. This was another missed opportunity to find out what was happening to Elsie in the home environment.

7.10.14 There was good communication and relevant information sharing between ASC and Carers Northumberland, recognising that the latter was gaining access to information about Elsie's care.

7.10.15 Later in January 2024, the care provider updated the ASC social worker about Elsie declining calls and wanting to cancel all calls. The social worker shared her concerns with Carers Northumberland.

7.10.16 When Carers Northumberland raised a safeguarding referral via telephone on 22/04/ 2024 due to the serious concerns child A shared about Elsie '*lying on a puppy pad urinating in situ, not eating, washing, dressing or taking her medication*', no update was provided by ASC to them.

7.10.17 It was recorded that Elsie had '*completely shut down*'. Child A disclosed there was '*no cleaning at all*'; child A could not get to the bath of use the kitchen properly. The reviewer is curious as to how long this had been the situation for Elsie and for everyone living within this place.

7.10.18 These significant concerns should have prompted immediate actions. This was a missed opportunity for professional assessment and intervention without delay.

7.10.19 The ASC safeguarding team requested urgent home visit by the community team, but this was delayed due to query about who should undertake the home visit and the safety of the visit.

7.10.20 The police documentation states that an ACN submission is 'based upon the submitting officer's assessment of risk, in particular risk of abuse or neglect'. 'This will allow information to be shared with the LA and determine the most appropriate action to be taken to safeguard the adult.'

7.10.21 'The information submitted on an ACN should be accurate, adequate and relevant.' The importance of accurate details in recording applies to all professionals – words such as rubbish and clutter and clean could be subjective in the absence of application of relevant tools (e.g. clutter scale) and reference to objective measures.

7.10.22 It appears to the reviewer that when serious concerns surfaced in April due to child A's disclosure, there was no previous shared understanding between agencies of the significant issues of this case. All other

professionals, including the CSC social worker who visited on the day Elsie was removed from home and the IRO who took over the case of child A, questioned how Elsie could have been left unattended and child A '*forgotten*' for so long.

7.10.23 The critical analysis of CSC provided evidence of their work with regards to the care of child A, which is outside the remit of this SAR. The reviewer observed, however, that other professionals noted 'no further action' (NFA) and had no knowledge or understanding of the work of CSC.

7.10.24 A robust risk assessment and clear risk management plan supported by a multi-agency strategy could have put into question that the least restrictive option was no longer proportionate to the escalating risks.

7.10.25 The first national SAR analysis highlighted that '*a rigid focus on assessment processes, thresholds and eligibility was seen as unhelpful where it stopped practitioners and agencies from taking a person-centred approach when assessing and seeking to meet needs and to mitigate risks*'.[67]

7.10.26 The national analysis also highlighted that the poor recognition of risk meant that '*sometimes practitioners were simply not worried enough to take action*'.[68] In this case, the reviewer is of the view that the declining situation should have made practitioners '*worried enough to take action*', at a much earlier stage.

7.10.27 The second national SAR analysis again highlighted the most prominent practice shortcomings include risk assessment and management (82%).[69]

7.10.28 It is acknowledged by the reviewer of the significant challenges professionals had in working with Elsie, as she continued to decline and refuse intervention and contact. However, when repeated offers and referrals did not bring about meaningful improvement and change, timely risk assessment could have informed a protection plan at a much earlier stage.

7.10.29 Bringing everyone together under a clear multi-agency strategy would have facilitated each other's understanding and communication of the whole picture and identification and agreement of clear outcomes and related roles and responsibilities.

7.10.30 Reflection and learning on inter-professional communication and multi-agency partnership work

[67] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[68] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[69] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023-executive

7.10.30.1 Robust multi-agency risk assessment must include open discussion and agreement on the management of risks, fully exploring the adult's history, and the power relationships and family dynamics in a complex case.

7.10.30.2 Robust multi-agency risk assessment must also include contingency planning. All professionals across the partnership should be part of the discussion about what could go wrong and what contingencies are needed.

7.10.30.3 Bernicia shared that, given the concerns regarding the home situation, their inclusion could have allowed them to play a bigger role in the multi-agency safeguarding response.

7.10.30.4 Bernicia pointed out that working relationships are often already established between families and their staff, which could aid communication and engagement when there is initial resistance to offers of support. They indicated this may not happen perhaps because they are not a statutory agency.

7.10.30.5 SARs have highlighted gaps in communication and partnership work between statutory services and third sector organisations, due to a lack of parity of esteem.

7.10.30.6 The research of the Institute of Public Care (IPC) highlights the important role providers can play in safeguarding and in SAR learning. '*There may be situations where a care service needs to take more of a lead to push things forward. Care services being proactive and confident in seeking a safeguarding response is a key issue, particularly for smaller care providers. This is one reason why we suggest a wider discussion about how the statutory agencies and care providers work together around safeguarding.*'[70]

7.10.30.7 '*The point at which the adult stopped receiving a care service was often seen with hindsight as a missed opportunity for further investigation or a fuller multi-agency response.*'[71]

7.10.30.8 Although this research is focused on the working relationship between statutory agencies and care providers, the reviewer believes that the learning is also relevant for housing providers.

7.10.30.9 In complex cases, multi-agency information sharing, discussion and planning needs to happen at the important frontline level where practitioners work with the adult. Management of quality assurance needs to happen simultaneously at the strategic level where senior managers of the Partnership maintain strong leadership and robust oversight and ensure accountability. This may require independent chairing of meetings where a multi-agency

[70] https://ipc.brookes.ac.uk/publications/how-can-care-providers-learn-from-safeguarding-adult-reviews/
[71] https://ipc.brookes.ac.uk/publications/how-can-care-providers-learn-from-safeguarding-adult-reviews/

strategy plan is coordinated, professional challenge can be raised and escalation triggered if required.

7.10.30.10 Learning needs to be supported by clear and robust single agency and multi-agency escalation pathways.

7.10.30.11 'A core feature of safer organisational and multi-agency systems is where there is a recognition of the value of challenge in order to avoid the risk of one view being formed of a case, thereby excluding other possibilities. A safer system is one where there is constant reflection and learning to inform quality enhancement, supporting a culture of professional challenge.'[72]

7.10.30.12 This is addressed in 9.7 and 9.11.

8. Other Related SAR Learning

8.1 The Adults Safeguarding Partnership recently commissioned an independent thematic analysis on self-neglect, which is due to be finalised. This has identified some areas of learning and recommendations which are similar to this SAR, and relevant actions are to be taken in a joined-up way.

8.2 The SARG have agreed to take forward the recommendation from this thematic analysis of a Multi-Agency Risk Management (MARM) framework. (see 11.8)

8.3 The SAR of Gaynor, published by the Tameside Adults Safeguarding Partnership Board[73], shares similar contributing factors and learning:

8.3.1 expectations and assumptions of Gaynor's willingness as a mother and a grandmother to support family members within her home

8.3.2 Gaynor was morbidly obese which contributed to her mobility problems

8.3.3 Gaynor suffered depression after the death of her eldest son

8.3.4 family relationships were described as 'very fraught' and the family believed that she was controlling

8.3.5 Gaynor was assessed to have mental capacity for refusing hospital admission

8.3.6 lack of shared understanding between agencies about the standard of hygiene within the home

8.4 The Rapid Review of Gayle, published by the Manchester Safeguarding Partnership[74], also shares similar contributing factors and learning:

[72] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[73] https://www.tameside.gov.uk/TamesideMBC/media/adultservices/Gaynor-SAR.pdf
[74] https://nationalnetwork.org.uk/2022/2022-06-30-SAR-Gayle22-Executive-Summary.pdf

8.4.1 morbid obesity and other co-morbidities considered as a safeguarding risk factor

8.4.2 relevance of family history and previous life course events, including the death of Gayle's father

8.4.3 Gayle's family carer, her younger brother (who has his own additional needs), was often asked by her not to call anyone for help

8.4.4 professional reliance on self-reporting by Gayle's carer / brother

8.4.5 limited touchpoints with the GP and housing provider

8.4.6 lack of objective assessment of living conditions in relation to immediate or cumulative avoidable harm

8.5 The Carers Thematic Learning Review, published by the Manchester Safeguarding Partnership[75], also shares similar contributing factors and learning:

8.5.1 caring as a social determinant of health

8.5.2 unknown impact of personal adversity and traumatic events on adults and their family carers

8.5.3 unknown internal relationship dynamics between adults and their family carers such as co-dependency, mutual protection and potential emotionally controlling behaviour

8.5.4 factors influencing family carer's mindset and decision making, such as personal and family values and expectations

8.6 The SAR of Margaret, published by the Richmond and Wandsworth Safeguarding Adults Board[76], adopted the SCIE Learning Together model. The review highlights professional norms and culture and systems findings.

9. Positive Changes and Improvement Actions in Progress

9.1 ASC completed an After Action Review (AAR) on 1/5/2024 after the death of Elsie. This has identified immediate learning needs, including missed opportunities for safeguarding referrals, lack of home visits when concerns were escalating, lack of attention to home environment and completion of self-neglect toolkit, and case closure due to non-engagement despite multiple concerns. Debrief, reflection and discussion with relevant teams were undertaken. The Principles of Engagement checklist was reissued to all ASC staff.

9.2 At the time of the case of Elsie, safeguarding decisions for people with care and support needs were made by the NCC's safeguarding team. Since March

[75] https://www.manchestersafeguardingpartnership.co.uk/wp-content/uploads/2016/08/2022-01-20-MSP-Carers-Thematic-Learning-Review-Executive-Summary.pdf
[76] https://sabrichmondandwandsworth.org.uk/media/1477/safeguarding-_adults_review_margaret.pdf

2025, safeguarding decisions for open cases are made by NCC's community teams, with the support of the safeguarding team.

9.3 ASC now has an allocation checklist tool, requiring the allocator to consider the rationale as to which level of allocated worker is required.

9.4 ASC is developing a case closure document – the manager has to record the manager's agreement with closure and the reasons for closure. Guidance is being developed about the need for MDT overview and escalation process.

9.5 The police shared that training was rolled out by MASH in 2024 to all frontline officers about the requirement of ACN submissions.

9.6 An independent thematic analysis on self-neglect was recently completed for the Adults Safeguarding Partnership. This has identified some areas of learning and recommendations which are similar to this SAR, and relevant actions are to be taken in a joined-up way.

9.7 The new multi-agency risk management process must be aligned with current multi-disciplinary team (MDT) pathways and compliant with the statutory S42 duty, supported by clear governance and accountability and strong leadership. Independent chairing of multi-agency meetings should be considered, to enable effective challenge between agencies, robustness of shared risk assessment and management and shared decision making, within an agreed time frame, and escalation to effect changes. A co-ordinated and collaborative response to complex safeguarding cases should be in place, ensuring improved connection and consultation across all relevant agencies in safeguarding adults and safeguarding children work including the GP and third sector organisations. (This may take the form of a formal Multi-Agency Risk Management (MARM) framework or a multi-agency high risk complex case panel.)

9.8 The NCASP utilises a whole family approach across all agencies, under which all partners must consider the child, the parent and the family as a whole.[77]

9.9 This appears to be lacking in the case of EW. The NCASP needs to ensure a 'Think Family, Think Safeguarding, Think Relationships' model[78] is embedded across all agencies working with vulnerable adults and children. This approach is to be embedded into all other relevant strategies as an overarching model of good practice, supported by learning of systemic practice. This should include the review of processes of information sharing and joint working between CSC and ASC and relevant partners, joint training between children's and adults safeguarding partnerships, leadership and workforce development.

[77] https://www.northumberland.gov.uk/About/Partners/Northumberland-Childrens-and-Adults-Safeguarding-P.aspx

[78] https://www.warringtonsafeguardingpartnerships.org.uk/p/i-work-or-volunteer-with-adults/think-family-think-relationships-1

9.10 NCCSC is currently expanding their FGC team. This case highlights the potential opportunity of applying the model of Family Group Conference (FGC) and other models of mediation in safeguarding work with adults as well as with children and their families. The development of the CSC FGC team can promote the extension of this work to ASC. (EW's family pointed out that it is important to consider potential challenges where family members are estranged.)

9.11 The Children's Review Group shared that the NCASP is progressing with one of a number of recommendations (recommendation 19) from the Safeguarding Practice Review of Sophia completed in 2024. The NCASP is supporting ongoing multi-agency opportunities for group reflection on specific elements of multi-agency working (or a specific circumstance for a child), to strengthen networks and promote partnership reflection and learning.

9.12 There is added value for these to be extended across NCCASC and NCCSC, to ensure the application of professional curiosity and trauma-informed practice by frontline staff, in complex safeguarding cases. This should include the consistent support of frontline staff under internal supervisory arrangements including robust criteria for case closure, as well as multi-agency and inter-professional learning and reflection space. The learning should be facilitated at a partnership level, so as to promote discussion and dialogue across organisations.

9.13 The Northumberland Kinship Team provides dedicated assessment and support to kinship carers and their families. It is important for ASC practitioners and managers and partners of the Adult Safeguarding Partnership to be made aware of the resources on kinship care[79]. A conscious analysis of equalities considerations and implications of intersectionality within the wider local socio-economic context should be a core part of safeguarding work with adults, children and families.

9.14 NCC ASC and CSC have come together with Carers Northumberland to adopt the 'No Wrong Doors for Young Carers' template Memorandum of Understanding[80], designed to improve joint working between adult and children's social care services and other key organisations in the identification and support for young carers and their families in Northumberland. It covers a range of areas such as approaches to identification, whole-family support and transitions from children's to adult services, and aims to ensure that young carers and any other members of the household with caring responsibilities are identified and supported at the earliest opportunity.

[79] https://padlet.com/kinshipsupport/northumberlandkinship
[80] https://carers.org/campaigning-for-change/no-wrong-doors-for-young-carers-a-review-and-refresh

10. Conclusions

10.1 This is a human story about one family, where there were complex relationship dynamics and inter-dependencies.

10.2 Whilst there were pockets of good practice demonstrating respect and dignity for the individual, a 'Think Family, Think Safeguarding, Think Relationships' approach was missing.

10.3 '*Abuse is about the misuse of power and control that one person has over another. Where there is dependency, there is a possibility of abuse or neglect unless proportionate safeguards are put in place. Intent is not an issue at the point of deciding whether an act or failure to act on one or more occasions is abuse. It is the impact of what is done or not done on the person and the harm or risk of significant harm to that individual that arises, at the time or over time, which matters.*'[81]

10.4 It is important for professionals to find and record the voice of the adult at risk, to make sure that their wishes, views and beliefs are represented and their rights are secured.

10.5 Good safeguarding practice must incorporate Making Safeguarding Personal as well as the consideration of trauma and loss and the application of professional curiosity, to ensure professionals develop the confidence to have courageous conversations with the whole family whilst focusing on the wider wellbeing of the adult at risk.

10.6 Good safeguarding practice also requires partnership work across all agencies working with vulnerable adults and families and children, embedded into all strategies, training, management and practice.

[81] https://lx.iriss.org.uk/content/scie-report-39-protecting-adults-risk-london-multi-agency-policy-and-procedures-safeguard.html

11. Recommendations

11.1 It is recommended for the NCASP to seek assurance from partners that essential existing policies and guidance relating to learning from this review, are widely disseminated to all relevant staff, that their understanding is refreshed and embedded at practice and management levels. (This includes 'Principles of Engagement', 'Safeguarding Adults Plus Size Guidance', 'Self-Neglect Policy' containing the 'hoarding assessment form', and others that the Partnership may identify.)

11.2 It is recommended for all relevant partners of the NCASP to review and update their policies and procedures with regards to fulfilling their statutory responsibility of advocacy for adults at risk. All relevant staff need to understand the important role of rights-based advocacy. Clear information on referral processes, communication channels and available resources and networks is to be disseminated across the partnership. (There may be other third sector resources, e.g. local befriending services, carers organisations and community groups, to be included in this review.)

11.3 It is recommended for the NCASP to review the membership of the Partnership subgroups, to ensure that the multi-agency partnership includes meaningful representation and contribution of relevant local third sector partners, including advocacy and carers organisations and housing providers. This should include parity of esteem across all local partners including third sector organisations and provider services.

11.4 It is recommended for the NCASP to seek assurance from all partners that relevant frontline staff are trained and apply the statutory principle of the MCA in supporting decision making, including advance care planning, substitute decision-making authority, the role of independent advocacy and the overlap between the MCA and DoLS.

11.5 It is recommended for the NCASP to review the offer and take-up of multi-agency training on specific subject areas, relevant to the learning from this SAR. This is to include promotion of mixed audience to enable essential networking and conversations across all partners working in adult and children's social care, and introduction of advanced levels of training to ensure application in practice in complex cases.

11.6 It is recommended for all partners of the NCASP to review the application by relevant staff of Making Safeguarding Personal within the statutory safeguarding adults framework, to raise awareness of the wider definition of neglect and understanding of 'safe care at home'. Wider cross-partnership dialogue and agreement is to take place on improving professional understanding of neglect and the application of this in practice with adults at risk. (This may include opportunities for multi-agency learning and reflection on neglect, such as training, toolkit and other resources.)

11.7 It is recommended for the NCASP to agree on the delivery of learning sessions at a multi-agency and inter-disciplinary level, following the

completion of this SAR. This is to ensure wider dissemination of learning and promotion of improvement actions at all relevant levels, including practice, management, systems, commissioning and strategic levels.

12. Glossary

AAR	After Action Review
ACN	Adult Concern Notification
ASC	Adult Social Care, Northumberland County Council
CAF	Critical Analysis Form
CCN	Child Concern Notification
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
CRPD	Convention on the Rights of Persons with Disabilities
CSC	Children's Social Care, Northumberland County Council
DHSC	Department of Health and Social Care
DN	District Nurse
DoLS	Deprivation of Liberty Safeguards
DWP	Department of Work and Pensions
ERC	Enquiry and Referral Coordination
GP	General Practitioner
ICB	Integrated Care Board
IHM	Intensive Housing Management
INT	Integrated Nursing Team
IPC	Institute of Public Care
LE	Learning Event
LPA	Lasting Power of Attorney
MARM	Multi-Agency Risk Management
MCA	Mental Capacity Act (2005)
MDT	Multi-disciplinary team
NCASP	Northumberland Children and Adults Safeguarding Partnership
NCC	Northumberland County Council
NEAS	North East Ambulance Service
NFA	No Further Action
NHCFT	Northumbria Healthcare NHS Foundation Trust
NESECH	Northumbria Specialist Emergency Care Hospital
OT	Occupational Therapist
PCN	Primary Care Network
PTSD	Post-traumatic stress disorder
SAB	Safeguarding Adults Board
SALT	Speech and Language Therapist
SAR	Safeguarding Adults Review
SARG	Safeguarding Adults Review Group
STSS	Short Term Support Service
TAF	Team around the Family
ToR	Terms of Reference