



Safeguarding Adults Review
Hertfordshire SAB
'Iris'

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1. Introduction

Iris was a 98-year-old woman living with one of her sons. She had moved from another area in recent years and thus wasn't known to services locally until she already had considerable needs for care and support, the appearance of dementia, visual impairment and mobility issues. Iris had a sister who she was thought to have retained phone contact with until her needs increased. According to information gathered for this review, her son told practitioners that she was a 'quiet person who did not like a lot of company' and that she had not left home for several years. She had been widowed when she was in her forties, in her younger years she worked in a fashion shop. She previously attended Catholic church and her recorded religion was Christian. She used to like making dolls/crafts/cards. She was described by one care home who supported her as a 'sweet lady'. She largely gave 'yes' or 'no' answers to questions meaning it was challenging for those supporting her to get a true sense of her as a person, her life experiences and perspectives, both at the time, and for this review.

Iris predominantly lived with one of her sons during the period this review considers (2022-2024) although she also spent time in hospital and two care homes. This son held Lasting Power of Attorney¹ (LPA) for both Health and Welfare, and Property and Financial Affairs. He cared for her at home and whilst there were some safeguarding concerns about how he cared for her, it was recognised that they had a relationship that was important to both.

1:1 Purpose of review

A SAR referral was made for Iris in October 2024. There were concerns about how practitioners, managers and services understood and challenged Iris's son on his behaviour and LPA role. This included whether legal measures to investigate and potentially remove the LPA were taken in a timely manner. Services questioned if there had been effective communication between them to safeguard her and sought exploration of the role of safeguarding enquiries in her life. It was the decision of Hertfordshire Safeguarding Adults Board (HSAB) that the criteria was met for a discretionary Safeguarding Adults Review (SAR).

The criteria for a SAR is set out in section 44 of the Care Act 2014²; a Safeguarding Adults Board (SAB) must arrange for a review where an adult in its area with needs for care and support (whether or not the local authority is meeting those needs) has either died or been harmed, and there is concern about how services worked together to safeguard the adult³.

1.2 This review sets out to:

- understand how services worked together to safeguard Iris and how staff were supported to utilise existing legislation, policies and guidance
- highlight good practice
- incorporate learning from other SARs with similar themes and national research on key issues relevant to this SAR

- identify learning and suggest recommendations for services to take forward

2. Iris's voice

There has been no response from Iris's known family regarding participation in this review, and they are under no obligation here. This review seeks instead to capture her experience through the documentation and verbal accounts given by practitioners who knew her. It is recognised that not having individual or family input into the review means it has limitations in terms of non-professional perspectives.

Iris's protected characteristics were as follows: she was a 98-year-old female, white, British, Christian and disabled. She was visually impaired with long term health conditions and had the appearance of dementia (no formal diagnosis on records; this is discussed later in the report). We seek to understand throughout this review if any of these protected characteristics impacted on how services worked with her. The types of abuse/neglect we consider in this review are predominantly domestic abuse, emotional/psychological abuse and neglect/acts of omission.

3 Methodology

3.1 The author has taken a rapid, hybrid approach, using a systems focused approach to analyse safeguarding meeting minutes and chronologies, asking for brief clarifications on service involvement and delivery where required. This proportional approach has deliberately been selected to improve the timeliness and effectiveness of the SAR; the desired outcome being that learning is highlighted and implemented efficiently across services. National research on related issues including other SARs has been incorporated, due to the limits of this methodology, this is not extensive. Practitioner voices have been captured via a group discussion with practitioners from key services who were involved at the time, alongside participation from two care providers. A larger learning event was not required, as within Hertfordshire services there have already been similar events for practitioners particularly around LPA. There have been discussions with strategic practitioners who were part of the Safeguarding Adult Board (SAB) core panel for this review; they have been able to share an overview of evolving practice and the challenges and strengths around service delivery. In any methodology there are benefits and limitations. A rapid style SAR will deliver findings and learning in a timely manner; however, it is recognised that there are limits to the nuance and detail that a more traditional SAR allows for. This review will provide enough detail to evidence the themes and findings. These will be discussed in depth in the main body of the report before being summarised with accompanying practical recommendations for HSAB and partner agencies to take forward. There are no known parallel processes to consider.

3.2 The author wishes to thank all the participants for their honest reflections. This review also incorporates elements of appreciative enquiry; a methodology used in

SARs to highlight good practice. It is key to ensure in any SAR that there is a balance between learning from what *doesn't work* and what *does work*. In any review, there is a need to identify and avoid hindsight bias; the tendency to review events as having been more predictable than they were, after they have occurred³. The learning identified in this review is intended to be helpful, recognising that working with people and families can be highly complex, and practitioners, managers and services are often working intensively without the resource they ideally need.

3.3 The SAR author is a registered and currently practicing social worker. She is independent of Hertfordshire services. Previously, she spent time on secondment with the Office of the Public Guardian (OPG) in a strategic safeguarding role and has published research on safeguarding issues. She is relatively new to SARs; this is her fourth SAR, and her first for Hertfordshire SAB.

4 Terms of reference and key lines of enquiry

To be able to break down the key aspects of Iris's experiences, several key questions and themes to explore have been developed. These are called 'terms of reference' and 'key lines of enquiry'. They are listed below and are discussed throughout the report.

4.1 What can this review tell us about how practitioners, managers and agencies understand and work with Lasting Powers of Attorney?

- Legal literacy e.g. use of the Mental Capacity Act (including s44 ill treatment or wilful neglect), Care Act 2014
- Understanding of the roles and responsibilities of LPA
- Understanding and use of the Office of the Public Guardian
- Understanding and use of the Court of Protection

4.2 How can we use this review to support practitioners, managers and agencies working with older people in familial settings where there are safeguarding concerns about domestic abuse, neglect and acts of omission, including where access to the person is limited by another person(s)?

- Use of independent advocacy and how Iris's wishes and decision-making capabilities were supported
- The impact on paid carers where they are also at risk of harm and fear, and what support they might need from professionals
- Engagement with wider family/networks of support
- Legal literacy including criminal legislation e.g. Domestic Abuse Act 2021, the Mental Capacity Act (including s44), the Care Act 2014 (s42, s10), Human Rights Act 1998
- How agencies worked together to safeguard the individual when access was limited or prevented by family
- Understanding and application of relevant policies and guidance across services

4.3 How can we use this review to understand more about best practice when working with informal carers where there are safeguarding concerns or areas of risk?

- Use of advocacy for informal carers
- Use of the third sector e.g. Carers charities
- Challenges of supporting both an individual and their informal carer

4.4 How did agencies work together and share information about Iris?

- Focus on the decision- making process for Iris to return to live with her son after a period in a care home
- Use of advocacy, and how Iris's wishes, feelings and capacity were supported
- Communication between agencies during and after meetings and decisions
- Communication regarding police and section 42 safeguarding involvement and closures of enquiries/investigations
- How safety plans and risk assessments were agreed and shared
- Contingency and escalation measures in place and how these were shared

5 Organisations involved in this review

5.1 Direct participation:

- Hertfordshire County Council
- Hertfordshire Constabulary
- East and North Hertfordshire NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Domiciliary Care Provider 'A'
- Care home 'B'
- All Age Continuing Health Care (CHC) Herts and West Essex ICB
- GP surgery

5.2 Provided supplementary information:

- The Office of the Public Guardian
- Refuge
- Department for Work and Pensions
- East of England Ambulance Service NHS Trust

6 Setting context for this SAR; national themes, and how they relate to Hertfordshire

6.1 Denied access to individual

Iris's son refused certain professionals/services accessing Iris or was seen by them as being obstructive to their care delivery, it is acknowledged that he did not see his behaviour in this way. Agencies did work together when this happened; utilising professionals the son would allow in such as the GP and an Occupational Therapist. When her son stopped the visits from some of CHT (June 2023, after the safeguarding they raised), there was evidence of appropriate planning around this, liaising with the GP to see if they could encourage the son to accept a matron visiting instead. On one occasion the police were asked by HCC to facilitate access. The recording for this indicates that her son allowed the police in, but HCC did not see her.

Denied access and power of entry is a national area of interest. In England, the police have a power of entry (Police and Criminal Evidence Act 1984)⁴, however there must be an immediate threat to life, limb or property. There are times when the Mental Health Act 1983⁵ can also be used. The lack of power of entry has been debated within adult social care⁶, and was discussed in the second national analysis of SARs⁷; 5% of the SARs examined highlighted concerns about denied and/or difficult access, and the absence of power of entry, leading to the report concluding that 'there remains, therefore, a gap in adult safeguarding law in England'⁷. There is also a notable difference here between countries in the United Kingdom; under the Adult Support and Protection Act (Scotland) 2007⁸ and Social Services and Well-being (Wales) Act 2014⁹, social workers in Scotland and Wales do have powers of entry in safeguarding cases, granted through warrants. Northern Ireland has the same lack of entry power as England.

The Inherent jurisdiction of the High Court can be used where people are believed to have capacity in relation to specific decisions, this would not have applied to Iris as she was deemed to lack capacity on three occasions in relation to her care. There are powers under the Mental Capacity Act 2005¹⁰ (16.2) whereby a council can apply to the Court of Protection, to facilitate access to an adult who lacks capacity, or where there is a reason to believe they lack capacity, to make decisions about their safety, and access is impeded¹¹. In Iris's case however the son allowed access more often than he did not, this may have led to uncertainty about whether the powers of the Court of Protection were required, instead the police were asked to support on one occasion. Services for Iris utilised the professional who her son did trust to gain access to Iris. Whilst this is practical and can be seen as good practice, it also meant services relied heavily on the perspectives of those who were allowed in. It may also have also placed additional pressures on those practitioners to keep a 'good enough' relationship with her son to avoid the risk of denied access. This is also recognised in the national analysis, which recognised that despite evidence of skilled practitioners, access was not always given and considers the impact on practitioners of working with families who are evasive or obstructive. Denied access is enough of a national concern that it forms one of the analysis' improvement priorities (IP 10), with a request that the Department for Health and Social Care should consider 'recommending legislation for an adult safeguarding power of entry along the lines of the provision available in Wales and Scotland. DHSC should also consider the inclusion of social workers in the

protections afforded by the Assaults on Emergency Workers (Offences) Act 2018^{7, 12}. We recognise through this SAR the resilience and courage of practitioners in working diligently to access Iris regularly; this is a complex issue to navigate.

6.2 Safeguarding and 'premature case closure'

Under section 42 of the Care Act 2014², local authorities must make (or cause to be made) enquiries where there is reasonable grounds to suspect that an adult in its area (whether or not ordinarily resident there) (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In this SAR, there were two safeguarding enquiries closed without including all the appropriate services in that decision, and although there were safety plans, there was ineffective follow up. We see this theme echoed in the second national SAR analysis, often referred to as 'premature case closure'. The reasons behind closures outlined in the national analysis are often relating to the person refusing consent for more involvement, or a lack of understanding of the nature or impact of a safeguarding concern. The national finding does not just apply to safeguarding closures, and is seen across services, but safeguarding closures are of relevance in the case of Iris. In this SAR the reasons why enquiries were closed in the way they were, was not explicit. Instead, these have been discussed with strategic representatives from HCC to understand practice at the time, and now.

6.3 Adult children caring for elderly parents

Within this SAR, several practitioners talked about their experiences; anecdotally they are seeing an increase in safeguarding concerns or challenging situations involving adult children caring for elderly parents. HCT commented that this often related to 'rough' or poor moving and handling techniques by adult sons caring for their elderly mothers. It would be helpful to explore if this 'feeling' is seen in data locally and whether that applies nationally too. In the UK we have an ageing population and there are significant numbers of adult children caring for their parents. NHS England define a carer as, 'anyone, including children and adults, who looks after a family member, partner or friend who needs help due to illness, frailty, disability, mental health problems, or addiction, and cannot cope without their support'¹³. There are an estimated 5.8 million unpaid carers in the UK and the impact of unpaid caring is not to be underestimated; Carer's UK research found that over three quarters (79%) of carers feel stressed or anxious, and half of carers (49%) feel depressed. 54% of carers said their physical health had suffered¹⁴. There is some recognition of the strain unpaid carers can be under, physically and mentally, with unpaid carers also having rights to assessment and support under the Care Act 2014 (s10)². In the case of Iris, her son was offered a carers assessment, which he originally declined but later did accept.

Where there are safeguarding concerns about unpaid carers abusing or neglecting a cared for person, these are inevitably complex situations. Abuse and neglect within a

family/unpaid carer scenario may take many overlapping forms and this may mean it is harder to categorise or specify. For example, it may be categorised as domestic abuse, neglect/acts of omission, physical abuse, financial, emotional/psychological or verbal abuse, or all of the above. There may be coercion and control, and abuse may still be happening even if a criminal threshold is not met. We see discussions around whether control or harm is intentional or not through other related SARs, such as that of 'Evelyn'¹⁵ (Richmond and Wandsworth) which has many similarities with this SAR. For practitioners and services, they are balancing unwise decisions relating to risk from family members with their adult safeguarding duties to safeguard and protect and respect for the rights of individuals to live their lives and conduct their relationships without interference. This report will discuss the interplay between the Human Rights Act 1998¹⁶, Care Act 2014² and Mental Capacity Act 2005¹⁰.

6.4 Lasting Power of Attorney

A Lasting Power of Attorney (LPA) is a legal document that allows an individual to appoint one or more people (known as attorneys) to help them make decisions or make decisions on their behalf. It is set out in MCA 2005 (s9)¹⁰ and in the Code of Practice (Chapter 7)¹⁷. The individual needs to have mental capacity at the time of making the LPA. It is intended as a safeguard for the potential that they may lack capacity in future for important decisions. Such roles come with rights and responsibilities, primarily that they must act in the donor's (individual's) best interests including taking steps to safeguard them. The Office of the Public Guardian (OPG) has a process for raising concerns about any power of attorney¹⁸ and this includes where there are concerns that the person is making decisions that are not in the best interests of the person they are responsible for. The OPG also has its own safeguarding policy which explains in more detail its role¹⁹. If there are disagreements between professionals and attorneys about what is in the individual's best interests, the Code of Practice (6.55) states that if the disagreement 'cannot be settled any other way, either the carers, the staff or the attorney or deputy can apply to the Court of Protection'¹⁷. This SAR explores the attempts made locally to resolve disagreements with Iris's son and whether legal action was taken; the timeliness around this is a key concern and theme.

There has been some criticism of the LPA system nationally, with concerns that people could be coerced into making them. Indeed, there is a grey area in general around coercion and undue influence in the Mental Capacity Act 2005; this is not unique to setting up an LPA. The principle of LPA is that people can make their own decision at the point of creating an LPA, even if others deem this to be an unwise decision. However just because someone has appointed a particular person as their attorney does not mean they intend for others to be excluded, and circumstances do change including the ability and willingness of the attorney to continue in the role. With an LPA in place, there are legal routes to hold the attorney to account, whereas there is potentially less accountability for family members who haven't signed legal agreements to safeguard an individual. This SAR explores practitioners, managers

and services' overall understanding of how and when to challenge attorneys, and the role of the OPG and Court of Protection.

A search was carried out as part of this review to find other SARs relating to LPA specifically. The results were few. Some SARs involving LPA did not necessarily share themes in common with this SAR and the impact of LPA within it therefore they have not been included in this report. The SAR 'Evelyn'¹⁵ has the most commonalities with this SAR; there was a lack of curiosity about other family members who were not attorneys, and the son who had LPA was not effectively challenged through utilising the OPG or Court of Protection. Similarly, in SAR 'John'²⁰ (West Berkshire), agencies dealt exclusively with the LPA: 'the selection of one family member and not others should not be taken to mean that the person did not want other members of their family involved in their future care'¹⁹. In SAR 'Edith'²¹ (Hampshire) the OPG's investigation function for LPAs was not utilised by agencies effectively, a dominant theme in this SAR for Iris.

The earliest SAR found that involved an LPA was that of 'Leocardo'²² (Brent) which found that 'where families hold Lasting Power of Attorney, a safe system is one where professionals understand the role of the Court of Protection and use it if appropriate'. This SAR included the outcome of the coroner, who found in this case that 'the local authority duty to keep Leocardo safe outweighed the importance of balancing this with the wishes of his family who held Lasting Power of Attorney'²². This review commented 'this is a departure from what case law has set out' and it was an action from this SAR for the local authority to seek an update from their legal adviser on any case law that tests this 'weighting' further²². There are clear commonalities here with this review of Iris; the weighting the LPA has been given potentially over the objective safety (physically and mentally) of the individual, and services not effectively utilising the investigative powers of the OPG or the legal powers to remove attorneys (or otherwise hold them to account) through the Court of Protection.

7 Chronology of key events

May 2023 Concerns about son's care of a wound and bruising, specifically he was seen to be not following nursing advice. Involvement from GP, community nursing and occupational therapy. Safeguarding concern raised and taken into s42 enquiry by HCC. No formal care package in place, all care is provided by son. GP was asked to visit which was completed.

June 2023 Second safeguarding concern raised. Concerns about moving and handling by son raised by CHT. He prevented access to Iris for some of CHT due to the concern being raised.

September 2023 son refused access to social worker and district nurse. Police gained entry and reported that Iris was 'frail and thin', that one of her arms was taped, with a wound on her cheek and 'some sort of dressing by her nose'. She told officers she was 'ok'. Her son re-iterated that he would not allow access to any district nurses or social services but was happy for the Occupational Therapist and GP to continue to

visit. HCC considered mental capacity assessment however no evidence that this was undertaken. GP did visit and provided feedback.

November 2023 HCC close the safeguarding enquiry; outcome being concerns were not substantiated as Iris's son was not thought to be intentionally neglecting her. Lack of follow up on the agreed actions primarily that it was agreed she needed formal care to be in place. Son did not follow this through and remained her sole carer. There was a lack of clarity between HCC and HCT with the latter not knowing this is what the son had agreed to. This is a theme throughout the enquiries.

January 2024 Concerns about domestic abuse. Son is allegedly overheard by a call handler shouting at and assaulting Iris. Police attend, and her son is arrested for alleged assault. Home was indicative of some hoarding and was cluttered. Iris had bruising and marks on her arm, wounds and appeared dazed and confused. Iris is taken to hospital for medical review. The hospital reported that during personal care, Iris had been saying 'please don't hurt me' and 'I haven't done anything wrong'. Also reported no 'clear view' of the cause of her injuries or bruises. Differences between emergency service reports regarding possible burn and bite marks, confirmed the hospital would need access to a specialist forensic orthodontist to review this. An Independent Domestic Abuse Advisor (IDVA) is appointed, and she is discussed at a Multi-Agency Risk Assessment Conference (MARAC).

Iris is discharged to a care home as an interim safety measure due to concerns about son being bailed back to their shared address. Assessed there to lack mental capacity in relation to how and where her care needs are met, best interest decision is made that staying in a care home is in her best interests. This is due to both her increasing physical needs, declining cognitive health, and the safeguarding concerns. Her son is not part of this process as he is bailed not to have contact with her. There is an action for HCC to contact the OPG, which was not completed.

February 2024 Iris moves to a longer-term care home 'care home B', there for three months. Another action for HCC to contact the OPG, not completed. Notable improvements to her emotional wellbeing; smiling and engaging more with staff and other residents. Accepting of the care offered, having initially been agitated when first settling in.

Initial safeguarding findings in early 2024 are that concerns are largely substantiated. However safeguarding enquiry and police investigation continues. Iris's son is interviewed under caution. In his interview, he denied any assault. He openly admitted that he had sworn at his mother during the telephone call, although he denied the expletives alleged, but admitted that he lost his temper as Iris was continually scratching at her pre-existing wounds, which he was powerless to prevent. He stated that he did not trust adult services, but that he was failing to be able to continue to care for his mother whose needs were becoming greater. Police do not charge son with assault due to lack of evidence to proceed (this is covered in more detail later in the report). Criminal investigation closed on the 15/03/2024.

The care home reported that when her son was allowed to start visiting her there were several times when there were difficulties with his behaviour. Examples given were that he would make upsetting comments in front of other residents and their visitors, referring to the care home as a 'madhouse' for example. They reported that he could also be verbally abusive and intimidating to staff. Due to these concerns the care home informed him he could only see Iris in the in-house café, which he did adhere to. It is noted later in safeguarding meeting minutes that she did not continue to bruise in either care home nor was she seen to bite herself. She was noted to pick at scabs including the one on her nose. This is important in relation to how the decision was weighted about her returning home.

May 2024 HCC's safeguarding investigation determines that the concerns about Iris's son being abusive are largely unsubstantiated. This is weighted heavily on the police's outcome and does not consider sufficiently the safeguarding history. It is a significant change from their February findings. Iris's son is clear that he wishes for Iris to return home with him. Iris is assessed as lacking the mental capacity to make this decision for herself. IMCA is appointed. A best interest assessment determines that it would both be least restrictive, and in her best interests to return home with her son. This is largely based on the safeguarding outcome being 'unsubstantiated' and her son agreeing to a private package of care for her which has never been tried before. The best interest assessment records that her son is the 'decision maker' and that the purpose of the assessment is to see if HCC agree with his decision. This is a key period within this SAR that will be examined more closely.

May 2024 Iris is discharged back home to live with her son. She is supported there by domiciliary 'care provider A' alongside practitioners from the GP surgery and HCT. A safeguarding concern is raised by the care provider after one week of her being back home, in relation to her son's behaviour. This referral is closed prematurely by adult social care at eligibility stage.

July 2024 Iris experiences a stroke and a significant decline in her health and wellbeing. She is admitted to hospital, and a Continuing Health Care (CHC) Fast Track decision is verified and funding agreed. This was a different hospital from the one she went to after the alleged assault. This is important as the hospital didn't have a safeguarding history for her. This means there is a shift from Iris paying privately for care (HCC records indicate that son had unpaid invoices for care) to the health service paying for her care due to her significant level of need.

August 2024 She is discharged from hospital back home to the care of her son, with a package of care provided by CHC, care provider 'A' in place. CHC were not aware of the safeguarding history for Iris and her son. Safeguarding concerns about son's care of Iris are raised and another enquiry commences under section 42 of the Care Act 2014. This is managed between HCC and the CHC team, with support from HCT who remain heavily involved.

September 2024 Care provider A are replaced by another care provider at Iris's son's request.

October 2024 Safeguarding concerns raised/discussed. CHC have discussions about a court order to remove the son as LPA, with their legal team. Discussions with son about the possibility of services making an urgent application to the Court for a health and welfare order to remove Iris from his care. Instead, a 24-hour care provider 'C' is put in place largely because Iris is too fragile to move and son agreed to this care. Iris died at home on 11.10.24, shortly after this care was put in place. No coroner involvement: this was an expected death.

8 Legal Literacy

8.1 Legal literacy is a phrase commonly used in SARs; it is not just practitioners, managers and services being aware of the law, but also being aware of the gaps and the complexities in how different pieces of legislation interacts with each other. It also means being aware of the principles, statutory and practical guidance, and codes of practice. We need to recognise the challenge this presents; and help our services to effectively rise to this on a practical level. This section of the report discusses the theoretical interaction between legislation relevant to Iris, practical considerations relating to safeguarding enquiry closures and the use of mental capacity assessments and best interest decisions. There is good practice noted alongside areas for improvement.

Safeguarding enquiries and outcomes, multi-agency working and leadership

8.2 There were several safeguarding enquiries during this review period, during 2023 and two in 2024. This report recognises that HCC no longer uses the terms 'substantiated, unsubstantiated, inconclusive' to describe enquiry outcomes. However, as these terms were in use during this period, they are utilised in this report. Unlike criminal investigations, adult social care base their findings on 'balance of probabilities'. The first safeguarding enquiry commenced in May 2023 and was closed in November 2023. At this time Iris had care and support needs but was not in receipt of a care package, her son provided unpaid care to her. There was evidence of good multi agency communication and practitioners working sensitively with the challenges of her son not wanting/struggling to engage with practitioners about the concerns. There were regular multi-disciplinary team meetings held by HCT who had an ongoing need to provide services to Iris at the time. Whilst these were aimed at providing the best possible support to Iris, it is a reflection of this report that there may have been a need for more clarity between HCC and HCT about their roles at the time. For example, there was a health led MCA concerning Iris's ability to make decisions about how her care needs were met (and who by). In HCC's recording they did not have a copy of this MCA. The outcome of the best interest decision that followed was that she 'did not require formal care at present' however this appears to be in direct contrast to the safeguarding enquiry which recorded that formal carers *were* required, and that her son was going to arrange private care [records show that he told HCC Iris had

savings over the financial threshold and would therefore be responsible for funding her own care]. It is not clear from the documentation why the MCA and Best Interest were health led; HCT were providing an ongoing service to Iris and saw her regularly however the reasoning is not explicit especially as it would be HCC who would usually help families arrange care where needed (even if self-funding) and especially as there was a safeguarding enquiry open. There was a need here for clearer communication between HCC and HCT, and a clearer delineation of their roles.

8.3 There was also no direct visit to Iris by anyone from HCC at the time, there were only telephone calls to her and her son. It is recognised that he would have had to facilitate their call to his mother anyway, and he would have been able to hear her half of the conversation therefore limiting the chances of her making any disclosures. It is not clear why HCC did not visit; whether this was one of the times he refused their visit. Asking another professional to visit is justifiable under certain circumstances. In this case, the GP was asked to visit which was appropriate as the concern related mainly to wound care. However, HCC have reflected that delegating safeguarding visits to other professionals is only appropriate if there are clear expectations about what that professional is being asked to complete including any feedback that HCC requires from the visit. HCC have also reflected that as her son was demonstrating that he was not making decisions in her best interests at that point, an urgent mental capacity assessment could have been completed by them- this was documented but not followed through on. Leadership does not mean completing all the actions yourself but does mean giving clear expectations and following up on actions. Denied or difficult access, and the use of advocacy is discussed later in this report.

8.4 The outcome of the enquiry was 'unsubstantiated' with the rationale that her son was not assessed to be 'intentionally neglecting' her. However there remained significant concerns about his care (or lack of) regarding her skin integrity, administration of medication and in relation to her wellbeing. Whilst neglect does not need to be intentional for a concern to be 'substantiated' the challenge here is the context around how able the carer is to meet the needs of the person. This is discussed in 'Evelyn' which references 'overzealous and coercive and controlling behaviours whether intentional or not'¹⁵. The second national SAR analysis also comments that in some cases they analysed safeguarding enquiries were prematurely closed where neglect was the concern, commenting that 'practitioners lacked understanding of how neglect might present; here there were unexplained injuries, nutritional concerns and a lack of access unless family were present, but these were not recorded as neglect'⁷.

8.5 The second safeguarding enquiry commenced in January 2024. HCC received a safeguarding concern about alleged assault on Iris by her son. The protection plan agreed by the local authority on receipt of the safeguarding concern was proportional and timely and a bed in a care home (via the Discharge to Assess pathway) was found, with an Independent Mental Capacity Advocate²³ (IMCA) referral also being made, which was good practice. There was senior management support within HCC for the first safeguarding meeting which was appropriate given the urgency and complexity of

the situation and is good practice. Senior support for enquiries was also noted from HCC throughout this, and the following safeguarding enquiry, which is good practice in complex safeguarding situations. An example of this was seen in February 2024 when there was a discussion between the safeguarding lead, enquiry officer and a manager (all within HCC), with the latter giving a robust documented overview of the situation and the actions being taken. Visible management oversight on the system is important for both supporting practitioners and providing a clear audit trail. HCCs findings in February 2024 were that concerns were substantiated but with 'risk removed' and 'actions taken'. The latter refers to a best interest decision that she needed to remain within a 24hour care home setting. It is worth reflecting on whether domestic abuse risks should be categorised so completely as 'risk removed' if there is still an ongoing relationship between the people involved; the domestic abuse service participating in this review argued that risk can be mitigated but does remain; rarely is it fully removed.

8.6 However, the second safeguarding enquiry was closed in May 2024 with the outcome being that concerns were largely 'unsubstantiated' and that there would be continued support from the social work team. This was a significant departure from the earlier findings. The later findings were heavily weighted on physical abuse and the police investigation outcome, and there was not full consideration of the history that predated the alleged assault, or the other harms and risks such as around verbal and emotional abuse, lack of physical care and moving and handling concerns. Criminal investigations have strict tests that need to be met to charge a person, however a lack of charging does not mean the allegation is untrue, instead it often means there was not enough or no evidence to meet thresholds. In HCC's enquiry, the phrase 'there has never been physical abuse' was used, which is inaccurate. When records have been cross referenced for this SAR there was a lack of clarity about bruising, but this is not apparent in the enquiry. The national SAR analysis picks up on this point, stating that in some cases 'the safeguarding response addressed one form of abuse and neglect that was being experienced but not others... Physical threats may be addressed but response to the psychological or emotional impacts of the abuse or neglect were less effective'⁷. The Care Act 2014 statutory guidance²⁴ states that neglect and acts of omission can include failure to provide access to appropriate health, care and support, ignoring medical, emotional or physical care needs. It goes onto say that 'it is important to recognise that abuse or neglect may be unintentional and may arise because a carer is struggling to care for another person. This makes the need to take action no less important, but in such circumstances, an appropriate response could be a support package for the carer and monitoring. However, the primary focus must still be how to safeguard the adult' (14.45-14.50)²⁴. This shows the complexity of the situation practitioners were working with, and potentially the lack of practical guidance at the time about how best to safeguard Iris.

8.7 There was insufficient recognition that there was a significant departure from the thinking at the time when she was transferred to the first care home (that concerns were substantiated). There are theoretical and practical considerations here about the

importance of understanding and utilising safeguarding history, recognising the impact/interplay of criminal investigations and section 42 enquiries, and management oversight to spot where there has been a significant shift in safeguarding outcomes in a short space of time.

8.8 Safeguarding closures- practical considerations

When the first safeguarding enquiry was closed, it was noted that 'actions had been taken to mitigate risks', and 'proportionality' was also cited. Although there was a case conference mid-way through this enquiry, it was closed without a follow up meeting. It would have been useful as a way of bringing all appropriate services together to conclude the enquiry and agree the risk management plan. There was no follow up to ensure that the care HCC had recommended had been put into place by her son. When the safeguarding was closed, her son was informed of this outcome which was good practice. His response was that he was 'never interested' in the safeguarding but had felt accused by the health team of neglecting his mother and that he believed the mental capacity assessment had been falsified. He did not want any further input from HCC or HCT. He felt 'nothing had changed in relation to his mother following input from health and safeguarding'. As it was intended that he would put care in place, some follow up should have been discussed as part of this conversation to manage his expectations about 'further input'. There was no discussion with Iris.

8.9 The notes state that feedback was provided to 'all professionals', this was emailed. There is no record of any disagreement with the outcome and closure. This either means none was identified or received, or none documented. There is no documentation to indicate if agencies were asked to contribute their views on possible outcomes and closure, before this was finalised. One of HCC's reflections for this SAR is that there is a need to identify who will coordinate efforts outside of the safeguarding process, with continuous MDT collaboration, and that this is best agreed through a closure meeting for a complex safeguarding enquiry such as this one. This is especially relevant as after the safeguarding enquiry closed this was followed by the area social work team also ending their involvement, around one month later.

8.10 The second safeguarding enquiry was closed in May 2024. There were two case conferences but no final meeting to bring together everyone involved to determine together the outcome and agree any further actions/risk management plan. There was a continued lack of following up on actions to contact the OPG- this is discussed later in the report. The safety plan for Iris returning home to live with her son in the late summer of 2024 was not shared with the Community Health Team or 'care provider A'. This meant that although it was robust in its nature, with her son agreeing to various 'conditions', the monitoring of it was likely to be less effective without those services having a greater awareness of it. There is no documented record of feedback being provided to the professionals involved or any recorded disagreements or views on the safeguarding outcome and closure. There is no evidence that the protection plan was shared and agreed by the community practitioners who would have needed to see it- the GP surgery and HCT. This meant there was no opportunity for those practitioners

to be aware of what her son had agreed to, and what they might need to escalate back to HCC. This is a continued theme from the first safeguarding enquiry. However, a safeguarding review was scheduled, which means the safeguarding was not 'fully closed'. What this means, or was intended to mean, is not clear from the recording.

8.11 Interestingly, in February 2024 HCC identified a 'need to learn lessons' from the earlier safeguarding where it was 'not clear that there was monitoring in place and as a result for two months there was lack of clarity about what contact was had with Iris'. It was reflected that the social worker had not been allowed access, only the police, and that the health team had no remit during that time as her health had improved. The meeting minutes state that 'services lost sight of Iris' and that from November 2023 services withdrew, but she still had care and support needs. Despite this recognition, by May 2024 when the second enquiry was closed this appears to have been lost again, as there was a lack of sharing and follow up on the safety plan agreed despite the increased impact of risks. There was no reference to practitioners making use of a domestic abuse specialist or the co-located IDVA within HCC, this was a missed opportunity. The national SAR analysis was critical of the lack of feedback to safeguarding referrers, commenting that this 'acted as a deterrent to future referrals and a lack of confidence in the safeguarding system'⁷. However, the report was equally critical of the 'failures by referrers to follow up on a lack of feedback'⁷. This is relevant to Iris as HCT have reflected that they did not use HSAB's escalation policy²⁵ (or any other means) to challenge the safeguarding closures when they did become aware of them. They have since shared the guidance and report being quicker to use this.

8.12 HCC have made several changes since the review period, including the appointment of a service manager to focus on operational function, a 'Cross Services' process and handbook to support consistency in safeguarding enquiries and more focused work around safeguarding meetings and closures, and measures around timeliness and handovers to other teams. Audits take place including peer audit reviews and these include regular direct communication with the Practice and Quality team. Furthermore, link workers have been attached to different operational teams and main partner agencies including HCT, and there is a consistent service manager level link with the Hertfordshire Constabulary Safeguarding Referrals hub to ensure a consistent referral process and a link for open investigations. HCC report that these measures have improved relationship with partners, stakeholder and agencies with established communication pathways.

9 Use of the MCA, interplay with Best Interest decisions and safeguarding outcomes

9.1 There was good practice evident across several services that the Mental Capacity Act 2005 was frequently used and referred to in documentation. There were three recorded capacity assessments for Iris. The first assessment (June 2023) was completed by HCT, in relation to her care needs. It was especially difficult to carry out as her son was in the property at the time and recorded the assessment on CCTV. His explanation was that the CCTV helped him to monitor her safety when he went out

and she was alone, however this was possible evidence of a tactic to control both Iris, and the people caring for her as they knew they would all be recorded. He later complained about how it had been carried out, and the outcome (that she lacked capacity for this). He was concerned that this would 'jeopardise' his plans for his brother to become an LPA for Iris, as individuals must have mental capacity to make the decision to create an LPA. Despite his frustration, this was potentially an opportunity to explore this issue further in terms of how he felt about having sole LPA responsibility and why he might want his brother's support. His complaints were robustly investigated which is good practice, and neither complaint was upheld.

9.2 As per the legislation and guidance, a 'best interest' decision followed: *'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'*¹⁰. The decision made after this assessment was that Iris should continue to be cared for at home as her son was seen as willing to engage. He was also offered a second assessment which he declined. HCC's reflection on this period is that they could have led this assessment and best interest process¹⁶, due to the safeguarding concerns around at the time. Furthermore, if there was a disagreement with the outcome of the MCA, then services did not need his consent to complete a second assessment. HCC have highlighted that there is an area of learning for them here about the need to share ideas about how to engage and involve the adult even if their carer declines, and that practice guidance on proportional responses based on identified risk levels would be useful for practitioners.

9.3 Two further MCAs took place; one in the first care home and one in the second care home, both were by HCC. They related to her decision-making ability in relation to meeting her care needs. The documentation shows well executed assessments, with reference to the legislation, principles and code of practice, which is excellent practice. Both times an IMCA was appointed which was good practice. Considerable steps were taken to ensure the best chance at communication. It is recognised that Iris gave limited answers, often 'yes' or 'no'. The outcome of both assessments was that Iris lacked the capacity for the decision about how and where to meet her care needs.

9. 4 Best interest decisions

The second decision outcome was that a 24-hour care home placement was in her best interests. This was due to her increased needs from frailty and deteriorating cognition, and the concerns about her son's provision of care. At this time, the safeguarding outcome had been that the concerns were 'substantiated' therefore this fed into the weighing up of the decision. Iris's son was not part of the process as although he had LPA he was on bail and was not allowed to visit or know where Iris was, therefore, he was not deemed a suitable decision maker. This was appropriate. Her IMCA agreed with the best interest decision. Input from the care home about her physical and emotional health (and improvements to this) were also considered appropriately.

9.5 In March 2024 the police visited Iris at the care home, the IMCA was also present. At the time she told them she wanted to remain in the care home and not return to her son. It is recognised that she gave different answers or did not answer at all at times when practitioners spoke to her about the safeguarding concerns. She was confused, sometimes thought to be referring to him as her husband. She was clear that she loved him and that she felt he did his best for her. She said at one point that she would like him to come and live with her, in the care home. She did not know she was in a care home at points. Although Iris was understood to be experiencing cognitive decline, a recognised pattern in domestic abuse is for victims to often give different answers/ 'change their story', and it is worth reflecting in this review whether this was given due consideration.

9.6 The third and final recorded best interest decision was made once several changes had taken place; Iris had moved to another care home, the police had not charged her son with assault and he was clear that he wanted her to return home, the safeguarding outcome had been updated to largely 'unsubstantiated'. It was also noted by HCC that Iris's communication generally improved when her son was present, and that she appeared relaxed in his presence. Feedback was again gained from the current care home who reported positive changes in Iris's health and wellbeing, physically and emotionally; Iris had gone from being very agitated at first to being more settled, smiling and mixing with other residents. They reported that she had not asked for or mentioned her son at this stage and that she did not have any new bruising since coming to stay with them.

9.7 The best interest process involved the son and accounted for the fact that formal care provision had never been in place at home and that trying this was therefore the least restrictive option for her. Whilst this is understandable in the context of the safeguarding findings at the time, between the safeguarding outcome and the best interest process there was insufficient weight given to the safeguarding history or the improvements to her health and wellbeing in both care homes. For example, whilst in the care homes Iris did not experience any new bruises and she went from being very agitated to more relaxed and started to smile and interact with other residents. The history of safeguarding concerns raised by professionals regarding the sons wound management and rough handling of Iris whilst in their personal residence was not sufficiently weighted, potentially because this behaviour was not observed in the care homes.

9.8 It was clear from recording that her son was exerting pressure for her to return home and that both he, and HCC believed him to be the decision maker. This pressure may have been better described as coercive control, and if there had been more links to domestic abuse support for practitioners it may have been viewed as such which may have then impacted on the best interest process. In the SAR 'Evelyn' the complexities of applying the principles of Making Safeguarding Personal²⁶, the Mental Capacity Act 2005¹⁰, safeguarding duties under the Care Act 2014² and the Human

Rights Act 1998¹⁶ are discussed. That report comments that there seemed to have been ‘little consideration... of the extent to which Evelyn’s family’s desire for her to remain in her own home (or in their homes) might be detrimental to her wellbeing’. The right to life (article 2)¹⁶ and the freedom from torture and inhuman or degrading treatment (article 3)¹⁶ are relevant in SAR Iris, alongside the right to respect for your private and family life, home and correspondence (article 8)¹⁶. The latter is often referred to as ‘the right’ whereas the exact wording is ‘the right to respect’ and this may be an important distinction to make. Fundamentally this was about Iris’s rights to respect for her family life, not her son’s rights, and this was not potentially recognised as fully as it could have been. This is also covered in the national SAR analysis which talks about the need to recognise risks from family members and misplaced professional optimism in relation to families. Furthermore, in the case of Iris, the decision was in complete contrast with the previous decision. Concerns were raised about the best interest decision by both her IMCA and the Safeguarding Advanced Practitioner who was also within HCC. The MCA Code of Practice¹⁷ (chapter 5) outlines the steps to take if there are disagreements about what is in someone’s best interests, this includes ‘get a second opinion’ and ultimately ‘the court might need to decide what is in the person’s best interest’. HCC raised this with the operational team manager who addressed concerns directly with her son and felt the issues raised were mitigated. This may have benefited from further exploration.

9.9 However, given that her son was agreeing to a care package at home, which hadn’t been tried before, and he was seen to be working with professionals on a safe discharge plan, it is understandable why this was seen as in her best interests. This report is mindful of avoiding hindsight bias, recognising this is a complex area and practitioners, managers and services are likely to benefit from more training and support around this. This is discussed further in the recommendations alongside discussions later in the report about disguised compliance by families.

9.10 Consideration of s44 of the Mental Capacity Act 2005

Under s44 of the Mental Capacity Act 2005¹⁰ people may be guilty of an offence if they ‘ill-treat or wilfully neglect the person they care for or represent’. These are separate offences, for a person to be found guilty of ill-treatment, they must either: have deliberately ill-treated the person or be reckless in the way they were ill-treating the person or not. The meaning of ‘wilful neglect’ varies depends on circumstances. But it usually means that a person has deliberately failed to carry out an act they knew they had a duty to do. There was no specific reference to this offence in the police records, there was one record of it being mentioned in a meeting held by HCC. Usually, an assault charge would take primacy however a charge of wilful neglect could also be applied in certain circumstances. In Iris’s case there was no charge of assault, further her son’s actions were seen as unintentional not wilful, both are likely explanations as to why this was not further considered.

10 Working with care providers and safeguarding

10.1 It was evident that for most of the safeguarding concerns raised, the section 42 eligibility criteria was correctly applied, and these concerns progressed to enquiry, with appropriate immediate safety plans in place. Eligibility decisions were made in a timely manner which is good practice. However, there was one safeguarding referral that was closed at eligibility stage. HCC have reflected that it was closed without the expected degree of exploration and scrutiny, citing that there was no documented oversight of the recent safeguarding history. This links to the reflections from the care provider 'A' (who made that safeguarding referral), that as carers they often have an insight into a situation that other services do not, but that this is not always given due consideration. This is briefly reflected in the second national SAR analysis 'one SAR found evidence a lack of parity of esteem given to the source of the referral, with safeguarding concerns raised by supported living staff given insufficient weight'⁷ and may be worth further exploration locally. There was also a need for more robust information sharing about her safeguarding history, the care provider 'A' state they were aware that there had been a safeguarding issue but did not have any further details. They reported this was not uncommon. It was also noted on CHC's return for this review that they were unaware of any safeguarding history. For the former, they reflected that this was not uncommon.

11 Working with Lasting Power of Attorney

11.1 There was a lack of clarity between services about the existence and validity of the LPA. The community health team had already ascertained the validity of the LPA however adult social care later checked with the OPG. The hospital where Iris was in 2024 after the alleged assault appear on their forms to have ticked 'no' to anyone having LPA, and this may have copied through to the Older People's Mental Health team referral, who also had the same on their form. An email trail in October 2024 from Hertfordshire police to HCC states 'the son had 'not been identified as being in position of trust at that point [when the allegation of assault had been filed]...I must assume that [son] has now applied for LPA since this investigation placing him into a position of trust' and asking if HCC knew what the LPA was for. The police stated that any new evidence e.g. bruising in care/lack of bruising can be submitted to them and 'OPG/COP to review whether the LPA remains in place'. Hertfordshire police confirmed in their return for this SAR that this would not have had any evidential bearing but would have instead determined if the investigation 'should be made by the police Adult Investigation Team (API) and not the local policing area'. Whilst it was good practice that the police raised an API investigation so that relevant information could be appended to the record for future reference, it is a sign of the lack of clarity between services about the validity of the LPA even at that late stage.

11.2 There was also a possible lack of understanding about the OPG's function, in documentation seen for this review there is reference to 'letting the OPG know' or 'contacting the OPG'. This gives the impression that practitioners were not clear that the OPG had an investigation role and could have been investigating alongside other agencies. It may explain the lack of urgency on contacting the OPG. Actions need to

be specific e.g. 'check validity of LPA with the OPG' or 'make a safeguarding referral to the OPG about the actions of the LPA'. There were several occasions when HCC took an action to contact the OPG to highlight safeguarding concerns (June '23, January '24, February '24) but this was not completed. This is despite HCC documenting in February 2024 that a referral could have been made to the OPG at their earlier safeguarding enquiry. HCC's own records show contact was only made in September 2024, seven months after this discussion. This was corroborated by the OPG's information return for this SAR; they received concerns in September 2024, and this was passed to the investigation unit however she passed away shortly afterwards. The OPG loses jurisdiction upon the death of a donor. The fact that the OPG had not been contacted was not clear to the other agencies involved in this review. This links to earlier learning about the need to revisit the actions agreed to ensure they have been completed, before closing enquiries. Delayed contact with the OPG is also a theme in other SARs about LPA and is echoed in the second national analysis of SARs, as is a lack of appropriate challenge to attorneys. For example, in SAR 'Evelyn' the LPA's decision were 'rarely challenged'¹⁵ however this is not the case in this SAR, where the son was regularly challenged on his behaviour, which was good practice. Both care providers who participated in this review demonstrated confidence with challenging attorneys and gave examples where they have needed to do this, both with Iris's son and in other situations, which is encouraging. However, one care provider was not aware they could report concerns directly to the OPG. This may be a theme amongst services locally, as it was only ever HCC who took the action to contact the OPG, despite any of the involved service having the ability to do this.

11.3 Practitioners have reflected that they felt her son's voice and wishes were given too much weight and that he often referenced the 'power' part of Lasting Power of Attorney without enough specific challenge by services as to the responsibilities he also had under this legal agreement. For example, within the MCA Code of Practice¹⁷ (chapter 7) there are clear expectations about the responsibilities attorneys have, including highlighting what would be a safeguarding concern; specifically 7:70 lists 'not allowing healthcare or social care staff to see the donor' as a sign that the attorney may be failing to act in a donor's best interests. There was no specific reference to this aspect of the Code of Practice within documentation seen, highlighting a possible need for services to increase their use and understanding of it in practice and recording. Her son was frequently referred to as 'the decision maker' however this could have been viewed and phrased differently, for example 'son has LPA which would in usual circumstances mean he is the decision maker, however due to the nature, intensity and frequency of safeguarding concerns, we consider him to be not acting in her best interests and therefore his role as decision maker is currently under question and we are seeking to challenge this formally through the Court of Protection'. Indeed, alongside a considerably delayed referral to the OPG, HCC did not seek their own legal advice about making an application to the Court of Protection at any time. It is not clear why. It was commendable that once the CHC team started supporting Iris, they sought legal advice in a timely manner and were prepared to make an urgent

application to the Court of Protection if required. The SAR 'Leocardo' talks about legal measures, commenting 'using the Court of Protection appropriately is more about technical knowledge'²². Since this review period, HCC and HCT have organised and attended events on LPA and the OPG therefore much of the suggested learning may already have taken place.

12 Working with older people and informal carers in familial settings where there are safeguarding concerns

12.1 Advocacy

Iris was appointed an IMCA in line with the Care Act 2014² (s68) for the two MCAs carried out by HCC, this was good practice. There was no evidence that Iris was appointed an IMCA for the best interest that HCT led on. There was not a specific advocate for any of the safeguarding enquiries. This is especially relevant for the first safeguarding enquiry where there was no direct conversation between Iris and HCC to gain her consent or discuss the safeguarding concerns with her; this means that E's understanding of the process or her views was not documented. In line with Making Safeguarding Personal²⁶ the individual needs to be central to safeguarding. To help someone participate, advocacy should be offered. Although her son had LPA, he was not a suitable advocate for any of the enquiries due to the safeguarding concerns being about his care of her. HCC have reflected that they would have expected advocacy to be sought in all the safeguarding enquiries. Iris's son could also have been offered advocacy potentially; where people posing risk (alleged perpetrators) may have substantial difficulty participating in the safeguarding process they can be offered advocacy, or the use of an established intermediary might have been useful to consider to better engage him in discussions. HCC have reflected for this review that they do use involved professionals from other services or an involved family member by agreement as intermediaries when required. In this situation there were other family members, but this was not fully explored.

12.2 Working with informal carers

It has been reflected in this review that practitioners felt they had inadvertently 'pandered' to Iris's son. The 'Think Family'²⁷ approach was discussed, this approach encourages involvement and holistic assessment of the whole family's needs and strengths, however it may have been that this was given too much weight. Her son commented that he felt he was being blamed by agencies for her deteriorating health. This created a conflict of interest for agencies in terms of balancing her voice and wellbeing as a priority and attempting to achieve a positive relationship with her son to support him to understand and respond to the valid concerns about inadequate care. The dilemma of how much to involve a family who are posing risk is seen nationally. Emerging research on section 42 enquiries for domestic abuse of older adults indicates that the involvement of family members is high (70% in one sample) and the concern here is the 'significant weight attached to the accused's view of the allegations made...we found that in many cases the word of the accused was more

powerful than that of the victim'²⁸. The research does explain its own limitations (sample size) however it is encouraging that this is being explored through research. SAR 'John'²⁰ found that 'across the health and social care system there is a strong emphasis on working closely with families, respecting autonomy, and self-determination, and minimising the interference and footprint of the state in a person's private and family life'. However, it goes on to comment that this should not be at the expense of professional curiosity.

12.3 Several SABs have produced guidance on safeguarding and informal carers, one such document references the risk that the cared for can pose to the carer 'they could be abusing their carer, however unintentionally, as a result of a condition they have... The carer may be doing their best but still struggling. They may put the person at risk because they snap under pressure, rather than intending to cause harm'²⁹. This is relevant to the case of Iris, as there was documentation to suggest that Iris had hit her son on at least one occasion. This was potentially not explored fully. HSAB have similarly invested in guidance and training to support practitioners to identify and understand the differences between an unpaid carer who is stressed, and their behaviour has resulted in harm (usually verbal or physical) and when these concerns should be seen as domestic abuse.

12.4 Disguised or feigned compliance

There was use of compromise with Iris's son throughout the review period, for example he was taping her fingers together to stop her scratching. Health professionals provided finger covers which he agreed to use instead. This shows the delicate balance between working with what was medically best for Iris, and what her son would allow; he had his own rationale for his methods. There were times when he agreed to safeguarding measures for Iris, such as the acceptance of the need for carers when he wanted her to leave the care home. However, practitioners reported that they felt he often told them, 'What we wanted to hear'. This is echoed in the 'Evelyn' SAR which comments 'there may have been an element of "disguised compliance", or perhaps more accurately "feigned compliance", in which professionals were told what they wanted to hear in order to prevent them from enquiring further'¹⁵. This SAR has several helpful suggestions we can apply to the review of Iris, for example about the use of chronologies as a useful tool in building a picture of 'persistently present themes and patterns'¹⁵.

12.5 From the documentation reviewed for this review, there was evidence throughout that practitioners and services offered and signposted Iris's son to appropriate support as an unpaid carer. For example, he was offered a carers assessment which he initially declined but later did accept. This carers assessment has not been seen for this review. He was signposted to carers charities and at one stage he was given respite hours funding so he could go out knowing carers would be sitting with Iris. We know from discussions with practitioners and documentation that he told others he felt 'blamed and criticised' by professionals when they raised safeguarding concerns, and his response was to complain about those practitioners and prevent people and

specific services from visiting Iris at home (by September 2023 he was refusing to allow social workers or district nurses to visit E). Regular complaints about individual practitioners can be emotionally draining stressful for those practitioners, and the impact of this needs to be understood. Support for practitioners can be achieved through regular supervision, and organisations dealing with complaints about their staff in a way that builds resilience and supports development.

13 Professional curiosity

13.1 Similar to the lack of data on older victims of domestic abuse, there is little known about perpetrators. It was reported during this SAR that anecdotally HCT and HCC have seen an increase in safeguarding concerns in relation to adult sons caring for elderly parents. It is a recommendation of this review that professional curiosity is applied to this, and work undertaken to measure the volume, nature, and impact of this across Hertfordshire.

13.2 During the review period, Iris's son was signposted to carers charities and given some respite hours funding. He felt blamed and criticised by professionals when they raised concerns. This is clear particularly from the police interview. It is not clear if he had any known or suspected neurodivergence or what his needs may have been. There was a lack of curiosity about his circumstances and motivations, particularly understanding why he was so reluctant to put formal care in place, and when carers were in place why he was obstructive towards them. This finding was also apparent in the 'Evelyn' SAR. In Iris's case, there is some recording around this captured within the best interest decisions when she was in the care home(s), however this is not explored in depth; there may have been cultural reasons that were not understood. However, it needs to be recognised that throughout enquiries even when her son was seen to be working with professionals this was not without challenge, and therefore the opportunities to talk calmly about such issues may not have been available. It was noted that he regularly talked over professionals and could be verbally abusive and intimidating at times. We must avoid hindsight bias here.

13.3 It was noted in meeting minutes that the hospital Iris went to in July 2024 was different to the one she attended after the alleged assault in January 2024. Against medical advice he drove Iris to another hospital. There was a suggestion in the meeting that her son was intending to use different hospitals with the avoidance of the history becoming known, more exploration of this may have been beneficial. This concern is shared with SAR 'Evelyn' where one of the concerns was that her son was 'presenting her to random hospitals that were not connected'¹⁵.

13.4 Practitioners in this SAR's focus group discussed their underlying concern that there may have been financial reasons for her son's reluctance to have formal care. There was awareness that Iris's property had been sold and there were concerns about lack of food in the fridge, but there was no documented follow up on any financial abuse concerns or questions more generally about his management of her financial affairs by any service. One of the safeguarding enquiries states there is 'no evidence

of financial abuse' but this does not appear to have been explored. As he had LPA for Financial and Property affairs as well as Health and Welfare LPA, there is an argument that this should have been considered. HCC stated for this review that there was a need to chase up unpaid invoices, it is not clear if this was part of any discussions had with her son. However, given the pressing and harmful nature of the other concerns about physical abuse, neglect, and emotional abuse, this is understandable. We see similarities again with SAR 'Evelyn'; 'there does not appear to have been consideration of whether or not Evelyn was experiencing other forms of abuse, for example, financial abuse and no attempts to check how Evelyn was managing her finances seems to have been made'¹⁵.

13.5 Little seems to have been recorded about her son, a partner is mentioned as is one hobby, however it is not clear if he worked or was claiming Carers Allowance³⁰ or other benefits for himself or her. His support network may have been limited to a partner, his brother was spoken to once by professionals and this was near Iris's death, when the CHC were put on the phone to him by the son she lived with. The brother stated that he had stayed with Iris and his brother and had 'witnessed' how hard it was for his brother and that he felt he was 'doing the best he could.' Care provider B reported that they had seen the other son in person and that he was not obstructive to their care. Lack of curiosity about other family members was also present in SAR 'Evelyn' with that review finding 'there does not appear to have been much curiosity about Evelyn's sons, including their ages, occupations and whether there were any partners or other family members'¹⁵.

13.6 In the case of Iris, there was mention of a niece and a sister and the need to try to find other family members. However, there is no evidence across any of the documentation provided for this review (by any service) that this was acted on or followed up. It was noted that when police asked Iris's son for details of other family members, he refused to share any, saying his brother lived abroad and his mother had chosen him as LPA. This links to earlier themes around people not chosen as LPA still being important especially if there are safeguarding concerns about the LPA, and concerns about isolation and control as a part of domestic abuse. It would have been good practice to contact the local authority where she had previously resided to see if they had any history or contacts they could share. Similarly, hospitals in the other area or the ICB there may have had her previous GP details who could have confirmed medical history and relevant history; though she was believed to have dementia there was no formal diagnosis on record for her in Hertfordshire. She was repeatedly registered and deregistered from the surgery, from 2019 onwards there were seven registrations and six de-registrations. Some of this is accounted for by her stays in care homes during this review period, however several take place before this period.

13.7 There were several references by various agencies throughout this review period to the property being in a 'poor state' 'cluttered' 'not much food in'. The police report states there were 'signs of hoarding and clutter' in the property. However, there was no exploration of these issues in any of the documentation viewed for this review, by

any service. One of the possible reasons for this was because services were 'firefighting' the more urgent physical and mental wellbeing safeguarding concerns and trying to support her son to engage with them on this.

14 Domestic Abuse Act 2021

14.1 The Domestic Abuse Act (2021)³¹ defines abusive behaviour as consisting of the following: physical or sexual abuse, threatening or violent behaviour, controlling or coercive behaviour, psychological, emotional, or other abuse, economic abuse. In this SAR, the chronology of incidents concerns physical abuse, psychological and emotional abuse. The legislation and accompanying statutory guidance recognise the needs for support services to 'avoid making assumptions about a victim's condition or health based on their age. For instance, injuries or mental health issues may be viewed as the result of a victim's health and social care needs, without enquiries being made around domestic abuse'³². Age UK has campaigned for more research and support for older people in relation to domestic abuse. In 2020 the Office for National Statistics scrapped the upper age limit (up to 74) on who they asked about domestic abuse for their Crime Survey for England and Wales, a positive move enabling data collection on crimes against older people.

14.2 Age UK's research tells us that older people are 'just as likely to be abused by an adult child or grandchild as they are a spouse or partner – this also means that men become at increased risk of being subjected to domestic abuse as they age... many older people subjected to abuse have a health condition or disability, which may mean they rely on their abuser for care and support'³³. The practical suggestion here is that the tools used by professionals need to consider the risk factors specifically affecting older people, and the 'wider range of potential perpetrators.' Similar findings are available in emerging research; 'key findings include older adults experiencing DA are equally, if not more, likely to be abused by an (adult) child/offspring, most adults at risk were female and suspects were male'²⁸, this research found that in their sample 29% of the victims had dementia- almost a third. Interestingly, and relevant to Iris, this research also found a lack of formal dementia diagnosis. Again, of relevance to HCC and HCT's concerns about an increase in safeguarding concerns about 'mums and sons', the research found that where perpetrators were male, they were most likely to be a partner (45%) or son (42%)²⁸. The second national analysis of SAR showed an increase in SARs featuring domestic abuse, with a growing recognition of coercive and controlling behaviour, with various related recommendations including that SABS should 'prioritise further multi-agency focus on the issue of adult family violence between siblings and parents as part of its wider approach to reducing the incidence of Domestic Violence'⁷.

In encouraging news, despite research indicating domestic abuse against older people is frequently categorised incorrectly, this was not the case for Iris. The safeguarding concerns were appropriately assessed as domestic abuse by all the agencies involved which is good practice, especially as research indicates that for older adults, abuse is often not categorised as domestic and can often be rationalised/viewed as 'carer

strain.' This is also reflective of the work undertaken by HSAB in this area and is a sign of safeguarding systems including SABs achieving good outcomes. For example, there is a partnership domestic abuse board who have recently been developing work specifically on older people and domestic abuse, and there has been increased scrutiny on this issue including where people lack relevant capacity. Furthermore, since this review period, HCC have increased their Domestic Abuse training and have focused work on Violence Against Women and Girls, and the complexities it entails. There is a particular focus on the impact on older people with dementia. This is being delivered creatively through sessions with practitioners and podcasts with related agencies.

14.3 There was also a referral to an Independent Domestic Violence Advocate (IDVA) in January 2024, and she was discussed later that month at a Multi-Agency Risk Assessment Conference (MARAC)³⁴ after the police referred her to that process, which was good practice. A MARAC is a meeting where relevant agencies share information on the high-risk domestic abuse cases in their area. The primary focus is to safeguard the adult victim³⁵. According to the minutes of that meeting, seen for this review, the following key agencies were not at that MARAC: Community Health Team (HCT) Hospital Trusts (ENHT) and HCC. HSAB are undertaking work in the partnership about MARAC including attendance as statutory partners particularly do need to be represented. In this review, lack of attendance did not affect the outcome. The MARAC attendees were under the impression that she was not going to return home to live with him, which at the time she was not, so this appears to have been an accurate perception of risk. Later in the period of review there was a discussion about re-referring to MARAC which was also good practice, however no re-referral was made. Hertfordshire Police arranged for an independent review of their involvement with Iris for this review. This relates primarily to the allegation of assault by her son in January 2024, and the subsequent police investigation that followed. There was clear timely investigation with the allegation taken seriously and treated as an assault in a domestic abuse context. There were a number of supervisory reviews from the Detective Sergeant, Detective Inspector and Chief Inspector throughout this investigation, examples of good management oversight. The investigation was timely and proportional, with good communication between the police and HCC, and the care home.

14.4 Working with victims and achieving best evidence

14.5 Iris was found to be unable to give evidence and according to the police return for this SAR, she was also consistently denying the allegation, though between agencies the initial reports on this at the time of the incident appear to differ. Her son also denied the allegation. There were no other witnesses to the incident overheard by the call handler, and that police state that there was no other evidence that they could have used to support a victimless prosecution, it was good practice that they considered this. There was no evidence to suggest that Iris's age or dementia stopped police from attempting to speak to her and progress the investigation, or that concerns were taken any less seriously because of these protected characteristics. This is good

practice. She was visited by police both at the time of the incident and several times afterwards, this was good practice. She was reviewed for a formal interview in relation to Achieving Best Evidence³⁵ and deemed not suitable due to her dementia. Medical advice was sought for this by the police.

14.6 The police state evidential difficulties were faced as they found no evidence of a physical assault and that the medical evidence strongly suggested that the injuries were 'older bruising as a possible result of falls and skin cancer, some of which were possibly self-inflicted'. The call was listened to, and the alleged physical assault was less clear, and due to these factors and both E and her son continuing to deny assault, no further action was taken against her son and no charges were brought. The police report states that Iris accounted for her injuries being accidental. However other services who saw her around the same time reported she said very little in any discussions they had, often only giving yes or no answers. On further review of the police's interactions with Iris for this review, they confirmed that for the initial incident it was evident that Iris could comprehend the questions she was being asked and answered within the context. However later in their investigation, responses from Iris were 'not particularly conversational'.

14.7 There were discussions in safeguarding meeting minutes between services including the police, about whether Iris bruised easily because of her health conditions and medication and it was noted that it would be important to know if she did continue to bruise in the care home however it does not appear this was followed up on by any service adequately. When the SAR author spoke to the second care home, where she was resident for several weeks, they confirmed that she did not sustain new bruising whilst under their care. This is also echoed in some of the documentation but there didn't appear to be a shared understanding about this. It was identified in the police investigation that her son had used abusive language towards her (he was overheard calling her a 'c**t') however it was 'within their home and did not amount to an offence in law'. An email trail however also shows the police referring to the son's language towards his mother as 'colourful'. This apparent 'downgrading' from abusive to colourful is subjective and potentially unhelpful, as it appears to minimise the impact of the emotional abuse.

15 Working together, sharing information

15.1 One of the six principles of adult safeguarding is partnership. In the second national SAR analysis, the negative observations on working together outweighed the positive; 'Of the 229 SARs included in the stage 2 analysis, 95 per cent identified aspects of interagency and interprofessional practice that could or should have been improved...how agencies and practitioners work together is an important element in the checks and balances that can keep the safeguarding system safe'⁷. There was clear evidence throughout this review period of services and practitioners working together. This was seen both within, and between services. For example, practitioner at the focus group for this SAR reported that HCT used more senior staff 'protect and support' more inexperienced practitioners and this was effective in ensuring there was

resilience in the face of intimidation and obstructive actions by Iris's son. There was clearly documented communication at various points between the police, care providers, HCC, HCT and the GP surgery. There was evidence throughout of person-centred safety planning within both multidisciplinary and section 42 safeguarding meetings, with clear rationale and actions. There were, in the main, clear plans to review in a timely manner which was also good practice.

15.2 There were examples of good information sharing. The care home highlighted how helpful the police were in keeping them up to date in relation to the son's bail conditions, including the lifting of those. Email trails show good communication between HCC and the police. The care agency reported that they were asked to attend some meetings and felt their contributions were valued. The care home reported that they were asked for their views. However, there were times when lack of clarity was apparent. For example, there were different recorded versions of the January 2024 alleged assault, one report stated that police had found Iris 'cowering in the toilet' but they later clarified in a meeting that she had been found 'on' the toilet 'not cowering'. Another report stated that Iris had 'disclosed she had been assaulted by her son' at the time however later the police stated that she had 'vehemently denied' the allegation at the time and afterwards. There were mentions of a burn mark (by the ambulance) and that Iris had 'refused to disclose the source of the burn' but later there is no reference to the burn in other records. There was a lack of clarity about her family when she was in hospital in January 2024 and transferred to the care home(s). The care home who participated in this review were not aware that E had another son, linking to the earlier suggestion that wider exploration of other family/informal support network may have been useful throughout safeguarding and investigative processes. It was also recorded on the Older People's Mental Health Team records that her 'sons' were not to have any contact with her, and also that there were 'no current family members that can be contacted for information due to recent safeguarding concerns'. It appears this information had been copied/pulled through from another source, but it not clear where. It was also added to their case note 'Paris' system. This highlights the importance of accurate information about all elements of a safeguarding concern.

16 Findings and recommendations

Finding 1: Practitioners, managers and services across all partner agencies need support to understand the complex interplay between the Human Rights Act (HRA)1998¹⁶, the Care Act 2014² and the Mental Capacity Act 2005¹⁰ when there are safeguarding concerns.

Recommendation 1:

- This SAR is used in learning sessions across partner agencies to support practitioners to understand where there are sometimes conflicting issues and gaps in legal/guidance, and the importance of a common understanding of risk
- HSAB, HCC and HPFT to ensure the HRA and its interplay with safeguarding legislation and guidance is in its safeguarding guidance and training offers

Finding 2: Practitioners and services need practical guidance in relation to working with informal carers when there are safeguarding concerns. Denied access can be a consistent feature of these types of concerns.

Recommendation 2:

- HSAB to seek assurance that partner agencies are aware of all the legislative routes to ensuring access to individuals
- Specific training on working with families who are evasive may be useful if this is not already offered to partner agencies and commissioned care providers.
- HCC safeguarding guidance needs to include setting clear expectations for all services when they are working together/involved in safeguarding enquiries. For example, if denied access means that some services are being allowed in, the expectation is clear about what they are being asked to do, including undertaking assessments, and what level of feedback is required
- HCC to ensure that practitioners and commissioned IMCA/advocacy providers are aware of their co-located IDVA service, and the resource they provide to support and advise staff on DA concerns
- HSAB to seek assurance from partner agencies that IMCAs and advocacy providers have full access to domestic abuse training
- This SAR's findings and recommendations to be linked to existing workstreams already happening within domestic abuse/Violence Against Women and Girls field including the ongoing work linked to adults with dementia

Finding 3: Improvements to safeguarding closures are required. This is especially in relation to those situations which require an element of ongoing monitoring and there are safety plans in place/suggested. If visits to an individual are to be delegated clear rationale and expectations should be recorded.

Recommendation 3:

- HCC and HPFT to consider increasing the use of safeguarding meetings before conclusion and closure of enquiries to ensure coordination with all services

involved, and incorporating the use of tools to aid practitioners in these being delivered efficiently

- HCC and HPFT to remind practitioners that if there is a need to identify who will coordinate efforts outside of the safeguarding process this is clear on recording and there is a plan in place to support this, before closure and build this into their training and guidance offers
- HCC and HPFT to carry out regular audits of safeguarding closures

Finding 4: There were repeated missed opportunities for any agency to inform the OPG in a timely manner of the concerns, and a delay in ascertaining the validity of the LPA by HCC.

Recommendation 4:

- HSAB to remind practitioners of their guidance on safeguarding concerns involving Lasting Power of Attorney, Deputyship, Enduring Power of Attorney, and the roles of the Office of the Public Guardian and Court of Protection in this, this could include a checklist of things to consider. HSAB to ensure that care providers locally are also sent this information (commissioners in HCC and HCT can support with dissemination)
- HCC, HPFT and ICB to seek assurance internally that all safeguarding enquiries involving concerns about LPA currently have active OPG involvement, or clear rationale why not, if not. This could be done through audits and may need to be re-audited on an annual basis.
- HSAB to use this SAR learning with all partner agencies to remind them of the importance of correctly recording information about Lasting Power of Attorney on their systems, and updating this (i.e. even if 'pulled through' the service should check it is accurate)

17 Conclusion

This SAR set out to examine and draw out findings on the complexities of adult safeguarding when the person thought to be causing harm is an unpaid family carer. It has examined the issue of denied access and the impact of how abuse and neglect are viewed when the victim is older, with dementia. It has considered the impact of caring and recognises the voices unheard in this SAR, Iris and her family namely. It has analysed the interplay between legislation, highlighting the complexities of this interplay and finds that the challenge for practitioners, managers and services in ascertaining what is in an individual's best interests is not to be underestimated. This must be seen in the context of public services being under considerable strain financially, the impact of which cannot be underestimated and should not be ignored in SARs.

We understand from this SAR the importance of coproduction in safeguarding enquiries, outcomes and the practicalities we need to ensure are in place at point of closure, particularly when there is a need for ongoing risk management. Further, this SAR helps to highlight where more support may be required in terms of how partner agencies refer to other organisations namely the OPG and how attorneys can, and should, be challenged including through the Court of Protection. We found good practice in a number of areas; mental capacity assessments, utilising the professional(s) who had a relatively good relationship with her son, multi-agency meetings, timely and efficient police investigations, challenging her son regularly. We did not find evidence that her protected characteristics impacted on how services worked with her, recognising that the impact of her apparent dementia was significant in terms of cognition and ability to take part in enquiries and investigations. This SAR shows the impact of work undertaken by SABs; HSAB have undertaken significant work supporting practitioners to understand the differences between 'carer strain' and domestic abuse, and this understanding was evident throughout this review period, across all services.

Ultimately, we recognise the difficult and complex nature of the safeguarding concerns around Iris, and the diligence, persistence and resilience of so many practitioners and paid carers across all the involved services in working to meet Iris's needs in whatever way they could. Working together here is key, practitioners need to feel supported by each other, leaning on each other's expertise and resources, this builds confidence and resilience.

1. [Make, register or end a lasting power of attorney: Overview - GOV.UK](#)
2. [Care Act 2014](#)
3. [Safeguarding Adults Reviews \(SARs\) under the Care Act - SCIE](#)
4. [Police and Criminal Evidence Act 1984](#)
5. [Mental Health Act 1983 https://www.legislation.gov.uk/ukpga/1983/20/contents](https://www.legislation.gov.uk/ukpga/1983/20/contents)
6. [Government to review case for powers of entry for social workers in adult safeguarding cases - Community Care](#)
7. [Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 \(executive summary\) | Local Government Association](#)
8. [Adult Support and Protection Act \(Scotland\) 2007](#)
9. [Social Services and Well-being \(Wales\) Act 2014](#)
10. [Mental Capacity Act 2005](#)
11. <https://www.scie.org.uk/safeguarding/adults/practice/gaining-access/>
12. <https://www.legislation.gov.uk/ukpga/2018/23>
13. [NHS commissioning » Who is considered a carer?](#)
14. [Key facts and figures | Carers UK](#)
15. [sar_report_evelyn.pdf](#)
16. [Human Rights Act 1998](#)
17. [Mental Capacity Act Code of Practice - GOV.UK](#)
18. [Report a concern about an attorney, deputy or guardian - GOV.UK \(www.gov.uk\)](#)

19. <https://www.gov.uk/government/publications/safeguarding-policy-protecting-vulnerable-adults/sd8-opgs-safeguarding-policy>
20. 'John' PowerPoint Presentation (West Berkshire) 2023.
21. [Edith SAR \(January 2025\) - Hampshire Safeguarding Adults Board,](#)
22. [LeocardoAdultESAR.pdf](#)
23. [Making decisions: the Independent Mental Capacity Advocate service \(web version\) - GOV.UK](#)
24. <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>
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33. [What we know now about older victims of domestic abuse | Discover | Age UK](#)
34. [Multi-Agency Risk Assessment Conference](#)
35. <https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/>
36. [Achieving best evidence in criminal proceedings - GOV.UK](#)