City and Hackney
Safeguarding Adults Board

Safeguarding Adults Review of the circumstances concerning Mrs Y

Overview Report

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Overview report writer

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SAFEGUARDING ADULTS REVIEW: Mrs. Y

Synopsis of circumstances that led to this Review:

Mrs. Y died on 14 May 2015, whilst admitted to the Homerton University Hospital Foundation Trust (HUHFT). Mrs. Y was 84 years of age at the time of her death and she was of Black British / Caribbean heritage. It is reported that Mrs. Y had three daughters who lived with her at various times prior to her death and who were known to multiple agencies.

Mrs. Y's case was referred to the Coroner's Court for further investigation following her death. The Coroner determined that Mrs. Y died of natural causes (bronchial pneumonia). However, after Mrs. Y was admitted to hospital, the HUHFT had referred a Safeguarding Adults Concern to the London Borough of Hackney (LBH) expressing concerns regarding potential issues of neglect of Mrs Y. A decline in cognition, weight loss, and increased visual impairment were noted. As a result of this referral and Mrs Y's subsequent death, a Safeguarding Adults Review (SAR) referral was made to the City & Hackney Safeguarding Adults Board (CHSAB). The referral identified that neglect was potentially a contributing factor in Mrs. Y's death despite receiving, direct or indirect, input from various agencies prior to her hospital admission.

Statutory duty to conduct a SAR:

The City & Hackney Safeguarding Adults Board (CHSAB) has a statutory duty under s.44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR):

- Where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

Decision to conduct a SAR:

The SAR & Case Review sub-group of the CHSAB determined at its meeting on 7 January 2016 that the circumstances of Mrs. Y's death met the criteria for undertaking a SAR. The CHSAB therefore set up a SAR Panel to conduct a review that would help the Board meet its objectives:

- To be provided with a report that analyses and makes recommendations that will contribute to improving safeguarding outcomes for adults at risk of abuse or neglect;
- To review the effectiveness of both single agency and multi-agency procedures in securing safeguarding of adults at risk of abuse or neglect;
- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together;
- To inform and improve single and inter-agency practice for safeguarding adults at risk of abuse or neglect;
- To contribute to the accountability to service users, the general public and relevant government departments and regulatory bodies of the agencies in City & Hackney responsible for safeguarding adults at risk of abuse or neglect.

The membership of the SAR Panel was as follows:

- **Panel Chair:** Dr Adi Cooper, Independent Chair of the City & Hackney Safeguarding Adults Board
- *Until June 2016* - Adrienne Stathakis, Interim Assistant Director of Adult Social Care, London Borough of Hackney
- *From July 2016* - Lisa Redfern, Interim Assistant Director for Adult Social Care, London Borough of Hackney (assuming Adrienne Stathakis' Panel role)
- *Until June 2016* - Martin Sexton, Senior Practitioner, Mental Capacity / DoLS lead, London Borough of Hackney (*left London Borough of Hackney in June 2016*)
- *From June 2016* - Margaretha Staines, Quality Assurance and Practice Development Practitioner, London Borough of Hackney (assuming Martin Sexton's Panel role as independent report author)

Agency representatives who participated in this process were:

- Bill Henderson, Housing Director, Newlon Housing Trust
- Charlotte Dingle, Senior Occupational Therapist/Single Point of Access Screener, Homerton University Hospital NHS Foundation Trust
- Lesley Rogers, Head of Healthcare Compliance, Homerton University Hospital NHS Foundation Trust

The Panel was supported by:

- Paul Griffiths, City & Hackney Safeguarding Adults Board Manager
- Jayde Maynard, City & Hackney Safeguarding Adults Board Business Support Officer

The panel met on 31 May 2016, 20 July 2016 and 13 October 2016, including meetings with agency representatives who participated in the process. The draft report was presented to the SAR Sub-Group on 20 October 2016 in accordance with CHSAB processes, before being presented to the CHSAB on 1 November 2016.

Terms of Reference for this SAR:

The Panel's full Terms of Reference may be found in Appendix 1. The specific objective of this SAR was:

To establish what learning from this case can inform practice when working with families where there are potential issues of neglect.

SAR Report Author:

Date Completed:	05 October 2016
Author:	Margaretha Staines
Role:	Quality Assurance and Practice Development Practitioner
Main Participating Agencies:	▪ Hackney's Adult Social Care Service ▪ Newlon Housing Trust ▪ Homerton University Hospital Foundation Trust ▪ London Ambulance Service

Contents:

1. Purpose of Report

1.1 To keep Mrs. Y at the centre of the review, its findings and recommendations, by attempting to convey her experience and voice throughout this report.

1.2 To establish a chronology of events prior to Mrs. Y's death which includes details of input provided by multiple agencies as well as taking into consideration the interventions with other members of Mrs. Y's family unit.

1.3 To stimulate each participating agency to reflect critically on its own practice, policies and procedures as well as to constructively challenge the practice of the other stakeholders involved.

1.4 To identify lessons learned and recommendations for improvements that the CHSAB and the relevant agencies could make when working with similar cases in the future.

2. Details of Mrs. Y and her family network

2.1 Details about Mrs. Y

As previously mentioned, Mrs. Y was an 84 year old lady of Black British / Caribbean heritage. She lived in her house in Hackney until she was admitted to hospital prior to her death in 2015. Her daughters lived with her periodically. There was limited background information available about Mrs Y.

The information provided to this review suggests that the agencies supporting Mrs. Y communicated with her daughters rather than directly with her. It appears as if Mrs. Y, at least on some occasions, willingly requested that her daughters manage her affairs on her behalf. This statement can be evidenced by examples obtained from written records:

- Prior to 2000, Mrs. Y signed an authority with Newlon Housing Trust, her housing provider, which enabled her eldest daughter, V, to deal with some rent matters on her behalf. This later changed when daughter, T, started dealing with matters on behalf of Mrs. Y and became the main contact with Newlon Housing Trust, as well as for most of the other agencies supporting Mrs. Y.

- On 30 May 2013, the police were contacted to conduct a welfare check on Mrs. Y. Police had to force entry into Mrs. Y's home and found her in a neglectful state inside the property. Mrs. Y required medical treatment but she refused to attend hospital without her daughter T being present. Despite the best efforts from both the police and London Ambulance Service (LAS), staff tending to Mrs. Y, she refused to be admitted to hospital and agreed for her daughter, T, to take her to hospital later that evening.

There has been no evidence which suggested that Mrs. Y expressed any concerns with her daughter, T, managing her affairs on her behalf.

Records indicate that Mrs. Y had a number of aliases that were used in addition to her known name. The reason why Mrs. Y used these aliases is not known. Mrs. Y had two separate profiles with different names on the LBH Adults Social Care electronic recording system, Mosaic, which has since been merged into a single profile under Mrs. Y's known name.

2.2 Physical health and medical history

Mrs. Y's physical health conditions and medical history included the following:

2.2.1 **History of sensory impairment** – It is reported that Mrs. Y received treatment and input from Moorfields Eye Hospital in 2003 to 2004. However, in 2015 it is reported that Mrs. Y failed to attend follow up appointments scheduled at Moorfields for further treatment of her cataracts as well as her general eye sight. Medical notes indicate that at the time of Mrs. Y's death, she suffered with very poor eye sight.

It is also reported that Mrs. Y was hard of hearing, which often acted as a barrier in communicating with her.

There is no evidence which would suggest that Mrs. Y had hearing aids or that she sought or received input related to her sensory impairments following her initial input from Moorfields Eye Hospital.

2.2.2 **History of leg ulceration to the pretibial area of the left leg** – Medical notes indicate that Mrs. Y received input from a Tissue Viability Nurse (TVN) in May 2011. It is reported that Mrs. Y's left leg was particularly problematic as she also had pitting oedema and an unspecified deformity of her left leg.

Her mobility was significantly affected by her condition as well as the significant level of pain that Mrs. Y was experiencing as a result of her leg ulcer. When the LAS and police attended Mrs. Y's property on 30 May 2013, Mrs. Y said that she was unable to move freely and without support in her home due to the condition of her leg ulcers.

The LAS attended to Mrs. Y's property on 10 March 2015, after it was reported that Mrs. Y had fallen out of bed and injured herself. Mrs. Y expressed a fear of falling after her daughter, V, had removed the carpets in the bathroom, which may have increased the risk of Mrs. Y slipping. Also during this incident, it was reported that Mrs. Y was sitting on a '*mobility chair*' although it is not entirely clear what this piece of equipment was or how Mrs. Y acquired such a chair.

Following Mrs. Y's admission to hospital on 10 March 2015, her daughter reported that Mrs. Y had become completely bed bound approximately two months prior to her admission.

2.2.3 **History of having a stroke** – Medical notes indicate that Mrs. Y experienced a large right hemisphere stroke, which was likely to have occurred three years prior to her hospital admission in 2015. However, medical notes provide conflicting information about when exactly Mrs. Y might have had the stroke. Some records state that she experienced the stroke two months prior to her admission to hospital and other records state that she had the stroke three years prior to the admission.

This confusion is likely to have occurred as result of the lack of contact that medical professionals had with Mrs. Y prior to her admission to hospital and that agencies had to rely on verbal accounts from her daughter, T, to try and established what happened to Mrs. Y.

It was reported that Mrs. Y became dependent on her daughter for support but had not received appropriate medical or hospital treatment following her stroke. It was also reported that Mrs. Y suffered from slurred speech, decreased mobility and left sided weakness following the stroke.

2.2.4 **Communication difficulties** – Various written records indicate that Mrs. Y was able to speak English but communication was limited as she reportedly suffered from dysphasia and was hard of hearing. It is also stated that Mrs. Y did not communicate much whilst being admitted to hospital.

2.2.5 **Experienced a decline in cognitive functioning** – No concerns regarding Mrs. Y's cognitive functioning were raised prior to her hospital admission on 10 March 2015.

The LAS attended Mrs. Y's home on 30 May 2013 after police forced entry into her home due to concerns for her welfare. During this incident, when Mrs. Y refused to be taken to hospital

for treatment, LAS staff recorded that Mrs. Y had the necessary mental capacity to make this decision. On 8 May 2015, a Stroke Consultant at HUHFT recorded that a Mental Capacity Assessment (MCA) was conducted which determined that Mrs. Y did not have the necessary mental capacity to make an informed decision about her treatment.

There is almost a two year gap between the above mentioned insights into Mrs. Y's capacity. This is due to the fact that there is no recorded contact with Mrs. Y during the entire 2014.

No evidence has been found to indicate that Mrs. Y was ever diagnosed with any particular cognitive impairment but she had continued to deteriorate whilst admitted to hospital in 2015 and lost the ability to verbalise towards the end of her life.

It should be noted that communicating with Mrs. Y may have been challenging as it was reported that she was hard of hearing and her speech was affected following her stroke (dysphasia). Therefore, any attempts to establish Mrs. Y's mental capacity in relation to a given decision would have been challenging.

2.2.6 **Displayed potential signs of neglect upon admission to hospital on 10 March 2015** – It is reported that Mrs. Y was '*cachectic (and) clinically dehydrated*' following initial assessment upon admission to hospital. Medical records indicate that Mrs. Y's daughter had reported that she had been losing weight prior to her hospital admission and that daughter had concerns about her mother's nutrition. When Mrs. Y was admitted to hospital she had a low BMI and blood tests revealed low phosphate levels, which may suggest probable malnutrition.

2.2.7 **Deterioration whilst in hospital to 14 May 2015**– Whilst in hospital it was recommended that Mrs Y required a NG/PEG feed tube as she was not taking food or drink orally. However, T reported that that Mrs Y was opposed to this and refused to agree to this intervention. There was also an incident regarding mouth care which led to T being advised not to continue to do this. Hospital records highlight attempts by staff to discuss these issues with T, seek other family member involvement, raise safeguarding concerns and an IMCA visited Mrs Y on 11 May 2015. Palliative Care Team involvement was declined on 12 May 2015 and an urgent DoLS authorisation was pout in place with a view to preventing T from visiting Mrs Y without supervision. Mrs Y dies on 14 May 2015.

2.3 Family Network:

There are different reports as to how many children Mrs. Y had. On admission to the Royal London Hospital (RLH) on 10 March 2015, it is reported that Mrs. Y had four children but this remains unconfirmed. However, it is mainly accepted that Mrs. Y had three daughters living with her at various times prior to her death in May 2015, referred to in this report as V, W and T.

Mrs. Y was the only tenant at her house in Hackney, managed by Newlon Housing Trust, and that her daughters were known as residents rather than tenants. Mrs. Y was a tenant with Newlon Housing Trust since 1995.

There are also conflicting reports as to what the exact relationship was between Mrs. Y and her daughters. Some records state that all three daughters were adopted by Mrs. Y, other records state that Mrs. Y was their foster mother and one particular statement made by Mrs. Y's daughter, W, reports that V and W were Mrs. Y's foster daughters whilst T was her biological child. Contact was made with Hackney's Children Services to ascertain if they had any relevant records, which could provide some clarification to the nature of their relationships, but this was unproductive.

Reports from neighbours, as obtained by police and Adult Social Care (ASC) staff, describe Mrs. Y and her family as being a bit reclusive and that they kept to themselves. One neighbour reported that Mrs. Y's daughters could often be heard '*swearing loudly*.'

There were some reported tensions between Mrs. Y, her daughters and their neighbours. Newlon Housing Trust received a number of complaints from neighbours regarding the state of Mrs. Y's garden. Hackney's Anti-Social Behaviour Team also followed up complaints from Mrs. Y's neighbour in relation to the condition of the garden and it was reported that Mrs. Y's front and rear gardens were very overgrown.

2.3.1 Daughter V - It is reported that Mrs. Y's eldest daughter, V, has some involvement with the criminal justice system and that she was known to mental health services whilst living with Mrs. Y. In 2000, Mrs. Y signed an authority with Newlon Housing Trust which enabled V to deal with some rent matters on her behalf. (This later changed to daughter T.)

There are some references to the relationship between Mrs T and V which indicate complex family dynamics. For example, on 30 May 2013, the police provided a very rare and significant account of direct contact with Mrs. Y when they attended her property, accompanied by the LAS. It is recorded that Mrs. Y reported that V locked her in her room for long periods of time and prevented people's access to her; that V removed the carpet in the bathroom, which Mrs. Y felt was placing her safety at risk, as the floor became slippery, and which may have placed her at greater risk of falls; and that V had attempted to stab her sister, T, with a knife. Mrs. Y also reported that the reason for her legs being infected was as a result of V preventing professionals from accessing her. The police confirmed that V was arrested and charged with assault following the knife incident. Shortly after the incident occurred, V moved out of Mrs. Y's house.

Various written records indicated that Mrs. Y's house was unkempt and cluttered and it is recorded that Mrs. Y and T had made reference to this being a result of V's hoarding behaviour. (However, when the LAS attended Mrs. Y's home on 30 May 2013, it was reported that W had also demonstrated a '*reluctance*' regarding the crew clearing out some of the clutter to facilitate Mrs. Y's safe transfer.)

Records indicate that V, allegedly like Mrs. Y, used various aliases at different times. Her reasons for doing so are unknown.

2.3.2 Daughter W - Records indicate that Mrs. Y's daughter, W, has a long history of severe and enduring mental illness. She first received input from mental health services in 2006 when she was admitted for inpatient treatment. She was discharged later the same year for non-engagement with the mental health services.

On 27 October 2015, W was admitted to the HUHFT after being removed by the police and LAS from Mrs. Y's house, having been found in a severe state of neglect and having serious concerns for her welfare. Her sister, T, claimed to be responsible for W's care prior to her admission to hospital and was also managing W's finances. W is now being supported appropriately by adult social care services.

There is very little information which could provide insight into the relationship between W and Mrs. Y. W once identified Mrs. Y as her foster mother. It was also reported that W described her sister T as being '*like a mother to her*.'

An Independent Mental Capacity Advocate (IMCA) was contacted to obtain more information about Mrs. Y and W, who reported that W has never provided any significant information about Mrs. Y and barely mentions her. The IMCA confirmed written records which stated that W has a close connection to T and that she considers T to be a mother figure to her.

Daughter T - It is reported that Mrs. Y's daughter, T, is able to articulate and assert herself well and demonstrates a level of confidence when interacting with professionals: T is able to speak comfortably within formal meetings and she is always well prepared for any meeting she attends.

There are no reported mental health history or concerns.

T identified herself as being the main carer for both Mrs. Y and W. She was responsible for managing their finances, shopping, correspondence as well as various other personal and practical care tasks. It is reported that T lived with Mrs. Y in her home, that T is very protective of her family unit and that she would go to great lengths to keep them together. She advocated actively on behalf of her mother; it is reported that she managed all of Mrs. Y's affairs and acted as the main contact for agencies supporting Mrs. Y. She demonstrates a good understanding of health, social care and legal pathways and how to navigate some of these. T coordinated most of the contact with Newlon Housing Trust in relation to repairs and rent related matters.

T is reported to present as someone who is highly resistant to support provided from outside of the family. The evidence for this review suggests that T's relationships with professionals were quite fraught and may have been based on a level of mistrust of professionals that T may have held. She was reported as very rarely responding to telephone calls or messages left for her and records show that T often did not engage with attempts to provide support, despite identifying herself as both Mrs. Y and W's main carer. For example, there were three significant contacts between ASC and T during which it was reported that T was highly resistant to input from Social Services; she declined input from Social Services on every occasion, although one occasion did agree to an Occupational Therapist visit. Records indicate that T visited her mother on a daily basis whilst Mrs. Y was in hospital. Statements made by hospital staff described them as finding T as being '*intimidating and problematic*' at times, and that she often interfered with the treatment provided to Mrs. Y whilst in hospital, and she was advised to not try to prevent the nurses from caring for Mrs. Y.

Numerous efforts were made to engage T in the conduct of this review in order to provide her with the opportunity to provide her account of the events that took place prior to her mother's death. However, T declined to participate and so the review could not benefit from some significant familial insights into Mrs. Y's situation, into life at the family home and Mrs. Y's interactions.

At the time of Mrs. Y's death, there was an ongoing Safeguarding Adults Enquiry into concerns that Mrs. Y was the victim of neglect, triggered following Mrs. Y's hospital admission. The principal concern was that Mrs Y. had not been able to access health and social care services or attend medical appointments as required. Further, the property was found in a state of disrepair, cluttered inside and unkempt and was considered not suitable for either Mrs. Y or W, considering their levels of need at the time.

2.3.3 Details of other family members or significant contacts:

The information reviewed makes very little reference to Mrs. Y having contact with other family members and despite efforts made it has not been possible to establish contact with them as part of this review.

2.3.4 Engaging Mrs. Y's family in the SAR:

Various attempts were made to engage Mrs. Y's family in the SAR and to obtain their views of the events prior to Mrs. Y's hospital admission and eventual death. However, it has not been possible to establish any significant contact with any of the family members.

The following attempts were made to engage Mrs. Y's family in the SAR:

- Telephone and written attempts were made to invite T to participate in the review. The opportunity to meet with T was offered to discuss Mrs. Y, but T did not attend the scheduled meeting.

- Telephone contact attempts were made to invite V to participate in the review. However, she did not respond to any of the messages left for her. V's address is not known and, therefore, no written attempts could be made to contact V.

- As noted above, various attempts have been made to establish contact with other family members but these have not been successful.

2.4 Agencies involved with Mrs. Y and her family:

Multiple agencies were providing input with Mrs. Y and her family at various points during the timeframe covered by this review – *May 2013 till March 2015*. At times, agencies were providing input simultaneously without being aware of one another's involvement. At other times, the involvement of one agency triggered the input of another (*see next section – Chronology and Appendix 2*).

The following agencies and professionals had, direct or indirect, input with Mrs. Y and her family prior to her death in 2015:

2.4.1 London Borough of Hackney: Adult Social Care (ASC) Services – The Information and Assessment Team (IAT) provided occasional input with Mrs. Y and her family between 2003 and 2015, whilst she was living in her home in the community. IAT is Hackney's 'front door' service for accessing adult social care support and provides input with individuals who are not actively in receipt of formally commissioned services. ASC services record their information electronically by using systems such as Comino (*pre 2014*) and Mosaic (*post 2014*).

Once Mrs. Y was admitted to hospital on 10 March 2015, her care provisions became the responsibility of the Integrated Hospital Discharge Team (HDT). Once an individual is admitted onto a hospital ward and a Section 2 notification is raised by the ward, then the HDT becomes responsible for providing input to facilitate safe discharge from hospital.

2.4.2 Newlon Housing Trust – Mrs. Y was a tenant with Newlon Housing Trust since 1995. She was classed as a 'General Needs' tenant. Under her tenancy agreement, Mrs. Y had an obligation to pay rent, report repairs, provide access when required and behave in a tenant like manner. Newlon is a registered provider of social housing which had various duties to Mrs. Y, as a tenant, under the Regulatory Standards for social housing.

During the timeframe of this review, Newlon's operations were divided internally into separate teams which dealt with different areas: Income (rent), repairs and gas safety, as well as a housing officer who dealt with environmental issues, tenancy matters, vulnerable residents and acted as a referral point for other teams with tenancy related issues. Gas safety checks were undertaken with concern for a tenant's wellbeing focused on gas safety issues. However, since April 2015, Newlon has changed this structure and subsumed responsibilities into new teams. This also led to a change in the agency's procedural pathway for dealing with vulnerable tenants. The cases of tenants who are deemed to be vulnerable are now managed by two dedicated staff within Newlon's Service Centre.

Newlon records their information electronically by using systems such as Orchard for rent and repair related matters, Microsoft Customer Relations Management for repairs and Filestream for scanned paper documents.

Newlon compiled a report for this review that provided detailed accounts of their involvement with Mrs. Y and her family.

2.4.3 Homerton University Hospital Foundation Trust (HUHFT) – Prior to Mrs. Y's admission to the Royal London Hospital (RLH) on 10 March 2015, she had no direct or indirect contact with HUHFT aside from a radiology appointment in 2004. Mrs. Y was repatriated from the RLH to HUHFT on 1 April 2015 and was admitted to Graham ward which is a stroke specialist ward.

HUHFT records some of their information electronically by using systems such Rio and EPR.

HUHFT compiled a report for this review that provided detailed accounts of their involvement with Mrs. Y and her family.

2.4.4 Other Health Agencies – Mrs. Y had contact with various health professionals whilst living in the community. However, due to the lack of records or information available about some of the interventions provided by these professionals, it has not been possible to recreate a detailed account of their input.

Tissue Viability Nursing input – Electronic records indicate that Mrs. Y was seen by a TVN from Community Health in 2011. A plan for treating Mrs. Y's leg ulcers was developed and a recommendation for referral to Mrs. Y's General Practitioner (GP) were made. However, there are no further records of involvement from a TVN. Through attempts made to obtain more information, it was reported that the responsibility of treating Mrs. Y's legs were discharged to her GP.

GP intervention – There is some uncertainty relating to the GP care provided to Mrs. Y whilst living in her home. The evidence would suggest that Mrs. Y was registered with different GP practices over a period of years.

Records indicate that Mrs Y was most recently registered with a GP practice on 26 February 2015 – a couple of weeks prior to her hospital admission to RLH on 10 March 2015. Mrs. Y was registered by her daughter T, who has now left the practice. It is reported that Mrs. Y never accessed the practice.

Prior to being registered at this practice, Mrs. Y was registered with a different practice. However, this practice was demolished in 2014 and it is reported that NHS England worked with the City & Hackney CCG and the Local Medical Committee to disperse that practice's GP patient list. Evidence would indicate that Mrs. Y's named GP in this practice resigned as of 4 August 2014.

Following the closure of the GP practice, it would appear as if Mrs. Y's records were sent to the CCG's Shared Business Services (SBS). SBS deals with back office NHS functions and are responsible for sending records onto new premises amongst other things. Once a patient leaves any practice, their records will be sent centrally to SBS to be held securely and be re-distributed to the new practice once the records are requested from SBS.

The most recent practice confirmed that Mrs. Y's requested records never arrived from her previous GP's practice. They were informed that Mrs. Y had died and that her records had been sent to the Coroner.

There is no evidence to suggest that Mrs. Y was registered with any GP practice between the time that the previous practice closed down in 2014 and when her daughter registered Mrs. Y with the most recent practice on 26 February 2015. Mrs. Y would have suffered from leg ulcers during this period of time which would have required some level of treatment.

Early social care records made reference to Mrs. Y also being registered with a third practice but this could not be confirmed.

2.4.5 London Ambulance Services (LAS) – Between 30 May 2013 and 14 May 2015, the LAS had direct contact with Mrs. Y on two occasions after being called to her home. LAS are one of the very few agencies who provided accounts of actual conversations with Mrs. Y whilst she was still living in the community. Most other agencies had contact through her daughters or via brief telephone conversations.

The LAS compiled a report that provided a detailed account of the service's involvement with Mrs. Y and her family during the timeframe of this review.

The information provided by LAS was sourced from call logs which are records of 999 calls as well as Patient Report Forms (PRF), which are records of assessment and treatment details and are completed by the attending ambulance staff.

2.4.6 Police – The police had some contact with Mrs. Y during the period of time covered by this SAR. However, it appears as if most of their contacts were as a result of Mrs. Y's daughters. The police attended Mrs. Y's house on various occasions and their interventions were focused on either V or W.

However, a detailed report was provided by the police following a welfare check with Mrs. Y at her home. This contact took place on 30 May 2013.

2.4.7 Independent Mental Capacity Advocate (IMCA) – An IMCA was consulted to provide an account of their input with Mrs. Y. The IMCA reported that when they visited Mrs. Y in HUHFT, she was already very unwell and that they were not able to speak with her. The IMCA did not have the opportunity to meet any of Mrs. Y's daughters either. The IMCA reviewed her medical notes and spoke with the various professionals involved with her care.

Contact was also made with W's IMCA so as to gain greater insight into Mrs. Y and her family.

3. Chronology:

A chronology was compiled from information provided by the various agencies and professionals who had contact with Mrs. Y and / or her daughters. Written and electronic records were reviewed and interviews were conducted to compile a comprehensive account of the events that took place prior to Mrs. Y's death in May 2015. This is provided in Appendix 2.

4. Findings and Recommendations:

Item:	Findings and Recommendations:
4.1	**Findings: Mrs. Y remains unknown** – *Due to a significant lack of information about Mrs. Y, it has not been possible to establish a clear understanding of who she was in life. This seems to be a consistent theme for all the agencies who were involved, directly or indirectly, with Mrs. Y.*

It was extremely challenging to establish clear picture of Mrs. Y and to enable her voice to be heard, above all else, throughout this SAR. This aspect of the review would seem both symptomatic and expressive of this particular case. Very little information is recorded or known about Mrs. Y and recollections were provided mainly by agencies who had direct or indirect contact with her. Despite numerous efforts to engage Mrs. Y's daughter, T, it has not been possible to do so. In order to keep Mrs. Y at the centre of this review some assumptions and conclusions, based on a review of the evidence provided, have been made about Mrs. Y, her experiences and her views from details of events that took place. In these instances, examples have been provided to support the particular assumption or conclusion made.

Agencies and professionals had limited direct contact with Mrs. Y and communicated through a third party**.** Records indicate that most agencies and professionals spoke with Mrs. Y's daughter, T, rather than directly with her. T identified herself as being the main carer for her mother and initially there were no reports of major concern in relation to T or the support that she provided to Mrs. Y. Evidence provided during this review has shown that Mrs. Y had, at least on two occasions, consented to and requested that agencies contact one of her daughters rather than herself.

It could be assumed that Mrs. Y had the necessary mental capacity to consent to her daughter acting on her behalf as there is no evidence to suggest otherwise. It is a key principle of the Mental Capacity Act 2005 that a person must be presumed to have capacity unless it is established that she or he lacks capacity (MCA 2005, s.1(2)). Issues with capacity were only raised following Mrs. Y's admission to hospital on 10 March 2015, although it is possible that issues with her capacity arose prior to this time.

The evidence suggests that the fact that Mrs. Y was hard of hearing also acted as a barrier to having direct contact with her. Examples of direct contact with Mrs. Y are rare but there are two specific occasions which demonstrated that it was difficult to communicate with her. On 31 May 2013, the IAO made telephone contact with T and asked to speak with Mrs. Y. It is recorded that IAO had the opportunity to speak with Mrs. Y but that it was difficult to speak with her as she was hard of hearing. It was also reported that hospital staff had difficulty in communicating with Mrs. Y once she was admitted to hospital. There is no evidence that the Mrs. Y's hearing loss was further investigated by services prior to being admitted to hospital.

The evidence would indicate that the agencies, in general, adopted the practice of communicating directly with T, who was identified as Mrs. Y's main carer. This practice was not questioned until Mrs. Y's admission to hospital on 10 March 2013, when potential issues of neglect were raised which eventually amounted to the initiation of a Safeguarding Adults Concern and consequent Enquiry.

Coincidently, it is during Mrs. Y's hospital admission that it was possible for agencies to build a fuller picture of Mrs. Y's life in the community and the support provided by her daughter T. Prior to the hospital admission, interventions from agencies were brief and disjointed which made it difficult to obtain a complete view of Mrs. Y's situation and to identify concerns earlier.

It is also possible that Mrs. Y's contact with external agencies and other professionals were limited purposefully by her daughters. During an incident which took place on 30 May 2013, it is recorded that Mrs. Y had told LAS staff that it is her daughter V who

	prevented external agencies from having contact with Mrs. Y. She directly attributed the condition of her leg ulcers to the lack of contact with professionals. V had eventually left Mrs. Y's home after an incident during which she attempted to stab her sister, T, with a knife. There is no evidence to suggest that Mrs. Y had more contact with professionals once V left. The motivation for preventing Mrs. Y's access to external agencies and professionals is not known.

Recommendations:

1. Agencies should review their processes to ensure that emphasis is placed on obtaining consent from the person who is the subject of a referral that a third party may act on their behalf before automatically engaging with that third party. Processes should always aim to engage the individual directly and clearly record if this is not possible and why not, considerations of potential and actual risks, and how these have been addressed or mitigated.

2. Agencies should review third party arrangements when difficulties arise in contacting a third party acting on behalf of an individual or when a third party is not acting in a way that promotes the best interests of the individual and have clear and up to date systems in place to escalate concerns appropriately.

3. Agencies should consider how they can adopt more personalised approaches to working with individuals who are potentially vulnerable to abuse or neglect to try and gain an understanding of who the person is, how the person communicates (especially if the person is deaf and blind), how the person wishes to be supported and what the boundaries for intervention are. The person must always be placed at the centre of any interactions and interventions taken by external agencies.

4.2	**Findings: There was a lack of inter-agency communication and consequently opportunities to share information and identify risks were missed** - *Evidence obtained showed that there is much room for improvement in how agencies communicate and share information amongst one another pertaining to individuals who have the potential of being vulnerable* to harm or abuse. **4.2.1 Robust follow up is required after a referral concerning a potentially vulnerable person is made to another agency for input or action** – Newlon Housing Trust Housing Officer, made numerous referrals to IAT highlighting concerns about the complaints received by Mrs. Y's neighbour regarding the state of her rear and front garden which was overgrown and that Mrs. Y had not been seen for some time. There are conflicting notes as to how many times the Housing Officer referred Mrs. Y to IAT, however, there is evidence to prove that at least two referrals were received by IAT. The Housing Officer had sent both referrals via e-mail to an address which was owned by Children's Services. Children's Services forwarded the referrals onto IAT. Using incorrect contact details for agencies could potentially cause delays in getting vital information across which in turn would delay the action taken and intervention provided to those who are vulnerable or at risk. Using incorrect contact details can cause a delay in vital information being received by the appropriate service to action accordingly. This could also prompt potential Data Protection Act 1998 breaches if sensitive and confidential information is sent to an inappropriate destination.

	The information provided by Newlon and IAT records does not evidence that the Housing Officer took any further follow up action to obtain feedback from IAT after referring Mrs. Y. Feedback was requested from Hackney's Safeguarding Team by Hackney's Anti - Social Behaviour Team following the referrals made by the Housing Officer. However, it does not appear as if any further action was taken after the feedback was obtained. In many instances, a simple telephone conversation between the referrer and the receiving team, to follow up a referral, will stimulate collaborative working between agencies as information is shared and details about the vulnerable person's situation is gathered and put together to form a holistic view of what is going on in that person's life. This is also likely to elicit more effective and timely interventions. **4.2.2 Robust systems for providing feedback to referrers following the receipt of referrals, pertaining to individuals who are potentially vulnerable, are required** – ASC records do not contain any evidence to prove that IAT provided feedback to the Newlon Housing Trust Housing Officer after the receipt of at least two referrals. There is clear evidence that IAT took actions following the receipt of these referrals but they did not contact the referrer to have a discussion or to provide written feedback highlighting the outcome of the referral. Lack of feedback provided to referrers by ASC services, once a referral is received and actioned, is a long standing problem and not unique to Hackney. Recent legislative and procedural changes, such with the enactment of the Care Act 2014 and the London Multi-agency Safeguarding Adults Policy & Procedures (revised August 2016), as well as the CHSAB and Hackney's Self-Neglect Protocol, have prompted greater interagency communication and feedback when there are safeguarding or self-neglect concerns. These principles should be adopted by all agencies when working with individuals who are potentially vulnerable to abuse, neglect or harm. Also, the Safeguarding Adults Alert forms used at the time did not contain prompts to provide feedback to referrers. However, updated forms used by ASC services now contain such a prompt with the option of providing details of feedback provided. Whilst this system is now in place, learning from this SAR indicates that assurance of its effectiveness would be helpful. Again, as per the issue raised in Section 4.2.1, a telephone conversation or e-mail correspondence could have prompted some dialogue between the referrer and the receiving team which could have stimulated a more collaborative approach to intervening with Mrs. Y and her family.
Recommendations: **4.** Agencies must ensure that the staff they employ have access to the correct contact details for vital services such as ASC, LAS, police, etc. **5.** Agencies should establish processes to provide feedback to those making referrals to them regarding the outcomes of those referrals.	
4.3	**Findings: The manner in which health services handled the closure of Mrs. Y's GP practice does not give rise to any major concerns** - *Consultation with the City and*

Hackney CCG clarified the process for transferring patient records from one GP practice to the next (as set out above). The evidence indicates that this process was followed and that it would have been the responsibility of Mrs. Y and / or her main carer to register with a new practice following the closure in 2014 of the practice where she was registered.

Although unconfirmed, it is likely that there would have been some communication from the closing practice to inform its patients of its pending closure. T was identified as Mrs. M's main carer during the closure of the practice and records indicate that she consistently told people that she was responsible for managing Mrs. Y's correspondence. It is not clear why it took T from the closure of the one practice in August 2014 (approximately) to February 2015, to register her mother with a new GP practice. The onus would have been on Mrs. Y and / or her main carer to register her with a GP practice following the closure of the previous practice. It would have also been their choice as to which GP practice, located within their catchment area, they could register with, provided that it was possible and appropriate for them to register there.

As previously noted, Mrs. Y was registered with her new practice, on 26 February 2015 but that the practice never received her records prior to her death on 14 May 2015. Mrs. Y was admitted to hospital as from 10 March 2015 after which she would not have utilised the services of her newly registered GP. Although it is worrying that the GP practice did not have access to Mrs. Y records during the 3 months (approximately) prior to her death, it is unlikely that this would have had an impact on the care and support provided to Mrs. Y as there is no indication that Mrs. Y did visit the new practice or requested a home visit from the new GP. It seems unlikely also that Mrs. Y was registered with another GP or accessing input from any GP between the closure of the previous practice in August 2014 (approximately) and registering with the most recent practice in February 2015. The CCG confirmed that Mrs. Y was not registered with another practice during this time.

There is no evidence to suggest that Mrs. Y or T pursued input and treatment for her ulcerated legs, which it can be assumed would have been in a deteriorating condition, during the period of time in question. Also, there was an evidenced history of reluctance to engage with support services. This raises some questions in relation to the extent to which Mrs. Y's situation might have been a result of a combination of both self-neglect as well as potential carer neglect.

Social care records contain no evidence of Mrs. Y's GP's ever contacting the ASC service to report concerns for her care and welfare or to request support for her. Therefore, this may suggest that the GP's treating Mrs. Y did not have concerns regarding her welfare or that they had so limited contact with her that it was not possible to identify concerns. However, without access to Mrs. Y's medical notes, this cannot be confirmed without any reasonable doubt.

Recommendations:

6. The City and Hackney Clinical Commissioning Group should consider how it can encourage GP practices both to identify registered patients who are vulnerable and highlight these patients for attention when a GP practice or a GP's list of registered patients is closing.

4.4	**Findings: Evidence would suggest that Mrs. Y and her family had a history of not engaging with vital services** – *The chronology compiled for this review evidences numerous examples of Mrs. Y or her daughters avoiding engagement with services or disengaging once contact and input is being provided. Whatever the reason for their reluctance to engage, it is clear that the lack of input has had a detrimental effect on Mrs. Y's physical health and general state of well-being, which could also have had a negative impact on the family unit.* Police reported that Mrs. Y had stated that it was her daughter V who locked her in her room and prevented people from having access to her. However, it is her daughter T who was reluctant to accept or completely refused input from social services, district nurses, and Health professionals whilst Mrs. Y was admitted to hospital, LAS input, as well as Newlon Housing Trust interventions. Since the enactment of coercive control legislation (s.76 of the Serious Crime Act 2015), the police may now take a different approach to Mrs. Y's situation and see it as potential domestic abuse, thus prompting a response whereby they would work differently with Social Services to understand what was going on with this family and how to support vulnerable family members more robustly. Also, it appears as if following periods in time where multiple agencies attempted to provide input with Mrs. Y and her family simultaneously, they withdrew and disengaged completely. This is evidenced in the chronology of the events that took place prior to Mrs. Y's admission to hospital. Input from numerous agencies were provided to Mrs. Y and her family during 2013. However, the family disengaged and no contact was made with them again till 2015. Mrs. Y and her family are described by neighbours as being reclusive and keeping to themselves. It is possible that they experienced the simultaneous input from multiple professionals as overwhelming and responded by withdrawing. This posed a particular problem for those agencies responsible for supporting Mrs. Y and her family. It is also possible that Mrs. Y's contact with external agencies and other professionals were limited purposefully by her daughters. During an incident which took place on 30 May 2013, it is recorded that Mrs. Y had told LAS staff that it is her daughter V who prevented external agencies from having contact with Mrs. Y. She directly attributed the condition of her leg ulcers to the lack of contact with professionals. V had eventually left Mrs. Y's home after an incident during which she attempted to stab her sister, T, with a knife. There is no evidence to suggest that Mrs. Y had more contact with professionals once V left. The motivation for preventing Mrs. Y access to external agencies and professionals is not known.

Recommendations:

7. Agencies should establish mechanisms for identifying complex situations of repeated non-engagement with services and potential neglect or self-neglect, for supporting staff to act on concerns about this, and escalating such concerns through the local adult safeguarding process.

4.5	**Findings: There were clear themes of self-neglect and hoarding emerging from various contacts with Mrs. Y and her daughters, which should have triggered appropriate responses in line with legislative and policy frameworks –** *With greater emphasis being placed on self-neglect and hoarding following the introduction of the Care Act 2014, all agencies are required to adopt more robust policies for dealing with these issues.* Referrals received by ASC services, particularly from LAS and police, indicated that Mrs. Y's home was unkempt, cluttered and that she may be a hoarder. This should have triggered a response which was consistent with the current Self - Neglect Policy which has been implemented across various partner agencies which have signed up to the policy. However, at the time that these referrals were received by IAT in 2013, the legislative frameworks, multi-agency approach, and internal policy were not yet implemented. Other agencies would benefit from developing and implementing self-neglect and hoarding policies, which provides clear guidance to staff working for the particular agency on how to respond appropriately to reports of self- neglect and hoarding. Agencies should use the London Multi-Agency Safeguarding Adults Policy & Procedures as a common framework, as well as the local Self-Neglect protocol, which could help inform those agencies' internal policies and procedures to ensure robust responses to those who are potentially vulnerable to abuse and neglect. Agencies' internal policies and procedures need to be consistent with the London-wide Multi-agency Safeguarding Adults Policy & Procedures.

Recommendations:

8. Agencies should develop and implement internal policies and guidance which support staff to identify and respond appropriately to individuals who might be at risk of self-neglect or vulnerable to hoarding. The policies and guidance should be informed by national and local legislative and policy frameworks to ensure that those who are most vulnerable are engaged and supported. These must be proportionate to the type of input provided and the accountability level of the particular agency.

4.6	**Findings: At the time of the interventions with Mrs. Y, ASC services did not have an appropriate policy and guidance in place to inform working with people who do not engage, missed care calls or with people who are reported to have not been seen for some time** – *The ASC No Reply / Person Not Seen Policy was developed and implemented in 2015 to guide the actions when an individual have not been seen for a while and where there are reported concerns for their welfare.*

Recommendations:

9. Agencies should develop No Reply/Person Not Seen Policies to support staff in their efforts to contact and work with those people who are not engaging with a service and who might be living in the community at risk abuse or neglect or self-neglect, and for supporting staff to act on concerns about this.

5. Summary of Recommendations:

1.	Agencies should review their processes to ensure that emphasis is placed on obtaining consent from the person who is the subject of a referral that a third party may act on their behalf before automatically engaging with that third party. Processes should always aim to engage the individual directly and clearly record if this is not possible and why not, considerations of potential and actual risks, and how these have been addressed or mitigated.
2.	Agencies should review third party arrangements when difficulties arise in contacting a third party acting on behalf of an individual or when a third party is not acting in a way that promotes the best interests of the individual and have clear and up to date systems in place to escalate concerns appropriately.
3.	Agencies should consider how they can adopt more personalised approaches to working with individuals who are potentially vulnerable to abuse or neglect to try and gain an understanding of who the person is, how the person communicates (especially if the person is deaf and blind), how the person wishes to be supported and what the boundaries for intervention are. The person must always be placed at the centre of any interactions and interventions taken by external agencies.
4.	Agencies must ensure that the staff they employ have access to the correct contact details for vital services such as ASC, LAS, police, etc.
5.	Agencies should establish processes to provide feedback to those making referrals to them regarding the outcomes of those referrals.
6.	The City and Hackney Clinical Commissioning Group should consider how it can encourage GP practices both to identify registered patients who are vulnerable and highlight these patients for attention when a GP practice or a GP's list of registered patients is closing.
7.	Agencies should establish mechanisms for identifying complex situations of repeated non-engagement with services and potential neglect or self-neglect, for supporting staff to act on concerns about this, and escalating such concerns through the local adult safeguarding process.
8.	Agencies should develop and implement internal policies and guidance which support staff to identify and respond appropriately to individuals who might be at risk of self-neglect or vulnerable to hoarding. The policies and guidance should be informed by national and local legislative and policy frameworks to ensure that those who are most vulnerable are engaged and supported. These must be proportionate to the type of input provided and the accountability level of the particular agency.
9.	Agencies should develop No Reply/Person Not Seen Policies to support staff in their efforts to contact and work with those people who are not engaging with a service and who might be living in the community at risk abuse or neglect or self-neglect, and for supporting staff to act on concerns about this.

6. Glossary:

	Terms:	Descriptions:
6.1	**Attendance Allowance**	'*An individual can receive £55.10 or £82.30 a week to help with personal care because the person is physically or mentally disabled and over 65 or over.* *This is called Attendance Allowance. It is paid in 2 different rates and how much the person receives depends on the level of care that they need because of their disability.* *The other benefits a person receives can increase with the receipt of Attendance Allowance.*' **Internet:** Gov.UK – www.gov.uk
6.2	**Body Mass Index (BMI)**	'*BMI is a measure that adults and children can use to see if they are a healthy weight for their height. It produces a projection for a health weight range.'* **Internet:** NHS – www.nhs.uk
6.3	**Cachectic**	'*Weight loss and deterioration in physical condition.*' **Internet:** Patient – http://patient.info/
6.4	**Clinical Commissioning Groups (CCG)**	'*CCG's are clinically – led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.'* **Internet:** NHS Clinical Commissioners – www.nhscc.org
6.5	**Deprivation of Liberty Safeguards (DoLS)**	'*The Mental Capacity Act Deprivation of Liberty Safeguards were introduced to prevent deprivations of liberty without proper safeguards including independent consideration and authorisation.* **Internet:** Gov.UK – www.gov.uk
6.6	**Dysphasia**	'*Dysphasia, also known as aphasia, is the name for the most common language disorder caused by stoke. It can affect how a person speaks, their ability to understand what is being said, and their reading and writing skills. It does not affect their intelligence.*' **Internet:** Stroke Association – www.stroke.org.uk

6.7	**Hyper Pigmentation**	'*Hyper pigmentation is a common, usually harmless condition, in which patches of skin become darker in colour than the normal surrounding skin. This darkening occurs when an excess of melanin, the brown pigment that produces normal skin colour, forms deposits in the skin.'* **Internet:** NHS – www.nhs.uk
6.8	**Leg Ulcers**	*'A leg ulcer is a long – lasting (chronic) sore that takes more than four to six weeks to heal. They usually develop on the inside of the leg, just above the ankle. The symptoms of a venous leg ulcer include pain, itching and welling in the affected leg.'* **Internet:** NHS – www.nhs.uk
6.9	**Mental Capacity Assessment (MCA)**	'*The Mental Capacity Act 2005 states that a person lack capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. A MCA is required to determine a person's capacity related to a specific decision.'* **Internet:** Social Care Institute for Excellence – www.scie.org.uk
6.10	**NG Feed**	'*A nasogastric tube is a narrow bore tube passed into the stomach via the nose. It is used for short or medium term nutritional support, and also for the aspiration of stomach contents.* *A NG feed describes the act of providing nutrition by using a nasogastric tube.'* **Internet:** NHS – www.nhs.uk
6.11	**PEG**	'*Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.'* **Internet:** NHS – www.nhs.uk
6.12	**Pitting Oedema**	'*Observable swelling of body tissues due to an accumulation of fluids.'* **Internet:** NHS – www.nhs.uk

6.13	**Pretibial**	'The inner of the two bones of the leg, that extend from the knee to the ankle.' **Internet:** Wikipedia – https://en.m.wikipedia.org
6.14	**Right Hemisphere Stroke**	'*A stroke which affects the right hemisphere / side of the brain and which impacts functions such as paralysis on the left side of the body, vision problems, and memory loss.'* **Internet:** UK Stroke Association – www.strokeassociation.org
6.15	**Section 2 Notification**	'*A Section 2 notification is a request sent by hospital wards for an assessment of a patient to take place where it appears that the person may need social care input when discharged from hospital.'* **Internet:** NHS England – www.england.nhs.uk
6.16	**Sensory Impairment**	'Sensory impairment is when one of a person's senses; sight, hearing, smell, touch, taste and spatial awareness, is no longer normal and it has an impact on the daily functioning of the person who suffers the impairment.' **Internet:** NHS – www.nhs.uk