Redbridge Safeguarding Adults

Redbridge
Safeguarding Adults Board

Safeguarding Adults Review (SAR)

‘Barbara’

Executive Summary

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Independent Reviewer:

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1. Introduction

1.1 Barbara was born on the 11 August 1942 and was 80 years old when she died. She was a heavy smoker and was described as “like a little bird” in appearance. At the time of her death, she was living on her own in a local authority flat. Very few details are known of Barbara’s life. It is known that she grew up in Dagenham with two siblings – both pre-deceased her – and had been married, it is thought for approximately 12 years but had been separated if not divorced from her husband for many years. There were no known children of the marriage. It is also understood that she had worked as a shop assistant and as a cleaner. Her only extant blood relative was a niece but they were not in contact and they declined the offer to participate in the SAR.

1.2 Barbara had lived at her last address in Ilford for some 10 years, having moved from an address in Romford. Both addresses were council housing and she requested a mutual exchange, but her reasons for doing so are not known. Barbara had no known friends or social contacts, having effectively socially isolated herself. She was not known to the statutory agencies other than her landlord (the Local Authority) and she had infrequent contact with her GP Practice, who she had been registered with since she lived in Romford.

1.3 Barbara first came to the Police’s attention on the 11 July 2022, when a neighbour contacted them to complain that she was harassing him and accusing him of stealing from her flat. A Police Community Support Officer visited Barbara who described being burgled and having individuals coming into her flat at night. A Merlin report was raised and forwarded to Adult Social Care (ASC).

1.4 The Police continued to visit Barbara as she appeared to be deteriorating physically and mentally, contacting the Emergency Duty Team (EDT) on the 13 July 2022 as their concerns had escalated and asking for advice on her mental capacity. EDT didn’t go out but contacted ASC the next day. ASC didn’t visit immediately, requesting a health assessment to ascertain if there were physical reasons for her confusion on the 9 August 2022.

1.5 The North East London Foundation Trust’s (NELFT) Adult Mental Health Community Treatment Team (CTT) visited Barbara on the 9 August 2022 and, having diagnosed unspecified dementia due to her non-engagement, referrals were made to Adult Mental Health, her GP and ASC and a safeguarding alert was raised on the basis of self-neglect.

1.6 ASC First Contact Team visited Barbara on the 17 August 2022 and, on the basis of a Best Interest Decision, a support package was put in place and other support services offered, the latter Barbara rejected. The outcome of the safeguarding alert was that the local Self-neglect protocol would be implemented via the Care Management processes. Barbara didn’t engage with the care provider, often refusing

them access to the flat, and the support package was terminated at the beginning of October 2022.

1.7 Barbara's allocated Social Worker made several attempts to contact Barbara after the beginning of October, but she was either not in or normally denied them access to the flat. On two occasions, the Emergency Services were called to Barbara's flat, but she invariably denied them access and said she was fine.

1.8 At the beginning of November 2022, the neighbour contacted the Police again due to concerns about Barbara's behaviour, but she again stated she was fine. On the 25 November 2022, the neighbour again contacted the Police as Barbara hadn't been seen for several days; they gained access to the flat and found her deceased in a chair. It was confirmed that she died of natural causes which were Bronchopneumonia, Chronic Obstructive Pulmonary Disease (COPD), and a possible heart attack.

1.9 The case was referred to the Redbridge 'One Panel' by the Police for consideration for a Safeguarding Adults Review (SAR) on the 20 February 2023. The rationale for referral was that there were concerns regarding the response by the Local Authority to safeguarding alerts raised and concerns over potential neglect. The referral was considered at the One Panel's meeting on the 14 March 2023 and it was agreed that the criteria for a SAR were met based on the limited multi-agency response to Barbara's self-neglect. The Overview Report was ratified by the Board at its meeting in January 2024.

2. Information Gathering

2.1 Independent Management Reviews and chronologies were submitted for the review period, the 1July – 30 November 2022, by the following agencies with regard to their involvement with Barbara:

- Harold Hill Health Centre (GP)
- Immaculate Care (domiciliary care provider)
- London Ambulance Service (LAS)
- LB Redbridge Adult Health and Social Care
- LB Redbridge Housing Service
- North East London NHS Foundation Trust (NELFT)
- Metropolitan Police Service (MPS)

3. Issues to be Addressed

3.1 The SAR needs to recognise that some of the events that impacted on Barbara pre-date the Review Period. While the SAR neither saw nor requested information relating to these events, they are relevant and learning needs to be taken from them.

3.2 The following eight areas of Issues to be Addressed were identified:

i. Adult Social Care

- a lack of clarity as to the recorded status and purpose of a Merlin Report
- a lack of a clearly recorded reason for and purpose of allocating a case to a Social Worker
- a lack of urgency with which the receipt of referrals or safeguarding concerns were met and subsequent actions initiated
- a lack of an active interface between the internal Care Management Procedures and the multi-agency Safeguarding Adults Procedures
- a lack of a clear referral process to ensure joint assessments are completed with health colleagues
- a lack of a robust commissioning process to ensure safe services are commissioned, terminated or suspended, support packages are structured with appropriate trigger points for reviews, particularly in cases of self-neglect
- a lack of "professional curiosity" to probe behind issues and information to ascertain possible underlying causations
- the quality of professional supervision and support provided to staff with direct contact with service users, including the option of reflective practice and peer support

ii. Adult Safeguarding

- A failure to implement the multi-agency Safeguarding Adults Procedures in accordance with the principles of Making Safeguarding Personal and the provisions of the Mental Capacity Act 2005
- a lack of consistency in reporting procedures across the Greater London area resulting in possible confusion due to the use of more than one form to raise safeguarding concerns
- a lack of clarity around the interface between different multi-agency procedures that led to a lack of managerial ownership of the case and the inappropriate closing of the Safeguarding Adults Procedures before all assessments and their outcomes were known
- a lack of clear recording of the implementation of the multi-agency Safeguarding Adults Procedures or the consistent sharing of information in a timely manner
- The quality of safeguarding adult training and awareness raising opportunities provided to and expected of health and social care staff and externally commissioned landlord services

iii. Emergency Duty Team

- a lack of clarity of the thresholds for the EDT to respond with direct contact with the subject of any referral
- a lack of clarity of the thresholds for HASS to advise the EDT of cases that may be referred to them and agree and appropriate response from the EDT

- a lack of clarity of the interface between the EDT and the multi-agency Safeguarding Adult Procedures

iv. Service Providers

- Support packages should not be initiated, other than in emergency situations, without a full risk assessment being completed
- Support staff should record the details of all tasks completed during visits and why any weren't completed
- The service commissioner and any case accountable professional should be automatically informed of any occasion when a commissioned service was not delivered and why
- Where a service is commissioned as part of a safeguarding plan, failure to consistently deliver the service should result in either a review of the safeguarding plan or a further safeguarding concern being raised

v. Health Services

- The robustness of the procedure to be followed when a patient moves out of the "catchment area" of a GP Practice to ensure easy and ready access to primary health care services, particularly patients with chronic health conditions
- The robustness of Did Not Attend Policies and Procedures, including the procedures to be followed when repeat prescriptions are not being requested for chronic and life-threatening conditions
- The lack of flexibility in the operating procedures of the CTT that prevented a joint assessment of Barbara with SW1
- The London Ambulance Service not advising Barbara's GP of their attendances at her flat

vi. Housing

- The robustness of the commissioning and allocation processes for landlord services to ensure appropriate concerns are raised about adults and children with health and social care needs
- The robustness of the local authority's internal recording processes to ensure effective information sharing between departments

vii. Mental Capacity Act 2005

- Barbara's capacity to make decisions about her finances was never queried or assessed
- The implications of Barbara's assessed lack of capacity were not fully identified or considered within the existing legal options for further action
- The level of legal literacy of operational staff and their line managers and their access to specialist legal advice

viii. Police

- a lack of clarity about the nature of Police referrals to HASS as to whether they were for a need for social care or to raise a safeguarding concern
- a lack of clarity as to whether a MASH was operative in Redbridge
- a lack of consistency in the contemporaneous completion of BRAG risk assessments and Merlin Reports

ix. Good Practice

- There were numerous examples of staff across all agencies persisting in attempting to get alongside Barbara despite her refusal to engage with them.
- There were numerous examples of good information sharing between agencies about their concerns for Barbra and of the outcomes of their visits to/assessments of her situation/needs.
- It was good practice for the Police to continue to monitor Barbara, to escalate their concerns when they perceived a deterioration in her situation and to respond promptly to contacts from her neighbours
- It was good practice to recognise, while undertaking a s9 assessment under the Care Act 2014, that Barbara may have lacked capacity and to complete a capacity assessment and a Best Interest Decision to provide her with a support package.
- It was good practice on the part of the Bank to contact HASS with concerns about Barbara's confusion and capacity.
- It was good practice to identify the need to refer Barbara for the support of an IMCA.

4. Conclusion

4.1 This SAR has identified examples where practice has raised concern as well as where procedures and processes haven't been effective in coordinating multi-agency practice. It has also highlighted the tension that exists, particularly in social care, between an Interventionist and an Autonomist approach. Good Practice as well as legislation requires agencies to respect the autonomy of the individual while, at the same time, placing a Duty of Care on them.

4.2 This tension requires staff to be professionally curious, to be reflective on their practice and to be legally literate, though not legal experts. In order to achieve this, staff need access to regular and high-quality supervision and peer support as well as access to specialist advice. This SAR suggests that these were not consistently available.

4.3 Had these been available, it is unlikely that Barbara's death could have been prevented without removing her from her flat. She had chosen to socially isolate herself when there were no reasons to question her capacity and it is unlikely that she could have been persuaded to move to a more restrictive environment where she could've been provided with a greater level of support than she was prepared to

accept in her flat. However, this doesn't mean that the different options available shouldn't have been explored to enable the Duty of Care that lies with the statutory agencies to be exercised while still respecting Barbara's autonomy.

4.4 The Board has agreed an Action Plan to meet the Issues to Be Addressed – above - identified in this SAR.