Brent Safeguarding Adult Board

Adult 'I' Safeguarding Adults Review

Overview Report

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Introduction

1.1 Indira was a woman of Asian heritage and in her 80s when she died in 2022. At the time of her death Indira was living in the London Brough of Brent, in a privately owned home, with her son who was her primary carer. Indira had schizophrenia and reportedly had dementia. Indira was found to be severely underweight and malnourished on admission to Hospital prior to her death. There were concerns about poor living conditions dating back to 2017, and concerns about abuse and neglect from her son. It was reported that there was neither heating nor hot water in the home and there was evidence of hoarding and poor hygiene.

1.2 The cause of Indira's death was recorded as right middle and lower lobe pneumonia, and coronary atherosclerosis.

1.3 The decision to undertake a Safeguarding Adults Review (SAR) was agreed by the Brent Case Review Group in April 2023, in accordance with the Care Act 2014. The Case Review Group meeting considered information provided by all the agencies involved with the person, who is the subject of this review, and following discussions concluded that there was reasonable cause for concern about how Brent partners worked together to safeguard the adult who sadly died.

1.4 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures[1]. All Brent SAB members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

1.5 This review has been anonymised, by referring to the person who is the subject of this review as Indira. This was done in accordance with Brent's naming conventions for SARs and with agreement of the panel, in the absence of contribution from her family.

[1] London-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (londonadass.org.uk)

Terms of Reference

2.1 The scoping period of this review was from 2017, when safeguarding concerns were first reported, to the date of Indira's death in 2022. In addition, agencies were be asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This included any significant events that fell outside the timeframes, if agencies considered that it would add value and learning to the review.

2.2 The panel agreed the following key lines of enquiry for the review:

- Why was support ended in 2018, following the son asking for help in 2017? What follow up was planned?

- Indira was found to be severely malnourished in 2022, and there were reports of physical abuse. What was known, and what actions were taken, by professionals in relation to Indira's health and care from 2018 until the call to London Ambulance Service was made in 2022?

- How do agencies respond to signs of hoarding or homes without working utilities, when there is an individual with significant care and support needs?

- How do agencies assess the needs of an individual who is being cared for by a family member? And how do agencies respond to issues around gaining access to the patient/client which is being managed by the family member?

- What consideration is given to ethnicity, language and culture within the family?

- In respect of all Key Lines of Enquiry, was Indira's experience reflective of the Brent system between 2017 and 2022? Would it be reflective of the system in 2024?

Legal Context

3.1 In accordance with section 44 of the Care Act 2014, SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

3.2 SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

3.3 SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

3.4 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.[2]

Methodology

4.1 This Review reflected on multi-agency work systemically and aims to answer the question why things happened. Importantly it will recognise good practice and strengths that can be built upon, as well as things that need to be done differently, to encourage improvements.

4.2 The methodological approach sought to engage frontline practitioners and their managers in the review of the case, focusing on why those involved acted in a certain way at the time. It was a collaborative and analytical process which combined written summaries of information and a practitioner learning event. This model is based on the expectation that Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time.

4.3 Due to unforeseen circumstances, the commencement of this SAR was delayed. Whilst there is a need to ensure that mandatory SARs are completed, this review has been undertaken in a proportionate way, in consideration of the length of time and changes in policy and practice.

Chronology

5.1 The chronology considered as four key episodes of involvement between 2017 and 2022.

Key Episode 1 – Input from Community Mental Health and Referrals to Adult Social Care

5.2 In 2017 Indira was open to Central & North West London Older People's Healthy Aging Community Mental Health Team (CNWL OPHA CMHT) and was allocated to a Care Coordinator, an Occupational Therapist who spoke the same Indo-Aryan language as Indira. An initial assessment was completed and a referral to Brent Adult Social Care was made for a section 9 Care Act 2014 assessment.[3]

[2] Care and support statutory guidance

[3] Section 9 of the Care Cat 2014 imposes a duty upon the local authority to assess a persons need for care and support, what those needs are, the impact of those needs upon the persons wellbeing, the outcomes they wish to achieve, and whether, and if so to what extent, the provision of care and support could contribute to the achievement of those outcomes.

5.3 The Care Coordinator identified that Indira and her son required support as they were living in a 'cluttered' environment, with no heating. Throughout 2017 and early 2018, the Care Coordinator visited Indira at home, despite difficulties securing contact with Indira to arrange home visits, due to Indira's son cancelling and rescheduling appointments.

5.4 Other professionals entering the home also observed 'clutter' and a safeguarding concern was raised by London Ambulance Service with concerns about Indira's welfare and the state of her property.

5.5 Adult Social Care attempted to contact Indira, following the Care Coordinators referral, but were unsuccessful so sent Indira a letter with Adult Social Care's contact details.

5.6 The Care Coordinator made further requests to Adult Social Care for an urgent needs assessment for Indira and a carers assessment for her son, support with clutter and day centre provision. Adult Social Care made successful contact with Indira's son who was advised to contact British Gas regarding the lack of heating. Indira's son said that he was "clearing some boxes" and would contact services in the future if necessary. Adult Social Care contacted the Care Coordinator to say they would conduct an assessment for Indira by telephone within eight weeks. The Care Coordinator followed up again with Adult Social Care advising a face-to-face visit to Indira for an assessment.

5.7 The Care coordinator continued to observe the poor home conditions during their visits and phoned Adult Social Care again, who reported that no contact had been made with Indira. Adult Social Care phoned Indira's son in early 2018 to arrange a face-to-face visit. Indira's son declined Adult Social Care involvement and said he would contact Adult Social Care should he and Indira require support.

5.8 The Care Coordinator discharged Indira from CNWL OPHA CMHT as her mental health was stable. It was the Care Coordinators belief that Adult Social Care would be assessing Indira's needs in the near future.

5.9 Throughout the remainder of 2018 there were four home visits by health professionals. A visit by an HCA noted that Indira was unkempt and confused. Indira's son was giving Indira herbal medicines, and the HCA advised him to check with Indira's GP as the herbal products could interfere with prescribed medication. A District Nurse visited and observed a burn on Indira's hand, as well as Indira's clothing being dirty. A visit by Central London Community Healthcare NHS Trust (CLCH), described the home environment as dirty. Indira's son asked about getting help to tidy and he agreed to a referral as he said he was busy caring for Indira and did not have time to clean. Prior to the next episode of involvement, Indira was last seen in September 2018.

Key Episode 2 – Hospital attendances

5.10 Indira was taken to Hospital on three occasions during 2019 and this was her only contact with professionals.

5.11 Indira was taken to the Hospital 1 for-right hip pain following a possible fall. The Hospital contacted Adult Social Care Out of Hours service to advise that although Indira was ready for discharge, professionals wanted to know whether it was safe for Indira to return home. The Adult Social Care advised that based on their records the last contact was in early 2018 therefore, they were in no position to confirm that Indira could be safely discharged home. The Hospital confirmed that an Occupational Therapist had visited the property and completed an assessment, and that Indira's son would continue looking after his mother. Adult Social Care concluded that it remained the decision of Hospital 1 to discharge Indira. The Hospital considered Indira to have fluctuating capacity, so she was discharged with her son advocating as her main carer.

5.12 Indira attended Hospital 1 following an unwitnessed fall and pain in her neck Indira was discharged with advice given to her son about manual handling techniques. The Hospital Occupational Therapist referred to Adult Social Care and stated "a package of care was recommended and declined as [Indira's son] is keen to maintain role of main carer. However, he does acknowledge it has become increasingly difficult to provide the level of support his mother requires. He finds it very difficult to leave her for any length of time e.g., to go shopping. She is at high risk of falls and has a cognitive impairment". Adult Social Care phoned Indira's son and he was provided with contact details for Elder's Voice, Brent Carers and for Adult Social Care should he need input from them in the future.

5.13 In late 2019 Indira was taken to Hospital 1 following a fall at home five days previous and her son noticing evolving facial bruising over the last few days and redness around left eye which was getting worse. Indira was discharged with advice and an occupational therapy assessment.

Key Episode 3 – Contact during the covid pandemic

5.14 In early 2020 Indira's son cancelled a home visit from the Bladder and Bowel team due to concerns about the risk of Covid 19, the visit was rescheduled and took place as a telephone assessment. Indira's son reported that Indira was very confused, slept two hours at a time, and mobilised with assistance.

5.15 Also in early 2020, the CNWL OPHA CMHT Care Coordinator received a call from Indira's son who reported that he was having challenges going shopping. He was given the relevant telephone numbers, but he rang back saying that the numbers given were not helpful. He was advised to contact the GP to get a letter to access shopping services for high risk shielding patients.[4] Indira's son reported that his mother's memory was worsening but remained stable in her mental health. He wanted a

[4] Coronavirus » Information for GPs advising both shielding and non-shielding patients on support available during the COVID-19 pandemic

memory assessment for Indira but was informed that the memory service was closed due to the covid pandemic and were not accepting referrals.

Key Episode 4 – Contact with services in the 18 months preceding Indira's death

5.16 In late 2020 Indira was admitted to Hospital 1. Her son said that Indira's dementia had been deteriorated and thought she was a bit more breathless than usual. He said the clutter at home had been tidied. He said they had been managing well at home and did not require any further assistance or equipment, and that a commode would increase the risk of falls. Hospital 1 reported that Indira had fluctuating capacity but was able to communicate and consent on assessment.

5.17 Indira's son contacted Indira's GP twice in late 2020 concerned about her confusion and occasional chest pain. The GP spoke to Indira's son a few months later, and he said there were no issues with Indira or her medication.

5.18 Later in 2021 Indira's son requested a GP appointment as Indira was sleeping a lot and losing a weight. The GP recorded that Indira's blood pressure at home was 103/59 and weight 40kg (a 20% loss from previous reading). Over the next six months the GP left multiple messages and voicemails for Indira and her son but received no response.

5.19 Indira was seen at home by district nursing for a blood test and a few days later by the Bladder and Bowel Service. The Bladder and bowel service had no concerns about Indira's presentation, although described the home as 'congested'.

5.20 Indira was booked to attend the Hospital 1 breast clinic, but her son said Indira was too frail to attend the Hospital and felt that her breasts were unchanged and had no concerns. The breast clinic wrote to Indira's GP and asked that the GP examine Indira and let Hospital 1 know if there were any changes. The GP telephoned Indira's son to offer a face-to-face appointment for a breast exam, however, he refused to bring Indira in due to the winter weather.

5.21 On a day in 2022, Hospital 2 phoned Adult Social Care to say that Indira had been brought in by ambulance. Hospital 2 said that Indira was at high risk of death due to malnutrition, weighing only 25kg. Hospital 2 also called police to report that Indira's son had told them he had hurt his mother. The police also referred the concern to Adult Social Care.

5.22 The London Ambulance Service referred a safeguarding concern to Adult Social Care stating that Indira had been lying on the floor in her own faeces and urine. She was admitted to Hospital 2 soiled and in filthy clothes, very dirty hands and fingernails, very malnourished, with dry lips and sore mouth. London Ambulance Service reported that incontinence pads had not been changed for a while, and she was sitting in faeces. They also reported mould throughout the house. Indira's son had reported that he would pick Indira up from her chair at night and lay her on the floor to sleep at night, with no blankets, just lying on top of the heavily soiled carpet with a couple of pillows. In the morning, he would pick Indira up from the floor and leave her in the chair. The

kitchen was grimy and filthy, unusable, and Indira's son was using an air frier in the living room. The clutter was waist height in the hallway up to head height in the living room, describing the home environment as level five hoarding, with no heating available and Indira's son using the oven to warm the flat. London Ambulance Service reported that Indira was mute and unable to communicate. They reported that Indira had had a number of falls at home, had possibly injured her head and had a large area of bruising on her left lower leg. London Ambulance Service also made a Hoarding and Fire Risk referral to the fire service.

5.23 Upon receiving notification of concerns, Adult Social Care spoke with Indira's son by phone, and he admitted hitting and kicking his mother to keep her quiet. Adult Social Care commenced a safeguarding enquiry and visited Indira's property with the police.

Analysis

6.1 The analysis section considers and addresses the key lines of enquiry, and in respect of each key line of enquiry, whether Indira's experience was reflective of the Brent system at the time and whether it would be reflective of the system in 2024.

Why was support ended in 2018, following the son asking for help in 2017? What follow up was planned?

6.2 CNWL OPHA CMHT commenced involvement in early 2017 following a referral from the GP. The Care Coordinator visited Indira at home on a regular basis and identified a number of social care needs which led to onward referrals to Adult Social Care. The CNWL OPHA CMHT support ended because, from a mental health perspective, Indira was being looked after and her mental health was stable. However, the case remained open to CNWL OPHA CMHT until the case coordinator was assured of Adult Social Care's involvement.

6.3 Key episode one of the chronologies demonstrates that Indira 's son agreed to referrals being made to Adult Social Care, rather than him actively seeking help in 2017, and it appeared he agreed to referrals to appease the care coordinator. The care coordinator spoke to Indira's son about carer stress, but he declined support although was signposted to services. Indira had told the care coordinator that she did not want any other help and the care coordinator reported that it took a while for Indira to 'warm up' to a referral being made by the care coordinator who offered to be there with them for the assessment.

6.4 At the time of case closure to the CNWL OPHA CMHT, the care coordinator was of the understanding that Indira and her son were engaging with Adult Social Care, a social worker had been allocated and that an assessment would be undertaken. This was a misapprehension. The care coordinator made six referrals to Adult Social Care. In October Adult Social Care advised the care coordinator that they would undertake an assessment within eight weeks, and in January they attempted to arrange a face-to-face visit but Indira's son declined this on the basis that Indira was a 'private person'. This was taken at face value with no documentation of speaking to Indira directly. No one had checked whether Indira's son had the legal authority to make decisions on

Indira's behalf and this is explored further later in the analysis. Whilst Indira's son gave reassurances, no one had eyes on Indira or her situation, or joined up with others who were able to gain access, such as the care coordinator.

6.5 Unfortunately, the fact that an assessment did not take place was not fed back to the care coordinator thus highlighting a gap in practice. If the CNWL OPHA CMHT had been made aware that Adult Social Care were taking no further action, the CNWL OPHA CMHT would have been a position to escalate the matter. Adult Social Care reported to the review that it is now policy for feedback to be provided to referrers, although adherence to this policy is sporadic and requires further work to fully establish compliance with the policy in practice.

6.6 The Care Act 2014[5] (section 9(1)) states that:

> *Where it appears to a local authority that an adult may have needs for care and support, the authority must assess—*
>
> *a) whether the adult does have needs for care and support, and*
> *b) if the adult does, what those needs are.*

6.7 The same duty applies in respect of carers (section 10(1), Care Act 2014). However, a local authority does not have to undertake an assessment of need if the adult refuses, unless they lack the mental capacity to make that decision, or they are experiencing abuse or neglect.

6.8 At this time, there was nothing to suggest that Indira lacked mental capacity, but there is also no evidence that she was asked directly if she wanted an assessment, or that Adult Social Care liaised with the care coordinator to get a view about Indira 's mental capacity. Indira's son was making decisions on Indira's behalf although there was no evidence that he had the legal authority to do so, i.e., a lasting power of attorney, or that he was making decisions in her best interests. As stated above, no one checked if he held Lasting Power of Attorney or Deputyship for Indira.

6.9 A formal mental capacity assessment would have ascertained Indira's mental capacity. If she lacked mental capacity, and an assessment continued to be refused, a Best Interest forum would have allowed professionals to explore how Indira's son was coping at home and whether an assessment was in her best interests.

6.10 Adult social care reported that since 2022 there has been a lot of work around legal literacy and safeguarding training. They recognised that they should always be seeking consent from the adult and that now more effort would be made to speak directly to the adult and seek their consent.

6.11 There were no arrangements in place for follow up by the CNWL OPHA CMHT, with regards to Indira's mental health needs, following case closure; the mechanism for

[5] Care Act 2014 (legislation.gov.uk)

follow up by the CNWL OPHA CMHT was based upon a re-referral by the GP if needed. The GP saw Indira following her discharge from CNWL OPHA CMHT for unrelated health concerns but noted no further concerns for Indira's mental health warranting a referral to CNWL OPHA CMHT. There would have been no mechanism in place for Adult Social Care to follow up as neither Indira nor her son were in receipt of services which would require and trigger a review.

6.12 Further concerns were noted by agencies between 2018 and 2022, with only one of these concerns being raised with Adult Social Care in March 2019.

Indira was found to be severely malnourished in 2022, and there were reports of physical abuse. What was known, and what actions were taken, by professionals in relation to Indira's health and care from 2018 until the call to London Ambulance Service was made in 2022?

6.13 The first safeguarding concern was raised by the London Ambulance Service in 2017 with concerns about Indira's welfare and the state of her property which was cluttered, hoarded, food left outside the fridge, oven door left ajar with "gas" escaping, and Indira dressed "haphazardly". The safeguarding referral received by Adult Social Care was forwarded for a Care Act assessment, which Indira's son declined, stating that everything was ok. Such concerns continued to be raised throughout 2017 and 2018 by the Care Coordinator.

6.14 The Care Act 2014 (section 42(1-2) states that:

… where a local authority has reasonable cause 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.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

6.15 Adult Social Care stated that, although the Care Act 2014 identifies self-neglect as a category of abuse, self-neglect may not necessarily prompt a section 42 enquiry (this approach is reflected in the Care and Support Statutory Guidance).[6] Cases of self-neglect are considered on a case-by-case basis and if the adult at risk is not in receipt of a care and support package the expectation is that it is addressed through care management where a care and support plan can be drawn up and regularly reviewed with the adult and other involved professionals. The care and support plan will include

[6] Care and support statutory guidance - GOV.UK (www.gov.uk) para. 14.17

interventions that will reduce or eliminate the self-neglect to the adult and those who may also be at risk such as neighbours. If this is not successful a safeguarding referral may have to be made. If a safeguarding referral is made in circumstances such as these it is likely that a section 42 safeguarding enquiry would be raised and transferred to the long-term team for multi-agency risk assessment and safeguarding plan and review.

6.16 However, in accordance with the Care Act 2014, the local authority (Adult Social Care) had a duty to make enquiries in respect of the concern raised. Furthermore, it had not been established whether Indira was at risk of, or experiencing, self-neglect[7] *or* neglect[8]. The chronology suggests that the clutter in the flat was attributable to Indira's son, not Indira and that Indira did not like the mess. Her son was her carer and it had not been established what areas of daily living Indira required support with which would have also assisted in identifying whether she was experiencing self-neglect or neglect. If she was experiencing neglect, then the explanation for not undertaking a safeguarding enquiry provided by Adult Social Care would not stand in this case.

6.17 Adult social care advised that they have relaunched the self-neglect policy and recognise that they have a duty around self-neglect, and so other professionals should not be afraid to chase and escalate in such cases. The review panel member shared that work has been undertaken between CNWL NHS Trust and Adult Social Care in using the self-neglect toolkit and clutter rating tool, as well as who to refer concerns to and when to trigger the Brent 'high risk' panel, which is supported by a one-page briefing for practitioners. Where CNWL NHS Trust previously lacked confidence in this area, there are now greater assurances of compliance. Latest statistics show that the number of self-neglect safeguarding enquiries have increased from 0 in 2017/18 to 70 in 2023/4, which account for 13.86% of all enquiries undertaken in the Borough that year. In addition, this is within the context of the number of safeguarding enquiries started in 2023/24 being almost half the number that commenced in 2017/18.[9]

6.18 In March 2019 Adult Social Care received an Out of Hours contact from Hospital 1 to advise that professionals had concerns about whether Indira was safe to be discharged home. The out of hours emergency duty team responded by saying that they had not had contact with Indira since January 2018 and therefore were not in position to provide a view. The nature of Hospital 1's concerns is unclear, and it seems that no professional curiosity was exercised by the emergency duty team, which may have enabled them to assess the level of concern and consider a safeguarding enquiry or Care Act assessment.

6.19 There were no further safeguarding concerns raised during the scoping period, however, many agencies noted concerns including: the use of herbal medicines, Indira

[7] This covers a wide range of behaviour neglecting to care for one's own personal hygiene, health or surroundings and includes behaviour such as hoarding.
[8] Neglect (or acts of omission) includes: ignoring medical, emotional or physical care needs; failure to provide access to appropriate health, care and support or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating.
[9] Safeguarding Adults England, Interactive Report.

being in dirty clothes and unkempt, clutter and congestion in the home, a burn to Indira's hand, and weight loss. The care coordinator was concerned about the state of the home environment but reported no signs of abuse. Curiously Indira was seen twice at home in August 2021, but no concerns were noted other than congestion in the home.

6.20 This highlights concerns about professionals understanding of neglect and hoarding, how to raise or escalate concerns, and management oversight within agencies. The review panel reflected that practitioners were not seeing or recognising the risk, considering each 'incident' or observation in isolation, without the consideration of the wider context and history. Furthermore, practitioners reported that the excuses provided by Indira's son were felt to be reasonable on each occasion, again considering each of those excuses in isolation. Aside from the input from CNWL OPHA CMHT, agency contact with Indira was sporadic and infrequent which meant practitioners did not build up a consistent picture of what was going on for Indira and her son.

6.21 Indira was not seen in person in her home environment between September 2018 and August 2021, this was exacerbated in 2020 by the covid pandemic which moved a number of services to remote working and remote interventions with their clients/patients, although alone does not explain the non-contact outside of the covid pandemic period. The policies and procedures during the covid pandemic introduced the prohibition of many face to face visits, although for some agencies face to face visits were based on assessment of risk including risk to the person i.e., a significant safeguarding risk may have warranted an in-person visit, and some agencies such as police were unaffected with continued in person attendance by officers. Furthermore, both staff and those receiving services, and their carers, were extremely cautious and concerned about the risk of infection.

6.22 The review panel reflected that since the risks associated with covid have subsided, many agencies have not fully returned to their previous way of working with remote contact remaining the default in some cases. The review panel therefore reflected the need for clear guidance around methods of contact i.e., when remote contact is appropriate and when in person contact is required.

How do agencies respond to signs of hoarding or homes without working utilities, when there is an individual with significant care and support needs?

6.23 Indira lived in a two-bedroom flat with her son. It was widely reported that the flat was 'cluttered' and there was no heating. There were also reports that Indira was unkempt and that both she and her environment were dirty. Indira had said that she did not like the mess and the clutter in the flat would have compromised her ability to mobilise around it.

6.24 As stated above, the concerns about hoarding and lack of working utilities was responded to by the London Ambulance Service and the care coordinator, during key episode one, by raising a safeguarding concern, and requesting a Care Act

assessment and Carer's assessment, respectively. Other agencies who noted concerns about the home environment during the remaining scoping period responded by noting these concerns in their records but took no further formal action, such as discussion with line managers and supervisors, or making referrals to Adult Social Care.

6.25 The learning event highlighted that professionals were not clear about how hoarding should be responded to. Professionals stated that it is difficult to get help when someone is living in a home that is in disrepair and that professionals often feel helpless, this is made even harder when the property is privately owned. Reportedly, some professionals were also unclear at the time about how they or Adult Social Care respond to hoarding, 'with nowhere to go but environmental health'. Furthermore, as stated above, professionals did not have contact with Indira frequently enough to establish a picture, alongside assurances from Indira's son that the matter would be dealt with.

6.26 The use of language is also important when talking about hoarding. Agencies used words like 'clutter' and 'congestion', which are subjective and offer no common understanding when conveying what they have seen to other professionals. Furthermore, people's views of what is clutter is subjective, people have different standards and what one person considers a cluttered environment might not be viewed in the same way as another person. There therefore needs to be more consistency across agencies in the language used and how hoarding is described.

6.27 The clutter image rating[10] (also known as the clutter scale) provides a series of visual representations of rooms in various stages of clutter, from completely clutter-free to severely cluttered, to enable people to get an accurate sense of a clutter problem. It provides a more objective assessment of clutter, and an indication of the level of clutter that might start to constitute hoarding, that can be shared and commonly understood between professionals.

6.28 There was only one reference to the use of the clutter image rating, which came when London Ambulance Service transferred Indira to Hospital 2 in March 2023, where they assessed a clutter rating of 5, along with a description of the clutter being at waist height in the hallway and up to head height in the living room. This assessment would have been commonly understood by all professionals familiar with the clutter scale and the appropriate action would have followed in response.

6.29 In June 2024, Brent Safeguarding Adults Board produced a Self-Neglect Toolkit[11] to provide a pathway for practitioners when working with people who self-neglect, including those who exhibit hoarding behaviours. The toolkit draws on the evidence base of what good looks like. It aims to ensure a multi-agency approach to support people who self-neglect, to change their behaviour and reduce the risks to themselves and others. The toolkit includes the Clutter Image Rating and a self-neglect and hoarding assessment, which then indicates the level and type of response required.

[10] Clutter Image Rating (hoardingdisordersuk.org)
[11] Brent_Self_Neglect_Toolkit_M_2024komprimiert.pdf (inzu.net)

How do agencies assess the needs of an individual who is being cared for by a family member? And how do agencies respond to issues around gaining access to the patient/client which is being managed by the family member?

6.30 In responding to this key line of enquiry there are a number of themes to consider including: access to people with care and support needs, the voice of the cared for person, supporting carers, and older people's experiences of domestic abuse.

6.31 Initially Indira's son's input was viewed positively, and the impression given to professionals was that he was very caring towards his mother. The thought was that he was disorganised and whilst he was making efforts to clear the flat his disorganisation prevented him from doing so and led to missed appointments.

6.32 The review panel reflected that it is common for older people to have carers who commandeer contact and gatekeep access. In Indira's case professionals went from seeing her on a monthly basis in 2017 to having very few contacts with her, including a number of failed contacts. Calls for ambulances were also cancelled during the time period subject to review and it appears that Indira was last seen for her annual appointment at the breast clinic in 2017, with Indira's son citing difficulties in getting her to the appointment as a reason for cancellation. He used a variety of excuses for cancelling appointments, including winter weather, ill health and covid. These excuses seemed reasonable at the time when taken in isolation with a lack of multi-agency overview which would have demonstrated a pattern in cancellations and 'Did Not Attend' occurrences.

6.33 The review identified that there was a lack of professional curiosity by professionals around these cancelled appointments, 'Did Not Attends' and failed contacts. However, CNWL OPHA CMHT demonstrated persistence in ensuring appointments took place and followed up when appointments were cancelled, ensuring access was gained, and as such they were able to maintain contact and see Indira on a monthly basis throughout their involvement in 2017. It is believed that Indira's son's engagement with the CNWL OPHA CMHT Care Coordinator was made easier because they could converse in the same language which established some form of rapport and trust.

6.34 The GP practice reflected that Indira had been a heavy user of services until she was last seen in September 2021, however, there was no mechanism to flag missed appointments or non-contact as an issue as each request for an appointment, for her multitude of medical issues, was done in isolation rather than taking a holistic approach. The Surgery now regularly reviews all of its patients on the 'house bound' and 'end of life' registers to ensure their care needs are being met, and they have a named GP to oversee vulnerable patients. CLCH reported that they now have a No Access /Not Seen Policy in place. The Adult Social Care Safeguarding Team reported that where there are issues around access to an adult at risk this would be first managed informally and legal options, including the Police and Landlord's power of entry, would then be considered.

6.35 Whilst the CNWL OPHA CMHT care coordinator was able to converse with Indira and Indira said that her son was taking care of her and that he was her representative, Indira's voice was largely absent throughout, largely due to the language barrier (explored further below). Her son was also making decisions on her behalf, yet his legal authority to do so was never verified and Indira's mental capacity was never formally assessed. Furthermore, there was no exploration as to whether Indira's son was making decisions in Indira's best interests. Covid restrictions also played a significant role, with the majority of consultations being undertaken by phone, which made it easier for any abuse to be missed as the son always spoke on behalf of Indira.

6.36 The GP surgery reflected that upon review of their records, the son had absolute power over his mother's care. When he rearranged breast cancer appointments or did not respond to messages from the surgery, this was not adequately followed up to ensure that the care he was providing was adequate.

6.37 Following Indira's admission to Hospital 2 in March 2022, police identified the events as a high-risk domestic abuse incident and referred to the Multi-Agency Risk Assessment Conference. The review reflected that there were clear signs of domestic abuse, and that the son was controlling.

6.38 Research by SafeLives[12] has identified that victims of domestic abuse aged 61 and over are much more likely to experience abuse from an adult family member (44%) than those 60 and under (6%) and are more likely to have a disability (48%). Furthermore, older victims live with abuse for prolonged periods before seeking help and are three times less likely to try to leave.

6.39 The key issues for older people experiencing domestic abuse include systematic invisibility, with older people being unrepresented in domestic abuse service; long term abuse and dependency issues; generational attitudes about abuse that may make it hard to identify; increased risk of adult family abuse; services that are not effectively targeted at older victims, and do not always meet their needs; and a need for more coordination between services. Professionals also experience the dilemma of 'support versus protection', and the wish for ongoing and maintaining relationships.

6.40 The panel asked whether Indira's son was deliberately harming Indira, incompetent, or disorganised with potential needs of his own. No one asked Indira and no one questioned him in attempt to establish this. A carers assessment was requested by the care coordinator but declined by Indira's son.

6.41 Section 10(1) of the Care Act states that:

Where it appears to a local authority that a carer may have needs for support (whether currently or in the future), the authority must assess—

a) whether the carer does have needs for support (or is likely to do so in the future), and

[12] Safe Later Lives | Older people & domestic abuse - SafeLives

b) if the carer does, what those needs are (or are likely to be in the future)

6.42 However, if the carer declines a carers assessment, the local authority is not required to carry out that assessment[13], there are no exceptions as per the duty to assess and refusal of assessment for a person with care and support needs. The review panel reported that it is often seen in cases of safeguarding that carers assessments are declined. That said, if an assessment had been carried out for Indira consideration would have been given to the care provided by her son.

What consideration is given to ethnicity, language and culture within the family?

6.43 Between 2016 and 2021, the percentage of adults receiving long-term support from Asian ethnic groups increased from 4.4% to 5.1%.[14] Brent is a very diverse borough with over 150 languages spoken. Language differences, cultural appropriateness of services and cultural notions of duty, as well as experiences of inequality and racism, can influence service uptake.

6.44 Research consistently suggests that Asian ethnic groups and their informal caregivers are less likely to use formal services than their White counterparts. This is despite the fact Asian caregivers are more likely to express greater need for services. While members of the global majority community must not be stereotyped as cultures where family automatically "look after their own" it is important to recognise that this phenomenon may have multiple explanations. For example, care from formal care services may be stigmatised because of its source i.e., 'welfare' or it may be viewed as a criticism that informal family-based support has proved unsatisfactory.[15]

6.45 Whilst we cannot assume the experiences of Indira, we know that she was a divorced woman who experienced mental health issues, and this had resulted in alienation and rejection by her community due to the stigma around divorce and mental health. There was a lack of evidence that Indira and her son's culture was fully explored, for example, the use of herbal medicines and gender roles with Indira's son as Indira's primary carer and male staff attending to deliver care. When working with Asian service users and their families, consideration needs to be given to a range of factors including cultural norms, gender roles, generational perspectives, religious practices and communication preferences, as well as assessing individual needs.

6.46 The lack of a common language can present a significant barrier to accessing and using mainstream/statutory social care services, such as difficulties in finding out about and understanding services and not being fully involved in the assessment process

[13] Care Act 2014, section 11(5)

[14] Adult social care – long term support - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

[15] Social Care Access for adult BAME and LGBT+ populations: a rapid realist review (2021). Booth, A., Hock, E., Preston, L. and Uttley, L. School of Health and Related Research (ScHARR), University of Sheffield, Sheffield,.

and as a result can end up receiving care that does not meet their needs and is not culturally appropriate.

6.47 Indira spoke an Indo-Aryan language. However, there was no evidence that services used interpreters when working with Indira, and whilst using families as interpreters is not considered best practice, there was little evidence that Indira's son was used as an interpreter either, which reflects the absence of Indira's voice throughout the period under review. Two of the agencies reported that their records indicated that Indira was an English speaker and was able to communicate with professionals, proposing that as Indira's mental health deteriorated, she reverted to speaking her native language, however there is no clear evidence to support this. The only professional who was able to communicate directly with Indira was the CNWL OPHA CMHT care coordinator who was able to speak the same language as Indira. Indira's son was allowed to become the only point of contact for Indira, and this was not viewed as problematic, even when he used this position to repeatedly cancel and decline treatment for Indira.

6.48 The use of interpreters may help to ensure that service users' needs are met and that they receive appropriate care. Guidance issued by the Office for Health Improvement and Disparities states that working with professional interpreters will:

- ensure accuracy and impartiality of interpreting.
- minimise legal risk of misinterpretation of important information.
- minimise safeguarding risk (where friends or family speak on behalf of the person)
- allow family members and friends to attend appointments and support the person without the added pressure of needing to interpret.
- foster trust with the person.[16]

6.49 The agencies contributing to this review all stated that they are conscious about culture, considering the impact of ethnicity, language, culture and other protected upon lived experience, understanding cultural and religious beliefs, values and priorities, and providing equitable and culturally sensitive care, recognising this is key to engagement and building trusting relationships. Other agencies referenced utilising religious/cultural groups for support and training in cultural competence. Furthermore, agencies stated that they do not use family members as interpreters but use professional interpreters or language line.

6.50 However, these policies and procedures are not reflective of Indira's experience in this case. The review panel members reflected on a number of barriers to culturally appropriate practice. Whilst professionals are aware of the importance of using independent interpreters, there are often issues with availability and delays to securing interpreters, especially face to face, and a shortage of interpreters for some languages and dialects. Professionals will therefore resort to google translate or translation apps or utilise carers and family members to get the work done in within the context of increasingly demanding caseloads. In some cases, the level of risk dictates that a

[16] Language interpreting and translation: migrant health guide - GOV.UK (www.gov.uk)

response cannot be delayed until an interpreter is available. Furthermore, review panel members said that professionals can be fearful of 'getting it wrong'.

6.51 Good practice was demonstrated by CNWL OPHA CMHT who seek to 'match' service users to allocated workers, resulting in a Care Coordinator with a shred language. Other agencies stated that they seek to do this where possible now.

Good Practice

7.1 Good practice was demonstrated by CNWL OPHA CMHT in matching Indira with a Care Coordinator who spoke the same language, which appears to have enabled Indira's son and Indira to engage with the service to greater extent than they did with other services. As such the CNWL OPHA CMHT were able to maintain 'eyes on' the situation and environment and identify risks and need for onward referrals. Furthermore, CNWL OPHA CMHT kept Indira's case open until they were, albeit mistakenly, satisfied that Adult Social Care were engaged with the family. CNWL OPHA CMHT commented that the service would not typically keep a case open where there is no ongoing mental health need or role for the CNWL OPHA CMHT. To hold onto every case until assurances are received from another service that a referral has been accepted and allocated would significantly impact CNWL OPHA CMHT caseloads and would be unmanageable.

7.2 Good practice was also demonstrated by Hospital 2 during Indira's final admission when they referred to the police as well as to Adult Social Care, recognising the significance of potential abuse that had occurred.

Conclusions and Wider Systems Learning

8.1 The review has highlighted from this case, wider areas of systems learning, some of which have been addressed in the time since these events occurred.

Self-neglect and hoarding

8.2 The review has highlighted that historically professionals struggled to identify signs of self-neglect and hoarding, lacked confidence in how and where to share these concerns and lacked understanding of how it could be addressed. The review has also highlighted the impact of language used to describe home environments where there are concerns of hoarding.

8.3 The review panel members have provided assurances that work has been undertaken in recent years to improve practice in this area. The refreshed Brent Self-neglect and Hoarding Toolkit has been published and work has been undertaken between agencies to improve use of the Toolkit and Clutter rating tool, which provides a common language for describing hoarding, and who to refer concerns to. The Borough has seen

an increase in self-neglect safeguarding enquiries which have increased from 0 enquiries to 70 across a six-year period, and as a percentage of safeguarding enquiries undertaken is above the national average. The Brent Safeguarding Adults Board has committed to focussing on assessing the Toolkit's practical implementation across various agencies and evaluating its impact on individual experiences.

8.4 The High-Risk panel is also now available to address complex/high-risk cases, such as cases involving non-engagement, self-neglect, hoarding, complex domestic violence, and complex mental health issues, through information sharing and developing coordinated multi-agency approaches to safeguard vulnerable individuals.

8.5 In addition, the Brent Safeguarding Adult Board have agreed to carry forward self-neglect as a priority for the 2024-26 period. Work will include publication of self-neglect protocol, dissemination of learning across the system, scrutiny of safeguarding data regarding self-neglect, multi-agency audits, feedback from those with lived experience of self-neglect, and liaison with voluntary groups and agencies providing support for those who self-neglect.

8.6 Furthermore, the ICB and police have commissioned training courses in response to learning from previous SARs involving self-neglect and hoarding and Adult Social Care have initiated regular audits to assess safeguarding decisions.

'Did Not Attends' and cancellations

8.7 The review highlighted the lack of response to 'Did Not Attends' and cancelled appointments between 2017 and 2022, where patterns were not identified or responded to.

8.8 The GP surgery confirmed that they now regularly review all of its patients on the 'house bound' and 'end of life' registers to ensure their care needs are being met, and they have a named GP to oversee vulnerable patients. CLCH reported that they now have a No Access /Not Seen Policy in place. The Adult Social Care Safeguarding Team reported that where there are issues around access to an adult at risk this would be firstly managed informally and then legal options would then be considered, including Mental Capacity legislation, the Police and Landlord's power of entry.

Multi-agency approaches

8.9 The review has highlighted that whilst there was some communication between agencies and information shared, they mainly working in isolation from each other, each holding their own pieces of the jigsaw.

8.10 As referenced above, the Self-Neglect and Hoarding Toolkit has been refreshed, this toolkit promotes a multi-agency response to self-neglect and hoarding, encompassing a common language and understanding of the issue and clear guidance for response.

8.11 The High-Risk panel is now available to professionals to refer complex and high-risk cases involving non-engagement, self-neglect, hoarding, complex domestic violence, and complex mental health issues. The panel aims to reduce the risk of harm to individuals through information sharing and developing coordinated multi-agency approaches to safeguard vulnerable individuals. The panel is held monthly, with the option for urgent ad hoc meetings.

Escalation

8.12 The review has highlighted that sometimes there is disagreement between agencies and that sometimes agencies seek to absolve their responsibilities for a person who is at risk of harm. Disagreements can arise in relation to individual agency roles and responsibilities to act or to coordinate multi-agency action; monitoring the progress of the adult's care plan to keep them safe; effective communication; agency criteria of need; perception that one agency is not following the London Multi-agency Safeguarding Policy and Procedures; and where perceptions of risk differ. Professionals can feel disempowered not knowing what to do in these instances.

8.13 The Brent Safeguarding Adults Board Escalation Policy was implemented in September 2024. It sets out a four-stage process for resolution, starting with practitioner-to-practitioner discussion, escalating to line manager/safeguarding lead, head of service/director and culminating in referral to the Safeguarding Adults Board Independent Chair.

8.14 Further to the areas of learning highlighted above, the review has identified systems learning which require further consideration and will be translated into recommendations.

Feedback Loops

8.15 Whilst the agencies involved in this review referenced their polices around feeding back outcomes to referrers, it is evident that this policy is not always translated into practice. In some agencies, feedback to the referred is not provided until the individual is discharged from the referred to service, for example, a GP referring to CNWL OPHA CMHT.

8.16 Feedback to referrers is important in enabling professionals to gain a clearer picture of what is going on for an individual and recognising patterns around engagement. It also allows for escalation, as per the recently implemented Brent Safeguarding Adults Board Escalation Policy should a referrer not be satisfied with the outcome of a referral, or where the risk perceived by the referrer has not been fully understood by the referred to agency.

8.17 The review panel members highlighted the need to assure themselves that policy is translated into practice and that assurance mechanisms are in place and utilised to provide this. Feedback as a two-way process was also raised, where feedback is sought as well as provided. In some cases, agencies felt that their policies required review and rewording.

Legal authority for decision making

8.18 Carers and family members can have the legal authority to make decisions on behalf of an individual who lacks the mental capacity to make a specific decision, if they hold Lasting Power of Attorney or Deputyship for that individual. Otherwise, they have no legal authority to make decisions on the individuals' behalf, and any decisions to be made should be as a result of a Best Interest decision involving all interested parties. This means that being someone's carer or next of kin does not automatically give them the right to make decisions on behalf of the cared for person/relative.

8.19 The review found that professionals were not and continue not to routinely ask about a carer or family members decision making authority and lack the confidence to do so. Review panel members reflected that if a carer or family member offers this information it is more likely that the professional will follow up and seek evidence.

8.20 Decision making authority should be proactively enquired about, recorded and copies of Power of Attorney/Deputyship stored. If a person presents as being a Lasting Power of Attorney or Deputy, professionals should search for evidence via the Office of the Public Guardian. Professionals should also have the confidence to question the appropriateness of the conduct of someone acting as an Attorney or Guardian, where it appears they are not acting in the persons best interests and know how and where to escalate these concerns.

8.21 In the absence of someone with the legal authority to make decisions, any decisions made should be as a result of the Best Interest decision process.

Cultural competence and humility

8.22 Cultural competence comprises behaviours, attitudes, and policies that ensure that a system, agency, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups.

8.23 Whilst all the agencies involved in this review were able to confirm that they had Equality, Diversity and Inclusion policies and procedures, and training available to their staff, it was evident that these are not always translated into practice.

8.24 People need their culture to be recognised, and their cultural needs met to promote wellbeing and engagement. Some people's cultural needs are more likely to be met because they are closer to cultural norms in the service, yet, as stated above, Brent is

a very diverse borough. Where culture is not recognised and understood it can create barriers to accessing services.

8.25 Professionals also need to demonstrate cultural humility, going beyond cultural competence, through an ongoing process of self-reflection leading to a deeper understanding and respect for cultural differences. It involves engaging with others humbly, authentically, and from a place of learning, learning directly from people of different cultures.

In person contact

8.26 In this case Indira was rarely seen in person by professionals and so professionals were unable to assess either Indira or her environment or identify risk. The review confirmed that the covid pandemic impacted upon the opportunities to see people in person and that new ways of working introduced by the covid pandemic remain today. This has raised a systems issue around how professionals interact with services users, particularly in the context of increased workload pressures and reduced resources.

8.27 The review has highlighted the importance of face-to-face contact and having 'eyes on' to enable a better understanding of a person circumstances, their needs and the risks. Remote contact should not be the default and the method of contact with a service user should be based upon the presenting information and potential risk.

Recommendations

1. The SAB should set out how it will measure the impact of the self-neglect work being undertaken, through quarterly measures.

2. SAB partners to provide assurance on referral management in their services. This assurance will need to include how agencies have a defined process, with measures, training, and expectations for staff in relation to escalation of concerns about responses to referrals.

3. This SAR shows how Indira's voice was lost during the period reviewed. Therefore, it is recommended that the Brent SAB produce a one-page learning brief that focuses on decision making for the care and treatment of an individual with care and support needs. This briefing should include how to use Lasting Power of Attorney and deputyship for consent to care and treatment, including when to challenge decisions. The briefing should set out how practitioners can gain closer collaboration with advocacy and legal teams to support understanding decision making powers on an individual basis. This recommendation should also be shared with the Brent MCA Task and Finish Group to include in the training and guidance being developed.

4. SAB partner agencies (ASC, CLCH, CNWL) to review the effectiveness of their cultural competence frameworks or policies, highlighting good practice and identifying any areas for development.

5. It is crucial that people with care and support needs who are in their own homes are not restricted in their face-to-face contact with services by those caring for them. It is important that there is a good understanding about what is restricting the contact to support an individual with care and support needs. Therefore, SAB partner agencies to provide assurance to the SAB that, where face to face contact is not the normal practice for the service when an individual is receiving care in their own home, the agency rationalises this decision on a case by case situation.