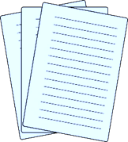
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**Safeguarding Adults Review - ‘Lola and Mike’**

***What is a Safeguarding Adults Review?*** A Safeguarding Adult Board, as part of its s.44 Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

**‘(*1)*** *A SAB* ***must*** *arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*

***(a)*** *there is* ***reasonable cause*** *for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***And***

***(b)*** *condition 1* ***or*** *2 is met (see below)*

***(2)******Condition 1******is met if: -***

***(a)*** *the adult has died,* ***and (b)*** *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

***(3)******Condition 2 is met if: -***

***(a)*** *the adult is still alive,* ***and (b)*** *the SAB knows or suspects that the adult has experienced serious abuse or neglect*

*SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should 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. The apportioning of blame is not the purpose of the review.’*

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Description automatically generatedAbout this briefing –*** A Safeguarding Adults Review (SAR) has been undertaken and the BSAB has reviewed the information pertaining to this family and have agreed it should be a joint SAR. For the purposes of the SAR the woman/mother/client is known as Lola and her son/man/carer is known as Mike. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners. Please take time to reflect on the findings and consider how you can learn, develop and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

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Description automatically generatedCare and support needs are identified in the Care Act 2014 as the following –***

Lola was in contact with a range of health and social care services as well as victim support, housing, and police services prior to her unexpected death. At thetime of her death, her son Mike, also a vulnerable adult was not living in the family home due to court orders preventing him due to ongoing familiarial domestic abuse.

***Lola had 11 identified Care & Support needs with evidence below: -***

1. **Managing and maintaining nutrition -** Lola is unable to do food shopping. Based on what we have known about the property it is likely that the home environment did not have suitable cooking facilities, Lola had a poor diet and nutrition, evidenced by little or no fresh food and high consumption of alcohol.
2. **Maintaining personal hygiene –** Lola was unkempt in appearance, and body odour. It has been reported that Lola had faeces on her. Lola was unaware of this and doesn’t see anything wrong with her appearance. It is unknown if there were suitable washing facilities.
3. **Managing toilet needs** **-** Toilet inside the house was not working. Biohazardous waste was found in the property and not disposed of appropriately. It is unknown if Lola suffered from any incontinence issues. It could have been likely given the alcohol consumption.
4. **Being appropriately clothed** **-** Lola would wear the same clothes; they had stains and body odour.
5. **Being able to make use of the adults home safely-** Lola was living in unclean environment; human and dog faeces were reported to be found in the house and on Lola. Toilet was not working, and it was reported that Lola was putting her faeces in bags and then outside the front of the house. This was Biohazardous waste and unsafe. Lola was intoxicated most of the time and could not maintain the home safely.
6. **Maintaining a habitable home environment -** The household maintenance was neglected and there were many hazards within the home making it unsafe, this was possibly decades of neglect within
7. **The home environment** - There was a lack of adequate electricity and heating. The ceiling was falling down. Concerns over flies. Living space was not maintained. There was a large hole in the ceiling of the hallway, the plastered ceiling had fallen exposing floor beams, Lola stated this occurred along time ago. No carpet in the hallway or living room floor. The property had an overwhelming (it smelt of dog and human faeces) and there were dog faeces visible on the lounge floor. Lola’s son had been financially abusing Lola and Lola had fallen into debt. House in a serious state of disrepair and there are no carpets or wall coverings.
8. **Developing and maintaining family or other personal**

**relationship –** Lola persistently declined access to

property to professionals except Police. Lola did not have a GP – as the previous GP surgery closed down and was not able to register at a new GP. Lola declined to allow housing association and social worker entry to inspect property multiple times. Repeated episodes of anti-social behaviour and victim of domestic abuse, but also acting as a DA perpetrator. Lola had poor insight and did not recognise her self-neglect and the impact on her son. Lola has dogs which she loved and was able to provide adequate care for.

1. **Accessing and engaging in work, training,**

**education, or volunteering -** Lola was unable to

access training, work, education, or volunteering.

1. **Making use of necessary facilities or services in the**

**local community, including public transport, and**

**recreational facilities or services-**Lola was unable to attend appointments without support, she described herself as agoraphobic. She was socially isolated; she had a sister and a niece who would keep in touch and report and problems and concerns to L&Q.

1. **Carrying out any caring responsibilities the adult**

**has for a child –** there was history of Lola not being able to carry out responsibilities to her son when he was a child; he was an adult at the time of the review, but he did not always live with her.

***This review also identified that Mike was a vulnerable adult and had 10 Care & Support needs, that were not seen by any professionals involved with Lola or Mike, they are listed below, with evidence:-***

* 1. ***Managing and maintaining nutrition –***Mike was

able to do food shopping. It is likely that the home environment did not have suitable cooking facilities, poor diet, and nutrition, evidenced by little or no fresh food and high levels of alcohol consumption.

* 1. **Maintaining personal hygiene –** Mike was unkempt

in appearance, and body odour. It is unknown if there were suitable washing facilities.

* 1. **Managing toilet needs -** The home toilet was not

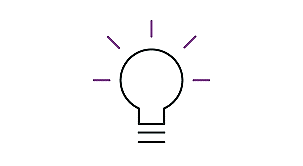
working, and biohazardous waste was found in the property and not disposed of appropriately. It is not known if Mike suffered from any incontinence issues. It could have been likely given the alcohol consumption.

* 1. **Being appropriately clothed** *–* Mike would wear the same clothes; they had stains and body odour.
  2. **Being able to make use of the adults home safely** -Mike was living in unclean environment, human and dog faeces were reported to be found in the house.

Toilet was not working, and it was unknown how Mike was accessing toilet facilities. There was

evidence of biohazardous waste. Mike was intoxicated a lot of the time; he would also use drugs.

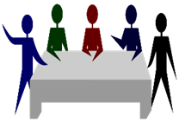
* 1. **Maintaining a habitable home environment -** The household maintenance was neglected and there were many hazards within the home making it unsafe, this was possibly decades of neglect within the home environment. There was a lack of adequate electricity and heating. The ceiling was falling down. Concerns over flies. Living space was not maintained. There was a large hole in the ceiling of the hallway, the plastered ceiling had fallen exposing floor beams, Mike stated this occurred along time ago. No carpet in the hallway or living room floor. The property had an overwhelming odour (it smelt of dog and human faeces) and there were dog faeces visible on the lounge floor. Mike had been financially abusing his mother and she had fallen into debt. House in a serious state of disrepair and there are no carpets or wall coverings*.*
  2. **Developing and maintaining family or other personal relationship -** Mike did not have a GP – previous GP surgery closed down and was not able to register at a new GP. Repeated episodes of anti-social behaviour, perpetrator of domestic abuse and also a victim when his mother would be drunk. Mike had poor insight and did not recognise his self-neglect.
  3. **Accessing and engaging in work, training, education, or volunteering -**Mike was unable to access training, work, education, or volunteering. However, he would find handy man jobs locally.
  4. **Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services -** Mike was able to access the community.
  5. **Carrying out any caring responsibilities the adult has for a child –** Mike was a carer to his vulnerable mother.

***About the review process –*** BSAB is resolved to consider how reviews can be more effective in terms of balancing the time that agencies are involved in such reviews, timeliness of reviews and learning, and outcomes that can improve the service provided as partners. The methodology used for this review was analysis of how agencies worked with Lola and Mike as well as with each other. The way the BSAB captured this information was through a Chronology of involvement and Individual

Management Review from each agency to form a Joint Chronology of which agency knew what when in relation to Lola and/or Mike. Lola and Mike were known across Bexley services. The review group worked together to produce the

Report with Local Bexley Reviewer, Tracey Cook who led and wrote the review. The BSAB Independent Chair, Andy

Rabey, signed off this report after independent guidance and scrutiny.



***Summary of Lola and Mike – Lola*** was a 57-year-old woman, white British, no known religion, sexual orientation was not known. She was unemployed and received state benefits. Lola was a mother, strong willed, independent, and family minded. Lola was close to her extended family (sister and niece). Lola was an animal lover, vegetarian and spoke well of family members. Lola wanted to manage her own lifestyle. Lola lived in a house that was owned by the housing association London and Quadrant (L&Q). The house was in a very poor condition, and she did not allow any maintenance or repairs on the property. Lola was self-neglecting; biohazardous waste was present in the house and on Lola. The Care Act 2014 defines self-neglect as neglecting to care for one’s personal hygiene, health, and surroundings. Lola had 2 dogs which she loved and were very attached too. There was dog urine and faeces in the house. Lola had described herself as agoraphobic, there are no known diagnosed learning disabilities or mental health issues. Lola had care and support needs under The Care Act 2014 that included: managing personal care and hygiene, toileting needs, managing food and nutrition, maintaining, and running a home, safe use of the home and accessing the community. Lola was not receiving medication and was not registered with a GP surgery until just prior to her death. Lola had not seen a GP for many years. Lola was housebound, frail, unkempt, underweight, she also had anxiety and managed this using alcohol. Lola reported that she believed she had anorexia. Lola had one child; a son called Mike whom she loved very much.

***Mike*** was 28-year-old white British male, he lived with his mother Lola. He was her carer, and he loved her. Mike was also unemployed and had history of substance misuse, (drugs & alcohol). Mike wasn’t able to read or write. There is no evidence of a learning disability. No known religion, no known sexual orientation. Mike and Lola were both isolated and did not engage/interact with the local community. Mike was the main carer for Lola and did the shopping. There was familial domestic abuse. Little is known about Mike and Lola’s background and life experiences. They were very isolated and did not have any friends, they had 2 family members however they were not heavily involved in their care or in visiting them regularly. Lola’s sister wanted to be involved however she sadly died, the remaining family member who was Lola’s niece has not engaged in this process. The panel identified that there were no parallel reviews or investigations linked to either Lola or Mike.

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Description automatically generatedThe SAR identified over 25 Learning Points for you and your agency to consider.***

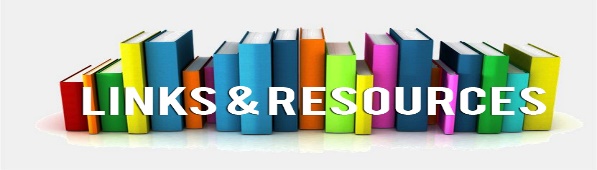
***There are also 33 Recommendations made by the Reviewer, Independent Chair and the Review Panel, which are listed below: -***

1. BSAB to consider revamping and relaunching the Self Neglect Toolkit.
2. Liquid Logic systems does not share Adult Social Care/Children’s Social Care information - this is for the BSAB to challenge this.
3. BSAB to consider including Self Neglect and Hoarding cases at their Vulnerable Adults Panel and include on recording systems that this Vulnerable Adult Panel is identified.
4. BSAB to consider Self Neglect/Hoarding Champions linked to Safeguarding Adults Champions to be consider in the vulnerable adult Panel / Toolkit.
5. Consider including a check list for social workers in the Self Neglect Toolkit to give continuity and support.
6. BSAB to consider including relation-based language about how the trauma is linked to the Self Neglect. Consider support / debriefing exercises for professionals when working in complex environments.
7. All self-neglect and hoarding referrals to be raised as a section 42.
8. Multi-Agency Risk Assessment to be completed on high-risk cases. To identify, assess, manage and escalation process. Professionals meeting – Local Authority has powers to act:
9. Ensuring that the Risk Assessment is completed including the DASH tool, then, shared so that the risks are identified and shared with partner agencies.
10. Engaging in a Multi-Agency Risk Assessment planning meeting and follow the action plans understanding the escalation processes.
11. Ensuring that staff understand their roles and responsibilities and share this in a multi-agency manner.
12. Unmanaged risk and understanding the impact on services and the individual's wellbeing.
13. Mental Capacity Assessment (MCA) and Executive Functioning: Ensuring professionals when understanding their roles/responsibilities they have up to date legal literacy knowledge and demonstrate their knowledge in a defensible manner.
14. Ensuring that professionals are making decisions around Self neglect. Ensuring the rationale and decision-making is clear, concise, recorded, and shared.
15. Professionals meeting – Local Authority has powers to act on the escalation of concerns.
16. Share intelligence across adult and children social care
17. Self-neglect – weekly checks or weekly visit to maintain regular contact and ensure welfare of the individual.
18. Identifying the 'trusted' professional and working in a multi-agency approach to support the individual.
19. All social workers to complete SAR review to aid learning and development-(a). Consider developing Social Work practice and development by being part of the SAR reviewing and learning process. (b) Consider frontline workers are involved in Safeguarding Adult Reviews both directly by attending Panel and attending Learning Events.
20. Admin - Ensure that Admin are not fulfilling Social Work duties such as closing cases.
21. Ensuring that the Safeguarding Adults Manager/Enquiry Officer have addressed the risks, plan and updated partner agencies before closing a case or reallocating to Case Management. Empower not just Social Workers but all professionals to disagree with seniors’ directives and seek further guidance. Ensure that ALL self-neglect cases have a multi-agency response and that on IT systems (Liquid Logic) it is a mandatory recording of a multi-agency response and to include date and any other evidence.
22. Mike should have had his own allocated worker to complete recommendations from MARAC – such as needs assessment, MCA and carers assessment and advocacy. – (a). Consider when a Perpetrator or Victim has an unidentified 'need' that Adult Social Care would be contacted to complete an assessment. (b) Ensure Safeguarding practice does distinguish between Perpetrator/Victim, and each are seen. (c) Ensure that Perpetrators are not seen only as a 'perpetrator' but professional biases are considered and seen in their own right. (d) Consider commissioning Perpetrator Prevention services - Perpetrator Programme. Including Familial Abuse; Trauma-Informed Practice - Think Family. (e) Consider not allocating the same Social Worker to the Perp/Victim in the same case due to the conflict of interests. (f) Consider High Risk Panel re: Perpetrators - MAPPA (criterion high); Consider CR MARAC where wider-community risk is identified as DA MARAC is Victim-lead.
23. GP- Ensure patients' needs are met by appropriate communication and assessments made - i.e when illiterate don't write to them and where reasonable adjustment should be made.
24. When a GP surgery is closing support is offered to vulnerable adults are supported to re-register.
25. Police to raise awareness of Domestic Violence Protection Notice (DVPO) process and guidelines.- Police to raise awareness of DVPO process and guidelines: a) Consider a Debrief/Reminder from Senior Leadership Team to Officers around their duties around DVPO and SPOC with regards to DVPO; and b) Consider having a SPOC on DVPO for support to frontline officers.
26. The Met Police raise awareness on more thorough recording of Crime Reporting Information System (CRIS) reports when attending incidents that are alleging domestic abuse.
27. The Met to share information with key partners when an adult comes to Police notice and Merlin reports to be shared.
28. The Met to provide investigating officers of Domestic Abuse a debrief and the Mets policy on DVPO. Review local practice in regard to urgent requests from the MARAC regarding high-risk victims and ensure access to resources.
29. L&Q could have used professional curiosity to gain intelligence about the conditions of the property and social worker could have challenged this and escalated due to the nature and severity of the housing conditions, could also have stressed the importance of the safeguarding concerns and it was hazard to Lola and Mike’s health. Core areas for improvements are: Inspections on properties should be followed up with Local Authority where there are vulnerable adults; 2) Risk assessment on high-risk cases should be completed and shared with professionals;

3) If L&Q cannot attend meetings – to send a representative to prevent delays; and 4) Effective communication or court orders – consider Equality Act given that Mike could not read.

***Questions for you to consider -***

1. How well do you understand Carer’s Assessments?
2. How confident are you when working with complex family dynamics, as well as, escalating when you do not feel comfortable?
3. Did you know Bexley has a ‘Joint Think Family Protocol’?
4. Do you see Self-Neglect as an unwise decision instead of a category of abuse as listed in the Care Act 2014?
5. How much do you know about Safeguarding Adults and Escalation processes? New Domestic Abuse Bill 2021 duties?
6. How accessible are your services for someone to speak with staff about their care and support needs especially when struggling with psychosis?
7. What risk management procedures are in place to support in ensuring risk assessments are of a sufficiently high standard and include feedback from key agencies and significant others in the person’s life?
8. How does your agency engage with MARAC and other high-risk panels?
9. Anything else to ensure you and your organisation understand Safeguarding is ‘everyone’s responsibility’.

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[***SAR-Lola and Mike Final Report***](https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-Lola-and-Mike-Familiar-Domestic-Abuse.pdf) ***– Click here for full report***

* Bexley Safeguarding Adults Board website –<http://www.safeguardingadultsinbexley.com>
  + The website holds an annual [SAR Themed Learning & Development Programme](chrome-extension://efaidnbhttps:/www.safeguardingadultsinbexley.com/wp-content/uploads/2023-24-BSAB-Learning-Development-Programme-1.pdf)
  + Tools and Resources for all Bexley Organisations
  + Other SAR published reports
  + 7-Minute Briefings
  + Other Resources and Links
* Email Bexley SAB at [bsab@bexley.gov.uk](mailto:bsab@bexley.gov.uk) for any support on embedding this learning.

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