Safeguarding Adult Review
Lola & Mike

FINAL Report

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Bexley Safeguarding Adult Board
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1. Introduction

The subject of this review is a white British woman in her fifties who died at home with her dogs beside her on 24th March; and her son who had lived with her and was the main carer died on 7th May following a head injury. This family were well known to multiple services due to the domestic abuse, poor living conditions and neglect. Bexley Adult Safeguarding Board 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 Mike. 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. Lola was also a carer for Mike, and they had a co-dependent relationship.

2. Purpose of a Safeguarding Adults Review

Section 44 of the Care Act 2014 places a statutory requirement on the Bexley Safeguarding Adults Board (BSAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Bexley Safeguarding Adults Board the power to commission a SAR into any other case:

'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) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other 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).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to – a) identifying the lessons to be learnt from the adult's case, and b) applying those lessons to future cases.

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.

SARs are about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

This case was referred to the BSAB on 4th April 2022 by Debee Simpson, Domestic Abuse Sexual Violence Manager who identified that the criteria for a SAR may have been met.

The BSAB's Safeguarding Adults Review subgroup confirmed on 3rd May 2022 that the criteria under s44 of the Care Act had been met and that circumstances leading to Lola and Mikes Death should be reviewed.

3. Timescales

This review covered the period from January 2017- May 2022

4. Methodology

Combined IMR / Chronology Analysis see below descriptions: -

Individual Management Reviews to Analyse Individual Agency Performance:
Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced.

Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.

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- Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

Multi-agency Combined Chronology:

- Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies.

- A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.

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- Chronologies are important tools that are particularly useful when combined across agencies using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making, and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

Additional information for the methodology the TOR members noted were: Consider MARAC initial information for information timeline, January 2017 If salient, ask for more information if more than 2 years

5. Involvement of Family Members and Friends

The Care Act 2014 requires SABs to inform and engage with individuals and including their family as part of the SAR process.

BSAB wrote to Lola's sister to invite to participate in the review and she wrote back stating that she would like to engage. However, when contacted, there was no response, and it was later found that she had also died and Lola's surviving niece did not engage.

6. Contributing Organisations

Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the Review Panel.

Each of the following organisations contributed to the review…

Agency/ Contributor	Nature of Contribution
Integrated Care Board, Bexley	Statutory Partner
The Metropolitan Police Service	IMR / Chronology
Victim Support	IMR / Chronology
Unique Personnel Care (Impact Project Solutions)	IMR / Chronology
London Borough of Bexley : • Adult Social Care (ASC) • Domestic Abuse (DA) Services • Children's Social Care (CSS) • Multi-Agency Risk Assessment Conference (MARAC)	 IMR / Chronology IMR/ Chronology Chronology Chronology
London and Quadrant Housing Association (L&Q)	IMR / Chronology
Pier Road – South London and Maudsley (SLAM)	Chronology
London Ambulance Service (LAS)	IMR / Chronology
RSPCA	Chronology
Lewisham & Greenwich NHS Trust	Chronology
Dartford and Gravesham Trust	Chronology
Oxleas NHS Foundation Trust	Chronology
Bexley Medical Group – GP Surgery	Chronology

7. Review Panel Members

The Review Panel was made up of an Author/Reviewer and senior representatives of organisations that had relevant contact with Lola and Mike.

The members of the panel were:

Agency	Name	Job Title
Integrated Care Board, Bexley	Philippa Uren Dr Jennifer Liddington	Designate Nurse for Adult Safeguarding Lead GP
The Metropolitan Police Service	Justin Armstrong	Homicide & Statutory Safeguarding Review Operations Manager (SCRG) Specialist Crime Review Group at Metropolitan Police
Victim Support	Andrew Meekings Juile Sergeant	Senior Domestic Abuse Operations Manager Senior Domestic Abuse Advisor
London Borough of Bexley : • Adult Social Care (ASC) • Domestic Abuse (DA) Services • Children Social Care (CSS) • Multi-Agency Risk Assessment Conference (MARAC)	Sue Chandler and Maxine Hammond Deborah Simpson Carol Coffey Louise West	Head of Safeguarding Adults / Principal Social Worker and Head of Complex Care Domestic Violence Strategy Manager Leaving Care Team Manager MARAC Co-ordinator & Trainer
London Ambulance Service (LAS)	Jade Speed	Safeguarding Liaison

Lewisham & Greenwich NHS Trust	Frankie Campbell	Safeguarding Lead
Dartford and Gravesham Trust	Gina Tomlin	Safeguarding Lead
Oxleas NHS Foundation Trust	Andrew Warren	Lead for Safeguarding Adults and Prevent

8. Local Author/Reviewer

The Local Reviewer, who is also the Chair of the Review Panel meetings, is Tracey Cook.

The Local Reviewer Tracey Cook qualified as a social worker in 2005. She is a Senior Social Worker in adult social care. She is an experienced safeguarding adults manager and enquiry officer; she is a practice educator and a domestic abuse champion and a safeguarding co-coordinator.

The Local Reviewer had little connection with the Bexley Safeguarding Adults Board other than being commissioned to undertake the review.

9. Parallel Reviews/Investigations

There are no other parallel reviews or investigations.

10. Publication/ Media

This SAR Report will be published on the Bexley Safeguarding Adults Board website - SAR Publications - Bexley Safeguarding Adults Board (safeguardingadultsinbexley.com)

11.Equality and Diversity

The report addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as prescribed in the public sector Equalities Act duties and considered if they were relevant to any aspect of this review.

The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from

the negligence of services towards persons to whom the characteristics were relevant.

At the initial Terms of Reference meeting the Chair discussed with the panel the cultural make-up of the family and no emerging concerns were raised.

The IMRs requested practitioners to consider any Equality and/or Diversity concerns or matters with each individual and none were highlighted for this review.

The panel agreed that a wider understanding of the Domestic Abuse services available within the area of Bexley would be helpful and commissioned services should be more aware of Domestic Abuse and how coercion and control does not allow for reasonable decision-making.

12. Background Information/ Pen Picture

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 were 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.

Cause of Deaths for Lola and Mike –

The Coroner reported that the Cause of Death for Lola was:

1. Cardiac Arrhythmia
2. Chronic Alcohol Abuse
3. Ischaemic Heart Disease

The Coroner reported that the Cause of Death for Mike was:

1. Head injury
2. Alcohol abuse

13.Chronology

2017

In 2017 the Police were called six times for Domestic Abuse incidents and anti-social behaviour between Mike and Lola. On two occasions Mike said he couldn't cope with caring for Lola and Lola said she relied on Mike. Both Mike and Lola declined to engage with officers, including, Lola's decision not to support a prosecution.

2018

No events reported or recorded.

2019

During this time the Police were called twice. This was the first time that Mike and Lola were presented at Bexley Multi Agency Risk assessment Committee (MARAC) where professionals heard that Lola was unwilling to substantiate any allegations of domestic abuse. Although a Police report was completed and sent to Adult Social Care; referrals were made to Solace – domestic abuse services

and Pier Road Project – drug and alcohol service for Lola; however she did not engage.

A Multi Agency Risk Assessment Conference (or MARAC) is a meeting that is held to discuss the most high risk cases of domestic abuse and sexual violence, to share information and to safety plan to safeguard a victim.

2020

There were 4 police calls outs during this period mainly due to verbal arguing, and both appeared to be under the influence of alcohol. Mike was threatening to self harm and a Police report was sent to Adult Social care.

Also, in this period, Lola stabbed Mike, but no charges were bought against her as Mike provided a no comment interview. The Investigating Officer concluded that Lola was more likely to be at risk of harm from Mike and decided against a prosecution based on their history.

A Police report was completed, fully detailing the condition of the house, Lola's vulnerabilities, and both of their struggles with addiction. This report was passed to Adult Social Care where they opened a safeguarding enquiry by allocating to a social worker.

The social worker reported it was challenging to engage with Lola for any intervention due to her distrust of services. Lola reported to her social worker that she knew her rights and was aware that only the Police have the powers of entry.

Due to the above knife incident, Lola and Mike were both presented at MARAC. The MARAC reported actions were for Housing Provider L&Q to complete a home visit with the social worker. It was also reported that Pier Road Project (drug and alcohol service) closed Mike's referral due to no response to initiate services.

An Oxleas Triage Nurse visited Lola and advised professionals that there were no mental health issues present at this time. Although Lola had been known in the past for a moderate depressive episode. The Triage Nurse did not see Mike on this occasion, but he was historically known to Children and Adolescent Mental Health Service (CAMHS) where suspected mental and behavioural disorders were identified. Additionally, it was identified that both Lola and Mike were not registered with a GP after their GP had closed down a couple years prior.

Lola's Social Worker was able to speak with her after several attempts, however, she did not allow her Social Worker into the house and only spoke with her at the door. It was reported by the Social Worker that she could still see the poor condition of both the property and of Lola. When the Social Worker tried addressing with Lola her concerns, Lola denied there were any issues and minimised the concerns. However,

the Social Worker's concerns around Lola's financial instability especially the inability to get food was accepted. The Social Worker reported that Lola had no money and no food and was able to get food delivered, she was happy that Lola accepted this. The Social Worker also offered a Care Act Assessment, however, Lola was not happy to have an assessment or accept any help from professionals. That was the only time she opened the door to social worker in 2020. A Care Act assessment requires consent, and she would not give her consent.

Information from ASC for the review –

Consent is not required for Safeguarding Adult enquiry; however, the client is required to give their views and wishes/outcome and they can decide not to be contacted to get involved with the enquiry The Safeguarding Adults enquiry can be done without the client's involvement.

Professionals tried to use the maintenance of the property as a main focus, because Lola was very anxious and not engaging for fear of losing her home. Lola had been informed by housing provider L&Q that they would need to do some repairs; and professionals thought it was a way to work jointly with L&Q to gain better access with Lola.

The Social Worker closed the safeguarding enquiry as requested by her Senior Social Worker. Where on reflection, the Social Worker reported that she did not want to close it, but was instructed by her senior, so they felt they had to. In addition, Lola's case file was accidentally closed due to an admin error when moving from a safeguarding enquiry into case management. Adult Social Care were unable to give a reason why a decision to close the safeguarding enquiry and allocate to case management was made.

In the same period, Mike had been seen at Queen Elizabeth Hospital following a mental health crisis where he self-inflicted injures to his arm with a knife. Mike had been waiting for a mental health assessment but left the hospital before being seen or treated. Later the same day, Mike was found by police intoxicated at a neighbour's house. The Police completed a report and sent to Oxleas Mental Health Team for follow up support, but Mike was discharged from their service due to non-engagement. It is not clear if any attempts were made to visit or phone Mike as he could not read.

Also, in this time, Mike was assaulted but would not disclose details to Police. Mike did disclose that he was experiencing anxiety and depression and was using cocaine and alcohol to cope. Police Officers offered Mike support details for his addiction and forwarded their report to Adult Social Care.

There was also a report where Mike called the Police and stated his mother Lola was trying to stab him. And Mike further stated he had a gun and wanted to shoot himself. When the Police arrived, Mike was intoxicated and detained; however, they discovered no firearms or any offences after speaking with Lola.

2021

There were over 25 police interventions/contact. The common themes during this period were domestic abuse, physical assaults resulting in injury. There was shouting, arguing, alcohol misuse, financial abuse, criminality, poor housing environment, neglect. Lola sustained multiple injuries in this 12-month period. The neighbours reported that domestic abuse was a regular occurrence as well as anti-social behaviour, possible animal welfare issues. Both Lola and Mike were frequently intoxicated. Lola was unwilling to assist with a prosecution and Lola declined medical treatment frequently for the injuries that Mike caused. Mike had experienced multiple assaults including head injuries which he could not recall how it had happened. Lola and Mike were heard multiple times at MARAC during this period, the concerns were also escalated to head of safeguarding due to the frequent MARAC referrals and lack of action from partner agencies.

Mike had breached the Domestic Violence Protection Order (DVPO), which were Applied for by the police in order to stop the DA (needs a bit of explanation as first mention). Referrals to the Independent Domestic Violence Advocate (IDVA) service were made for the first time in 2021.

Lola was referred to Criminal Justice Mental Health Service (CJMHS) via Lewisham Police custody where she'd been detained following an arrest due to assaulting her son Mike. Her referral was made on the grounds of her reportedly stating that she has mental health needs (which she would not disclose). Furthermore, there were concerns about her presenting with evidence of poor self-care. No overt symptoms of an acute mental disorder. The assessing mental health professional believed that the primary needs at that time appeared to be alcohol misuse related. It was considered that Lola could possibly benefit from a referral to a drugs & alcohol service but was not motivated to engage. Lola admitted to drinking around 3 litres of strong cider every day, sometimes wakes up at around 3am and will drink alcohol, she stated 'all I want to do is get drunk', it helps her to numb her feelings of low self-esteem. Lola reported that she always had problems with her confidence, she said other children bullied her because of how she looked and feels this has carried on to adulthood. Lola said has no desire to address her alcohol issue and just wants to continue to drink. Lola was asked about her physical health, she said she does not go to the doctors and will not allow her GP to carry out any tests on her as she does not want to know how her physical health is. She denied any thoughts of self-harm. No suicidal ideation.

Mike had attacked his neighbour with a hammer due to a 20 year dispute and was arrested.

Lola would not respond to calls or give access when the social worker visited. There were multiple failed home visits. The IDVA also reports multiple failed attempts at contact. It was a common theme during this period that Lola did not want any involvement from social services, the police or anybody she felt was a threat.

Lola and Mike were heard several times at MARAC and a multi-agency meeting was arranged. During this time the escalation of abuse was increasing.

London and Quadrant (L&Q) housing association was contacted multiple times during 2021 – they had reports from Lola's cousin about the assaults from Mike and the condition of the property. L&Q then spoke to neighbours who expressed their concerns for Lola. They allege they are continuously hearing Lola and her son argue and fight and they are always calling the Police. They also allege inside the property is in a bad state of repair. L&Q advised neighbours of direct contact details should further incidents arise. L&Q referred to their legal team for legal action.

Following a recent assault, violence and threats from Mike to kill Lola, Lola wanted help regarding a non-molestation order – this is the first time that Lola has considered taking any enforcement action against Mike. L&Q made the property secure and Mike was arrested and interviewed to which he gave a no comment interview. He was charged with assault, but this was withdrawn by the Crown Prosecution Service (CPS).

A Strategy meeting was cancelled due to key partners not being available. However this eventually did take place and L&Q sought legal action where a without notice injunction was issued against Mike to exclude him from the property and immediate surroundings, this also included the power of arrest. This would disrupt Mike's abusive behaviour towards Lola and the neighbours. The exclusion order was to be in place for a period of at least 2 years. The Letter Before Action, was sent to Lola which requested that she provides access for an inspection and/or works to be done, that she controls her dogs, she is not to be heard arguing/shouting with her son Mike and that she is to give L&Q access to inspect and carry out any works it deems necessary and also that she is to allow L&Q to attend to clean and clear the garden if she is not able to do so herself. Additionally the judge had listed for a return hearing. This is due to the fact the paperwork could not be served personally on Mike and was taped to the front door of the property. Mike could not read or write.

Lola was aware that a meeting was being held and she did tell L&Q that she does not trust anyone and will not give access. They attended and were only able to speak with neighbours.

Mike was arrested for breaching his bail conditions and while in custody threatened to kill himself.

The IDVA had built a relationship with Lola once successful contact was established. Lola shared with the IDVA that she relies on her son to buy her alcohol

but has not seen him in a week (this was due to DVPO) she does not like being around people and is agoraphobic; highlighted that she has not had much food, L&Q housing has offered her a temporary place to move whilst they complete repairs on her property, but she declined due to her dogs. IDVA arranged phone and food vouchers multiple times as Lola had difficulty accessing her money from the post office.

Lola gave access to L&Q and it was reported that the smell was overwhelming and determined that internally the property was uninhabitable. Lola stated, she would like a new bathroom and agreed for L&Q to go upstairs to assess the old one. The bathroom was in a dire state and also the bedroom which was visible from the landing. Entry into the other bedroom was not possible for Lola had locked her dogs inside. Lola was advised that contractors would not work in such conditions and Lola stated she would get a bucket and clean the floors to enable works to take place. Lola was informed it required a deep clean and she would not be permitted to remain inside the property whilst works were completed as there was also a huge hole in the kitchen ceiling and the upstairs bedroom.

Lola was offered assistance with her tenancy which she refused and stated she was quite happy living there and did not want any help. Lola declined support from social services. Lola became aggressive and abusive following this conversation.

L&Q were planning to apply to the courts for an injunction compelling Lola to move out and for L&Q to be allowed to force entry if necessary to clean and clear the property and effect all necessary repairs if Lola did not agree.

To relinquish Lola from being dependent on Mike, the Local Authority Adult Social Care agreed to provide 2 hours a week for a carer to support her to access the community and withdraw money and complete her shopping. Lola had agreed to have support with shopping once a week, she was happy to use the cab that was be sent by IDVA services to access the community with her carer for shopping. There were ongoing problems with Lola, shopping and accessing her money. A shopping service was problematic in that there were various issues with the cash card, unable to withdraw money, no transport and no carer. The carer purchased shopping from their own funds for Lola. This was later resolved by the social worker and IDVA.

The carer also recommended that Social Services visit Lola, and carry out assessment of needs, as the carer had serious concerns in relation to Lola's living condition and the environment.

While Mike was not living at the address he called Police to state he wanted someone to check on his mother as he was not allowed there because of an injunction. Police did not attend.

Lola received a visit from her sister and niece. Lola's sister shares her concerns that Mike could kill her and Lola did not have as much money as she thought. Mike had been round to her niece's house and made threats to her niece.

Mike had attended the address on 3 occasions in one day, and on the last visit he had kicked the door open. Lola had called the police and stated that Mike had wanted money and had scattered her Christmas presents about looking for her cash card. Lola reports this to the police but there is no mention of an injunction is reported to the police officers.

2022

During this period the Police were called 11 times.

Lola said that Mike cannot read and write and would need to get the court order read to him. So, when Mike turned up at the address in January, Lola opened the door and handed him the court order along with his other letters. Mike left, but Lola informed the Police that he returned later and forced his way into the property. It was Lola's report that Mike was clearly on drugs and had a bottle of drink in hand, he kept asking for her bank card, but she never gave it to him, which he then threatened to punch her, but she called the Police and he left. On Police arrival, the door was not damaged, and Lola declined to give the Police a statement.

Lola's IDVA requested that a copy of the court order against Mike to be shared with the Police so it could be added on Notice Of Seeking Possession (NOSP). Following Mike's forced entry to the property, L&Q were notified and made arrangements to secure the property and intended to notify the court that the court order was breached.

Following this incident, Lola and Mike were presented at MARAC again. The actions below were taken:

- IDVA provided support and safety planning to Lola
- Personal attack alarms provided to Lola
- Lola has been referred to foodbank and has been provided with a shopping voucher from Adult Social Care and Lola has been provided with a care package of 2 hours per week for carers to assist with shopping
- L&Q: An order is now in place against Mike which prevents him from attending Lola's address.
- Lola has been signposted to substance misuse support services.

- Lola has been provided with taxi transport to enable her to access the community so that she can get food shopping.
- Police had followed up on the action from MARAC to ensure that a nationally monitored alarm was installed within Lola's address, and that an officer should attend and assess the living conditions. Mike was placed on the Police monitoring system, but when monitored they noted it had been closed as unresolved. The Officer then escalated this with a line manager within the call handling department of the Metropolitan Police Service command and control room and ensured a further message was created and stressed the importance of action.
- Email and telephone discussion with MARAC chair safeguarding team in Adult Social Care (ASC) to establish whether further interventions can or should have been put in place to safeguard Lola.
- A Police welfare check was requested for Lola is a high-risk MARAC victim with learning difficulties and reports of her living in squalid conditions. Police attended but Lola would only allow access to the hallway where she demonstrated her electricity was working. The officers noted 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 and Lola kept her dogs in her bedroom throughout the interacting with officers. Lola denied having dog faeces on her at any time during a third-party visit and was suitably dressed for the cold house.

After the welfare visit by Police, Lola's IDVA called her and has reported the following:

She expressed being very annoyed that Police had been to her address for a welfare check, as Social Care had stated she was living in Squalor with no electric and that she was seen by the social worker to have dog poo up her legs. Lola said this was all lies and now does not want to engage with Social Care anymore.

The IDVA arranged for Lola more food and money via taxi service. Lola did not want the alarm and wants nothing to do with the Police due to their visit today. Lola informed IDVA that her property was in a poor state, and she said that the hall ceiling needs a bit of plasterboard and is a 15 minute job, and L&Q have said they will fix it.

Following this conversation, the IDVA emailed the chair of the MARAC to advise of what Lola shared with them and to flag concerns that Lola might disengage. The IDVA also shared that booking taxies for Lola is not sustainable anymore, it works for her to do her shopping, drinking is still an issue Lola tends to relapse and then allow her son back in the property. There was an issue with her benefits and was unable to withdraw any money for shopping. The IDVA called Lola's Social Worker and they worked to resolve this issue.

Subsequently, Lola's IDVA contacted Lola and enquired about the property maintenance work needed, Lola replied that only plasterboard on ceiling is required. It was identified at this point that Lola did not appear to be able to recognise the conditions and deterioration of the property that required more substantial work. Lola's Landlords at L&Q were taking the situation very seriously to where they were seeking an eviction via court, because Lola would not allow them access to conduct work.

Also, during this period, the RSPCA had removed Lola's dogs. Lola was extremely angry and did not think they were coming back and was threatening to kill herself. After being treated at the veterinarian the RSPCA later returned the dogs.

Lola's Social Worker had registered her with a GP, but Lola said she could not attend an appointment and declined a home visit.

Lola was referred to Oxleas Mental Health Team and was offered an appointment. However, during the call with Lola staff could hear in the background dogs making significant noise, described as not particularly friendly. Lola seemed very slow to process information and a significant amount of time was spent trying to explain to her where the Erith Centre was.

Lola was offered a home visit, but she declined stating that when people have come to her house, they 'write lies about me and then the trouble starts'. She reported that the Police had come and knocked on her door to ask how she is, and she reported that she wanted them to leave her alone.

Although Lola agreed to go to the Erith Centre, she later cancelled the appointment.

There was an anonymous call to 999 stating there was disturbance at Lola's property and believed that Mike was subject of a court order had returned to the house. Graded as an 'I' grade and Special Schemes (Special Schemes is given priority see appendix A) noted. On Police arrival they spoke to the only occupants in the house, who were two females who stated that Mike had not been there. No further concerns were noted.

In February the RSPCA advised Lola that they will be coming back in March to seize the dogs and prosecute her. Lola found this confusing since they brought the dogs back previously.

Also, Lola reported she has not seen the carer and she needed some food; her new card is not working and when she went out to post a letter she bumped into Mike. Lola said that Mike wants to come home but knows he can't because of the order. Lola said the Police turned up at her house last week, because they said she had called 999, but Lola said that she did not call them.

Lola has reported to her IDVA that she has not been able to get her money out, and she is getting warning letters from council tax, as she hasn't been able to pay them. She also needed to get another housing benefit letter, so that she can register the dogs with the PDSA in order to keep the RSPCA off her case. The Housing Association were also threatening to take legal action. IDVA agreed to contact Social worker to assist with the issues and contact was made with the Social Worker who confirmed the shopping issue has been addressed and she would make arrangements for the outstanding issues to be dealt with.

With support from her IDVA, Lola registered the dogs with the PDSA and was informed to contact her Social Worker if she needed anything. Lola contacted her Social Worker and was supported to go to the post office to withdraw money and was able to withdraw all her arrears from December 2021. Also, Lola wanted fish and chips for dinner before being dropped home.

The IDVA maintained regular contact with Lola, it was identified as the main source of contact. Lola had reported to the IDVA that she had been unwell; however, her card had been cancelled again, had no access to money and needs more shopping. The IDVA passed the concerns to the social worker to resolve.

During this period, Mike was referred by Street Rescue, who were supporting him to be rehoused to Pier Road Project to get help with alcohol use. It was reported that Mike was highly intoxicated most of the time, also in constant contact with Lola, and she was frequently asking for him to come home. Mike was engaging with Pier Road Project and was working on a plan for detox and to attend hospital appointments. Mental Capacity Assessments were unable to be completed as Mike was always intoxicated.

Mike wanted the non-molestation overturned so he and his mother could see each other.

The Social Worker reported that it was going to be really difficult to sustain the carers for Lola as she is really unkempt and is self-neglecting. The care provider manager had no success getting a carer for her and the manager was taking Lola shopping.

Lola was getting upset about the money issues and started swearing saying she was going to get the court order taken off Mike, as she wanted him back.

The Social Worker called Lola to ask what happened to the money that was withdrawn from the post office a week ago. Lola stated, she still has money, but she is not able to remember how much she withdrew in total. Lola was reminded of the amount and was asked if she had food for herself and her dogs. She said she has sufficient food.

Oxleas Mental Health Services contacted Mike, and reported he was under the influence of alcohol, repeating himself about being distressed about the court order, his mother's well-being and potential infection to face, threatening suicide but would not give address or location or call 999 himself. Staff left voicemail with crisis line number and that he should attend A&E.

Mike phoned 999 and was taken to hospital by the Police due to depression and had been assaulted weeks ago. Mike had injuries to his face and stated he was an alcoholic suffering from withdrawal, also stated that a court order had been made against him by his mother, and he was residing in Erith. Mike also stated that he wanted to go to hospital but not Queen Elizabeth Hospital, so the officers took him to Darent Valley Hospital to receive treatment. Mike was asking for medication from alcohol withdrawal.

Later in the same period, the Police received an anonymous 999 call, assumed by Police to be Mike, that Lola (his mother at the home address) was being evil, and "had gone off her nut". The operator noted the caller sounded very intoxicated, and he stated he had a court order and could not attend the address. Police attended and there was no reply at the address, after speaking to the neighbours they found out Lola was out at the vets.

Two days later the Police received a call from Mike stating that the man next door to his mother at the property had threatened her with a crossbow and a gun. The Police had automatic warnings referred to as "special schemes" (SS) on it stating the occupant of the premises may be at risk of Domestic Abuse, an alarm was installed, and occupants may be at risk of attack/harassment. The operator noted the informant sounded drunk, and he stated that he had a court order so could not go there. Police attended the property, but Lola was not seen.

Mike was supported to register with a GP by Pier Road and had missed several appointments after being given a prescription after his medical review where it was recorded that Mike tested positive for drugs and alcohol.

In February, the Police attended Lola's property due to anonymous caller advising that Lola had passed away. It was noted the property was in an extreme state of neglect. Lola was found deceased in her bedroom with her dogs beside her. It appeared to be a sudden death and non-suspicious. Professionals were notified of Lola's death.

Subsequently, Mike told Pier Road Project that his mother passed away and that he was staying with a friend. Mike missed his Pier Road appointment, he was feeling suicidal, and concerns were raised about his welfare. Mike was found by the Police drinking in a house known to be owned by another vulnerable adult (this is the same address he was found passed out in previously). This address was later noted as vulnerable to "cuckooing".

Information regarding Mike's Anti-Social Behaviour (ASB) were continuing to come into L&Q whilst awaiting court hearing date. There was a further housing court order granted in April 2022.

Mike was admitted to Darent Valley Hospital in May regarding fits. His friend called an ambulance and was advised that he had 2 fits and is still fitting. Mike constantly requested to go to hospital as he was having withdrawals and felt he could have a seizure at any time, he reported to hear load noises, very anxious regarding treatment and constantly asked what medication he would receive at the hospital. Mike was taken to Darent Valley Hospital. Whilst in hospital Mike wanted to stop drinking alcohol and had been drinking excessively for many years, and the death of his mother had made it difficult for him to stop. Darent Valley Hospital records state Mike had 3 seizures in last two days.

Pier Road Project made a call to Mike as he was concerned he was about to be evicted as there was damage to his flat, he was assured that Thames Reach who provide safe and supportive accommodation was sorting this out.

Mike was later found and reported deceased in the Erith area following a head trauma due to a fall.

14.Findings

Summary:

Lola and her son Mike had multiple complexities, which included self-neglect, substance misuse, domestic abuse, lack of health care including mental health support, neither of them was initially registered with a GP. Lola was totally reliant on Mike and as a result could not bring herself to make a statement or assist Police with a prosecution against Mike in the multiple times, he had abused her. As well as mental and physical abuse Mike was financially abusing his mother.

Neither of them trusted professionals and were isolated from their community, although, they were well known to their neighbours due to noise disturbances. Lola would only open the door to the Police because she believed they had powers of entry and was worried about losing her dogs and home. Lola was not willing to engage with most professionals, however she did eventually engage with her IDVA and Social Worker once Mike was banned from the property and was able to develop a relationship with them.

Lola was dependent on her son for shopping, collecting money and escorting to hospital appointments. The impact of Mike's caring responsibility for Lola also took its toll on him. Both Lola and Mike had unmet care and support needs and were also unfit carers for each other.

Agency Findings:

Bexley Safeguarding Adults Board:

The BSAB is not an operational or separate organisation but a statutory safeguarding adults board. They have created a Self-Neglect Toolkit available to practitioners which could have been considered to support the interaction with Lola, Mike, and professionals. Learning from other SARs indicates that short-term case management approach to people who self-neglect is unlikely to be successful. The need for traditional social work values of building relationship, gaining trust, being reliable and consistent, listening to people and assessing capacity at both a decision making and executive functioning level, considering of the person's history and why they have begun to self-neglect is essential.

Self-neglect-toolkit-1.pdf (safeguardingadultsinbexley.com)

MARAC

1. Like the BSAB MARAC is not an agency and does not have a case management function. The responsibility to take appropriate action rests with individual agencies, and referral to the MARAC does not transfer this responsibility. The purpose of the MARAC meeting is to bring together professionals from different agencies to share information and develop a coordinated plan to reduce the risk of harm to the person at risk.

2. Lola and Mike were repeatedly heard at MARAC. In total Lola and Mike were referred into MARAC 8 times and were open to Adult Social Care for 3 years, concerns were raised by MARAC Co-ordinator several times about the high risk and that the situation was escalating, this was raised with Head of Safeguarding Adults Team.

3. Although, it was good practice to present the case at MARAC, the lead agency was identified but may not have been the most appropriate and when the actions were not followed up there was an escalation by the MARAC Chair to a more senior manager in the agency but there was a clear lack of internal agency feedback to MARAC when they, as the lead agency, were not able to get actions completed. There was a lack of internal agency leadership even after the lack of responses was escalated to more senior managers across the various services was made by the MARAC Chair directly.

4. This review has raised frustrations from professionals as there are various forms of MARAC. Such as - Domestic Abuse (DA) MARAC differs from

Community Risk MARAC. The issues and concerns were not actioned appropriately. Likewise, DA MARAC does not focus on the perpetrator only on the victim. There were numerous calls and concerns which were raised to multi-agencies, there was a lack of triangulation between agencies, it was recorded that someone could end up dead, and still no further escalation was considered.

5. The Police Officer covering the MARAC meetings had a follow up action to install an alarm at Lola's address and should attend the address for a welfare check and noted that this had been closed without being resolved, this was escalated to a manager and ensured this action was completed, this was seen as good practice as it showed a good example of exploring professional curiosity. Finally, there had been 8 referrals to MARAC regarding Lola and Mike, 7 of those were Police generated, which again was identified as good practice.

Local Authority

1. The Adult Social Care Safeguarding Team have worked in partnership with the BSAB to change the culture and have commissioned their own learning and support which has seen success in achieving good outcome for people who self-neglect. There is current ongoing work to raise the profile and understanding on this subject, this is also a key focus point for the Safeguarding Adults Board Strategy for the coming year.

2. In the case of Lola and Mike, the Local Authority was unable to have oversight for the multi-agency response because of delays and cancellations from the housing provider L&Q. Although this was due to staff sickness and COVID lock down restrictions, safeguarding duties never stood down and should have been acted on by L&Q.

3. It was also found that Mike did not have a needs assessment, carers assessment, or risk assessment completed even though he had care and support needs identified by other professionals. Neither did he have a mental capacity assessment.

4. A needs assessment and subsequent risk assessments were also not completed for Lola. However, a Mental Capacity Assessment (MCA) was completed and at that time it was deemed that Lola had capacity however, Lola lacked understanding around executive function of capacity and self-neglect, this was not explored in further depth.

Care Act 2014 (legislation.gov.uk)

'Executive function is an umbrella term used to describe a set of mental skills that

are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions. When adversely affected by trauma, loss or bereavement, executive functions such Lola's self-care, impulse control, task initiation, sorting and organising can also be affected.

It is imperative that all agencies recognise that those affected by trauma, considered to be self-neglecting, and isolating themselves, are demonstrating some symptoms of executive brain function difficulties, potentially as a result of trauma, or a mixture of reasons. The aspects of care and support that are declined, require capacity assessment relating to decision making regarding self-care, care for the home environment, care for children and engaging with agencies and other aspects of life affected by executive brain function. The responses suggest that the person struggles to achieve these things, although they may well be able to describe in theory the processes required. The amygdala works as the brains alarm system alerting to danger. Triggered by these sensory assessments of danger, rather than processed assessment of risk, the brain sounds the alarm. Trying to analyse things, self-care, organise the house, attend appointments, remember dates and times can be as difficult as trying to do this with a fire alarm perpetually sounding. You may be able to speak of what you should do, but whether you could put it into action is another matter.

The person's brain is screaming out to them danger, danger, the body is tense, the person struggles to sleep, thoughts and memories are jumbled, primitive survival responses are triggered relating to increased sensory awareness and the person cannot understand why it is so difficult for them to achieve things that others seem to do easily. This means that the person is demonstrating that they can't do the tasks – can't (Inability) as opposed to will not (Informed choice). If you are under significant threat for example a bear coming to attack you, the brain shuts down executive functions such as self-care because it is not appropriate to be thinking through whether you are sweating and require deodorant for example. It is more appropriate to ignore how you look and smell and to respond impulsively to what you see, smell and hear around you.

An inability to do something to ensure ones' own wellbeing and safety because of a disturbance in the functioning of the mind or brain means that the person has eligible needs for care and support. Assessing whether these factors are at play allows us to correctly identify needs that are not being met because of trauma (Neglect rather than self-neglect).

This means that self-neglect is an errant term in circumstances where executive function difficulties such as social isolation, a lack of self-care, a lack of ability to

order and sort, a lack of motivation or difficulty beginning tasks, inability to change from one task to another are being demonstrated. The fact that the person can describe what they could do to achieve these tasks does not mean that the person is making a choice. It certainly doesn't mean that the person is capacitated to make decisions in relation to things affected by executive brain function. We would have to be reassured of all four functional aspects of the assessment and not just communication.

The demonstration of these inabilities in executive brain function means that the trauma, loss, bereavement, or adverse experience has triggered survival responses that favour impulsive response to perceived danger, focussed attention on threat rather than smelling nice or looking nice. The brain has chosen a course of action in response to perceived danger and without executive brain function there is nothing to indicate when the danger has ended.

Heightened sensory awareness which is a survival mechanism of the brain allowing faster responses, can also cause long term difficulties as the senses can easily be triggered and communicate danger because there are factors like when the trauma occurred. Repeated survival responses mean that the person struggles to access the processing aspect of the brain's executive functions.'

Guidance on MCA and executive brain functioning,139 Essex

5. Bexley Practitioners at the time did not fully understand the implications of executive capacity. It became apparent following the review that this had been misunderstood and had the mental capacity assessment been completed now the outcome would have found that Lola had lacked capacity. Executive capacity was not well understood however there has been work / training undertaken by Bexley Adult Social Services to ensure education and learning in this area is provided and the learning changes practice.

6. Practitioners reported that Mike did not have a mental capacity assessment due to being intoxicated when attending appointments. Mike had also lived with self-neglect for many years, alcohol misuse and had numerous head injuries. All these factors could have had an impact on his executive functioning of capacity.

7. Most significantly, Mike was not seen as a victim in his own right and there was unconscious bias. Mike was overlooked as someone who was also self-neglecting and was a victim. He had care and support needs which were not identified. He had no independent advocate or support worker to support and address his needs. Best practice could have seen Mike have his own social worker/support worker to advocate and represent his views. Mike could have been offered a carers assessment.

8. Mike had been known to misuse alcohol for several years, cognitive impairment is very common in dependent drinkers -
   - People are more likely to drink problematically because of traumatic brain injuries (TBI) or other brain damage experienced before birth, in childhood or in early adult life.
   - As a drinking career progresses brain damage caused by alcohol and poor nutrition and vitamin deficiency accumulates.
   - Physical damage to the brain from falls, fights, fits, and impulsive self-harm accumulates to similar effect.
   - This damage impairs memory but also impulse control, executive function, and the ability to regulate cognition, emotion, and behaviour, therefore, making it harder to engage with recovery.
   - The drinking lifestyle may generate other forms of cognitive impairment e.g., the damage from strokes, poor sleeping patterns or the 'brain fog' associated with hepatitis C.

   This accumulating damage generates a downward spiral. As the cognitive impairment increases, impulse control decreases, consequently drinking and the risk of further head injury may also increase. Those head injuries then further impair impulse control leading to the risk of more drinking.

   Therefore, anyone working with dependent drinkers needs to be aware of the impact of cognitive impairment. Their behaviour may be dismissed as a 'lifestyle choice' or attributed to intoxication rather than brain damage.

   The Blue Light Approach: Identifying and addressing cognitive impairment in dependent drinkers | Alcohol Change UK

9. It was also identified that the BSAB Self-Neglect Toolkit was not considered, and best practice could have seen escalation to senior leadership team, including service managers and director level. Best practice approach being a multi-agency risk assessment with shared accountability and ownership. Since 2022, procedures have been updated and a new implementation of a Serious Incident Notification, (SIN) has been put in place across the service.

10. The Safeguarding Enquiry in 2020 was closed prematurely, best practice to consider partnership agency working to explore the concerns, action to address the concerns and reduce the risks. It was understood at the time that Lola was deemed to have capacity around engaging in the safeguarding process, however the review has found there was lack of understanding around how contributing factors can affect a person decision making ability such as; coercive control, domestic abuse, trauma, head injuries, alcohol misuse, and self-neglect can affect a person's executive functioning.

11. It was not clear on Lola's records, why the safeguarding was closed and transferred to care management waiting list. The statutory duty was to apply the safeguarding process until the risks were mitigated and outcomes achieved; including risk assessing all previous safeguarding concerns to be taken into consideration before closing as well as partnership with other agencies.

12. When legal action was being considered by agencies, Bexley Adult Social Care did not approach their legal team, nor was the Anti-social Behaviour Panel, CR MARAC, Environmental Health, and London Fire Brigade considered as pathways to support Mike and Lola.

13. When Mike was given a court order to leave the property, this left Lola needing support with shopping and accessing finances. Lola was not self-aware of her own hygiene issues, and this was difficult to address with her. Lola missed her son, and he missed her too as expressed by them both to professionals throughout. Lola and Mike were co-dependent, but it was their only companionship as they were isolated. The Local Authority worked with a care provider to support Lola during this time.

14. There was no consideration as to who appropriate person to work with Lola in Mike's absence. The Bexley Joint Think Family Protocol was not considered, and this could have assisted in the work with both Lola and Mike. However, the Social Worker was not the main point of contact for Lola. The IDVA, was the main point of contact and there seemed to have been some confusion around roles and responsibilities of the IDVA. Best practice might have seen a structured plan as to who was going to communicate with Lola and have regular planned updates.

15. Lola and Mike were not capable of advocating for themselves and were both entitled to advocacy in their own right.

The review has identified the following care and support needs first for Lola then for Mike below: -

☐ 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.

☐ 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.

☐ 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.

☐ Being appropriately clothed - Lola would wear the same clothes; they had stains and body odour.

☐ 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.

☐ 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, 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 was 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

☐ 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.

☐ Accessing and engaging in work, training, education, or volunteering - Lola was unable to access training, work, education, or volunteering.

☐ 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 describes 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.

☐ 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.

Mike's care and support needs found were -

☐ 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.

☐ Maintaining personal hygiene – Mike was unkempt in appearance, and body odour.. It is unknown if there were suitable washing facilities.

☐ 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.

☐ Being appropriately clothed – Mike would wear the same clothes, they had stains and body odour.

☐ 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.

☐ 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 was 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.

☐ 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.

☐ 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.

☐ 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.

☐ Carrying out any caring responsibilities the adult has for a child – Mike was a carer to his mother.

London and Quadrant (L&Q)

1. There were significant Environmental Health concerns to take Lola to court. This was mainly due to the poor housing conditions, which Lola and Mike lived in for many years as they did not ask for support from L&Q for repairs or maintenance.

2. L&Q was able to arrange electricians to the property due to concerns about the wiring, Lola allowed entry, this was an example of good practice to engage with Lola about the need to make the home safe.

3. Once L&Q were able to assess the property it was unclear if alternatives were discussed or offered to Lola in terms of temporary re-housing options. L&Q obtained a court order, and this was stuck to the front door of the property. Mike could not read so he would not have known what it said directly. Lola had given Mike the notice and he asked a friend to read it. Also, once the court order was obtained, preventing Mike from going near the property, it meant that the risks from Mike to Lola were reduced, but any support for the property could not be done by Lola alone.

4. L&Q reported that at the time there were COVID lockdown restrictions in place therefore home visits were not taking place, best practice could have seen L&Q leadership team complete risk assessment with Lola and Mike given the complexities and level of risk particularly since Lola and Mike were a MARAC case and a safeguarding was actively open on Lola.

5. L&Q housing officer had cancelled several professionals meetings due to sickness/leave, therefore, the statutory duties were not fulfilled. Therefore causing delays in progressing the case further. Best practice could have seen a representative attend the meeting and then fed back to colleagues.

6. The review has also identified that L&Q could have made referrals to CR MARAC; Anti-social Behaviour Pane; or raise a safeguarding concern to the Local Authority due to the number of complaints received by neighbours, but by not doing so has highlighted missed opportunities.

7. L&Q reportedly tried calling social services about the concerns as Lola's cousin had raised but was unable to speak to anyone, and it is unclear when asked which department or team was contacted. The review has identified that best practice could have seen contact via the 'front door' the main Bexley Council telephone number. Also, L&Q could have escalated to BSAB as not getting through regarding a safeguarding concern.

London Metropolitan Police Services (MPS)

Mike and Lola were well known to the Police as identified in the chronology.

1. Mike was known to the Police on numerous occasions and regularly stopped and spoken to because of his involvement in criminal activity. There were multiple Police call outs and multiple Merlin Reports due to domestic incidents. The Police Merlin reports often describe the property as squalid, and uninhabitable. The constant arguing between Lola and Mike led to multiple complaints and at times violence between the neighbours. The neighbour reports that this has been going on 20 years. The volume of calls to Police and unsubstantiated allegations of assault led to a referral into MARAC in 2019.

2. There were 6 Police attended calls where a Merlin Reports were not completed. However, there were many occasions where Merlin's were completed and shared with partners.

3. The review has identified that the Police could have considered an evidence-based prosecution against Mike but this was not the case.

   Evidence led domestic abuse prosecutions - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)

4. The Police could have interviewed Mike regarding the damage to the property in April 2021 and breach of the Domestic Violence Protection Order (DVPO), this investigation was prematurely closed. Best practice could have seen consideration to securing the property.

   Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) guidance - GOV.UK (www.gov.uk)

5. Police were dealing with each isolated incident rather than considering the bigger picture and have reported that they are not experts in considering multi-agency response.

6. There were missed opportunities regarding familial domestic abuse due to Lola and Mike not engaging with services because Lola did not want to get her son in trouble and thus witness testimony was unavailable showed the complexities of co-dependency was present. However, since the start of this review the MPS launched a new response to repeat domestic abuse offenders called "Dauntless +".

'Dauntless + is new guidance that requires MPS to look at DA differently in that the best way to protect victims is to focus the attention on offenders to make sure Police identify, monitor and disrupt individuals who pose an ongoing and immediate risk to others through their offending behaviour. Some offenders within this cohort will be deliberately transient, harming and threatening to harm not only immediate partners or ex – partners, but those the partner cares for, including siblings, parents, and children. For these offenders, it is essential they are correctly identified when encountered and that officers do not deal with cases in isolation. Others within this cohort may abuse only one victim but whose level of offending also indicates that they pose serious risk. Using data from CRIS and other intelligent sources, subjects will be identified as those in the top 5% most harmful DA perpetrators per BCU based on how recently and frequently they have offended as well as how much harm they have caused. Once identified and thoroughly researched, a number of mandatory actions will kick in to make sure these highest priority offenders are monitored and dealt with appropriately. The guidance provides useful direction for anyone concerned with the response to, and investigation of, domestic abuse allegations including risk assessments and associated investigations, guidance for First Responders and Secondary Investigations, roles, and responsibilities.'

7. Mike appeared as one of the high-risk offenders on the SE BCU rated 19th at this stage and the Police response was often found as having a caring approach to Lola and Mike. However, not all Officers were aware of how to engage with Lola particularly when communicating with Lola. For example, on one occasion that Police attended to conduct a welfare visit the Police informed Lola that social services described her living conditions in graphic – non complimentary terms causing Lola to become very upset and denied this and was angry, this caused barriers to trusting agencies/professionals.

8. The Police could have used Anti-Social Behaviour orders to try to tackle the behaviour of Lola and Mike towards the neighbours, there are several actions that could have been used to try and address Mike's behaviour and put preventative measures in place which could have included Anti-Social Behaviour warning,

community protection warning, community protection notice, criminal behaviour order and finally a disclosure order. It was noted that the Metropolitan Police Service had during this time worked to increase their outreach to officers in order to educate them in the use of all the orders.

Victim Support - Independent Domestic Violence Advocate (IDVA)

IDVA and Social Worker could have completed a Mental Capacity Assessment jointly – using both disciplines to help determine Lola's decision-making abilities.

Unique Personnel Care Agency

Unique had a kind and caring approach; however best practice could have seen the operations manager contact brokerage and Social Worker to advise them when Lola had cancelled the shopping service each time and not delay in reporting to alleviate any further risk to Lola or to the provider.

15. Good Practice

Adult Social care

- The Social Worker on occasions took Lola to get food and money from the bank, this was the first time she came out of her property with a professional.
- Social Worker assisted Lola to register with a GP.
- Social Worker tried multiple attempts to engage Lola and was eventually successful when Mike was banned from the property.
- Social Worker recognised that the IDVA had built a good relationship with Lola and was able to communicate with Lola via the IDVA.
- MARAC Coordinator escalating concerns to the Head of Safeguarding Adults Team

MPS

When MPS was called to Lola and Mike's in September 2021, where Mike had punched Lola in the ribs, the response from officers was appropriate and caring with good recording of information and working with other agencies.

Victim support

In Lola's case, the IDVA was the main professional source and trusted contact. They were able to maintain regular contact and build an empathetic relationship.

Lola had a pattern of non-engaging with agencies had become more engaged with the IDVA since Mike was banned from the property.

The IDVA worked with Lola despite Lola not wanting to get her son Mike into any trouble by reporting him to the Police or other services. Mike was her only son and she loved him and was very protective of him. Lola did recognise with the help of the IDVA that she had a co-dependency and felt guilty. The dynamics of abuse between mother and son are highly complex and include feelings of guilt and blame that it is her fault, and the adult child is her responsibility.

The IDVA was able to validate these feelings, experiences and explored safer ways of interacting and challenged minimisation and guilt, she also explored methods of avoiding confrontation and the differences of Domestic Abuse between partners and parent/adult child violence. It is a common view that parents should be enabled to evict their adult child from within the home. But what we see and hear is that parents draw back from this, for similar reasons to those they expressed when the children were younger:

- This is a blood relationship, or alternatively one in which significant time and energy has been invested. It is not emotionally feasible to simply stop loving and caring for someone. This love and care extends to concern about what are perceived as worse alternatives – homelessness, prison, exploitation, death.
- For many young people, the gap between chronological age and developmental age may mean there remains a need for guidance, and daily living support, which may not be adequately available elsewhere.
- The level of fear and abuse may have worn a family down so low that there is no longer a belief that there is any choice.
- Additionally, we see co-dependency with Lola and Mike as Lola relies on her son as a main source of support.

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The IDVA recognised that Lola would need services to support her in Mike's absence and there was risk that Lola would allow access and therefore increase risk of further violence, the IDVA advocated on Lola's behalf to get her the support she needed, IDVA also arranged transport which was outside of their usual provision.

The IDVA felt that Lola had limited understanding of the IDVA's role and the role of other agencies. Lola believed that the role of agencies would have a negative impact on her life. Lola only agreed to have support with food and finances because Mike was banned from the property, and she had been fully dependent

on him for support. Lola became more engaging with the IDVA once Mike was not living at the property.

The IDVA provided weekly support for food, vouchers, phone credit and transport which is outside of the IDVA role to maintain the relationship with Lola.

- The IDVA was caring and empathic and was the first professional to get Lola to engage with support.
- The work with the IDVA showed Lola had a reduction in the amount of alcohol that Lola was consuming.
- The IDVA escalated concerns to the Social Worker when they arose.
- The IDVA went over and beyond to keep the relationship maintained.

Unique Personnel Care Agency

The care provider, Unique Personnel, provided a weekly shopping service to Lola from November 2021 to March 2022.

Although the review identified that the care agency was not able to provide care and support to someone who was unkempt and self-neglecting like Lola, they maintained a service as long as they could.

The operations manager raised concerns immediately with social worker and brokerage about what he had observed, Lola had requested that she stay in the car while he completed her shopping, it was also noted that Lola did not have any money and the carer/ops manager would use his own resources to fund the shopping.

Throughout this period, he used his own resources to fund the shopping for Lola had no funds or the post office card was not working. Lola would also cancel the shopping service – claiming that she still has some food at home.

16. Recommendations

The Review Panel makes the following recommendations from this SAR:

	Agency	**Recommendation**
1.	BSAB	1. Self-neglect tool kit - 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.
2.	Local Authority: Adult Social care	1. All self-neglect and hoarding referrals to be raised as a section 42. 2. 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: 3. Ensuring that the Risk Assessment is completed including the DASH tool, then, shared so that the risks are identified and shared with partner agencies. 4. Engaging in a Multi-Agency Risk Assessment planning meeting and follow the action plans understanding the escalation processes. 5. Ensuring that staff understand their roles and responsibilities and share this in a multi-agency manner. 6. Unmanaged risk and understanding the impact on services and the individual's wellbeing.

		7. 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. 8. Ensuring that professionals are making decisions around Self neglect. Ensuring the rationale and decision-making is clear, concise, recorded, and shared. 9. Professionals meeting – Local Authority has powers to act on the escalation of concerns 10. Share intelligence across adult and children social care 11. Self neglect – weekly checks or weekly visit to maintain regular contact and ensure welfare of the individual. 12. Identifying the 'trusted' professional and working in a multi-agency approach to support the individual. 13. 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. 14. Admin - Ensure that Admin are not fulfilling Social Work duties such as closing cases. 15. 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. 16. 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.
3.	Health - GP	1. 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. 2. When a GP surgery is closing support is offered to vulnerable adults are supported to re-register.
4.	Metropolitan Police Service (Police)	1. 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. 2. The Met Police raise awareness on more thorough recording of Crime Reporting Information System (CRIS) reports when attending incidents that are alleging domestic abuse. 3. The Met to share information with key partners when an adult comes to Police notice and Merlin reports to be shared. 4. 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.
5.	London and Quadrant (L&Q)	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. • Risk assessment on high-risk cases should be completed and shared with professionals. • If L&Q cannot attend meetings – to send a representative to prevent delays. • Effective communication or court orders – consider Equality Act given that Mike could not read.

17. Action Plan

SAR Theme/ Finding	Action To Be Taken	Lead Agency	Progress	Target Completion Date	Rag Rating

18. Appendices / Resources

MPS "Immediate Response" I Grade. (NCMS Emergency Contact.)

Those calls where the immediate presence of a Police Officer will have a significant impact on the outcome of the incident.

If the Officer is not required immediately then the S grade should be applied.

The MPS target response time for an "I" graded call is 15 minutes.

NCMS – National Contact Management Strategy : Definition ~ ~ Emergency Contact

An Emergency Contact will result in an Immediate, emergency Police response.

An Emergency Contact encompasses circumstances where an incident is reported to the Police which is taking place and in which there is, or is likely to be, a risk of;

- **Danger to life OR**
- **Use, or immediate threat of use, of violence OR**
- **Serious injury to a person and/or**
- **Serious damage to property.**

Where the Contact relates to an allegation of criminal conduct, it will be dealt with as an Emergency if;

- **The crime is, or is likely to be serious, and in progress OR**
- **An offender has just been disturbed at the scene OR**
- **An offender has been detained and poses, or is likely to pose, a risk to other people.**

Where the Contact relates to a traffic collision, it will be dealt with as an Emergency if;

- **It involves or is likely to involve serious personal injury OR**
- **The road is blocked, or there is a dangerous or excessive build up of traffic.**

Where the above circumstances do not apply, a Contact will still be classified as an Emergency if;

The circumstances are such that a Police contact handler has strong and objective reasons for believing that the incident should be classified as an Emergency.

An Emergency Contact will require Immediate response in line with force deployment police

Legislation

The Care Act (2014) and statutory guidance – self-neglect is included As a category under adult safeguarding.

Human Rights Act 1998 - Article 8 of the Human Rights Act 1998 gives us a right to respect for private and family life. However, this is not an absolute right and there may be justification to override it, for example, protection of health, prevention of crime, protection of the rights and freedoms of others.

Mental Health Act (2007) s.135 – if a person is believed to have a mental disorder and they are living alone and unable to care for themselves, a magistrate's court can authorise entry to remove them to a place of safety.

Mental Capacity Act (2005) s.16(2)(a) – the Court of Protection has the power to make an order regarding a decision on behalf of an individual. The court's decision about the welfare of an individual who is self-neglecting may include allowing access to assess capacity.

Public Health Act (1984) s.31-32 – local authority environmental health could use powers to clean and disinfect premises but only for the prevention of infectious diseases.

The Housing Act 1988 – a landlord may have grounds to evict a tenant due to breaches of the tenancy agreement. Prohibition order could have been used to close down the property, was Lola offered alternative accommodation, could Lola seen it or viewed it?

Health and Social Care Act 2012 – improve quality of care and outcomes for people and to reposition the mode of provision so that health service provision becomes more patient centred and facilitates choice.

Homelessness Reduction Act 2017 – duties to prevent and relieve homelessness, this is a new duty, for all eligible applicants threatened with homelessness regardless of priority need.

Policing and Crime Act 2017 – enables important changes of governance of fire and rescue services, the changes will build capacity, improve efficiency, increase public confidence, and further enhance local accountability.

Equality Act 2010 – the act protects people against discrimination, harassment or victimisation in employment and users of private and public services, based on 9 protected characteristics: age, disability, gender reassignment, marriage, civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Domestic Abuse Bill 2021 **–** promote awareness, protect, and support victims, introduce DVPO, transform justice response, improve performance across all agencies and local areas.