Bexley Safeguarding Adults Board

Safeguarding Adults Review: 01 July 2011 – 30 September 2019

Mary

Lucy Lord

SAR Independent Chair

March 2021

1. PREFACE

1.1 Confidentiality And Privacy

The subject of this SAR has been referred to as *"Mary"* to provide some measure of protection to the subject and their family's right to confidentiality and privacy. Pseudonyms have also been used for members of Mary's family.

1.2 Sympathies

The Independent Chair and the SAR Panel members offer their deepest sympathy to Mary's family and all those who have been affected by Mary's death. Amongst the findings of this review was that Mary was a much-loved and widely cherished individual by those who knew her.

1.3 Acknowledgement Of Thanks

The Independent Chair thanks the SAR Panel for the professional way they conducted the review.

The SAR process commenced during the onset of the Covid-19 pandemic and required a predominantly online approach consistent with public health measures taken by the UK Government. Despite seismic changes and significant flux, the SAR greatly benefitted from the full engagement of the SAR Panel throughout the process.

The Independent Chair and SAR panel would also like to express thanks to the practitioners, specialists and researchers who gave their time to the review and shared their thoughts, knowledge and experiences with candour, respect and humility.

Finally, thanks go to Practice Review & Learning Manager, Anita Eader and Coordinator, Alexandra Gregory of Bexley Safeguarding Adult Board who provided outstanding professional and administrative support throughout the review process.

2. CONTENTS

3. INTRODUCTION

Mary, a White British female, died at home on 4th September 2019 at the age of 63. Mary was born in Islington in 1956 and married her husband when she was 21. Mary and her husband had three sons together, and lived in Greenwich, Deptford, Essex, and finally in Bexley. The family moved to Bexley in 1999: Mary's husband died just three years later in 2002.

Mary was diagnosed with Multiple Sclerosis (MS) in 1992. Over the years, due to her progressive MS, her health had deteriorated to the point of being reliant on carers for all aspects of personal care. Mary used a wheelchair which she could steer with difficulty using the small amount of movement in her left hand. She had no use of her lower limbs or her right arm. Between 2002 and 2011, members of Mary's family attended to her care needs but, as her health deteriorated and her care needs increased, they requested and secured a domiciliary care package from LBB. Mary was a smoker, occasionally drank alcohol and smoked cannabis.[1]

On the night of Mary's death, her daughter-in-law, Hayley, called the London Ambulance Service (LAS) having found Mary in the in the early hours of the morning with no signs of life.[2] The LAS called the MPS to request their attendance as this was an unexpected death. On arrival, the LAS noted that Mary's family were on scene performing cardiopulmonary resuscitation. Following examination, the ambulance team noted that Mary had no signs of life and the onset of rigor mortis. An electrocardiogram indicated that Mary's heart rhythm was in asystole (no electrical activity present). Recognition of *"life extinct"* was recorded by the ambulance staff in the presence of the police and the family at 02:51h.[3]

[1]Inspire IMR/Police records.
[2]London Ambulance Service chronology.
[3]London Ambulance Service chronology/Metropolitan Police Service chronology.

The MPS referred the case to the Coroner as the cause of death was unknown. The Coroner did not hold an inquest into Mary's death.

Cause of death was recorded by the Coroner as; 1a sepsis[4]; 1b bronchopneumonia[5] and pyelonephritis[6]; and 1c multiple sclerosis[7] and diabetes mellitus[8].

[4]Sepsis, also called septicaemia or blood poisoning, is a life-threatening reaction to an infection.
National Health Service (2019) *"Sepsis"* [Online] Available at: https://www.nhs.uk/conditions/sepsis/ (Accessed: 01.02.2021).
[5]Bronchopneumonia is a type of pneumonia that causes inflammation in the alveoli in the lungs that may cause difficulty with breathing.
National Health Service (2019) *"Pneumonia"* [Online] Available at: https://www.nhs.uk/conditions/pneumonia/ (Accessed: 01.02.2021).
[6]Pyelonephritis is a type of urinary tract infection (UTI) that generally begins in the urethra or bladder and travels to one or both kidneys.
National Health Service (2021) *"Kidney infections"* [Online] Available at: https://www.nhs.uk/conditions/kidney-infection/ (Accessed: 01.02.2021).
[7]Multiple sclerosis is a condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance.
National Health Service (2021) *"Multiple sclerosis"* [Online] Available at: https://www.nhs.uk/conditions/multiple-sclerosis/ (Accessed: 01.02.2021).
[8]Diabetes mellitus is the Latin name for Type 1 diabetes which causes the level of glucose (sugar) in your blood to become too high. The body's immune system attacks and destroys the cells that produce insulin, which controls blood glucose levels.
National Health Service (2021) *"Diabetes"* [Online] Available at: https://www.nhs.uk/conditions/diabetes/ (Accessed: 01.02.2021).

4. SAFEGUARDING ADULT REVIEWS

Safeguarding Adult Reviews (SARs) were established by the Care Act 2014 (CA2014)[9] to respond to situations where serious harm has been experienced by an adult with care and support needs.

Bexley Safeguarding Adults Board (BSAB) has a statutory duty under s44(1)-(3) of the CA2014 to arrange a SAR where:

> *(1) An 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.*
>
> *(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.*

Full Terms of Reference, rationale for the scope and the SAR methodology leading to this overview report can be found in APPENDIX B.

[9] *Care Act 2014 c23* [Online] Available at: https://www.legislation.gov.uk/ukpga/2014/23/enacted (Accessed: 01.02.2021).

A SAR referral was made on 26th January 2020 by the assigned social worker for Mary's case in Bexley's Adult Social Care team. The Bexley SAR Subgroup considered this referral on 28th January 2020 and a recommendation was made to the BSAB to undertake a SAR. The Independent Chair of Bexley SAB endorsed this decision, and a SAR panel was appointed in February 2020. Due to progress of the Covid-19 pandemic and the movement to virtual working, the first SAR review meeting was held via video conference on Tuesday, 9th June, chaired by Lucy Lord, Independent Reviewer.

The SAR Panel met monthly via video conference to progress the review. The intention was to complete the review within 6 months of the first panel meeting in June, however, the pandemic led to delays in the submission of some Individual Management Reports (IMR) due to staff needing to work from home, having limited access to case management systems or being unavailable due to illness. These delays extended the total period required for the SAR review. Therefore, an early observations report was provided to the Independent Chair of BSAB in August 2020 regarding emerging findings that may require action by agencies prior to the SAR completion, to enable the deployment of change/or agency systems improvement, at the earliest point. The final overview report was provided to the BSAB for the March 2021 meeting and signed off at that meeting.

The membership of the SAR Panel comprised the members of the BSAB-SAR sub-group, with the addition of co-opted members representing at senior level the agencies which had commissioned or provided services to Mary.

SAR panel members for this review were:

Agency	Panel Member
Avante Community Support	Angela Johnson, Head of Home Care
Dartford and Gravesham NHS Trust	Eileen McBride, Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLS) Lead
Bexley Clinical Commissioning Group	Karen Upton, Clinical Lead Clare Hunter, Designated Nurse for Safeguarding
Bexley Safeguarding Adults Board	Anita Eader, Practice Review & Learning Manager
Bexley Safeguarding Children's Board	Amanda Gillard, Practice Review & Learning Manager
Inspire Community Trust	Debbie Taylor, Centre Manager
Lewisham & Greenwich NHS Trust	Kadiatu Fofanah, Adult Safeguarding Advisor
LBB, Adult Social Care	Bonny Waterman, Interim Operational Manager Malcolm Bainsfair, Principal Social Worker
LBB, Brokerage	Carol Parrott, Interim Adult Social Care and Commissioning Manager
LBB, Children's Social Care	Corne Van Staden, Services Manager
LBB, Domestic Abuse and Sexual Violence Team	Deborah Simpson, Manager
LBB, Housing Services[10]	No representative.
Metropolitan Police Service	Sergeant Trevor Walton, Safeguarding Lead
South-East London Clinical Commissioning Group (Bexley Borough)	Philippa Uren, Designate Nurse for Adult Safeguarding

[10]Although invited to each meeting, no representative from LBB Housing attended the SAR panel.

Agency	Panel Member
Oxleas NHS Trust	**Stacy Washington**, Head of Safeguarding Adults & Prevent
Independent Chair and SAR Report Author	**Lucy Lord**

Bexley Women's Aid and Solace Women's Aid were contacted to establish whether Mary was known to their services. As Mary was not known to their services, they were not involved in this review.

Considerable thanks go out to the SAR Panel members who remained engaged throughout the process. The consistency of the SAR Panel members meant that discussions were meaningful and in-depth, with each meeting building upon the last. Given that the meetings al took place during the Covid-19 pandemic and various levels of lockdown, this was particularly remarkable.

4.1 SAR Review Principles

The six safeguarding principles outlined in Care and Support Statutory Guidance[11] were taken into consideration throughout this SAR process; these are:

Safeguarding Principles	
Empowerment	People being supported and encouraged to make their own decisions and informed consent.
Prevention	It is better to take action before harm occurs.
Proportionality	The least intrusive response appropriate to the risk presented.

[11]Department of Health & Social Care (2020) *"Statutory guidance: Care and support statutory guidance"*. [Online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance (Accessed: 01.02.2021).

Safeguarding Principles	
Protection	The least intrusive response appropriate to the risk presented.
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability	Accountability and transparency in safeguarding practice.

The review also followed the five principles for conducting a SAR, as defined by the Social Care Institute for Excellence and recommended in the London Safeguarding Adult Review Principles and Checklist[12]. These are:

SAR Conduct Principles	
Share Learning	The aim of a SAR is not to place blame, but to share learning that provides the opportunity to learn and improve the way agencies work individually and together.
Process	Each case and SAR should be treated as unique. The process should include the recommended elements and be proportional to the case, utilising the appropriate methodology to maximise learning.
Open and honest	Throughout the SAR Process all parties should communicate and voice their opinions and their views openly and honestly with an appropriate *"tell it like it is"* approach without fear of blame for actions taken in good faith.

[12]London Assembly (2018) *"London Safeguarding Adult Review (SAR) Principles and Checklist – a guidance"*. [Online] Available at: http://londonadass.org.uk/wp-content/uploads/2018/03/London-Safeguarding-Adult-Review-SAR-Principles-and-Checklist-V2.pdf (Accessed: 01.02.2021).

SAR Conduct Principles	
Understanding and sensitive	The circumstances of the case require a level of sensitivity especially when the individual and/or their relatives are involved. Those involved need to be aware of the risk of hindsight bias and outcome bias in the review process.
Encouraging excellence	The act of sharing the learning with and across agencies involved to promote and encourage excellence within safeguarding.

4.2 Family Engagement

Mary's family were sent a letter of invitation to engage with the SAR. No response was initially received as the family had moved to a new house. A new letter was arranged to be hand delivered by a professional engaged with the family at their new address which was received. As a result, the Independent Chair and the BSAB Practice Review & Learning Manager met with Mary's son, Ian, over video conference (we were unable to meet face to face due to Covid-19 control measures preventing unnecessary gatherings and travel). The review has benefitted from the input from Ian, who not only offered his views but was also able to confirm that the findings of the report resonated with his own experience.

5. REVIEW PROCESS

5.1 Terms Of Reference

The full Terms of Reference for SAR Mary are provided in APPENDIX B, within which the BSAB identified the following specific issues to be explored by this review:

- Risk Management.
  - What was the post incident response and was it adequate?
  - Any deficits in risk assessment, care, recording, and ward handovers?
  - Safeguarding concerns raised?
  - Working in partnership?
  - Evidence of Making Safeguarding Personal?
- Information sharing and confidentiality.
- Previous Safeguarding Adult Reviews.
- Particular issues relating to ethnicity, disability, sexual orientation or faith.
- Known research that may contribute.
- Participation of the family.

5.2 Review Period

This review considers interagency involvement covering the period between 01st July 2011 and 30th September 2019. The review period was broken in to three Key Practice Episodes (KPE) as follows:

Review Period	Review Episode
01.04.2019 – 30.09.2019	Key Practice Episode 1 (KPE1)
01.04.2018 – 31.03.2019	Key Practice Episode 2 (KPE2)
01.07.2011 – 31.03.2018	Key Practice Episode 3 (KPE3)

KPE1 and KPE2 covered a timeframe where there is likely to be learning within contemporary systems and multiagency working as opposed to identifying learning from historical systems that may have already changed. KPE3 was reviewed for background information and for the consideration of repeating patterns of neglect and abuse, including forms of domestic abuse.

5.3 Methodology

The review methodology taken draws on systems learning theory to evaluate and analyse information and evidence gathered from available data and documentary records, practitioners and decision-makers in agencies and teams, national research, and the involvement of Mary's family.

The Independent Chair of the SAR Panel oversaw the review process and was commissioned as Independent Reviewer. Information was gathered from IMRs submitted by agencies who had been identified as having relevant contact with Mary. Each IMR included an analysis of the service provided during the denoted period covered by the SAR and an identification of lessons learned, challenges, opportunities, recommendations for their organisation or other agencies/multi-agency working and any immediate plans of action in response to learning. Authors were encouraged to highlight both good and poor practice, particularly in relation to the Making Safeguarding Personal principles, and to share context relating to issues such as; resourcing, workload, supervision, support, and training/experience of staff involved. Any issues relevant to equality, for example disability, sexual orientation, culture and/or faith were also be considered by the IMR writer. If none were relevant, a statement to the effect that these have been considered was included.

Various additional documentation was submitted to the review, including a Level 3 Desktop review from Oxleas NHS Trust. A total of 204 case related documents (including IMRs) were considered within this review, which underpinned the breadth and depth of learning and recommendations from this review.

Individual conversations were held with practitioners who had directly supported Mary. Other specialist practitioners also contributed to the review, particularly in relation to new and emerging research, which helped shape the review findings and recommendations. A full list of individuals who engaged with this review is provided in APPENDIX A.

The chronologies from IMRs and information gathered from other key documents and individual conversations with practitioners were combined into an integrated chronology and shared with the SAR panel. Panel members then identified, discussed and agreed learning, findings and recommendations which are provided in this overview report.

In the spirit of Making Safeguarding Personal, family members were identified, and invited to take part in this review. Mary's son, Ian, engaged with the SAR process by sharing information and providing insights into the findings. Several attempts were made to share and review the draft of this overview report prior to finalisation, but these were ultimately unsuccessful.

The review took place at a time when public health measures were introduced by HM Government to contain the spread of the Covid-19 virus. This meant that stakeholder involvement approach needed to change – from face-to-face meetings and a workshop-based approach to individual interviews and group meetings conducted via video conference. The Independent Chair would have liked to have met with the family in person, and arrangements were made for a face-to-face meeting with Ian, Mary's son, on two occasions during a short period when meeting restrictions were eased. Unfortunately, Ian did not make the pre-arranged meeting. However, we were able to meet via video conference shortly there-after.

5.4 Parallel Processes

There have been no parallel processes, including criminal investigations or other investigative processes in relation to Mary's death.

5.5 Equality And Diversity

The review adheres to the Equality Act 2010, and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the SAR panel as part of the Terms of Reference and throughout the review process.

As far as the SAR panel has been able to determine, including through interviews with Mary's family and key practitioners, Mary did not hold any strong or religious beliefs or have any language or acute learning needs which would have impacted on any services that were offered to her. Over the ten years Mary spoke to one occupational therapist about living withing a Travelling community, but she never identified herself as from a Traveller community to any other professional or in any forms. Mary's family also stated that Mary was not from the Traveller community. Mary never disclosed her sexual orientation.

There is no evidence that would indicate that Mary was discriminated against by services or individuals with whom she came into contact with, and no barriers to accessing services in relation to inequality were identified.

5.6 Author Of The Overview Report

BSAB appointed Lucy Lord as Independent Chair and author of the overview report on the 28th February 2020.

Lucy is a consultant specialising in safeguarding and support to survivors of domestic abuse. Lucy was a Director at the national domestic abuse charity, Women's Aid, for ten years where she played an important part in national development and roll out a whole system response to survivors and perpetrators of domestic abuse. The multi-million-pound project was developed in partnership with the Home Office, the National Lottery, SafeLives, and front-line specialist domestic abuse service organisations across the country.

6. MARY

6.1 Mary's Family

Mary had three sons: Ian, John, and Kyle. When she died, Mary was living with John, his partner Hayley, and up to six of their children in a three-bedroom property which she had rented since 1999. Mary's son Ian had moved away from the property to live and work in North-East London, and her son Kyle lived elsewhere in the local area. Kyle rarely featured in documents provided as part of this review and was not involved in Mary's care.

Outside of Mary's formal home care package, she was primarily cared for by Hayley and Ian. The behaviour of John, who lived with Mary, was often cited as the reason that care agencies ultimately withdrew their services.

Between them, Mary's sons had fourteen children. Mary was a doting and loving grandmother. When she was previously able, she watched them horse-riding in the local meadows. She loved being involved in her grandchildren's lives and she often talked about them to the staff and her friends at the day centre. Occasionally Mary's grandchildren were left in her care, which posed a child safeguarding risk as she could not adequately mobilise to attend to their needs or respond to an emergency, such as a fire. Over the review period, safeguarding concerns were raised for this and other concerns relating to the safety and well-being of the children. Consequently, LBB Children's Social Care team were involved with the family at various points during the review period. However, at the time of Mary's death, LBB Children's Social Care were not involved with the family.

6.2 Mary's Health

Mary was diagnosed with multiple sclerosis (MS) in 1992. Over the years, due to her progressive MS, her health had deteriorated to the point of being reliant on carers for

all aspects of personal care. Mary used a wheelchair which she could steer with difficulty using the small amount of movement in her left hand. She had no use of her lower limbs or her right arm.

In 2014, Mary was diagnosed with Type 2 Diabetes Mellitus which was controlled by tablets and diet.

In 2016, Mary had a suprapubic catheter inserted and was placed under the care of a urologist. She had frequent input from the district nurses for regular catheter change, particularly to attend to blockages. She frequently experienced urinary tract infections (UTIs) and had been experiencing symptoms of a UTI for several days before she died.

Mary was a smoker, occasionally drank alcohol and smoked cannabis.

6.3 Mary's Care And Support Needs

Mary had a double handed domiciliary care package with visits from carers twice a day in July 2011, increasing to three times a day from August 2012. Between 2011 and 2019, Mary had nine different care agencies. Every agency raised concerns relating to Mary's living environment and the risk of neglect and abuse. All withdrew their services. One did so on two separate occasions having returned after five years but withdrawing their services for a second time for similar reasons to the first occasion. At the time of her death, Mary was not receiving her daily domiciliary care package, as her care provider had withdrawn their services due to a violent incident at Mary's home. Whilst the local authority sought a care package provider, Mary was being cared for by her family at home.

Mary attended Inspire day centre three times a week and told family and professionals that she thoroughly enjoyed the day centre, which she called *"The Club"*.

Mary used her time at the day centre to undertake the administration and management of her care provision, with the support of Inspire staff support. She would use this time and space to report any malfunctions with her equipment or difficulties arising with care agencies.

6.4 Mary's Housing

Mary rented a fully adapted three-bedroom semi-detached house, owned by Orbit, on an assured non-shorthold tenancy. Mary moved into the property in 1999 and it had since been adapted to meet her needs.

Originally Mary lived in the property with her husband with a bedroom upstairs, but since her husband's death and her children leaving home, Mary had moved downstairs, sleeping in a hospital bed in the front room/lounge. Damage to walls and doorways was common due to the difficulty of manoeuvring Mary's powered wheelchair in the limited space available.

In 2015 John, Hayley, and five grandchildren moved into the property. The property was described by the Housing occupational therapist as *"severely over-crowded and lacking space"*, with up to three adults, six children, and at least two dogs living there. Mary's bedroom was the main living room used by all the family.

From January 2018 Mary had no access to personal washing facilities due to the state of disrepair of the downstairs bathroom floor and the loss of her specialist shower chair. She was particularly distressed by this lack of amenity. According to her family, Mary liked to feel pampered and pretty, and she told professionals that she enjoyed taking showers and feeling clean. From January 2018 to the day she died in September 2019, Mary was bed-washed and never again enjoyed a shower.

Since 2012, Mary had regularly articulated her wish to be moved to a two-bedroom bungalow with a live-in carer to multiple professionals, including her social workers. However, she did not want to make her family homeless by moving to a smaller property.

Unbeknown to Mary, from late 2018, LBB were progressing the potential purchase of an adapted caravan for Mary to be near her Ian in North-East London and to live independently. A fully adapted caravan had been identified near where Ian lived, and the team were obtaining the necessary approvals before discussing it with Mary. This option would have enabled Mary to live independently with a care package and to be near Ian. It had not however been discussed with Mary so as not to raise her hopes prior to full approval.

6.5 Mary's Finances

Mary did not work and was dependent on state benefits. Mary was in receipt of a high-rate Personal Independence Payment, as well as Employment and Support Allowance and Housing Benefit. She described the money she received to Inspire day centre staff as *"going into the pot"* towards all the family's needs. Inspire staff reported that Mary would often attend the day centre with no money, and owed money to both the day centre and other residents having borrowed money to pay for lunch, day trips, treats and gifts. She particularly liked to buy products being sold by other day centre residents to treat herself and others. Her family remarked that she had a significant collection of unopened Avon products piled up in various rooms around her house.

6.6 Historical Safeguarding Concerns

A total of four s42 Safeguarding Enquiries were opened between 2015 and Mary's death in 2019. An earlier safeguarding enquiry was opened in 2012, prior to the

enactment of the CA2014. Safeguarding concerns raised in 2012 remained present and unresolved throughout the review period.

7. CHRONOLOGY

The following table provides a summary of key incidents in chronological order. These were considered pertinent to this SAR by the review panel and Independent Chair and provided the basis to findings and learnings in the following sections of this overview report.

Further detail of each incident is available in APPENDIX D.

Date	Summary	Agencies
04.07.2011	**Mary's case allocated to a social worker** to undertake a home visit following concerns raised by local district nurse to Mary's occupational therapist on 10th and 14th June regarding the state of Mary's property. Concerns included the presence of dog faeces, food, multiple dirty nappies and dirty clothing on the floor. Concerns regarding the unsanitary home environment substantiated by Orbit.	LBB ASC Orbit
05.07.2011 and 13.07.2011	**Social worker completes two home visits**. At the first visit the social worker notes concerns relating to the environment, abuse and neglect. Social worker commences process to secure a domiciliary care package and advises Mary that the property must be cleaned and tidied. At the second visit, the social worker notes some improvement to the environment, but that "*there is still more that needs doing*".	LBB ASC
18.07.2011	**Carewatch Home Care Services (Carewatch) commence** delivery of daily home care package of: • 30 mins am x 7 days x 2 carers for personal care. • 30 mins x 7 days x 2 carer for lunch services.	Carewatch LBB Brokerage LBB ASC
20.07.2011	**Concerns raised by Carewatch** to LBB ASC in relation to Mary's living environment and possible animal neglect.	Carewatch LBB Brokerage LBB ASC
25.07.2011	**Concerns raised by Carewatch** to LBB ASC and LBB Brokerage in relation to Mary's living environment.	Carewatch LBB Brokerage LBB ASC

Date	Summary	Agencies
08.08.2011	Social worker discussion with Bexley's Safeguarding Manager in relation to Mary's living conditions and neglect from family. **Referred as a safeguarding to facilitate a strategy meeting.**	LBB ASC
11.08.2011	Orbit notes **issues since January 2011, when John moved in** with Mary. **Joint unannounced visit arranged** with social worker and Orbit Housing Officer for 15th August 2011. No record of visit in Orbit or LBB files.	LBB ASC Orbit
30.08.2011	**Further concerns raised by Carewatch** in relation to Mary's living environment, abuse of Mary and of children living at the property. LBB Children and Families Social worker notified.	Carewatch LBB ASC LBB CSC
01.09.2011	**Joint Home Visit**, social worker and LBB East Child Care Unit. **Environment improved.** Care package working well according to Mary. No further concerns. **Social worker will monitor prior to closing case.**	LBB ASC LBB CSC
30.09.2011	LBB Community occupational therapist awaiting the **installation of a ceiling track hoist in the living room** to assist with moving Mary and arranged for the delivery of a **new, more supportive riser recliner chair to promote better posture.** **No fridge in property, John has undertaken to purchase one.**	LBB OT
30.09.2011	**Call to 999 - Ambulance.** Mary experiencing rectal pain. Referred to NHS Direct.	LAS
11.10.2011	**Occupational therapist Home visit.** Notes that **home environment is acceptable. Concerns raised by family about a Carewatch carer. Concerns raised by Carewatch;** One directly with family regarding key safe security, and one to occupational therapist regarding neglect of Mary's needs. **Occupational therapist identified various care and support needs**, including a ceiling hoist, shower chair and a concessionary phone. **Mary enquires about benefits.** She asks for lift to be removed and kitchen to be refit for family's use as she no longer uses it.	LBB OT Carewatch
18.10.2011	Mary assessed: **Does not meet criteria for a concessionary telephone. Occupational therapist challenges decision** noting *"great concern"* as Mary requires a *"support mechanism that has no dependency upon her family"* per historical case notes.	LBB ASC LBB OT

Date	Summary	Agencies
20.10.2011	**Concerns raised by Carewatch** following family member being aggressive towards carer during visit. **John reports carer made negative comments which he found offensive and insulting.** John asked the carer to leave. Carewatch inform social worker that they have no carers willing to visit client due to John's behaviour. LBB Brokerage are requested by social worker to seek new care provider.	Carewatch LBB ASC Family LBB Brokerage
22.10.2011	**Police attend Mary's house to conduct a s18 search** after Kyle was arrested for possession of class B substance. **Noted concern regarding home environment.**	Police
16.11.2011	**Call to 999 - Ambulance.** Mary's legs gave way, keeps falling. Referred to General Practitioner (GP). GP followed up. Family requests a GP visit.	LAS GP
23.11.2011	**Concerns raised by Carewatch** to LBB Brokerage regarding living conditions, neglect by family and dogs at property.	Carewatch LBB Brokerage
28.11.2011	**Concerns raised by Carewatch** regarding home environment. Carers refusing to attend. **Withdraw services** with final call being AM call on 29th November 2011.	Carewatch LBB ASC
29.11.2011	**Athlone Care Agency (Athlone) commence home care package** of: • 30 mins am x 7 days x 2 carers for personal care. • 30 mins x 7 days x 2 carer for lunch services.	Athlone LBB Brokerage
20.01.2012	**Ian refuses installation of ceiling hoist.**	LBB OT
31.01.2012	**Safeguarding Strategy meeting** - LBB ASC and Athlone. Various actions noted for attendees and update meeting scheduled for six weeks later.	LBB ASC LBB OT LBB Brokerage Athlone
15.03.2012	**Safeguarding Strategy meeting** - follow up actions from meeting above. Neglect from family- Substantiated. Financial abuse concerns noted in minutes of meeting. No related action noted. Neglect from family substantiated. Safeguarding concluded.	LBB ASC LBB OT

Date	Summary	Agencies
15.03.2012	At Mary's request, **LBB increase formal daily home care package hours to:** • 45 mins am x 7 days x 2 carers for personal care. • 30 mins x 7 days x 2 carers lunch. • +30 mins pm x 7 x 2 carers put to bed. Commencing 16th March 2012.	LBB ASC LBB Brokerage Athlone
19.03.2012	**Athlone** note having issues with no clean towels or clothes for Mary.	LBB ASC Athlone
20.03.2012	**Mary starts attending Inspire Day Centre 1 day per week.** As a safeguarding action from the Safeguarding meetings in January.	LBB ASC LBB Brokerage Inspire
10.04.2012	**Extra day at Inspire each week.** Mary starts attending Inspire's day centre two times week.	LBB ASC Inspire
15.05.2012	**Athlone report problems with moving and handling** due to bed being too low and the height control mechanism being broken.	Athlone LBB Brokerage LBB ASC
12.07.2012	**Athlone Care hand back care provision to LBB** due to unresolved issues of moving and handling.	Athlone
12.07.2012	**Kent Social Care Professionals (KSCP) commence home care package** of: • 30 mins am x 7 days x 2 carers for personal care. • 30 mins x 7 days x 2 carer for lunch services. • 30 mins pm x 7 x 2 carers put to bed.	KSCP LBB Brokerage LBB ASC
30.07.2012	**Social worker Home visit. Notes Mary looks well, and house is clean and tidy,** *"looking cleaner and tidier than I have ever seen it"*. Hayley, John and the children have now moved out, Kyle and Ian have moved back in. Dogs living with Hayley and John.	LBB ASC
23.08.2012	**Increase in morning call approved** to one hour. Home care now: • 1 hour am x 7 days x 2 carers personal care. • 30 mins x 7 days x 2 carers for lunch. • 30 mins pm x 7 days x 2 carers put to bed services. Panel declined Mary's request for a 4th call as client not doubly incontinent.	LBB ASC LBB Brokerage
27.09.2012	**Mary requests LBB reconsider her request for 4th daily call.** She also expresses her **desire to move from her house to a two-bedroom bungalow** with Ian as a live-in carer.	LBB ASC

Date	Summary	Agencies
20.10.2012	**Call to 999 - Ambulance.** **Mary had fallen out of standing hoist and incurred a leg and hip injury.** Carers were on scene. Mary declined to be conveyed to hospital as she had no in injuries. No record on LBB files.	KSCP LAS
22.10.2012	The Multi-Disciplinary Management Plan, which forms part of Inspire's client case records, rates Mary as **very high risk/need** and it is noted that *"the family often neglect her care."*.	Inspire LBB ASC
23.10.2012	Panel agree to **increase in care and support services, to *"maintain Mary's safety and wellbeing whilst in the community"*.** From 24th October 2012 these are as follows: • 60mins x 7 x 2 carers - AM. • 30mins x 5 x 2 carers - Lunch (not Tue/Thurs as at Day Centre). • 15mins x 5 x 2 carers - Tea (not Tue/Thurs as at Day Centre). • 30mins x 7 x 2 carers - PM. • Day care - Inspire Day Centre x 2 days a week (Tue and Thur).	LBB ASC
10.01.2013	**KSCP raise concerns** to LBB ASC regarding moving and handling. Standing hoist causing difficulty with transfers.	KSCP LBB ASC
28.03.2013	**KSCP raise concerns** regarding living conditions, neglect of Mary by family and animal cruelty and abuse at property to LBB ASC social worker. **Carers refuse to attend.**	KSCP LBB Brokerage LBB ASC
29.03.2013	Social worker notes issues are ongoing and recommends that LBB Brokerage contact KSCP to make a **referral to Children and Families.**	KSCP LBB Brokerage LBB ASC
05.04.2013	Following safeguarding concerns raised by KSCP, **Children's Social Care undertake a home visit.** First refused entry by John, second attend with Police	LBB CSC Police
09.04.2013	**KSCP carers leave property due to personal safety concerns.** Carers report being verbally abused by Mary's son, John. Carers refuse to return. **Police requested to attend with Care Agency Managers** for put to bed call in PM to provide assurance of safety and carry out welfare check on children in property. Police commit to calling agency, but no call received by agency. Agency complete put to bed call without Police attendance.	KSCP LBB EDT Police

Date	Summary	Agencies
10.04.2013	**KSCP Management attend to evening care visit. Note house much cleaner and tidier** than on previous visits. Son, John, was apologetic about shouting at the carers earlier. Police support and welfare visit cancelled.	KSCP LBB EDT Police
10.04.2013	**Care agency state intention to withdraw services.** Believed John blamed them for Children's Services being in contact. **Social worker sets up visit with Mary at Day Centre to discuss.**	KSCP LBB ASC
11.04.2013	**Social worker speaks to Mary** via telephone call at Inspire day centre to discuss issues raised by KSCP and to advise that a new care provider will be starting on 15th April 2013. Mary asks the social worker to visit her at home on 16th April 2013 to discuss concerns. Social worker requests that Hayley and John are involved in the meeting during the home visit.	LBB ASC
15.04.2013	**PCT Diamond Care (PCTDC) commence home care package.**	PCTDC
16.04.2013	**PCTDC raise concerns** with moving and handling - unable to use standing hoist as considered unsafe.	LBB EDT
17.04.2013	**Home Visit** by social worker. At Mary's request, social worker closes the safeguarding referral raised following concerns from former care agency, KSCP in March.	LBB ASC
12.06.2013	**PCTDC report difficulties gaining access to client and abuse from Mary's son, John.** Care agency states that there is no food to provide breakfast for client and that this is a regular occurrence.	LBB Brokerage LBB ASC
12.08.2013	**Safeguarding formally closed.** Summary notes that Mary has capacity to make decisions about her life, care and living conditions and has refused to consent to any safeguarding investigations. *"At this point in time there is no further support required from adult social care social work."*.	LBB ASC
30.08.2013	**Son, Ian, calls Orbit re: Mary moving to a smaller property.**	Orbit
01.01.2014	**John has non-molestation order recorded** on Police National Computer records.	Police
10.01.2014	**Ian provides Mary with alternative accommodation** due to electricity issues at house. Shares concerns relating to his brother John's behaviour towards his mother which has historically affected her safety and wellbeing.	Orbit

Date	Summary	Agencies
15.04.2014	**PCTDC unable to provide care due to dog.**	PCTDC LBB EDT
01.12.2014	**PCTDC withdraw services** as they were unable to provide carers that were willing to go into the home.	PCTDC LBB Brokerage
02.12.2014	**Inspire commence home care package.**	Inspire
02.12.2014	**Inspire raise concerns** with moving and handling. Carers are unable to use standing hoist as considered unsafe. Also request occupational therapist assessment of bathroom.	Inspire LBB ASC
01.02.2015	**Inspire raise concerns relating to home environment for children. LBB CSC review and close case** noting *"Concerns not substantiated aside from the over-crowding."*.	Inspire LBB CSC
24.02.2015	**Inspire raise safeguarding concern** via telephone. Note that Mary may be being coerced and financially abused by her family.	Inspire LBB ASC
25.02.2015	**Inspire withdraw services** noting that carers are sustaining unacceptable levels of verbal abuse, which could also escalate to physical abuse and intimidation.	Inspire LBB Brokerage LBB ASC
26.02.2015	**Social worker discusses safeguarding concern with Mary** and Hayley. **Considers safeguarding concerns are not substantiated.** The safeguarding is **closed at Mary's request.** Mary is now without a formal home care package.	LBB ASC
02.03.2015	**Ian raises complaint to Inspire** regarding their home care services. He forwards the email to LBB Brokerage on 4th March. Inspire provide LBB with a complaint response on 14th March 2015 and send response to the family.	Inspire LBB Brokerage Family
18.03.2015	**Aquaflow commence home care package delivery.**	Aquaflow
26.03.2015	**Hayley, John and five children are living with Mary**.	Orbit
13.04.2015	**Aquaflow raise concerns** with moving and handling, Mary's living conditions and well-being. Carers are reporting that they cannot continue to provide care due to their own health and safety.	Aquaflow LBB Brokerage
22.04.2015 24.04.2015 27.04.2015	**Aquaflow raises same concerns** with moving and handling as above. They are short of staff willing to deliver care package. Mary visibly distressed by not being able to shower.	Aquaflow LBB Brokerage
29.04.2015	**Aquaflow end care package delivery.**	Aquaflow LBB Brokerage

Mary

Date	Summary	Agencies
30.04.2015	**Haven Social Care (HSC) commence home care package delivery.**	HSC LBB Brokerage
05.05.2015	**HSC do not attend due to dogs** not being put away. Mary calls LBB Brokerage whilst at Inspire Day Centre requests new carers and is noted as tearful.	Inspire LBB Brokerage
16.06.2015	**Mary requests Orbit to add Hayley to tenancy.** Daughter in law and 5 children have moved into property.	Orbit
12.07.2015	**HSC request to hand back package.** New provider secured but cancelled as **family resolve issues raised. HSC continue care package.**	HSC LBB Brokerage
15.09.2015	**Mary calls Orbit regarding adding daughter in law to tenancy.** Orbit stated could not approve as property would be over-crowded. Call made whilst at Inspire Day Centre.	Orbit Inspire
06.10.2015	**Inspire Day Centre raise Safeguarding Concern.** Social worker undertakes investigation through October. Mary denies all allegations. Social worker notes that there is insufficient evidence to confirm allegations. Safeguarding referral closed at Mary's request.	LBB ASC Inspire HSC
22.12.2015	Panel agreed to **increase in Day Centre provision** to three days per week.	Inspire LBB ASC LBB Brokerage
02.2016	**Ceiling Hoist fitted at Mary's home.**	LBB OT
24.02.2016	**Inspire raise concerns regarding the management of Mary's money by her family, and neglect at home.** No action taken.	Inspire LBB ASC
01.04.2016	**Safeguarding concern raised by London Hire Ltd (London Hire).** Case not progressed as a safeguarding. Referred to LBB ASC to follow up.	London Hire LBB ASC BITU
17.05.2016	**Anti-Social Behaviour of Mary's family witnessed by Orbit and neighbour.** Orbit speaks to Mary and send a warning letter regarding behaviour and risk to tenancy.	Orbit
23.06.2016	**Mary attends Darent Valley Hospital for Cystoscopy and Supra Public Catheter admission.**	DGT

Date	Summary	Agencies
05.07.2016	05th July 2016 onwards: **Following suprapubic catheter insertion there are multiple calls to district nurse service** for bypassing catheter, urinary tract infections and suprapubic site infections. Also, regular need of bladder wash outs and skin assessments.	Oxleas
31.10.2016	**Police execute a search warrant in the family home** under s23 Misuse of Drugs Act 1971[13]. **House described as *"filthy and very messy"*** Referred to LBB CSC. Visits completed by LBB CSC and case closed as concerns are not substantiated.	Police LBB CSC
21.11.2016	**HSC abruptly end care package delivery** due to serious issues raised.	HSC LBB Brokerage
21.11.2016	**Eleanor Care (EC) commence home care package delivery.**	EC LBB Brokerage
24.11.2016	**EC hand back care package** due to environment. Carers feeling uncomfortable and threatened.	EC LBB Brokerage
24.11.2016	**Carewatch commence home care package delivery.**	Carewatch LBB Brokerage
16.12.2016	Positive urinary tract infection. **District nurse requests antibiotics from GP.**	Oxleas GP
18.03.2017	**999 Call from district nurse. Blocked suprapubic catheter and dark and odorous urine.** Ambulance staff note Mary's catheter had been bypassing since the previous day. Mary conveyed to Darent Valley Hospital for catheter insertion.	Oxleas LAS DGT
05.05.2017	**Carewatch raise safeguarding concerns** including drug usage, unruly dogs and poor home environment.	Carewatch LBB ASC
26.07.2017	**Carewatch raise safeguarding concerns** in relation to lack of toiletries; broken microwave; dirty dishes; lack of food and smell of cannabis in the house. Safeguarding investigated by social worker. LBB Triage note concerns are addressed and close case on 10th August 2017.	Carewatch LBB ASC LBB Brokerage LBB Triage
21.08.2017	**Carewatch raise Safeguarding Concern** as Mary left alone for the weekend. Mary has no means of contact in an emergency.	Carewatch LBB ASC Inspire

[13]*Misuse of Drugs Act 1971 c38* [Online] Available at: https://www.legislation.gov.uk/ukpga/1971/38 (Accessed: 01.02.2021)

Mary

Date	Summary	Agencies
29.08.2017	**Social worker discusses Linkline with Mary** to provide Mary with a means of contact. Mary would like this to be installed.	LBB ASC
27.09.2017	**Mary does not attend Inspire day centre** due to lack of money. Referred to LBB Commissioning Team as part of Common Assistant Tool (CAT) Annual Care Plan Review.	LBB Commissioning
10.10.2017	**Linkline referral closed** due to client not responding to communication.	LBB Triage
01.11.2017	**Safeguarding concern raised by Carewatch.** Mary discloses abuse and neglect by family and requests support to move from property. Safeguarding investigation undertaken by social worker – completed 14th November 2017. Outcome of the enquiry is to close the safeguarding as Mary does not wish to proceed. Mary requests support to move to a smaller property.	Carewatch LBB ASC
09.11.2017	**Mary calls to reiterate request to move to a smaller property.** She states the situation at home is not good, particularly with John. She states that she wants to live on her own with a live-in carer. Forwarded to social worker.	LBB Triage LBB ASC
14.11.2017	**Safeguarding concern from Carewatch** raising concerns about Mary's medication management. Forwarded to social worker.	Carewatch LBB Triage LBB ASC
17.11.2017	**Carewatch raise safeguarding concerns** to LBB Triage team**.** John being aggressive and hitting something. Carers felt unsafe. Noted children at property. LBB Triage spoke to LBB CSC who advised LBB Triage to ask Carewatch to complete a new referral form. Mary is currently being supported by a social worker in LBB ASC as part of a s42 Safeguarding Enquiry. Case closed to LBB Triage.	Carewatch LBB Triage LBB CSC
27.12.2017	**District nurse attends to suspected UTI.** Antibiotics requested from GP.	Oxleas GP
04.01.2018	**January 2018 the case was allocated to a social care assistant in LBB's ASC Team,** to complete a needs assessment. Needs assessment and Moving and Handing Assessment completed.	LBB ASC
18.01.2018	**Carewatch hand back care package** due no change in situation following concerns raised, and fear of repercussions from John in relation to previous concerns raised. Mary is now without a formal care package.	Carewatch LBB Brokerage

Date	Summary	Agencies
19.01.2018	**Visit to Mary at Inspire Day Centre. Mary offered emergency respite whilst new care provider/Wolsley House secured.** Mary declines. Social worker notes action for social care assistant to liaise with LBB Housing to speed up Mary's housing application	LBB ASC LBB Brokerage
22.01.2018	**Social care assistant calls Mary for a welfare check.** No concerns. **Home visit by social worker and social care assistant** notes John has moved out of property, and Ian will assist Hayley with care. No concerns following home visit. Mary willing to go to Wolsley House for respite care whilst home care agency secured. LBB Brokerage and LBB Triage work to arranging Mary to attend Wolsley House. Mary's shower chair is sent to Wolsley House in anticipation of her move.	LBB ASC
25.01.2018	**Avante commence home care package delivery.**	Avante LBB Brokerage LBB ASC
26.02.2018	**Avante raise privacy concerns** with social care assistant. Family members and friends of family present when giving Mary full body wash in her bedroom, which is also the family's main living room.	Avante LBB ASC
06.03.2018	**Social worker and social care assistant visit Mary to discuss Avante's concerns.** Recommend purchase of a room divider. Mary notes family cannot afford to purchase. Mary also requests the return of her shower chair from Wolsley House.	LBB ASC
26.04.2018	**Unable to locate Mary's Shower Chair.** Stores consider likely has been reallocated.	LBB ASC LBB Stores
30.04.2018	**Avante telephone to raise concerns** regarding difficulty in cooking in Mary's kitchen due to broken/missing appliances. Mary still wants to move. Social care assistant tasked with progressing.	LBB ASC
01.05.2018	**Home visit by LBB occupational therapist.** Issues raised in relation to living environment, shower room and bed positioning.	LBB OT
02.05.2018	**Avante call to raise concerns** regarding difficulty cooking, rats, dog faeces and urine on towels. Concerned noted by LBB Triage and emailed to social care assistant.	Avante LBB Triage LBB ASC
07.06.2018	**Occupational therapist undertakes home visit.** Concerned with living conditions. Mary notes that she had not had any further information about her application for supported living/moving.	LBB OT LBB ASC

Date	Summary	Agencies
14.06.2018	In case discussion meeting with supervisor, **social care assistant tasked with urgently discussing Avante's concerns** with Mary and exploring with Mary what she would like to do next. LBB occupational therapist contacts LBB Housing to ascertain status. LBB Housing advise that Mary is not on the housing register and that she needs to complete the application form.	LBB ASC LBB OT LBB Housing
22.06.2018	**Mary's Personal Independence Payment (PIP) stopped.** Inspire request support from LBB social care assistant to complete forms. social care assistant responds not LBB responsibility to assist.	Inspire LBB ASC
16.07.2018	**Notes Mary still wishes to move** to a property with live-in care.	LBB ASC
06.08.2018	**Avante call occupational therapist** regarding meeting Mary's needs following visit in June. Occupational therapist undertakes to speak to social care assistant to discuss how to progress.	Avante LBB ASC
07.08.2018	**Occupational therapist visits Mary at Inspire day centre.** Mary confirms she want to be considered for rehousing with a live-in carer. Mary is unclear about who is dealing with her rehousing application. Social care assistant phones and leaves messages for Mary with details of people to call to progress issues raised on voicemail and with Inspire. Information includes direct phone number for contact in LBB Housing to progress rehousing application.	LBB ASC Inspire
16.08.2018	**Mary's finger broken by London Hire** when taking Mary to Inspire day centre. Mary attends day centre and her son, Ian, is informed of incident. Ian, attends the day centre and takes Mary to Erith Urgent Care Centre. Erith Urgent Care Centre advise Mary attends Queen Elizabeth Hospital for an x-ray, and to go home and call for an ambulance. Ambulance called, attend to Mary at home and convey to Darent Valley Hospital. **Safeguarding concern raised by family.** No response, update or apology provided to family by LBB ASC or London Hire. **Inspire raise safeguarding concern.** Forwarded by LBB Triage to social care assistant to undertake enquiries. No update provided to Inspire.	London Hire LBB ASC Inspire DGT BITU

Date	Summary	Agencies
20.08.2018	Social care assistant visits Mary at home following incident on 16th August 2018 when Mary's finger was broken by staff member of London Hire. **Safeguarding concern raised by family.** Social care assistant consults with senior social worker and it's decided that this can be case managed and is not a safeguarding. Social care assistant emails London Hire requesting that they send an apology to the family. Family noted during SAR process that they received no response, update or apology.	LBB ASC London Hire BITU
13.09.2018	Social care assistant visits Mary at Day Centre to advise that **it will not be possible to rehouse Mary.** Social care assistant notes that this is because her house is already fully adapted, and that *"Mary has allowed her house to become over-crowded"*. Mary is very disappointed. In subsequent supervision meeting on 17th September 2018, the social care assistant is instructed to visit the family to discuss the housing situation as the house appears to be overcrowded. Social care assistant and occupational therapist also commence investigation of the purchase of a fully adapted caravan near Ian.	LBB ASC
28.09.2018	Social care assistant asked to visit Mary at Inspire day centre as **Mary has come in upset. Family being abusive. Mary wants to move out.** Social care assistant advises Mary to ask her family to leave as property is over-crowded. Social care assistant undertakes to visit Mary at home to discuss family's moving plans. Mary asks for Ian to be present.	LBB ASC Inspire
01.10.2018	Ian calls Screeners to let them know John will be at the house today, as social care assistant had wanted to meet Mary and Ian alone.	LBB ASC
01.10.2018	Social care assistant and social worker visit Mary at home. Discussed family's progress of housing application. **Social worker recommends Mary videos herself explaining that she is evicting family to assist Hayley with housing application under homelessness criteria.** Social care assistant offers to support Hayley with housing application at the Civic Offices.	LBB ASC

Date	Summary	Agencies
02.10.2018	Occupational therapist visits Mary at Inspire Day Centre. Mary notes that if she wants a live-in carer, she has been told that she needs to evict her family and states her family are aware of this. Mary states they need their own place and that she needs her own space. Occupational therapist notes action to progress shower room repairs.	LBB ASC
27.11.2018	Occupational therapist visits Mary at Inspire day centre to discuss bathroom refurb. Mary states that her preference continues to be that she moves to a new property with a live-in carer, in a new home. Occupational therapist states prospect of Mary being rehoused in the foreseeable future is unlikely. Occupational therapist discussed rehousing position with the social care assistant assigned to Mary's case, who agreed remains unlikely.	LLB ASC
30.11.2018	Social care assistant supervision notes – social care assistant is to meet with Mary and explain that she is unlikely to be a priority to be rehoused, and that moving to a two-bed property would not automatically mean that she would be agreed for a live-in carer and receive funding for adaptations.	LBB ASC
18.12.2018	Occupational therapist visits Mary at Inspire day centre. Disabled Facilities Grant application form discussed and signed by Mary. Occupational therapist supports Mary to respond to letter from the Department of Work and Pensions (DWP). Mary is changing from Disability Living Allowance (DLA) benefit to a Personal Independence Payment (PIP) and is awaiting the outcome of her needs assessment. Mary is concerned that her benefit payments have stopped until a decision on her claim is made.	LBB ASC Inspire DWP

Mary

Date	Summary	Agencies
30.01.2019	**Safeguarding concern raised by Avante.** Avante call to raise several concerns, including dogs and dog faeces and urine in the downstairs shower room, neglect of Mary's needs by family and the smell of cannabis. Avante ask for a call back from the social care assistant assigned to Mary. Concerns raised lead to a safeguarding investigation undertaken with social worker and social care assistant. Safeguarding Investigation Outcome: Referral raised as a s42 Safeguarding Enquiry and allocated to a senior social worker (safeguarding adult manager) and a social worker. Safeguarding Planning form completed by social worker in LBB ASC team with no involvement outside of team. Plan is to continue with previous approach of support: to continue to seek ways to separate family from Mary and to monitor. LBB Triage note *"The care agency is reporting multiple complex issues that require intervention to prevent client being without the care she requires. Multiple complex family issues and client reporting that she wants to live on her own."*.	Avante LBB ASC LBB Triage
13.02.2019	**Housing occupational therapist carries out home visit with housing MeSH (Metro-wide Engagement for Shelter and Housing) officer**, who has been handling Mary's case since 2018. Both suspect that the property statutorily over-crowded. Occupational therapist notes Mary's *"strong desire to live independently from family"*. The report recommends that Mary bids for wheelchair adapted properties and to have an updated assessment of need to see if she qualified for 24hr care which would determine the bedroom size needed.	LBB Housing LBB MeSh
26.02.2019	DWP contacted. **PIP claim has been declined.** Mary is assisted by Inspire day centre to call DWP and progress an appeal.	Inspire DWP
01.03.2019	**Inspire day centre staff assist Mary with DWP appeal.** Inspire advise Mary to ask family to assist but note will assist next week if family unable to do so.	Inspire DWP
07.03.2019	**Risk of eviction and homelessness.** Outright Possession Order letter from Orbit. Overdue rent of £1,324.51.	Orbit

Date	Summary	Agencies
12.03.2019	Senior allocations officer in LBB Housing notes that delay on getting Mary on to the housing register is the **need for ID/supporting documents.** Housing have been sending letters to Mary at home requesting this information since September 2018.	LBB Housing
13.03.2019	Occupational therapist misunderstands that Mary is on the housing register and **asks Grants team not to proceed with bathroom refurbishment.**	LBB ASC
15.03.2019	**Inspire day centre staff assist Mary with DWP appeal.** Still waiting for re-consideration (6-9 weeks). DWP note PIP made a home visit but were turned away by Mary's son (which son not confirmed, John lives at property).	Inspire DWP
19.03.2019	**Avante raise safeguarding concerns with social care assistant.** Same concerns as raised 30th January 2019. No record on Liquid Logic/LBB case management system.	Avante LBB ASC
21.03.2019	**LBB Homelessness Prevention team visit Mary at home** to discuss options to prevent eviction.	LBB HP
25.03.2019	**Orbit agree to eviction date extension**, holding off from applying for an eviction warrant until the 30th April 2019.	Orbit
11.04.2019	**Arrears and court costs repaid in full by debit card.** The source of funds is not known.	Orbit
29.04.2019	**Social care assistant and Avante carry out home visit** to discuss concerns raised in January and March.	LBB ASC Avante
02.05.2019	**Neurologist assessment** notes: • Mary has limited use of her upper limbs and she relies on her carers to feed her. • She is able to steer her wheelchair with her left hand. • She is considering to downsizing her three-bedroom house to a flat with a live in carer. • She had a supra-pubic catheter that is changed every couple of weeks, she gets lots of sediment, this can sometimes happen if there is dehydration or infection.	LGT

Date	Summary	Agencies
20.05.2019	**District nurse visit notes verbal abuse by granddaughter towards Mary** whilst nurse is attending to blocked catheter. Nurse raises concern with family. **Complaint raised by family against nurse.** No further action.	Oxleas
30.05.2019	MeSH team to set up meeting with social care assistant and occupational therapist to **progress Mary's housing.** No meeting set up prior to Mary's death.	LBB MeSH LBB ASC
04.07.2019	**Avante raise safeguarding concerns** directly to social care assistant. Mary advised during a care visit that she had not had a meal for three days, Hayley, had taken her phone away, she had not seen any post and the last time she had seen a bank statement was a year ago. No note made of concerns raised on Liquid Logic (LBB Client Case Management system).	Avante LBB ASC
18.07.2019	Occupational therapist and social care assistant complete a **home visit to follow up on concerns raised by carers and rehousing.** Hayley denies concerns relating potential abuse, neglect and economic abuse of Mary. No notes on Mary's response. John, is at home during visit. Mary assigned various actions to resolve recurrent issues. Mary advised by occupational therapist to remove herself from the housing register as is causing delays to bathroom refurbishment.	LBB ASC
22.07.2019	**Avante raise safeguarding concerns** directly to social care assistant regarding abuse, neglect and home environment. No note made on Liquid Logic (LBB Client Case Management system).	Avante LBB ASC
26.07.2019	**LBB senior housing officer confirms that Mary is not on the housing register.**	LBB Housing LBB ASC
02.08.2019	Mary calls the LBB brokerage manager requesting her 45-minute care call to be increased to an hour and for **a carer to go shopping once a week when money comes in.** No note is made on Liquid Logic.	LBB Brokerage
05.08.2019	**Social care assistant arranges joint home visit with Avante** and occupational therapist on 12th August 2019 to discuss recurring issues with Mary.	LBB ASC Avante

Date	Summary	Agencies
09.08.2019	**Violent incident at Mary's home involving Hayley, John and a visitor. Pregnant woman involved**, believed to be Hayley or John's daughter**. Carer physically assaulted and both carers verbally abused by John. Care agency withdraws care package with immediate effect.** Mary has no formal care package from the evening of 10th August 2019 and is cared for at home by her family from this point onwards.	Avante LBB RR LBB OoH
09.08.2019 to 12.08.2019	**No report made to the Police regarding the violent incident.** Children were present at the time.	Avante LBB OoH LBB RR LBB ASC LBB Triage
11.08.2019	**LBB Rapid Response (RR) unable to secure emergency care providers.** Attempted to contact family over weekend. Spoke to Hayley on Sunday and confirmed family is happy to provide care over the weekend until another provider is secured. Hayley asks for care to be sorted as soon as possible. Notified allocated case worker: social care assistant.	LBB RR
12.08.2019	**Occupational therapist attends pre-arranged home visit**, unaware that Avante have withdrawn their services following the incident on Friday. Mary in bed (10am). She has not had her personal care needs attended to nor has she eaten or drunk anything that morning.	LBB ASC
14.08.2019	**Mary bought into hospital by ambulance.** She was being washed by John, and the supra-pubic catheter had come out.	DGT
20.08.2019	Inspire call LBB Brokerage to advise that **Mary has not attended the day centre since 08th August 2019**: family are unable to get her up in time for transport. LBB Brokerage undertake to advise social care assistant. No record on Liquid Logic.	LBB Brokerage Inspire

Date	Summary	Agencies
23.08.2019	**Oxleas District Nurses raise safeguarding concern** via Screeners. District nurses have been attending to Mary's catheter and other health needs for over five years. Mary in bed, no bedding and Mary's clothes soaked in urine. Nurse gives personal care to Mary and discusses current situation. Nurse reports that Mary's personal hygiene was poor, and she had a variety of foods in her hair and on her body and clothes. No drinks within Mary's reach, and Mary's tongue and lips very dry with film on the front of her teeth – drink offered and accepted. Mary informed nurse that her care agency stopped visiting and her son now provides all personal care. Mary reported she was embarrassed with her son providing personal care. Mary reported that she no longer attended her day centre three times per week, as her son worked 9-5 daily and no one else could get her ready for the transport in time, therefore could no longer attend. Oxleas are not contacted regarding the safeguarding, and do not follow up.	Oxleas LBB Screeners
23.08.2019 to 27.08.2019	**Temperature range between 27 to 33 degrees Celsius** over the Bank Holiday weekend in Bexley.	-
27.08.2019	**LBB Triage Link Safeguarding Alert received 23rd August 2019 to existing open s42 Safeguarding Enquiry.** Notified both workers to follow up. Social worker and social care assistant discuss. Social care assistant notes LBB Brokerage is having difficulties to secure a provider for this case and are working to move Mary to Direct Payments, where the family can purchase a care service directly and not be restricted by the council's supplier list. No further action to LBB ASC.	LBB Triage LBB ASC
	Inspire call LBB Brokerage to advise that **Mary has still not attended the day centre since 08th August 2019.** LBB Brokerage emails social care assistant, LBB Brokerage Team and Head of Operations. Concerns about relying on family for care and that Mary is missing a key element of her care package. No note on Liquid Logic.	LBB Brokerage Inspire LBB ASC
27.08.2019	**Ian calls into single point of access to report that Mary's urine was *"purple"* in colour,** but catheter not blocked and no pain expressed. Advice given to increased fluids and monitor and to call back if not resolving.	Oxleas

Date	Summary	Agencies
28.08.2019	**Social care assistant and occupational therapist carry out welfare visit with Mary at home. Visit in response to concerns that Mary has not been able to attend Inspire** as she was not ready in the mornings for the transport to take her. (Time 1:30pm) **The occupational therapist noted that the air *"smelt of infection"*.** Liquid Logic notes state that *"Mary looked well and made no complaints about her food/drink provision. However, it is appreciated that she may not wish to comment about the family's care provision whilst there were present."*. Mary, confirmed by Hayley and Ian, reported that **she was experiencing pain on her back.** Hayley and Ian reported that the **area was red.** During visit, occupational therapist and the social care assistant witness **call to alert the district nurses of Mary catheter care needs and tissue viability.** The occupational therapist noted that Ian *"urged them to come as urine colour with albumin in it, smell, etc for Mary was really poor"*. They understood that the district nurses would visit later that day. Agreement reached that whilst Bexley continued to work to source an agency willing and able to take on the full contract, they would also seek to secure an agency to get Mary ready to go to the day centre on the mornings that she was scheduled to attend.	LBB ASC
	Mary calls District Nurses day team for by-passing catheter. Referral passed to LBB Out of Hours (OoH) service, informs them that catheter bypassing since yesterday (27th August 2019). Mary noted to be laying on a wet pad and wet bedsheets. Mary declined for district nurse to check her pressure areas.	Oxleas
30.08.2019	**GP attempts to call Mary re: symptoms.** Failed encounter. Called twice. No record of why this call was attempted. Likely call was made in response to a family member calling the GP.	GP

Date	Summary	Agencies
01.09.2019	**District nurses visit Mary for catheter care.** Daughter-in-law reports that she was expecting a GP to visit as they had *"spoken to the surgery about a possible urine infection in the week"*. No GP record of conversation. **Both district nurses report strong odour to urine, catheter changed and drained urine. Pressure sores checked, reported to be healing and less red. Mary asked if she would reach her drinks on table in front of her - replied no**, her family help her. **District nurse notes that Mary's mouth is very dry.** Mary confirms that carers are not yet been reinstated.	Oxleas
02.09.2019	**GP speaks to Hayley via telephone.** Report *"urine smelly"*. Mary has been having burning pain when passing urine. **GP prescribes antibiotics** and requests family call again if no improvement.	GP
04.09.2019	**Mary dies in the early hours of the morning.** Recorded as Sudden Death. Police record death as not suspicious.	Police LAS
24.092019	Coroner emails Social worker with **Cause of death for Mary:** 1. **1a sepsis,** 2. **1b bronchopneumonia and pyelonephritis, and** 3. **1c multiple sclerosis and diabetes mellitus.**	Coroner LBB ASC

8. EVIDENCE-BASED MODEL OF GOOD PRACTICE

During this SAR review process, the first national thematic analysis of published and unpublished SARs in England since implementation of s44 CA2014 was released.[14] The analysis covered all SARs completed between April 2017 and March 2019 inclusive, and to ensure a methodical analysis, the content of each SAR was considered within a previously applied four-domain framework. The four-domain framework has been successfully applied in the London[15], South West[16] and East Midlands[17] thematic reviews.

The authors of these SARs noted that the absence of a national review of SAR learning has deprived SABs and their partner agencies of an easily recognised pathway through which they can locate local learning themes within a national picture. The project provided an important foundation to developing a structured national SAR dataset, like national datasets held by national departments in social care and health. Given the severity, importance, and potential for learning from SARs, there is a strong case to be made for a systematic approach to recording key information about every SAR conducted in England, and a routine process of analysing this data for the benefit of the sector.

BSAB input into the previous London-wide thematic review in 2017 and have been working towards mapping their learning to the national learning themes, and vice versa. As such, to assist with future local, regional, and national analyses, and to

[14]Local Government Association (2020) *"Analysis of Safeguarding Adult Reviews April 2017 – March 2019"*. [Online] Available at: https://www.local.gov.uk/sites/default/files/documents/National SAR Analysis Final Report WEB.pdf (Accessed: 01.02.2021).
[15]London Assembly (2017) *"Learning from SARS; A report for the London Safeguarding Adults Board"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf (Accessed: 01.02.2021).
[16]Somerset Safeguarding Adults Board (2017) *"What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews. A report for South-West region safeguarding adults boards"*. [Online] Available at: https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SW-SCRs-SARs-Report-Final-Version-2017.pdf (Accessed: 01.02.2021).
[17]Nottinghamshire County Council (2017) *"East Midlands Safeguarding Adult Network Report from a thematic review of Safeguarding Adult Reviews within the East Midlands"*. [Online] Available at: https://www.nottinghamshire.gov.uk/media/132275/emsanthematicreviewsars.pdf (Accessed: 01.02.2021).

inform national priorities for sector-led development and improvement, the findings of this report are categorised and analysed within the four-domain model, details of which follow below.

8.1 The Four Domain Analytic Framework For Safeguarding Adults Reviews

The Four Domain Analytic Framework, in line with Making Safeguarding Personal, is as follows:

Four Domain Analytic Framework	
Domain A	Focuses on direct practice with the individual.
Domain B	Focuses on inter-professional and interagency collaboration, seeking to review how practitioners worked together.
Domain C	Assesses organisational features affecting how practitioners and teams worked together, including the presence or absence of support by their employer.
Domain D	Captures the work of the Safeguarding Adults Boards in leading, oversight and governance of safeguarding across the borough.

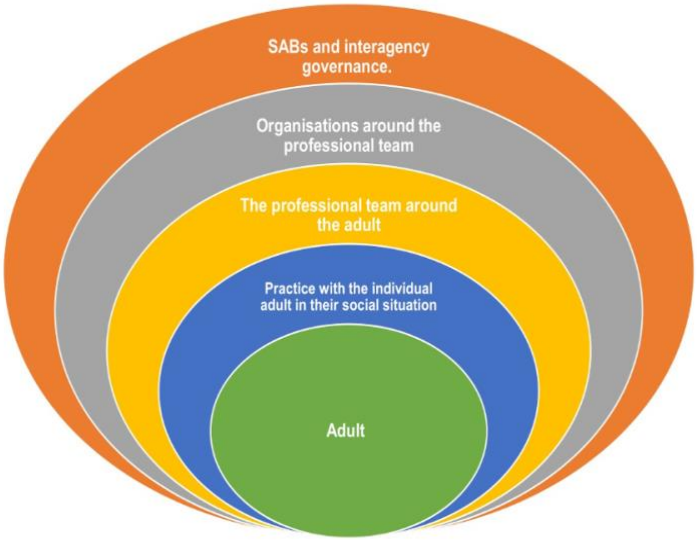

Figure 1: Preston-Shoot, M. (2019) *"Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice"*, Journal of Adult Protection 21(4), p219-234

9. THEMATIC ANALYSIS

The SAR panel's key findings are summarised below using the four-domain framework described in the previous section. Further case related evidence of the findings is provided under each Domain, Theme, and Sub Theme in APPENDIX E which was the version developed and discussed with the panel as part of the SAR review process:

9.1 Domain A: The Adult – Direct Practice With Mary

9.1.1 Theme: Recognising And Responding To Specific Forms Of Abuse And Neglect

9.1.1.1 Sub Theme: Domestic Abuse

Finding Summary: Domestic abuse was under-recognised and under-reported. No agency completed a DASH risk assessment[18] or discussed concerns with a domestic abuse specialist. Signs of domestic abuse featured throughout this case, in particular economic abuse, but at no time was Mary's case considered through a domestic abuse/coercive control lens nor was a domestic abuse process triggered. Had professionals explored the signs of domestic abuse in Mary's case, additional avenues of support would have opened for Mary, including potentially expediting her requests to be rehoused in a smaller two-bed property with a live-in carer, away from her extended family.

Commentary: Domestic abuse was recorded by a social worker in the local authority's safeguarding enquiry notes in 2012 and 2017 where the terms *"financial abuse"* and *"emotional abuse"* were used. In 2015, an Inspire Manager raised concerns of financial

[18]The purpose of the Domestic Abuse, Stalking and Honour (DASH) risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm.
Bexley Safeguarding Adults Board (2018) *"Domestic Abuse, Sexual Violence and Violence Against Women & Girls (VAWG) Training Prospectus"*. [Online] Available at: https://www.safeguardingadultsinbexley.com/wp-content/uploads/Bexley-Training-Prospectus-V1-2.pdf (Accessed: 01.02.2021).

abuse and coercive control. However, no action was taken in relation to these concerns.

None of staff within LBB's Adult Social Care team involved in the final safeguarding enquiry, which was open when Mary died, considered Mary to be a victim of domestic abuse. During the interview process, they demonstrated an outdated understanding of domestic abuse, aligning with the *"Little Mo"*[19] stereotype of a shy, retiring, physically beaten woman. It was partly this focus on the word violence in the term *"Domestic Violence"*, invoking thoughts of observed physical harm, that led the Government to changing the term *"Domestic Violence and Abuse"* and more recently to *"Domestic Abuse"*.

For all agencies, the review process (particularly interviews with those directly supporting Mary) uncovered many previously unrecorded incidents of domestic abuse, principally in relation to economic abuse[20]. Carers regularly raised concerns about the lack of food available for Mary. In July 2019, Avante reported to the social care assistant that Mary had not had a meal for 3 days, her daughter in law had taken her phone away, that she had not seen any post and the last time she had seen a bank statement was a year ago. Inspire workers observed that Mary never had any money despite being in receipt of multiple benefit payments. However, none were considered as potential indicators of domestic abuse. Further back, on 01st April 2016, London Hire raised a safeguarding concern in relation to economic abuse, but concerns were added to the case for the occupational therapist to follow up on (rather than a social worker) and to raise an alert if there are any concerns. Mary had not been able to find a £10 note in her bag that the family member said Mary had been

[19]The Little Mo domestic abuse storyline ran in the British soap EastEnders from 2000-2002. *"Little Mo Mitchell"* (2021) Wikipedia. [Online] Available at: https://en.wikipedia.org/wiki/Little_Mo_Mitchell (Accessed: 01.02.2021).

[20]Economic abuse is an aspect of coercive control restricting a victims' access to resources to limit freedom. Surviving Economic Abuse (2021) *"What is economic abuse?"*. [Online] Available at: https://survivingeconomicabuse.org/what-is-economic-abuse/ (Accessed: 01.02.2021).

given that morning. The family member shouted that Mary was *"always losing money"*, and then gave her £3 and a bank card whilst shouting a pin number at speed.

The review process uncovered numerous incidences of missed opportunities to intervene with domestic abuse support options, which could have helped prevent Mary's continuing experiences of abuse and neglect at home, including considering the potential effects of domestic abuse and coercive control on Mary's decision-making. During this review process, the local authority has provided a significant level of awareness raising and training in domestic abuse for both its staff and local agencies, including most recently mandatory Introduction to the Multi-Agency Risk Assessment Conference[21] (MARAC) training for all front line Adult Social Care staff.

9.1.1.1 Sub Theme: Self-Neglect – Hoarding

Finding Summary: Mary's home was cluttered with evidence of hoarding. This was noted by the social worker in 2011 and again in 2013. No investigation or assessment was undertaken to determine whether any form of abuse was taking place.

Commentary: Ian told the Independent Chair that Mary liked to have everything around her, and as a result her living space was cluttered and messy. He, and Inspire staff, noted that Mary loved to buy Avon products whilst at the day centre, which she hoarded around the house. Multiple carers, LBB Housing, and members of the LBB ASC team described the house as dirty and cluttered.

No investigation was undertaken into the reasons for the clutter and mess to determine whether any form of abuse was taking place. There is also no indication of

[21]The MARAC is a regular meeting where agencies discuss high risk domestic abuse cases, and together develop a safety plan for the victim (and their children).
London Borough of Bexley (2021) *"Multi Agency Risk Assessment Conference (MARAC)"*. [Online] Available at: https://www.bexley.gov.uk/services/community-safety-and-environment/domestic-abuse/multi-agency-risk-assessment-conference-marac (Accessed: 01.02.2021).

professionals using BSAB's Self-Neglect and Hoarding Toolkit for practitioners[22] launched in March 2018 following SAR Mr K (2017).

The CA2014 clarifies the relationship between self-neglect and safeguarding, and has made self-neglect a category of harm about which the local authority has a duty to make enquiries and to assess need with the promotion of well-being at the heart. It may not mean that each case of self-neglect must be opened as a s42 Safeguarding Enquiry but that each case must receive an appropriate response.

As with the domestic abuse related finding, in 9.1.1.1 Sub Theme: Domestic Abuse, indicators of self-neglect were overlooked, and as such there were missed opportunities to use BSAB's self-neglect procedures. Application of the procedures may have revealed additional options to safeguard Mary from continued abuse and neglect, including the prioritisation of her requests to move to a smaller property.

9.1.2 Theme: Assessing And Meeting Needs

9.1.2.1 Sub Theme: Safeguarding Action – Referral And Response

Finding Summary: Agencies followed safeguarding referral processes. However, the local authority safeguarding enquiry case leads did not consistently take a person-centred approach nor always follow Making Safeguarding Personal principles.

Commentary: Up until 2018, LBB ASC practitioners supporting Mary consistently chose to meet and speak with Mary at the day centre to ensure that she was not under any duress or pressure when speaking about her needs at home. However, on multiple occasions whilst the last safeguarding was open in 2019, the consistency of this person-centred approach lapsed. At this time, safeguarding concerns raised by the

[22]Bexley Safeguarding Adults Board (2018) *"Self-Neglect and Hoarding Toolkit"*. [Online] Available at: http://www.safeguardingadultsinbexley.com/wp-content/uploads/Self-neglect-toolkit.pdf (Accessed: 01.02.2021).

care agency were discussed with, or in front of, family members at home. Most of the concerns raised were in relation to Mary's family. Actions from meetings were assigned to Mary to fix issues which had featured in her case since 2011. Further, in October 2018, a social worker from the local authority's ASC team accompanying the social care assistant to a home visit with Mary and Hayley, suggested that Hayley took a video of Mary explaining that she was evicting the family. This was to help with Hayley's separate housing application. The difficult and possibly dangerous position that this action might have placed Mary in, in terms of repercussions from her family, does not appear to have been considered. The video was never provided to the local authority.

When Oxleas District Nurses attended to Mary on 28th August, whilst John was present in the room, Mary declined the nurses to check on her pressure areas. At the nurses' previous visit on 23rd August, after which a safeguarding concern was raised, the case notes identified that Mary was *"embarrassed"* with John providing personal care, particularly if her bowels had been opened and stated that she had *"a sore bottom"*. There is no evidence to explore why Mary declined to be checked during this second visit on 28th August, and there is no record of Mary previously declining to be checked. So, what had changed over the five days? Was Mary declining because of John's presence? She wasn't asked. The panel reflected that this was a missed opportunity, and that Mary should have been seen on her own, and sensitively asked about her well-being in relation to concerns raised by the previous nurse to ensure continued safety.

During the same visit on 28th August, the nurse offered to clean Mary, as she was reported to be laying on a wet pad and wet bedsheets. The family member refused the offer. In line with Making Safeguarding Personal principles, there is no indication that Mary was asked if she'd like to be cleaned.

Finally, a wider environmental factor influencing the outcome of Mary's care was that the temperature during the last two weeks of Mary's life reached 33°C. Mary's daughter-in-law and primary carer was heavily pregnant at the time. The three younger children were home from school. There was no air-conditioning in the house. Mary was consistently dehydrated and prone to UTIs, and she was living in an unclean environment in an over-crowded house. There is no evidence that any of this was considered when assessing and meeting Mary's needs at the time. No risk assessment was completed, so the effect of the heat was over-looked. Heat (as well as cold) should be factored in to assessing and meeting care needs.

In terms of positive practice, the review also uncovered an abundance of evidence of Making Safeguarding Personal principles in practice. Avante staff were tenacious and compassionate, raising multiple concerns to the local authority regarding Mary's well-being (six recorded in total, five in the last nine months of Mary's life) and were determined to improve Mary's living environment. Other care agencies also ensured that Mary was front and centre of their services. The day centre, Inspire, also placed Mary firmly at the centre of their services, including through the co-production and bi-annual review of Mary's goals and desired outcomes from her time at the day centre. This evidenced a solid and ongoing commitment to maximising Mary's health and well-being.

9.1.2.2 Sub Theme: Risk Awareness And Assessment

Finding Summary: The risk assessment completed by the local authority as part of the s42 Safeguarding Enquiry open from the end of January 2019 was inadequate. Further, the risk assessment was not reviewed or revised whilst the safeguarding was open, despite significant factors changing in Mary's case, such as the risk of eviction and the care agency's withdrawal of their daily care package.

Commentary: The risk assessment completed by the local authority as part of its response to the s42 Safeguarding Enquiry raised in January 2019 was inadequate. It

was created as part of the Safeguarding Planning by the social worker enquiry officer (EO), with support from the social care assistant and the occupational therapist. The Safeguarding Plan was signed off by the safeguarding adult manager. No other local authority department was involved, nor were any other agencies requested to co-develop and support the response: the response was developed in isolation within the LBB ASC team. This lack of multi-agency involvement led to the risk assessment being narrow in its focus, applying the same response to the same risks that had been apparent throughout Mary's case history, and it missed the risk of the carers (Avante) withdrawing their services. Avante had raised their potential withdrawal from providing this care package as a risk in January when they discussed their safeguarding concern with LBB Triage. This was recorded in Liquid Logic. Had Avante been involved in the safeguarding planning process, the risk of their potential service withdrawal might have been captured and a contingency plan developed as a result. Panel members suggested that perhaps staff do not feel supported or empowered to call multi-disciplinary team meetings for a safeguarding case. As such, a recommendation relating to exploring this potential gap and responding to any confirmed issues features in this report.

According to LBB Brokerage and Mary's social worker in 2011-2013, Mary's domiciliary care package was one of the three key services that safeguarded Mary against abuse or neglect. The social worker at that time and the brokerage manager referred to these services as Mary's *"Safety Plan"* but which this was not formally recorded anywhere. Once the care service provider withdrew their services, Mary's family were unable to get Mary up in time to go to the day centre, which was another of the three key elements in Mary's unofficial *"Safety Plan"*.

The third, and final element of Mary's *"Safety Plan"* was her housing which was already a hinderance to her safety and well-being. If we consider Mary's *"Safety Plan"* as a three-legged stool, with each element above being a leg of the stool, in the last few weeks of her life, there was just one unstable leg expected to maintain her safety.

Bexley's Safeguarding Policy[23] provides a risk management framework to which practitioners can work: the policy states that *"Positive risk management needs to be underpinned by widely shared and updated contingency planning for any anticipated adverse eventualities. This includes warning signs that indicate risks are increasing and the point at which they become unacceptable and therefore trigger a review. Not all risks will be immediately apparent; therefore, risk assessments need to be regularly updated as part of the safeguarding process and possibly beyond."*.

The panel agreed that the lack of risk awareness and assessment was a contributory factor in the relaxed response to the loss of the care package from 08th August 2019. The panel also noted that the risk-tolerance shown by those involved in the case at the local authority was possibly assisted by the *"rule of optimism"*, assisted by the view that the family had coped previously.

9.1.2.3 Sub Theme: Working With Families And Significant Others

Finding Summary: The CA2014 is clear on the need to safeguard carers. Mary's family was abandoned to care for Mary whilst LBB worked to fill gap in care package. The family asked for another provider to be secured as soon as possible. No Carers Assessment was completed. Agencies were also rarely observed to *"Think Family"* in relation to others living in the same household as Mary.

Commentary: The local authority did not work with the family to support Mary after her domiciliary care package ended. Instead, the family were abandoned to care for Mary without support. After having agreed with the family that they could cover for the weekend of 9th and 10th August, they were left to manage Mary's care without any support until Mary died on 4th September. Mary's primary carer, Hayley, had

[23]London Assembly (2019) *"London multi-agency adult safeguarding policy & procedures"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (Accessed: 01.02.2021).

expressed concern that she had other caring responsibilities (her children) and asked that formal carers be secured *"as soon as possible"* and *"within the shortest possible time"* There is no evidence that the family agreed to covering the care support package for longer than the weekend after the carers withdrew.

Similarly, no Carer's Assessment was completed, nor was the wellbeing of Mary's familial carers recorded as being considered during this period. When the carers withdrew on 9th August, Hayley, was in her third trimester of pregnancy, as was Mary's granddaughter who was also living at the property. The family were not proactively contacted to ascertain how they were coping. It was mid-way through the summer holidays, and it was known that there were at least three young children living at the house. Further it was the hottest August on record, with temperatures reaching 33 degrees Celsius in Bexley during that month. The local authority has a duty of care to familial carers made clear in s2.3 of the Care and Support Statutory Guidance[24] and must do a Carers Assessment for any carer who they think may need support now, or in the future. The Pan London Safeguarding Procedures[25] used by Bexley local authority also notes the importance of Carers' Assessment and suggests that whole family assessments might also be considered using the framework of *"Think Family"* as an appropriate way forward. In Mary's case the whole family assessment would have helped ascertain the presence of health and care needs that exceeded Mary's family's ability to meet; it may have also revealed any financial difficulties experienced by Mary's family and the family's management of Mary's income. Although the care gap period was expected to be short, an exploration of carer needs would have provided an opportunity to *"Think Family"* and potentially open other options to improve upon Mary's living situation. An exploration of the risks posed by carers, whether intentional or not, is further explored in the ADASS publication, Carers and Safeguarding Adults – Working Together to improve

[24]Department of Health & Social Care (2020) *"Statutory guidance: Care and support statutory guidance"*. [Online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance (Accessed: 01.02.2021).
[25]London Assembly (2019) *"London multi-agency adult safeguarding policy & procedures"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (Accessed: 01.02.2021).

outcomes[26], which would have helped complete a Whole Family/Carers Assessment at this time.

In terms of other agencies' working with Mary's family: Ian asked that carers are mindful that they are working in someone else's home and requested that carers raise concerns with the family in the first instance, rather than complaining to the local authority. This aligns with BSAB strategic priority to promote working with family members to involve them to reduce risks to individuals and to enhance support for them. In this case, Mary and her family could have benefited from a whole-family approach to her care needs. This may have included offering the family support with cleaning and maintenance at the property. The occupational therapist and social care assistant mentioned that John was decorating the lounge in summer 2019 and that the family were trying to improve their home environment. The social care assistant suggested that perhaps this could have been supported in some way by the local authority in partnership with Orbit. This (and other potential) direct multi-agency approach(es) to working with the family would likely have improved Mary's situation.

In terms of positive practice in relation to working with Mary's family, social care assistant offered to assist Hayley with her Bexley Housing application to assist her and her children in finding a secure home, there-by freeing Mary up to move to the two-bed bungalow without worrying about making her family homeless. Unfortunately, Hayley never took the social care assistant up on the offer.

There was noticeable absence of a *"Think Family"* approach, even when the family were providing significant levels of support, and a failure to consider the risks of children's exposure to the same environmental concerns that were consistently raised in safeguarding concerns for Mary. The panel felt this should lead to a

[26]Directors of Adult Social Services (2011). *"Carers and safeguarding adults – Working together to improve outcomes"*. [Online] Available at: https://www.adass.org.uk/adassmedia/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf (Accessed: 01.02.2021).

recommendation for borough-wide training for all agencies to communicate the *"Think Family"* approach.

9.1.2.4 Sub Theme: Responding To Characteristics Of The Individual

Finding Summary: Mary had MS and her health was noted by health professionals to be deteriorating.

Commentary: Mary had MS and her health was noted by health professionals to be deteriorating. She had extremely limited use of her left arm, and she required additional support to complete forms, write letters/emails or to make/take phone calls. She could not rely on her family for this support. Inspire supported Mary at the day centre but she needed someone to work with her at home on the rare occasion that complex forms needed completion (such as housing allocation forms and PIP). Inspire called the social care assistant in early 2019 to ask if Mary could be provided with support to complete her PIP related paperwork. The social care assistant declined. This is an area under review by LBB, particularly in terms of clients accessing benefits to which they are entitled and debt recovery/management. Had this option been explored and approved in Mary's case, it is possible that her PIP review appeal claim would not have been delayed, and as a result she may not have fallen behind in her rental payments and faced eviction. It was this cascade of events that delayed the social care assistant and the occupational therapist's progress on actions within the open safeguarding enquiry, as for six weeks between early March to mid-April 2019 all LBB efforts focussed on preventing Mary from becoming homeless.

All agencies supporting Mary had significant difficulty contacting her via letter, phone or email. None raised their concerns with the local authority. This was first raised, in 2011, by a social worker and raised in further safeguarding concerns since. It was however never resolved and exacerbated issues such as arranging repairs to the property, calls from the GP and alerts from Orbit relating to the risk of eviction for rental arrears.

In terms of positive practice, Inspire day centre provided records showing a continuity of support over many years from three dedicated staff members who were committed to supporting Mary whilst at the day centre in filling forms, making calls and being as independent as possible. This included a significant level of support to help Mary increase usage of her left hand.

9.1.3 Theme: Making Safeguarding Personal – Finding The Person

9.1.3.1 Sub Theme: Reluctance To Engage

Finding Summary: LBB ASC practitioners failed to Make Safeguarding Personal (empowerment principle): choice was not given, instead response was assumed.

Commentary: LBB ASC team members, assigned to Mary's case, did not offer respite when Mary's care package fell through as it was assumed Mary would decline as she had done in the past. Mary's refusal should not have been assumed, which is clearly stated in s14.95 of the Care and Support Statutory Guidance[27] as follows: *"because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time."*.

On 28th August 2019, during a welfare visit in response to the safeguarding concern raised by Oxleas District Nurses, the social care assistant and the occupational therapist again assumed Mary would decline their suggestion to call for an ambulance. They noted that *"Mary hated hospitals and wouldn't have consented to ringing them"*. The same non-assumption rule applies in this incidence: Mary should have been

[27]Department of Health & Social Care (2020) *"Statutory guidance: Care and support statutory guidance"*. [Online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance (Accessed: 01.02.2021).

involved in decision making about what to do/not to do in terms of her safety and well-being.

As noted in the Assessing and Meeting needs section above, during Oxleas district nurses' visit on 28th August, the nurse offered to clean Mary, as she was reported to be laying on a wet pad and wet bedsheets. The family member is recorded as refusing the offer. In line with Making Safeguarding Personal principles there is no indication that Mary was asked if she'd like to be cleaned.

In terms of good practice identified: When meeting with Mary as part of the s42 Safeguarding Enquiry in January 2019, the social worker offered Mary an advocate and a recording of the conversation. Mary declined in this instance, but it is acknowledged as good practice to have offered Mary the option. The social worker also ensured that the meeting took place at the Inspire day centre, to enable Mary to speak freely about her home life.

Also, in line with Making Safeguarding Personal, the Out of Hours social worker at the local authority ensured that they spoke directly with Mary. The aim was to confirm that Mary understood the situation and that she was happy for her family to provide care over the weekend until Monday 12th August, as had been previously discussed with Hayley. This conversation was clearly recorded on the local authority's shared case management system, Liquid Logic, and showed that the social worker was tenacious in finding Mary and ensuring that she understood and consented to the plan of action.

9.1.4 Theme: Practitioner Attributes

9.1.4.1 Sub Theme: Legal Literacy

Finding Summary: Agencies supporting Mary with her housing did not evidence knowledge or use of legal powers and duties in relation to over-crowding.

Commentary: In 2015, Orbit records show that Mary's daughter-in-law, Hayley had moved in with her partner (John) and five children. Later, records noted that Mary was no longer able to get up to a bedroom due to her family moving in upstairs. The term *"over-crowding"* was not used in Orbit's records but three adults and five children in a three-bedroom property should have at least warranted further investigation, given that it is illegal for landlords to let a property to more people that it is suitable for.[28]

In 2018, a social care assistant and a social worker met Mary at Inspire to update her on the progress of her rehousing application. They told Mary that she was responsible for her home becoming *"over-crowded"*, there-by specifically using the term twice in her notes at that time. However, no action was taken to alleviate or address the over-crowding. The issue of over-crowding was then recorded again in March 2019 following a home visit by a Housing occupational therapist and a representative of the LBB MeSH team. The LBB MeSH team representative undertook an action to *"refer to Environmental Health due to concerns that the family are statutorily overcrowded"*, and The Housing occupational therapist noted concerns of over-crowding in their formal report. Their concerns led LBB's Senior Housing Allocations Officer to ask Orbit for a tenancy check as over-crowding was suspected. An over-crowding assessment was never undertaken, it would have been helpful for Orbit to share if and how they had ruled it out. The Senior Housing Allocations Office stated that an over-crowding assessment tool would have been helpful. This is included in the recommendations.

As with other findings, a multi-agency approach to an issue arising for Mary, may have helped move forward on seemingly intractable obstacles: a primary obstacle in this case was in relation to Mary's re-housing. In this case, it appears unlikely that Mary's house was statutorily over-crowded using the space/room standard available online

[28]Ministry of Housing, Communities & Local Government (2020) *"Guidance How to rent a safe home"*. [Online] Available at: https://www.gov.uk/government/publications/how-to-rent-a-safe-home/how-to-rent-a-safe-home (Accessed: 01.02.2021).

through Shelter,[29] however, better inter-agency, multi-disciplinary communication relating to Mary's housing issues, may have provided alternative solutions to those already considered.

9.1.4.2 Sub Theme: Attention To Mental Capacity

Finding Summary: Respecting Mary's decision-making rights where she was assumed to have mental capacity discouraged the caseworker from engaging Mary in dialogue about the consequences of what practitioners consistently described as *"unwise decisions"*.

Commentary: Mary's mental capacity was assessed in January 2018 by a social worker, as part of the handover of Mary's case from the social worker to the social care assistant. Mary was then not assessed again before she died in September 2019. However, professionals continued to assume that she had full mental capacity. This assumption discouraged the LBB ASC team (social worker, social care assistant, and occupational therapist) from engaging Mary in dialogue about the risks and potential consequences of what were consistently described as *"unwise decisions"*.

During interviews with LBB ASC staff, many reflected that they had not considered the potential effect of coercive control/domestic abuse on Mary's decision-making capacity. Nor had they considered to check whether Mary's deteriorating health might have been having an effect of her decision-making. The panel felt that this was a common issue across the borough and recommended that the Bexley's Mental Capacity Toolkit[30] is revised to include attention to mental capacity in cases where coercive control is recognised or suspected. This forms part of the recommendations in the following section.

[29]ShelterLegal, England and Wales (2021) *"What is overcrowding?"*. [Online] Available at: https://england.shelter.org.uk/legal/housing_conditions/what_is_overcrowding (Accessed: 01.02.2021).
[30]Bexley Safeguarding Adults Board (2018) *"Mental Capacity Act 2005 Competency Toolkit"*. [Online] Available at: https://www.safeguardingadultsinbexley.com/wp-content/uploads/Mental-Capacity-Act-Toolkit-2.pdf (Accessed: 01.02.2021).

Had the professionals explored this route, they may have also explored the possibility of inherent jurisdiction. Inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be; (i) under constraint, or (ii) subject to coercion, or undue influence, or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent. The panel were concerned that some staff consider using the court process as a negative process. They were keen to encourage professionals to at least discuss and consider the use of legal tools in complex cases, and to see a change in attitude towards the process. This is reflected in the recommendations.

9.2 Domain B: The Team Around The Adult – Interagency Working

9.2.1 Theme: Information Sharing

9.2.1.1 Sub Theme: Record Sharing

Finding Summary: Different recording systems and levels of access impeded interagency communication and information flow.

Commentary: Stakeholders across this review expressed deep frustration regarding the current gap between the promised and actual joined up capabilities of Bexley's Connect Care system. In 2019, the record sharing capability gap was wider than it is currently, and so in Mary's case, there was no evidence of record sharing through Connect Care. The social care assistant was unaware of Mary's A&E attendance shortly after the carers withdrew and the Oxleas District Nurses were unable to see the open s42 Safeguarding Enquiry when they raised safeguarding concerns in August 2019.

Expert health representatives on the panel advised that GPs continue to have a standalone system, which is a national issue in terms of sharing information, and that

GPs are unable to access the Rio system used by Oxleas. This meant that GPs relied on others to update them on safeguarding enquiries or concerns. In Mary's case, they were not notified of the safeguarding or involved in its response, and so they did not adapt the service they provided to Mary.

Conversely, Oxleas District Nurse team can see GP case notes and other hospital information is accessible to them. This had previously helped with joined-up management of Mary's health management between the GP and the District Nurses in the past, particularly when responding to suspected UTIs. This is however a one-way information sharing pathway.

During this SAR review, current and aspirational ways of working between social care teams and health services formed part of a *"System of Systems"* review by the South East London CCG[31]. The review notes that GPs are a key partner, and their inclusion will reduce gaps in care pathways.

9.2.1.2 Sub Theme: Information Flow

Finding Summary: Interagency information flow was inconsistent where flow required practitioners to take proactive action.

Commentary: Although noted as a positive above, although Oxleas district nurses could record case notes on GP records, this wasn't always done. On multiple occasions the GP observed that they had no record of actions taken by the district nurses when attending to the patient. As GPs cannot access any shared information and use standalone systems, they rely on others to proactively update them and/or add notes to their system as necessary. The panel noted that a more formal mechanism is

[31]National Health Service (2020) *"Our Healthier South East London Recovery Plan - Working together to improve the health and wellbeing of our neighbourhoods and communities"*. [Online] Available at: https://www.ourhealthiersel.nhs.uk/2020%20Publications/SEL-Recovery-Plan-October-2020.pdf (Accessed: 01.02.2021).

required and suggested replicating the model of multi-disciplinary teams in Care Homes.

Also, as indicated in an earlier finding, information sharing between the local authority and Orbit was poor and the relationship, weak. LBB's Senior Housing Allocations Officer had to chase multiple times for a response to a tenancy check for Mary's property, and responses were factual and short. A member of the SAR review panel noted that there used to be a social housing provider forum coordinated by the local authority. These regular meetings and networking opportunities greatly assisted information flow between the two organisations. These had dropped away prior to the beginning of the pandemic in March 2020; however, the local authority intends to reinvigorate this forum as soon as is practicable when social constraints ease.

In terms of highlighting good practice, the staff at Inspire day centre regularly shared important information with other agencies, albeit it through more traditional communication means (predominantly telephone and email). Staff would arrange healthcare appointments, send important information to GP/District Nurses relating to sores management whilst Mary was on site, and help Mary make phone calls to the social care assistant and brokerage manager to resolve issues or new needs.

9.2.2 Theme: Safeguarding Processes

Finding Summary: There was no interagency safeguarding action taken as a result of the open safeguarding enquiry. Colleagues in local authority departments outside of the Adult Social Care team were unaware of, and not involved in, the safeguarding enquiry response. Further, there were multiple isolated incidences of safeguarding practice being inefficient or ineffective across most agencies.

Commentary: Under the Theme: Safeguarding Processes there was evidence of weaknesses in every agency involved in Mary's care during the last nine months of her life:

Avante raised a safeguarding concern with the local authority in late January 2019. As a result, the local authority opened a safeguarding enquiry, met with Mary and decided to keep the enquiry open. As the LBB ASC team undertook the safeguarding enquiry investigation and planning in isolation, no other team within the local authority nor any external agency were aware of the open safeguarding enquiry. This included Avante, who were also unaware that the safeguarding concern they had raised was now an open s42 Safeguarding Enquiry. As previously noted, the lack of multi-agency involvement weakened the safeguarding response and disregarded the Care and Support Statutory Guidance and Bexley's own safeguarding policy.

The LBB ASC social worker contacted Orbit on 21st February 2019 regarding drugs use and over-crowding at Mary's property, and requests to be contacted. An unannounced home visit was made by Orbit that same day: no evidence of drugs was found. Orbit's response time to the concerns raised by LBB's social worker was impressive, with under 5 hours lapsing between the note of the call and the diary entry after the visit, however, the social worker was not contacted back. Similarly, Orbit staff raised their own internal safeguarding concerns in March 2019, but no action was taken, and the local authority were not informed. As part of the review, Orbit acknowledged that they did not follow their local safeguarding procedure in this case and have recommunicated the procedure to all staff.

In April 2019, as part of the safeguarding enquiry response, the social care assistant arranged a joint home visit with Avante to discuss their safeguarding concerns with Mary and to agree actions. However, the approach was managed in isolation by the social care assistant, with no notes or follow up actions shared with either Avante or

Mary. This could not be described as an inter-agency safeguarding process but rather as involving an external agency in one action within a safeguarding enquiry.

Despite Mary being on the GP's Integrated Case Management (ICM) programme in Bexley,[32] there is no evidence that Mary's records were more closely scrutinised, nor that a more proactive healthcare approach was taken. The GP had no record of the open safeguarding and did not proactively communicate with adult social care at any time. Further, there is no evidence that the GP contacted the Oxleas District Nurse team to ask if they had any concerns, as nurses were known to visit Mary frequently for catheter care and UTIs. The GP had multiple missed appointments and failed encounters recorded for Mary but again this did not trigger any special intervention. This is despite knowing that Mary relied significantly on others for her daily needs. Finally, there is no evidence of the GP referring Mary back to the Urology Dept after her last missed appointment in February 2019, again, despite being on the ICM programme. The GPs weak position within a multi-agency response to safeguarding was recognized across the panel as an ongoing concern. This gap is being addressed through the *"System of Systems"* work by the South East London CCG described in 10.2.1 Theme: Information Sharing.

Finally, on 23rd August 2019 Oxleas District Nurses sent a safeguarding concern to the local authority via the Screeners system. The report was received by LBB Triage and forwarded to the team managing the open safeguarding enquiry. Neither LBB Triage nor the Adult Social Care team contacted Oxleas to provide Oxleas with an update on what was happening following their report. Oxleas staff noted that they found this lack of feedback dispiriting, as they never knew if their safeguarding had resulted in action or whether it had been investigated and dismissed. Oxleas representatives on

[32]Integrated Case Management is intended to bring together all partners in health and care support primary care clinicians with patients requiring whole-system support.
National Health Service (undated) *"Delivering the NHS Long Term Plan in Bexley and across South East London"*. [Online] Available at: https://www.bexleyccg.nhs.uk/Downloads/Patient%20Council/Presentations/System%20Reform%20Bexley.pdf (Accessed: 01.02.2021).

the panel noted that the process has vastly improved since August 2019, and that they are now receiving a timely response from the local authority confirming receipt and then shortly there-after a response on what has happened as a result of their report.

9.2.3 Theme: Case Co-Ordination

9.2.3.1 Sub Theme: Failure To Engage A Multi-Agency Approach

Finding Summary: Silo working by the LBB ASC Team led to missed opportunities to engage a multidisciplinary/multi-agency approach and a failure to develop and share risk plans and mitigation actions.

Commentary: Outside of the safeguarding process described in 9.2.2 Theme: Safeguarding Process above, there was a failure to engage a multi-disciplinary approach in the coordination of Mary's case and a failure to develop shared risk assessment and risk mitigation actions in general outside of a safeguarding enquiry.

The Adult Social Care team staff involved with Mary's case fixed their attention on Mary's care package and housing. At no time did they consider making closer connections with the health services supporting Mary as part of their ongoing risk and safeguarding management. The absence of shared risk assessment and a shared perspective on what intervention was therefore needed, led to a failure to explore the legal powers and duties available to all agencies.

9.2.3.2 Sub Theme: Leadership

Finding Summary: The lead practitioner did not take the lead on a coordinated, interagency approach to understanding and meeting Mary's needs nor in responding to the final safeguarding enquiry.

Commentary: The social care assistant was given responsibility and ownership for the management of Mary's safeguarding enquiry because they had built up a relationship with Mary since January 2018. However, the social care assistant did not take a leadership approach to the whole enquiry. Instead, and particularly during the last nine months of Mary's life when the safeguarding enquiry was open, actions were being carried out independently by the occupational therapist, social worker, and social care assistant in a piecemeal approach that chipped away at long-standing, complex issues. The result was a collection of actions towards goals within a Safeguarding Plan. The preferable approach would have seen the whole person, within a strengths-based, outcomes-led (not services-led) approach, described in the Dept of Health and Social Care Handbook (2019)[33]. This finding is related to the supervision findings in 9.3.3 Theme: Supervision and Support and 9.3.4 Theme: Management Oversight and Leadership, which revealed gaps in supervision and management oversight of Mary's case in general, particularly during the safeguarding enquiry process in 2019.

Further, the absence of inter-agency case management beyond the ongoing Support Plan (domiciliary care and Inspire day centre) meant that there was no coordinated approach to understanding the full risk picture and agreeing a shared strategy that could then be monitored by a lead practitioner. It is unclear as to why there was no movement towards a coordinated, shared inter-agency approach to understanding and meeting Mary's needs, as the LBB ASC practitioners involved in the case were well established in the team and knew the services supporting Mary. The social care assistant had met with and spoken to all the care services involved in Mary's care, although noticeably there is no record of any contact with the GP nor with the Oxleas District Nurses at any time. This highlights further the disconnect that weaves throughout this case between Bexley health and social care and is an area that social

[33]Department of Health & Social Care (2019) *"Strengths-based approach: Practice Framework and Practice Handbook"*. [Online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778134/strengths-based-approach-practice-framework-and-handbook.pdf (Accessed: 01.02.2021).

care and health representatives on the panel noted is a focus of continuous improvement across the borough.

Finally, a point which again bridges into supervision gaps but also to the operational disconnect between the LBB ASC and the LBB CSC teams was that the social care assistant did not consider the whole team around an adult as seen in children's services. Again, it is unclear as to why children's services were not proactively made aware of the open safeguarding enquiry. Having more *"eyes on Mary's case"* would have helped in forming a more rounded view of the risks posed to Mary and the relevant response. The disconnect between LBB ASC and LBB CSC was noted by the panel to be a common operational theme, and one that appeared in Bexley's SAR Mr K (2017). This is also a common SAR finding per the recent national SAR review[34], which noted that several SARs noted a disconnect and failure of collaboration between adult social care and children's services in the local authority, with SARs finding that adults and children's social care are "*so institutionally and culturally separate that taking a "think family" approach is not standard*". Again, during the review process, several stakeholders noted that work is underway to bridge operational gaps between LBB ASC and LBB CSC at the local authority to assist in a *"whole family"* approach to safeguarding. This includes joint practice meetings and training.

9.2.3.3 Sub Theme: Use Of Multidisciplinary Meetings And Complex Case Management Frameworks

Finding Summary: The lead practitioner did not build multi-agency case management relationships or employ multi-agency management activities or processes.

[34]Local Government Association (2020) *"Analysis of Safeguarding Adult Reviews April 2017 – March 2019"*. [Online] Available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf (Accessed: 01.02.2021).

Commentary: There was a lack of inter-agency case management in Mary's case prior to the last safeguarding raised in January 2019, a finding which was also found in Bexley's SAR Mr K (2017) and SAR Victoria (2020). This meant that networks and partnerships were not already established and embedded as part of usual case management when the safeguarding enquiry was opened in early 2019. Multiagency complex case and high-risk forums are available in Bexley, and any agency can convene a *"multi agency risk management meeting"*. Such meetings can provide a forum for all agencies involved, and the adult themselves together with their representative, to consider a proportionate response to the risks identified and plan to address these. This did not happen.

This finding relates to the finding that the LBB ASC worked in isolation to manage Mary's case. The behaviour observed in the records aligns with the outdated *"No Secrets"* approach to safeguarding and not one that aligned with the CA2014, with its legal framework obliging local authorities to lead within a multi-agency local adult safeguarding system. The local authority has already planned training and regular practice review meetings to address this.

9.3 Domain C: The Agencies Around The Team – Organisational Behaviour

Organisational behaviour in the agencies involved contributed to the practice observed in both direct work with the individual and in interagency working in 9.1 Domain A: The Adult – Direct Practice with Mary and 9.2 Domain B: The Team Around the Adult – Interagency Working.

9.3.1 Theme: Workload Pressures

Finding Summary: Two of the three practitioners involved in managing the safeguarding enquiry reported workload pressures.

Commentary: The social care assistant and safeguarding adult manager reported that they were under increased pressure with high complex caseloads and duties: the social care assistant noted that there was not enough time to work closely with complex families. The risk of poor decision making, inability to focus on case issues, and incomplete process adherence is high in such circumstances. This also impacted upon the social care assistant's ability to engage in preventive rather than reactive interventions, such as; timely commissioning of care and support, time to read case histories, communications with other agencies, attendance at/setting up multiagency meetings, time to reflect, time to build relationships, and the timeliness and progress of safeguarding actions. This finding is linked to the lack of inter-agency approach discussed above: had the ASC team taken an inter-agency shared approach to safeguarding, workload pressures should ultimately have been reduced through sharing the load, possibly even a resolution of seemingly intractable issues.

The review panel noted that, historically, high social worker caseloads had led to safeguarding enquiries being allocated to social care assistants rather than to social workers supported by a social care assistant. At interview, the social care assistant stated they were managing 40-50 complex cases and were allocated the same kind of cases as social workers except for those with a Court of Protection order. Without close guidance, supervision and support, this practice risks placing unqualified staff in to positions which require an enhanced knowledge and sensitivity to safeguarding law and practice. The safeguarding adult manager and social worker both felt that the social care assistant was capable of leading on the safeguarding enquiry, however the safeguarding practice noted across this case does not evidence this.

The Independent Chair asked the opinion of the authors of the national SAR review on this matter, to which they responded: "*What is necessary is that individual organisations ensure that staff have the appropriate knowledge and expertise to undertake work that is being, or might be assigned to them. There were examples relating to adult social care and primary care where this assurance was not met. Staff*

shortages, and a lack of knowledge and expertise, were findings in some of the SARs included in the national analysis.".

Their response also relates to the gap in supervision findings in 9.3.3 Theme: Supervision and Support and 9.3.4 Theme: Management Oversight and Leadership.

9.3.2 Theme: Staffing

Finding Summary: An unqualified social care practitioner was managing a complex case.

Commentary: The SAR panel agreed that allocating an unqualified social care practitioner a complex case was not in itself an issue, but that this finding is relevant to note combined with a lack of oversight, supervision, planning, quality assurance/competency framework and multi-agency/disciplinary approach which speaks to the potential competency gaps that were not identified, managed or eliminated.

9.3.3 Theme: Supervision And Support

Finding Summary: Supervision and support was irregular, light touch, and not at the level required for a case of this complexity.

Commentary: The social care assistant had three supervision meetings over the nine months that the safeguarding enquiry was open between January and September 2019. Only one case related action was raised over that period: on 04th February 2019, the social care assistant was directed to arrange a joint visit to Mary with Avante and the occupational therapist. This meeting was carried out 12 weeks later at Mary's home on 29th April 2019. There is no mention over this period of the social worker (EO) in the Liquid Logic case notes, and no formal support was provided to the social

care assistant by the social worker (EO) to progress the Safeguarding Plan actions for which they were responsible.

There was a lack of supervisory curiosity, challenge or reflective review of the approach taken over many years to respond to recurring issues in Mary's case. The supervisory relationship is fundamental for the delivery of effective social work services and there is a direct link between the quality of supervision and outcomes for service users. However, the level of supervision afforded to the social care assistant failed to provide a space to explore, reflect upon and find potential solutions to complex issues and there is never any record of consideration of legal/alternative options or escalation.

Staff in LBB ASC team and in LBB Brokerage noted that they were likely desensitised to the risks in Mary's case. The ASC team social worker, social care assistant and safeguarding adult manager also noted that this case was not unique and that they had several live cases which they considered more complex than Mary's. The panel agreed that in complex care cases, the safeguarding adult manager needs to provide a level of challenge to the social worker/allocated case worker. LBB representatives noted that challenge is not currently carried out often enough and is an area of improvement.

Finally, in this case, supervisory lines were fractured and un-necessarily complex which hindered safeguarding adult manager supervision and support in the safeguarding enquiry. The social worker was the EO for the safeguarding enquiry. However, the safeguarding adult manager who signed off on the Safeguarding Plan, was the direct supervisor of the social care assistant but not of the social worker. The social worker reported to a different safeguarding adult manager and had no supervision discussion of this case. The occupational therapist, who was assigned actions in the Safeguarding Plan, reported to an occupational therapist manager. Case related tasks were noted in Liquid Logic by the safeguarding adult manager and the occupational therapist

manager following their separate supervision meetings with the social care assistant and the occupational therapist, but there were no cross-team meetings to discuss this case. This issue has already been identified by LBB Adult Social Care and rectified. Now, the safeguarding adult manager supervisor of the social worker (EO) in a s42 Safeguarding Enquiry signs off on and oversees the safeguarding process in line with the Pan London Safeguarding Procedures[35]

9.3.4 Theme: Management Oversight And Leadership

Finding Summary: Management oversight and leadership was well below the level required for this protracted and complex case.

Commentary: The panel noted that for such a protracted high-risk case, with repeating patterns of the same issues from first recorded safeguarding by LBB social worker in July 2011, the lack of supervisory oversight was *"striking"*. This finding underlies a significant number of the other findings in this section.

A complex case with five previous safeguarding concerns was allocated to social care assistant with no evidence of a competency assessment, additional training, or enhanced/reflective supervision support. The social care assistant continued to lead on the case following the opening of the sixth safeguarding enquiry in 2019. It contained issues that had persisted since the first safeguarding concern in 2011, with concerns of familial neglect featuring prominently in each one.

Building on the finding regarding the lack of supervisory challenge in the previous section, an example of this can be seen in the absence of management oversight in the decision to accept, and continue to accept, Mary's family as an adequate

[35]London Assembly (2019) *"London multi-agency adult safeguarding policy & procedures"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (Accessed: 01.02.2021).

alternative to the formal care package. The safeguarding adult manager and the social worker were not adequately sighted on the situation, and as such there was no assertive leadership instructing the social care assistant to carry out a welfare check on Mary when her carers withdrew in early August 2019. This was particularly concerning given the open safeguarding which relied upon the Support Plan to reduce the risk of neglect.

There is a noticeable gap of 15 days (between 12th August 2019 and 27th August 2019) where there are no entries in Mary's case on Liquid Logic. During the case review, the safeguarding adult manager queried whether the social care assistant had been on annual leave during that period, but they had not. This gap particularly highlighted the lack of proactive follow up at this time, which was possibly due to the lack of risk assessment which was also discussed earlier. The reason given for the gap in proactive follow up was that this case was not considered high risk, as the family had provided care in the past, and that other cases had taken priority.

The first time the social care assistant met with family after the carers withdrew was in reaction to a safeguarding concern raised by Oxleas, and an email from the LBB brokerage manager raising concerns that Mary had not attended the day centre for three weeks. The LBB brokerage manager noted that they knew that Mary was vulnerable, and that the day centre was an important part of Mary's *"Safety Plan"* (which as noted earlier is not documented). This was why the LBB commissioning manager escalated concerns to Bexley's operations manager and to the social care assistant managing Mary's case. The Independent Chair and panel concluded that there was a significant lack of safeguarding action or safety planning over this period.

In terms of the safeguarding enquiry process itself, which commenced in January 2019, adherence to the Bexley's safeguarding process and oversight of the *"Safeguarding Plan"* was inadequate. Detailed evidence to this finding is provided in APPENDIX E, but in summary the findings relate to the weaknesses of the

Safeguarding Plan itself as a blueprint for people to work to, followed by a lack of management oversight and regular monitoring. The local authority's safeguarding process has been enhanced during the review period as this was known to be a recurrent issue. As well as safeguarding adult managers being responsible for the oversight of open safeguarding cases held by their team, there are also now automated system reminders for safeguarding adult managers to follow up on the progress in a safeguarding case after it has been open for three months and then again at six months.

9.3.5 Theme: Lack/Shortage Of Services

Finding Summary: The London-wide issue of housing stock supply was a consistent barrier to progress throughout the full review period of this case.

Commentary: The London-wide issue of limited social housing stock supply was a consistent issue in this case. Mary expressed her desire to move to a two-bedroom bungalow with a live-in carer from 2011 to her death. Mary and Ian attempted many avenues to secure a bungalow. However, in 2015 John, Hayley, and, their three children moved in, with two further older children living in the property on occasion.

From 2015 onwards, Mary's efforts to move were impeded by her concern that by doing so, she would render her grandchildren homeless. Mary sought assurance from professionals that this would not occur, but professionals consistently explained to Mary that there was short housing stock and long waiting lists. Mary was advised that as her house was adapted to her needs, she would not be priority.

This finding evidences the often-hidden effects of the lack of affordable housing in London. Practitioners agreed that although Mary's housing situation did not cause her death, had she attained her desire to move to a two-bedroom bungalow, the risks

relating to her home environment, carers withdrawing, and familial neglect would have been minimised and possibly avoided entirely.

9.3.6 Theme: Organisational Structure

9.3.6.1 Sub Theme: Organisational Practice Silos

Finding Summary: Practice silos were evident across the local authority but were not evident in any other agencies supporting Mary during the review period in relation to responding to Mary's care and support needs.

Commentary: The disconnect between adult social care and children's social care, discussed in 9.3 Domain C: The Agencies Around the Team – Organisational Behaviour and 9.2.3.2 Sub Theme: Leadership, was present throughout the case. LBB ASC did not advise LBB CSC that a safeguarding enquiry had been opened in a household where children are living and were previously subject to Child in Need plans (November 2017 and January 2019). Similarly, further back in time, LBB CSC did not speak to LBB ASC prior to closing a children welfare review case in May 2017. Had they done so, they would have discovered that the day after their visit the care agency (Carewatch) had raised a safeguarding concern including drug usage, unruly dogs and poor home environment.

Additionally, there was poor joined-up working between LBB Housing and the Adult Social Care team, with lengthy periods of time passing with no progress made on Mary being added to Bexley's housing register, despite sporadic emails between the two teams. LBB ASC did not inform LBB Housing or the MeSH team of the open s42 Safeguarding Enquiry, to explore additional avenues to expedite Mary's rehousing request. As a result, Mary's housing request was no further forwards more than eight years after she first shared her wishes as part of the first safeguarding enquiry in 2011.

There was a failure by the Police to *"Think Family"* when drugs were found at property on three occasions in 2012, 2016 and 2019. There were at least four minors living in the property and adults in the house had previous records of drug usage. When drugs were found at the property in 2019, CSC services had no case open at the time, but the ASC Team had an open s42 Safeguarding Enquiry. The completion of a Merlin[36] record for this incident may have assisted in the Adults Social Care team and Children's Social Care team working together to respond to the family's needs (including housing).

In terms of good practice, this was evidenced when the when the OT involved in Mary's case undertook internal enquiries to fund the purchase of a fully adapted caravan for Mary. A fully adapted caravan had been identified, and a discussion was underway with senior LBB executives to approve the purchase in principle before sharing the idea with Mary. The panel noted that this showed initiative and a change in thinking which created a solution to a challenging, seven-year problem.

9.3.6.2 Sub Theme: Information System Structure Silos

Finding Summary: Current LBB internal systems integration is not providing LBB practitioners with the safeguarding information they need in a timely and effective way.

Commentary: During interview, practitioners noted that LBB ASC and LBB CSC cannot see information from the other's section of Liquid Logic. The social care assistant and safeguarding adult manager did note that cross team communication has improved, thanks in part to a change in team structure where safeguarding adult managers supervise staff in both LBB CSC and LBB ASC. The social worker (EO) noted that the

36Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason.
"Merlin (database)" (2017) Wikipedia. [Online] Available at: https://en.wikipedia.org/wiki/Merlin_(database) (Accessed: 01.02.2021).

safeguarding forms now also include a question about children being involved which prompts LBB ASC to *"Think Family"*.

Also, during the interview process, LBB Housing team staff shared that their principal information management system (Civica) did not pull information from/link through to the principal case management system for LBB's social care teams (Liquid Logic). In practice this meant that staff in the housing team needed to open Liquid Logic separately to read case notes. This therefore required the housing officer to actively seek information which they had identified that they need and relied heavily on the officer to identify an information gap – such as whether there is an open safeguarding enquiry – and to investigate further. In a high demand environment, this proactivity did not occur in Mary's case. Therefore, none of the housing professionals were aware of Mary's open safeguarding enquiry. To what extent this would have assisted in Mary's rehousing application is not clear, but the senior housing allocation officer involved advised that had they known, they would have prioritised the case, going on to say *"We need to be more cohesive, we have different jobs but at the end of day there's an individual sitting waiting for something to happen."*.

9.3.7 Theme: Organisational Systems

9.3.7.1 Sub Theme: Policies And Procedures

Finding Summary: LBB Brokerage commissioning processes could be improved to escalate gaps in care packages to management and Oxleas safeguarding process could be improved by adding a step to follow up where there has been no response to a safeguarding concern raised. Organisational policies and procedures across other LBB departments and external agencies involved were mostly effective. Minor adjustments, in the spirit of continuous improvement, would improve future safeguarding practice across Bexley.

Commentary: Significant time passed before the gap in Mary's domiciliary care came to the attention of the LBB brokerage manager, and when it did, it was from an external source (Inspire). There was no increased priority status applied to covering Mary's home care package by either LBB Brokerage or by the social care assistant lead, despite the open safeguarding enquiry. Whilst this should have been picked up, and regularly followed up, by the social worker (EO)/social care assistant when reviewing the Safeguarding Plan or the Risk Assessment following the break-down of the care package, it would have been helpful for LBB Brokerage to also apply a priority status to the case and for the LBB Brokerage team to escalate concerns to management after a prolonged care gap.

Also, in relation to LBB Brokerage, it would be helpful to review the authority's commissioning contracts to include a notice period and/or commitment to a collaborative effort to work on an interim solution. This may have led to the agreement for two carers to attend on the mornings that Mary went to the day centre to preserve that element of Mary's care package. In Mary's case, Avante were able to immediately withdraw over the weekend, which meant that by the time the LBB brokerage manager was able to respond to the withdrawal on the Monday morning, the decision by the care agency had been made to fully withdraw.

Finally, in relation to LBB Brokerage, there was no contingency plan for when/if Avante withdrew. It was recorded on Liquid Logic in January 2019, when Avante raised a safeguarding concern, that the social care assistant had informed LBB Triage that Avante were the last care agency option for Mary. Liquid Logic notes written by Triage in January noted that Avante had further stated "*Avante do not want to pull out of this package of care but need Social Services help to maintain* [Mary] *safely at home urgently*". Further, between July 2011 and January 2019, there were nine incidences of a care provider withdrawing their services having previously raised safeguarding concerns. In future, LBB Brokerage could stay ahead of the curve for similar incidences with a contingency plan. This would also be useful for LBB OoH response teams where incidents occur in complex cases outside of normal working hours.

In relation to LBB ASC, there was a missed opportunity to speak to John to challenge his recurrent disruptive behaviour as part of investigation into safeguarding concern raised by Avante. It was alleged that John had intentionally damaged Mary's care equipment by cutting the hydraulics in her bed. We don't know the reason for this action, or indeed whether he had damaged the bed; however, the outcome was a cost to the local authority to repair. John's behaviour at the home continued to cause issues with Mary's home care providers, but there is no record of the local authority sharing their concerns with him about the detrimental effect his actions were having on Mary's home care package. This finding relates to the family involvement finding in 9.1.2.3 Sub Theme: Working with Families and Significant Others.

Oxleas District Nurses followed their Safeguarding Policy, which is based on the Pan London Safeguarding Procedures[37], when they sent their safeguarding concern to the local authority via Screeners on 23rd August 2019. The current procedure does not indicate the need to follow up. However, Oxleas representatives acknowledge the important principles of safeguarding within the CA2014 relating to the need for each professional and organisation to do *everything they can to ensure that adults at risk are protected from abuse, harm and neglect*. Oxleas have therefore, as a result of the findings of this SAR, undertaken to update the policy to include a follow up process if there is no response from the local authority within 48 hours of the safeguarding being raised.

Also in relation to Oxleas, from the start of 2019 (8 months) there are 17 notes of *"blocked catheter"* on Mary's Rio health records and at least two bladder wash outs. There is no evidence that health practitioners sought to identify and minimise the root cause of these frequent call outs. During the review process, The Head of Nursing at

[37]London Assembly (2019) *"London multi-agency adult safeguarding policy & procedures"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (Accessed: 01.02.2021).

Oxleas who presented to the panel helpfully separated this out in to two learnings; (1) that practice would be improved by a process where-by multiple call outs for catheter issues triggers a multi-disciplinary team meeting to review possible root causes and preventative action which could reduce the prevalence of issues that require call outs, and (2) where a patient who has MS is having recurring catheter issues, Oxleas nurses should involve an MS specialist nurse is consulted to make sure that medication is correct, and that the medication will minimise the risk of bladder issues.

The Oxleas District Nurse team acknowledged within their own reflective practice review following Mary's death that nurses should have taken Mary's temperature or carried out a urine test at one of the three visits made to Mary when a UTI was suspected. They noted that a raised temperature is an early indicator of sepsis and of escalating UTI, and that this would have assisted in earlier identification and response. This finding reflects a similar finding in Royal Greenwich Safeguarding Adult Board's SAR Mr F (2020) whose cause of death was Pyelonephritis associated with ascending Urinary Tract Infection. Mr F was an adult with Spina Bifida and Hydrocephalus, with an indwelling catheter.

Finally, following the safeguarding concern raised by Oxleas district nurses on 23rd August 2019, the family called the nursing team on 27th August 2019 with concerns that Mary's urine was purple. Whilst it was acknowledged by the panel that the safeguarding had not been responded to by the local authority at that time, a safeguarding concern was live to Oxleas and in line with the CA2014, the nurses had a duty to keep Mary safe. In response to the call, the Oxleas District Nurse advised to increase fluids and to monitor, no home visit was arranged. This process was reviewed in detail during the review, including with Oxleas' Head of Nursing and the Head of Safeguarding at a panel meeting. The summary finding was that the current system is sufficient but that Oxleas should undertake to follow up on and maintain professional curiosity about the outcome of a safeguarding concern raised. In this case, that would have included following up on the status of the safeguarding concern raised and the prioritisation of a home visit where there is a live safeguarding concern. Future

enhancements to Connect Care have occurred since August 2019, including the capacity to show if there are safeguarding adult concerns on the Connect Care Dashboard which is due to go live in January 2021.

Further evidence of ineffective policy and procedures, which may be a case of staff oversight or omission in current documents, were identified in LBB Stores; LBB Housing; LBB Out of Hours Social Care and Orbit. Details of these findings are provided under Theme: Organisational Systems in APPENDIX E.

9.3.8 Theme: Record Keeping

Finding Summary: There were instances of poor record keeping at LBB which hindered safeguarding management.

Commentary: In August 2019, at least four significant events were not recorded on Liquid Logic: These included; two Safeguarding concerns raised by Inspire relating to Mary's continued non-attendance at the day centre; a request from Mary for a personal shopper which she said was for *"when the money comes in"*; and, additional Home Care time. Only the second safeguarding concern raised by Inspire was shared via email to the social care assistant, the social worker (EO) and the safeguarding adult manager were not included on the email recipient list.

In multiple cases, Liquid Logic notes were added up to a week after activities had taken place. This included the last home visit to Mary by the social care assistant and occupational therapist on 28th August 2019, which was input on the evening of 04th September 2019, later in the day on which Mary died.

Some key safeguarding related meetings during the final Key Practice Episode – such as the Safeguarding meeting with Mary in January 2019 to discuss the safeguarding

concern raised by Avante, and an email from the social worker (and social worker (EO) for the s42 Safeguarding Enquiry) in February 2019 to Orbit to raise safeguarding concerns– were not recorded on Liquid Logic.

Further, as in most organisations, descriptions of conversations between colleagues over filing cabinets and common areas were mentioned during interviews, but corresponding records of conversations were missing in the case files. It is certain that there was more inter-departmental communication about Mary's case than the records show. However, whilst collegial conversations are undoubtedly helpful, these are a poor substitute to a well-managed multi-disciplinary/multi-agency meeting with clearly recorded discussions, actions and a follow up plan in a complex case such as Mary's.

9.4 Domain D: SAB Governance

9.4.1 Theme: Policy And Procedures

Finding Summary: There was no evidence of Police contact with the local authority to ascertain if there was an open safeguarding enquiry prior to recording the case as non-suspicious.

Commentary: Whilst this finding did not affect the outcome of the case, it is important to include as it may be an indication of weak communication channels between the Police and Adult Social Care and/or indicate that checking for an *"open safeguarding"* is not an important consideration when Police attend an unexpected death. As is known, Mary had a long history of safeguarding concerns and neglect, and the local authority had a s42 Safeguarding Enquiry open at the time of her death. Professionals supporting Mary had also suspected that she was a victim of domestic abuse, however, this was not shared outside of the local authority.

During this review, the Police were unable to provide records of a process undertaken to rule out Mary's death as suspicious, such as a Sudden Death/Unexpected Death process that the officers completed (eg: *"ABC – Assume nothing; Believe nobody; Challenge everything!"*[38]).

9.4.2 Theme: SAR Process

Finding Summary: The consistency of attendance by the SAR Panel members and their commitment to the meetings was exemplary. The process greatly benefitted from the same people attending each month and feeding into the process in-between meetings. In terms of the paperwork: IMR authors in the SAR process grappled with the IMR process and the quality of some IMRs suffered as a result.

Commentary: The consistency of the SAR Panel members throughout meant that discussions were meaningful and in-depth, with each meeting building upon the last. Given that the meetings all took place during the Covid-19 pandemic and various levels of lockdown, this was particularly remarkable.

Whilst there was strong co-operation from most agencies involved in the SAR process, co-operation with the SAR was difficult to obtain from Orbit, with an IMR/one year chronology and 12 documents being sent through to the SAB in late November and early December. The documents contained unique and important insights, particularly in relation to potential over-crowding and two safeguarding related enquiries in early 2019. Further, whilst client-facing representatives from LBB Housing engaged in the process, there was no senior LBB Housing representation on the SAR panel throughout the process, nor any engagement in discussing the findings and developing the recommendations. The issue of housing was a consistent thread throughout Mary's case, and insights and learning may have been missed as a result.

[38]College of Policing (2019) *"Practice advice: Dealing with sudden unexpected death"*. [Online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/922344/Dealing_with_sudden_unexpected_death.pdf (Accessed: 01.02.2021).

No IMRs were completed fully in line with the Care and Support Statutory Guidance. Important information was missing and discovered through reading all case notes or during interviews. Practitioners who authored IMRs had been directly involved in supporting Mary, chronologies were missed, and many were submitted late.

The panel considered the IMR process an area of continuous improvement, and as part of the review requested that the IMR form be revisited by the SAR sub-group in 2021. Training is planned for 03rd March 2021 to cover IMRs which are in line with the six safeguarding principles. Further, thanks to case management system updates, IMR authors can reflect the six safeguarding principles from their system to assist in writing IMRs. As is evident, work is underway to make the process as simple, efficient and effective as possible.

9.4.3 Theme: Bexley SAB's Role In Improving Practice

9.4.3.1 Sub Theme: Training And Awareness Raising

Finding Summary: Practitioners would benefit from reminders of existing or the development of new training.

Commentary: Practitioner knowledge gaps found during the review are dotted throughout the narrative above. There were no gaps identified for which there was no current available training, but it was recognised that some areas of training would benefit from a refresh – such as training relating to the Mental Capacity Act 2005[39] to include the potential effect of coercive control to present as an *"unwise decision"* or to affect someone's ability to make *"wise choices"*. There was also a gap in awareness of LBB expectations on reporting crime, so a recommunication of this expectation within

[39]*Mental Capacity Act 2005 c9* [Online] Available at: https://www.legislation.gov.uk/ukpga/2005/9 (Accessed: 01.02.2021).

all statutory and commissioned agencies across the borough would help remind people.

There is a significant amount of training now available or planned that speaks to the noticeable knowledge gaps found during this SAR review. This includes training on; the application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, Identification of and response to self-neglect and hoarding, and multiple domestic abuse training sessions run by Bexley's Domestic Abuse Partnership. There is also training planned by Oxleas in relation to catheter care and insights into Purple Urine Syndrome.

Finally, Oxleas are jointly working on with Lewisham & Greenwich NHS Trust, Lewisham CCG, Greenwich CCG and Bexley CCG to reduce Gram-negative bloodstream infections which play a major role in causing sepsis. This project is being supported by the Health Innovation Network, and as the enhanced sentinel surveillance programme shows that the most common source of infection is the urogenital tract, their focus has been on reducing and effectively treating urinary tract infections, with a particular focus on reducing indwelling long-term urinary catheters. With the benefit of hindsight, Mary was at high risk of sepsis given the combination of circumstances towards the end of her life. Nationally, sepsis is the most common cause of death recorded by the Coroner in SARs[40].

Further, a discussion with the founder and Executive Clinical Director of the UK Sepsis Trust, Dr Ron Daniels[41] revealed that with more care occurring in people's homes, the risk of sepsis is even higher and prevention and earliest identification by health

[40]Local Government Association (2020) *"Analysis of Safeguarding Adult Reviews April 2017 – March 2019"*. [Online] Available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf (Accessed: 01.02.2021).

[41]Lord, L. (2020) Telephone call to Dr Ron Daniels (CEO of UK Sepsis Trust, Executive Board member of Global Sepsis Alliance, Clinical Adviser (Sepsis) to World Health Organisation and Senior Lecturer at Queen Mary University, London), 19th November.

practitioners is crucial. Therefore, it would be prudent to revisit Sepsis Awareness training, across the borough.

10. RECOMMENDATIONS

Arising from the analysis undertaken within this review, the SAR Panel and Independent Chair recommend that the following actions are undertaken.

The name of the agency/ies to which the recommendation is directed is provided in the left-hand column. The recommendation details are contained within the middle column, and the suggested lead organisation, responsible for oversight and delivery, is in the final column on the right-hand side of the page. Agencies and organisations can use the search function to locate instances of their organisation's name.

Findings and related recommendations are provided together under each Domain, Theme and Sub Theme in APPENDIX E, which was the version developed with the panel as part of the SAR review.

10.1 Domain A: The Adult – Direct Practice With Mary

10.1.1 Theme: Recognising And Responding To Specific Forms Of Abuse And Neglect

10.1.1.1 Sub Theme: Domestic Abuse

Finding Summary: Domestic abuse of adults with care and support needs was under-recognised and under-reported. No agency completed a DASH risk assessment or discussed concerns with a domestic abuse specialist. Practitioners lacked an understanding of the nature and forms of domestic abuse.

Relevant Agencies	Recommendations	Lead Organisation
ALL	BSAB to be assured that examples of domestic abuse features in all member's safeguarding training, to ensure that staff can recognise and appropriately respond to domestic abuse.	BSAB

Relevant Agencies	Recommendations	Lead Organisation
	BSAB to be assured that all its member and commissioned agency staff complete domestic abuse training, to an appropriate level and complete refresher training on a rolling basis.	
	BSAB representatives support LBB's Domestic Abuse Champion programme.	
	Ensure all LBB staff allocated complex and/or open safeguarding enquiries have the appropriate level of domestic abuse training.	LBB ASC LBB CSC
	LBB to circulate regular briefings on good practice regarding all forms of abuse, particularly those highlighted by the CA2014 within adult safeguarding, such as domestic abuse.	LBB
	CCG to task all health agencies to undertake an audit of non-attendance in patient records and update relevant procedures to consider non-attendance as a sign of domestic abuse, including actions to take if signs are evident. Follow up to confirm completion within given timeframe.	CCG

10.1.1.2 Sub Theme: Self-Neglect – Hoarding

Finding Summary: Mary's home was cluttered with evidence of hoarding. No investigation or assessment was undertaken to determine whether any form of abuse was taking place.

Relevant Agencies	Recommendations	Lead Organisation
Avante LBB ASC Orbit Oxleas Family	Audit and Training: BSAB to be assured that all agencies will fully engage in partnership working to achieve the best outcome for people who hoard or self-neglect.	BSAB

10.1.2 Theme: Assessing And Meeting Needs

10.1.2.1 Sub Theme: Safeguarding Action – Referral And Response

Finding Summary: Agencies followed safeguarding referral processes. However, the local authority safeguarding enquiry case leads in this case did not consistently take a person-centred approach nor always follow Making Safeguarding Personal principles.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to seek assurance and measurable evidence (eg: training/increased supervision) from Social Care teams of practitioners' knowledge, skills and confidence in leading safeguarding enquiries, and of their understanding on the CA2014 and the six *"Making Safeguarding Personal"* principles.	LBB
Oxleas	Oxleas to run a report and dip test cases where a safeguarding concern has been raised to be assured that safeguarding conversations are happening between nurses, and that actions taken/planned to keep the subject safe are being recorded in progress notes.	Oxleas
	LBB to be assured that its process for responding to safeguarding concerns is helping to build stronger safeguarding connections and relationships between agencies.	LBB
BSAB	To be assured that all agencies consider all environmental factors and seasonal factors, including extreme weather conditions, in risk assessments, safety planning and safeguarding responses.	BSAB

10.1.2.2 Sub Theme: Risk Awareness And Assessment

Finding Summary: The risk assessment completed by the local authority as part of the s42 Safeguarding Enquiry open from the end of January 2019 was inadequate, and not reviewed or revised at any point during the eight months that it was open.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LLB to update Safeguarding Planning form to require Enquiry Officer to record Specific, Measurable, Action-oriented, Realistic and Timebound objectives and to be clear on the desired outcomes and how these will safeguard against abuse or neglect. The Plan should also be clear on the need to be regularly reviewed and revisited whenever there is a change in the adult's circumstances, including their Support Plan.	LBB

10.1.2.3 Sub Theme: Working With Families And Significant Others

Finding Summary: The CA2014 is clear on the need to safeguard carers. Family was abandoned to care for Mary whilst LBB worked to fill gap in care package.

Relevant Agencies	Recommendations	Lead Organisation
BSAB CCG Shield	Consider extending *"Think Family"* training across the borough with Health (GPs, District Nurses) Housing, Care Agencies, Police and Adults and Children's Social Care.	BSAB CCG Shield
Avante Care Agencies	Encourage carers to involve families in the safe delivery of their service whilst ensuring that the individual remains at the centre of their efforts.	Avante Care Agencies
LBB ASC	LBB reviews it processes relating to families providing interim support for adults with high care and support needs to ensure process is clear and sign off is provided at safeguarding adult manager level or higher. This is similar to the *"Duty of Care to Carers"* recommendation in SAR Paul (2019); safeguarding should consider the whole family. Training should provide examples in practice. At each stage, the local authority should be providing oversight and guidance.	LBB ASC

10.1.2.4 Sub Theme: Responding To Characteristics Of The Individual

Finding Summary: Mary had MS and her health was noted by health professionals to be deteriorating. She required additional support to complete forms, write letters/emails or to make/take phone calls. She could not rely on her family for this

support. No support was given by the local authority to source or signpost support when this need was expressed by Mary and Inspire.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to reinforce options available to LBB ASC team to commission external support for clients to complete processes to access statutory benefits or housing and/or to manage debt. Possibly an *"Appointee"* service.	LBB ASC
	LBB ASC to map what community based/charitable services are available locally to provide an Appointee type service and communicate internally. For example, DWP provide home visits to assist with form completion.	
	Review options available to social workers to provide vulnerable clients with their own personal means to make a phone call and ensure social workers/social care assistants are aware of these.	
	BSAB to consider a joint letter from the National Network for SAB Chairs to the Secretary of State for Work and Pensions, to request improvements in PIP claim process, using evidence from recent SAR findings.	BSAB

10.1.3 Theme: Making Safeguarding Personal – Finding The Person

10.1.3.1 Sub Theme: Reluctance To Engage

Finding Summary: LBB ASC team practitioners failed to make safeguarding personal (Empowerment): choice was not given, instead response was assumed.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	Ensure practice is clear that all safeguarding options are explored with the subject of a safeguarding concern whenever there is a choice to be made and be assured that practitioners document asking and the client's response each time a choice is made.	LBB ASC
Oxleas	Ensure practice is clear that whenever there is a choice to be made in relation to a client's health and/or care needs and be assured that practitioners record asking and the client's response each time a choice is made.	Oxleas

10.1.4 Theme: Practitioner Attributes

10.1.4.1 Sub Theme: Legal Literacy

Finding Summary: Agencies supporting Mary with her housing did not evidence knowledge or use of legal powers and duties in relation to over-crowding.

Relevant Agencies	Recommendations	Lead Organisation
LBB Housing MeSH	Ensure LBB Housing team are clear on their options when they suspect that a property is over-crowded/unfit for habitation or for which they have environmental concerns. Recommend creation of a tool to assist the team in assessing overcrowding.	LBB Housing
Orbit	Orbit to provide BSAB with assurance that it is undertaking tenancy checks when over-crowding is suspected or recorded, and that it is meeting its statutory duties in line with the Homes Act (2018) and Housing Act (1985) in relation to over-crowding.	Orbit

10.1.4.2 Sub Theme: Attention To Mental Capacity

Finding Summary: Respecting Mary's decision-making rights where she was assumed to have mental capacity discouraged the caseworker from engaging Mary in dialogue about the consequences of what practitioners consistently described as unwise decisions.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	Detail on the recommendation relating to this finding on Mental Capacity is located in 10.4 Domain D: SAB Governance. The intended outcome of this recommendation is that training leads to improved use of mental capacity assessments, by LBB staff, which includes consideration of domestic abuse/coercive control on decision making (similar recommendation to SAR Paul (2019)).	-

10.2 Domain B: The Team Around The Adult – Interagency Working

10.2.1 Theme: Information Sharing

10.2.1.1 Sub Theme: Record Sharing

Finding Summary: Different recording systems and levels of access impeded interagency communication and information flow.

Relevant Agencies	Recommendations	Lead Organisation
LBB Oxleas GP DGT LGT	Review efforts by CCG and local authority (possibly within Joint Health and Wellbeing Strategy) to help health, care and support agencies to be joined up with each other and other health related services (per the Care and Support Statutory Guidance).	BSAB
	Review progress of systems integration/read across (Bexley Connect Care and Coordinate my Care. Seek assurance that policies and procedures are up to date, staff are being supported to adopt new systems/processes, supervisors are encouraging good practice, training is being offered and taken up by staff and audit/spot checks are happening to help embed new practices. This is part of Bexley's *"System of Systems"* Endorsed by South East London CCG on 20th July 2020 and/or Our Healthier South East London Recovery Plan[42] and approved at the South East London CCG Board meeting of 05th November 2020[43].	

10.2.1.2 Sub Theme: Information Flow

Finding Summary: Interagency information flow was inconsistent where flow required practitioners to take proactive action.

[42]National Health Service (2020) *"Our Healthier South East London Recovery Plan - Working together to improve the health and wellbeing of our neighbourhoods and communities"*. [Online] Available at: https://www.ourhealthiersel.nhs.uk/2020%20Publications/SEL-Recovery-Plan-October-2020.pdf (Accessed: 01.02.2021).

[43]National Health Service (2020) *"Bexley Borough Based Board in Public"*. [Online] Available at: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjkvK72ruXuAhU3ahUIHedsBc0QFjAAegQIARAC&url=https%3A%2F%2Fselondonccg.nhs.uk%2Fwp-content%2Fplugins%2Fdownload-attachments%2Fincludes%2Fdownload.php%3Fid%3D4614&usg=AOvVaw085Z7llo6TuvKNFwc02UD6 (Accessed: 01.02.2021)

Relevant Agencies	Recommendations	Lead Organisation
Oxleas GP	Co-develop a standard form for District Nurses to add to client health records that GPs can access, in partnership Oxleas/GP representative.	Oxleas GP
CCG	CCG consider creating a task and finish group to build upon care home NHS multi-disciplinary team model to deliver comprehensive health and social care in the community in partnership with LBB.	CCG
Orbit	Orbit to develop agreed protocols and Service Level Agreements with all Bexley Social Housing providers relating to working together effectively.	Orbit
	Orbit to ensure named Safeguarding lead at Orbit is known to Adult Social Care team and dedicated safeguarding email address supplied for safeguarding concerns.	
LBB	LBB to consider reviving Bexley's Housing Provider Forums to improve communication and assist all members in their continuous improvement processes.	LBB
Oxleas LBB RR LBB Brokerage	BSAB to note panel exploration of an alternative emergency care option in this case: Oxleas have a nursing service to provide emergency care at home. The panel considered whether this service could have been explored for Mary whilst a new care agency was secured. This option was discounted as an option by the panel in this case as the service was not considered suitable and risked creating a precedence of nurses providing home care.	BSAB

10.2.2 Theme: Safeguarding Processes

Finding Summary: There was no interagency safeguarding action taken as a result of the open safeguarding enquiry because no agency external to LBB ASC team was aware of the open safeguarding or involved in the safeguarding plan. Internal council departments were also unaware and were not involved. Further, there were multiple isolated incidences of safeguarding practice being inefficient or ineffective across most agencies.

Relevant Agencies	Recommendations	Lead Organisation
Avante LBB ASC	The recommendation relating to working together/effective co-planning – in response to the lack of an interagency developed safeguarding plan or risk assessment - is provided in 10.2.3 Theme: Case Co-ordination.	-
	LBB to be assured that safeguarding concerns are acted upon within 48 hours and that referrers are updated on action taken because of their referral.	LBB
LBB ASC	LBB to consider updating process to oblige LBB Adult Social Care to contact any organisation raising a safeguarding concern, to encourage multi-agency working and strengthen communication channels, even if no action is planned in response.	LBB
CCG	CCG to oversee the development of a standard borough-wide process for following up on failed encounters. Ensure that the process includes consideration of the patient's personal circumstances (Making Safeguarding Personal) (eg: checking if on ICM programme/evidence of domestic abuse/recent mental capacity assessment/reliance on others to attend) and a duty to inform the local authority when failed encounter levels raise concerns. This is similar to the earlier recommendation for CCG under s9.1.1.1 (Domestic Abuse).	CCG
	Improve communication with other services supporting ICM patients and ensure important information (such as missed appointments) is shared.	
	Develop a process for ICM cases that captures a new safeguarding enquiry and ensures it is discussed at the next Local Care Network (LCN) meeting, with input invited from the social worker supporting the client.	
Bexley Care	Ensure distribution of information on how to refer cases into Bexley's LCN meetings across all social care and health networks, including domiciliary care and care homes.	Bexley Care
LBB ASC	LBB Triage/Screeners to review process on when to add a safeguarding concern to an existing safeguarding enquiry.	LBB Triage
LAS	Ensure staff know how to raise safeguarding concerns via Screeners.	LAS
Orbit	Provide BSAB with current safeguarding policy and provide assurance that staff understand and consistently follow policy.	Orbit

Relevant Agencies	Recommendations	Lead Organisation
	Build relationships with key departments within Bexley council to enhance multi-agency safeguarding.	
Oxleas	Where a safeguarding concern exists, including concerns relating to family input into the care, Oxleas process to ensure that the family/carer has called GP when advised to do so.	Oxleas
	Oxleas to mirror safeguarding process for children: when safeguarding raised, to ensure see and speak to client on their own.	

10.2.3 Theme: Case Co-Ordination

10.2.3.1 Sub Theme: Failure To Engage A Multi-Agency Approach

Finding Summary: Silo working by the LBB ASC Team led to missed opportunities to engage a multidisciplinary/multi-agency approach and a failure to develop and share risk plans and mitigation actions.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to be assured that safeguarding adult managers are ensuring that case workers consider multi-agency approaches in their case management. This includes community/non-commissioned/non-statutory services (such as charities).	LBB
	LBB to ensure Adults Social Care staff, including social workers, social worker (EO)s, and safeguarding adult managers, are confident and supported at a senior level to call multi-disciplinary team meetings to manage complex cases.	

10.2.3.2 Sub Theme: Leadership

Finding Summary: The lead practitioner did not lead on a coordinated, interagency approach to understanding and meeting Mary's needs.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	Recommendations relating to safeguarding adult manager and supervision support are covered in this document in the 10.3 Domain C: The Agencies Around the Team – Organisational Behaviour.	-

10.2.3.3 Sub Theme: Use Of Multidisciplinary Meetings And Complex Case Management Frameworks

Finding Summary: The lead practitioner did not build multi-agency case management relationships or employ multi-agency management activities or processes.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	SAB to seek assurance of use of frameworks for complex case management[44] by LBB's Adult Social Care teams.	BSAB
LBB ASC	LBB to ensure practitioners are capable of using LBB's complex case management tools and are encouraged to hold and attend colleagues' complex case management meetings.	LBB ASC

10.3 Domain C: The Agencies Around The Team – Organisational Behaviour

Organisational behaviour in the agencies involved contributed to the practice observed in both direct work with the individual and in interagency working in 10.1 Domain A: The Adult – Direct Practice with Mary and 10.2 Domain B: The Team Around the Adult – Interagency Working.

[44]The complex case management framework seeks to deliver a flexible and holistic, multi-agency response for vulnerable adults who have identified multiple needs, whose planned outcomes are not being achieved despite the best efforts of the inter-agency core group and for whom risks are increasing.

10.3.1 Theme: Workload Pressures

Finding Summary: Two of the three practitioner involved in managing the Safeguarding Enquiry reported workload pressures.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB reviews safeguarding processes with staff to make them as user friendly as possible. Review use of automated processes wherever possible, such as automated diarised follow ups for a Safeguarding Plan review, or where a client is without a service in their Support Plan.	LBB
	LBB ensures that safeguarding adult managers have adequate time within their workplans to give additional complex case support along with regular supervision to staff working on complex cases, to reflect on their role, review seemingly intractable issues in cases and apply a wider lens on all their work.	
	LBB social workers/social care assistants encouraged to express when they feel they have unsafe caseloads and to work with management to find solutions to address.	

10.3.2 Theme: Staffing

Finding Summary: An unqualified social care practitioner was managing a complex case. The SAR panel agreed that was not necessarily an issue, but that this finding combined with a lack of oversight, supervision, planning, quality assurance/competency framework and multi-agency/disciplinary approach, this finding is relevant.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to be assured that all complex case workers are adequately trained and that regular reviews are completed to monitor staff competence.	LBB

10.3.3 Theme: Supervision And Support

Finding Summary: Supervision and support was irregular, light touch, and not at the level required for a case of this complexity.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to review the case allocation process to include a formal competency assurance framework that reflects case complexity, including appropriate levels of management support, reflective supervision and training for staff.	LBB
	LBB to develop and make available resources which assist supervisors with reflective supervision with their staff. Managers at all levels to promote a *"learning culture"* with an ethos in which reflective practice and self-questioning are accepted and actively promoted. Research in Practice have recently developed a new resource on reflective supervision[45], which builds on their earlier resource from 2017.	
	Audit of cases with open adult safeguarding enquiries to ensure social workers are active in their management and that safeguarding policies and procedures are being followed.	
	LBB Supervisors are reminded to be alert to desensitisation. Inclusion of risk of desensitisation in relevant LBB procedure(s), with checklist of indicators to assist managers in early identification and response.	
	Review LBB's Clinical Supervision process and dip test sample of Adult Social Care team/anonymous staff survey to consider efficacy.	

10.3.4 Theme: Management Oversight And Leadership

Finding Summary: Management oversight and leadership was well below the level required for this protracted and complex case.

[45]Department for Education (2020) *"PSDP - Resources and Tools: Using the supervision relationship to promote reflection"*. [Online] Available at: https://practice-supervisors.rip.org.uk/wp-content/uploads/2020/01/KB-Using-the-supervision-relationship-to-promote-reflection.pdf (Accessed: 01.02.2021).

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB to explore/develop means to escalate cases where protracted high risk exists involving a capacity vulnerable adult – possible use of case examples in practice development forums.	LBB
	BSAB to seek assurance on the consideration and use of multi-agency involvement in all complex cases open to Adult Social Care, regardless of whether they are being progressed under s42 of the CA2014.	BSAB
	LBB ASC to seek assurance that safeguarding adult managers are considering need for a multi-agency meeting in every new safeguarding enquiry, and documenting decision.	LBB ASC
	Review current Safeguarding Enquiry Flowchart within Pan London Safeguarding Procedures[46] and revise locally to include need to complete risk assessments and to develop and action interim safeguarding plans which are Specific, Measurable, Action-oriented, Realistic and Time-bound (SMART).	BSAB
	LBB ASC to be assured of clarity of expectations within local Safeguarding Process/Forms for social workers (EO), safeguarding adult managers and any other staff with allocated responsibilities.	LBB ASC
	Provide training for safeguarding adult managers to complement the revised Safeguarding Process.	LBB
	Automated system reminder to review open safeguarding at least every three months.	Completed

10.3.5 Theme: Lack/Shortage Of Services

Finding Summary: The London-wide issue of housing stock supply was a consistent barrier to progress throughout the full review period of this case.

[46]London Assembly (2019) *"London multi-agency adult safeguarding policy & procedures"*. [Online] Available at: https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (Accessed: 01.02.2021).

Relevant Agencies	Recommendations	Lead Organisation
LBB Housing	BSAB to note hidden effects of housing shortages in London within this case: this case featured the hidden homelessness of a young family of two adults and five children in Bexley, and of a mother/grandmother being unable to move for fear of making her family homeless.	BSAB

10.3.6 Theme: Organisational Structure

10.3.6.1 Sub Theme: Organisational Practice Silos

Finding Summary: The disconnect between LBB ASC and LBB CSC, evidenced in previous Bexley SARs and a common national feature, was present throughout the case. Additionally, there was poor joined-up working between LBB Housing and the Adult Social Care team, with lengthy periods of time passing with no progress made on Mary being added to Bexley's housing register. There was however good practice in terms of seeking cross-organisational support when the LBB OT involved in Mary's case undertook internal enquiries to fund the purchase of a fully adapted caravan for Mary. A fully adapted caravan had been identified and a discussion was underway with senior LBB executives to approve the purchase in principle prior to sharing the idea with Mary. The panel noted that this showed initiative and a change in thinking which created a solution to a seemingly intractable, seven-year problem.

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC LBB CSC	LBB to consider joint training/practice *"Think Family"* sessions sharing good practice for LBB ASC and LBB CSC staff.	LBB
	Review LBB's Social Care teams cross referral process for safeguarding. Consider Liquid Logic notification process that pre-populates key information to be shared.	
	BSAB to be assured that LBB CSC policy is to check in with LBB ASC re: any current concerns relating to adults living in the same property prior to closing a case.	BSAB

Mary

Relevant Agencies	Recommendations	Lead Organisation
LBB ASC	LBB Senior Managers to encourage telephone and face to face communication between Adult Social Care and Housing, to consider *"task and finish"* type meetings, to progress long standing safeguarding/Support Plan issues tied to housing.	LBB
Police	Recommunicate need across Police Force to *"Think Family"* during a drugs raid at a property, and to follow due process in relation to reporting children present (eg: completion of a 101 book or a Merlin Pack).	Police

10.3.6.2 Sub Theme: Information System Structure Silos

Finding Summary: Current LBB internal systems integration is not providing staff with the safeguarding information they need in a timely and effective way.

Relevant Agencies	Recommendations	Lead Organisation
LBB Housing LBB ASC LBB MeSH	LBB to ensure all LBB IT systems show where a person is subject to a safeguarding enquiry.	LBB
	Ensure key safeguarding information is easy for council staff to access in their daily role.	

10.3.7 Theme: Organisational Systems

10.3.7.1 Sub Theme: Policies And Procedures

Finding Summary: Organisational policies and procedures across the agencies involved were mostly effective. Minor adjustments, in the spirit of continuous improvement, would improve future safeguarding practice across Bexley. Whilst no policy or procedure gap significantly affected the case outcome, their combined detrimental effect did have a noticeable impact.

Relevant Agencies	Recommendations	Lead Organisation
LBB Brokerage	LBB Brokerage to develop and apply escalation procedure for unfilled care packages: including, daily safeguarding adult manager, social worker (EO), and Brokerage management update of any unfilled care packages where there is an open safeguarding.	LBB Brokerage
	LBB Brokerage to consider legal support to add a notice period for care provider contracts reflecting provider and local authority statutory obligations under s18-20 of the CA2014.	
	LBB Brokerage to audit current cases to identify residents with an open safeguarding enquiry whose Support Plan is at risk of breaking down. Adult Social Care to then work with these residents to agree a Safety Plan/Contingency Plan should usual care arrangements fail with support from LBB Brokerage.	
	Develop a Risk Assessment report/process that can be run to complete the above records check on a regular basis.	
	Consider system automated flag on case file when high numbers of providers have withdrawn from providing support to a client, to highlight cases that need additional attention and/or a different approach.	
	Development of a de-escalation process for agencies in crisis, and early identification and formal response to cases where agencies are at risk of withdrawing.	
LBB ASC	LBB to develop and communicate a clear procedure relating to the *"intentional"* damage of council property whilst in a private dwelling for staff to follow.	LBB
LBB Stores	Review LBB Equipment Stores booking in process and ensure policy includes not loaning out equipment that is not part of stores inventory.	LBB Stores
	Ensure policy includes process for investigating source of unknown equipment and signing in to stores.	
	Ensure staff understand and follow stock management policies.	
LBB Housing	LBB Housing to ensure LBB ASC and Housing teams are clear on options available to expedite/treat differently/provide specialist support for Housing applications in situations such as Mary's. (eg: discussing with Housing IDVA).	LBB Housing

Relevant Agencies	Recommendations	Lead Organisation
	LBB Housing should input a definition for *"Case Closed"* into LBB Glossary of Terms (underway in Bexley per action noted in SAR Mrs A (2018)). Within LBB Housing the term *"Case Closed"* means *"inactive awaiting action from outside of LBB Housing".*	
	Representatives from Housing and Adult Social Care develop a checklist for housing to complete when working with LBB ASC on housing allocations for vulnerable clients.	LBB Housing LBB ASC
LBB Housing LBB MeSH	LBB Housing/MeSH team to ensure process following formal MeSH OT review includes updating Social Care lead on next steps/process and likely timeframes.	LBB Housing
LBB OoH	LBB to be assured that LBB OoH social worker/RR check for open safeguarding enquiry when responding to a case development, to ensure any decision made is informed as possible, and that senior management are involved or informed where necessary.	LBB
LBB ASC LBB CSC	Local authority develops and embeds a process for social care workers to notify the Coroner as soon as they are aware that a client has died when there is an open safeguarding enquiry.	LBB
	Local authority provides South London Coroner's office with Single Point of Contact for enquiries.	
Orbit	Finding: Orbit's safeguarding process was not followed on two occasions in early 2019 when Mary's last safeguarding enquiry was open as she was at risk of eviction. Recommendations relating to this finding are covered in 10.2 Domain B: The Team Around the Adult – Interagency Working.	Orbit
	Orbit to review tenant contact policy to ensure process is Equality Act (2010) compliant and does not disadvantage people with protected characteristics.	
Oxleas	Oxleas to work with the local authority to develop and agree a simple follow up process to help progress safeguarding concerns raised, and encourage professional knowledge sharing across the health and social care to improve safeguarding practice. Once agreed, Oxleas safeguarding policy will be updated accordingly.	Oxleas
	Oxleas to consider a system to centrally capture the number and status of safeguarding concerns raised by Oxleas to the local authority for measurement and evaluation.	

Relevant Agencies	Recommendations	Lead Organisation
	Oxleas district nurse team to consider developing a process where-by multiple call outs for catheter issues triggers a multi-disciplinary team meeting to review possible root causes and preventative action which could reduce the prevalence of issues that require a call out.	
	Where a patient who has MS is having recurring catheter issues, Oxleas to ensure that an MS specialist nurse is consulted to make sure that medication is correct, and that the medication will minimise the risk of bladder issues.	
	Oxleas district nurse teams ensure vital signs are recorded, in particular temperature, and report to GP if outside usual parameters when attending patients with a suspected urinary tract infection.	
	Oxleas to consider prioritisation of home visits where there is a safeguarding concern, including where a nurse has raised a concern and is awaiting a response from the local authority.	

10.3.8 Theme: Record Keeping

Finding Summary: There were instances of poor record keeping at LBB which hindered safeguarding management.

Relevant Agencies	Recommendations	Lead Organisation
LBB Brokerage	Ensure LBB teams is clear about requirement to record all case relevant information on Liquid Logic.	LBB
LBB ASC	LBB to recirculate the policy on the maximum number of days within which notes are to be added to Liquid Logic.	LBB
	(as above) Ensure LBB teams are clear about requirement to record all case relevant information on Liquid Logic.	
	Supervisors/Managers to oversee/regularly spot check and remind staff of the need to input all case relevant information on to Liquid Logic in a timely manner.	LBB

10.4 Domain D: SAB Governance

10.4.1 Theme: Policy And Procedures

Finding Summary: There was no evidence of Police contact with the local authority to ascertain if there was an open safeguarding enquiry prior to recording the case as non-suspicious.

Relevant Agencies	Recommendations	Lead Organisation
BSAB	BSAB to be assured that when attending an unexpected death, Police procedures are to contact the local authority to ascertain if there is an open Safeguarding/any concerns of neglect/abuse prior to recording a case as non-suspicious. This assists in ensuring that the Coroner does not close the case prior to the local authority's decision to commission a SAR/DHR.	BSAB
	BSAB to be provided with Police force policy and/or procedure to provide clarity on the usage of body worn camera when attending an unexpected death.	Police

10.4.2 Theme: SAR Process

Finding Summary: The consistency of attendance by the SAR Panel members and their commitment to the meetings was exemplary. The process greatly benefitted from the same people attending each month and feeding into the process in-between meetings. In terms of the paperwork: IMR Authors in the SAR process grappled with the IMR process and the quality of some IMRs suffered as a result.

Relevant Agencies	Recommendations	Lead Organisation
BSAB	Review measures available to the SAB for, seeking compliance with s45 of the CA2014, where an organisation fails to fulfil their statutory duty to provide information.	BSAB
	SAB to revisit the IMR form and completion process with the SAR sub-group and GPs representative.	
	SAB to be assured that all IMR Authors understand the information and process required to complete the form.	

Relevant Agencies	Recommendations	Lead Organisation
	SAB to be assured that managers signing off on IMRs have a checklist of what a good IMR looks like, including SMART recommendations.	
	SAB to consider offering a pre-IMR briefing so that IMR Authors understand the methodology and what organisational involvement is expected.	

10.4.3 Theme: Bexley SAB's Role In Improving Practice

10.4.3.1 Sub Theme: Training And Awareness Raising

Finding Summary: Practitioners would benefit from reminders of existing or the development of new training in relation to:

- Mental Capacity, and its value in opening alternative lines of professional responsibility and options. The panel noted that a lot more work is needed to go through some of the nuanced arrangements around mental capacity assessment, such as the effects of coercive control.
- Sepsis Awareness, with the benefit of hindsight, given the combination of circumstances towards the end of her life Mary was at high risk of Sepsis. Nationally, Sepsis is the most common cause of death recorded by the Coroner in SARs, and therefore it would be prudent to revisit Sepsis Awareness training across the borough.

Relevant Agencies	Recommendations	Lead Organisation
BSAB	BSAB to provide Mental Capacity Training to include training in relation to when and how to consider Inherent Jurisdiction.	BSAB
	BSAB to be assured that training provided covers the need to consider Mental Capacity in cases where coercive control is recognised or suspected.[47]	

[47]Coercive Control (present in most domestic abuse cases) is considered to hinder a person's ability to make *"wise choices"*. Footnote continues on the next page.

Relevant Agencies	Recommendations	Lead Organisation
	Bexley Health and Wellbeing Board to progress training and awareness programme on Sepsis.	CCG
	BSAB to ensure details of Bexley's principal social worker(s) are available on LBB intranet, clear on LBB organisation charts/phone listing, and available externally on-line where the role can have the most impact and profile[48].	BSAB
	BSAB to commission a borough-wide communication on the need to report crime, in partnership with Police. The aim of the campaign is to educate all statutory and statutory commissioned agencies on how to report crime and options relating to witness safety and anonymity.	

10.4.3.2 Sub Theme: Embedding Learning From Previous SAR Findings

Finding Summary: There are findings which have been raised in previous SARs in Bexley including cross-team working/preventing silos (SAR Mrs BA (2019), SAR Mrs A (2018) and SAR Mr K (2017)); attention to mental capacity (SAR Paul (2019) and SAR Mr K (2017)), the effects of coercive control on decision making (SAR Paul (2017)); and lack of inter-agency case management (SAR Victoria (2020) and SAR Mr K (2017).

Enfield Safeguarding Adults Board (2019) *"Enfield SAB thematic safeguarding adults review: Summary report domestic abuse and adults at risk"*. [Online] Available at: https://mylife.enfield.gov.uk/media/24948/hhasc667-domestic-abuse-and-adults-at-risk-2019.pdf (Accessed: 01.02.2021).
Research in Practice (2019) *"Safety Matters: Practitioners' Handbook Developing practice in safeguarding adults"*. [Online] Available at: https://www.researchinpractice.org.uk/media/3686/ripfahandbook_safetymatters_revised_third_edition_apr2019-update_web-1.pdf (Accessed: 01.02.2021).
Research in Practice (2016) *"Supporting people with social care needs who are experiencing coercive control. Guidance sheet two: Mental capacity and coercion – what does the law say?"*. [Online] Available at: https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance_sheet_two_Mental_capacity_and_coercion.pdf (Accessed: 01.02.2021).
Local Government Association (2015) *"Adult safeguarding and domestic abuse: A guide to support practitioners and managers"*. [Online] Available at: https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf (Accessed: 01.02.2021).
Per s1.28 - Department of Health & Social Care (2020) *"Statutory guidance: Care and support statutory guidance"*. [Online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance (Accessed: 01.02.2021).

Relevant Agencies	Recommendations	Lead Organisation
BSAB	Seek assurances that actions planned in response to findings from previous SARs are taking place, with the desired effect(s).	BSAB

11. REVISITING THE TERMS OF REFERENCE

Section 7 of the Terms of Reference (APPENDIX B) outlines seven specific issues to be addressed in this SAR. These elements are covered within the report under the relevant Domains and are summarised here as a conclusion to the overview report.

11.1 Specific Issues To Be Addressed

11.1.1 Risk Management

11.1.1.1 What Was The Post Incident Response And Was It Adequate?

The post incident response was inadequate in the following areas in date order:

September 2019: The Coroner was unaware of the open safeguarding enquiry. The panel discussed this information sharing gap and the principle social worker recommended that the safeguarding adult manager over-seeing a s42 Safeguarding Enquiry, ensures that the local Coroner is notified of the open safeguarding. This will ensure that the Coroner/their staff are aware of the open safeguarding when making investigation, post-mortem and inquest decisions.

September/October 2019: There is no record of CSC considering the welfare of the children living at the deceased property following Mary's death. The CSC team were alerted of Mary's death in September 2019 and were notified of the SAR and their required input in February 2020. A record check by CSC would have highlighted that all the children in the house were previously subject of a *"Child in Need"* plan in Bexley in 2017, providing reasonable cause to undertake further enquiries to decide whether to take any action to safeguard or promote the children's welfare.

February 2020: On the 22nd February 2020, the Police attended an incident where Mary's son is recorded as having used *"reasonable force"* on his daughter (17). The daughter is shown on police records as a victim of cruelty/neglect. No Merlin entry

was made. The report was shared with LBB's Children Social Care team (via direct contact – ie: not through a Merlin report).

February 2020: In relation to the above incident, CSC's IMR notes that a Police report was received in February 2020. The police concluded no further action and did not complete a Merlin record. No social care support was deemed necessary. There is no record of the process leading to CSC's decision not to undertake a welfare check, nor of the Police's contact in Liquid Logic records.

February 2020: There is no record that the Police considered criminal negligence prior to a conversation with Bexley Safeguarding Adult's Board, after the second panel meeting.

August 2020: During the SAR panel meeting of 04th August 2020, the SAR Independent Chair and many of the safeguarding professionals present raised concerns about the welfare of the children living at the deceased's property. At least three professionals suggested a welfare check to the CSC representative on the panel. The Children's Multi-Agency Safeguarding Hub representative was also present. In order to act, the LBB CSC representative required evidence to be supplied via email to the CSC admin email address prior to acting. I was particularly concerned that the welfare check recommendations made by several senior safeguarding representatives from across Bexley was not sufficient for the representative to act. Section 47 of the Children Act 1989[49] states that a local authority has a duty to *"make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare"* when there is *"reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm"*. Such enquiries, supported by other organisations and agencies, as appropriate, should be initiated where there are

[49]*Children Act 1989 c41* [Online] Available at: https://www.legislation.gov.uk/ukpga/1989/41 (Accessed: 01.02.2021).

concerns about all forms of abuse or neglect. The concerns raised by the SAR panel members should have been sufficient to create *"reasonable cause"* to trigger further enquiries. The case was referred to the Multi-Agency Safeguarding Hub on 7th August by Bexley Safeguarding Adult Board's Practice Review & Learning Manager.

11.1.1.2 Any Deficits In Risk Assessment, Care, Recording, And Ward Handovers?

The deficit in risk management is a key learning in this SAR. The Safeguarding Plan was to do more of the same that ASC had been doing since 2011, and to *"continue to monitor the situation"*. Detailed findings relating to the weakness of the Safeguarding Plan are provided in; 9.1.2.2 Sub Theme: Risk Awareness and Assessment, 9.2.2 Theme: Safeguarding Processes, 9.3.4 Theme: Management Oversight and Leadership, and in APPENDIX E under Domain C: Theme: Management Oversight and Leadership. The Safeguarding Plan was signed off by the safeguarding adult manager. Its three main weaknesses were: 1) That it had been created in complete isolation within the ASC team, with no input from either an inter-disciplinary team within LBB (eg: Brokerage/Housing/domestic abuse) nor an external agency (eg: Avante, inspire, Oxleas, GP); 2) that the plan was made up of piecemeal actions, undertaken by the occupational therapist and the social care assistant with no *"big picture"* thinking or formal meetings to reconsider the plan; and, 3) that there was no review of the plan, even when Mary's domiciliary care package fell away in August 2019 (when London was experiencing record high temperatures - up to 33°C in late August) and Mary was living in what was considered an over-crowded, dirty house with a primary carer who was due to give birth within days.

There were deficits in case note recording. In August 2019, at least four significant events were not recorded on Liquid Logic: These included; two Safeguarding concerns raised by Inspire relating to Mary's continued non-attendance at the day centre; a request from Mary for a personal shopper which she said was for *"when the money comes in"*; and, additional Home Care time. Only the second safeguarding concern

raised by Inspire was shared via email to the social care assistant, the social worker (EO) and the safeguarding adult manager were not included on the email recipient list.

Liquid Logic notes were added up to a week after activities occurred, such as the last home visit to Mary by the social care assistant and occupational therapist on 28th August 19 before Mary's death. This entry was input on to Liquid Logic, after Mary's death, on the evening of 04th September 2019.

Important safeguarding related meetings, such as the safeguarding meeting with Mary in January 2019 to discuss the safeguarding concern and an email from the social worker to Orbit Housing to raise concerns, were not recorded on Liquid Logic.

Further, as in most organisations, descriptions of conversations between colleagues over filing cabinets and common areas were mentioned, but corresponding records of conversations were missing in the case files. It is certain that there was more inter-departmental communication about Mary's case than the records show. However, whilst collegial conversations are undoubtedly helpful, these are a poor substitute to a well-managed multi-disciplinary/multi-agency meeting with clearly recorded discussions, actions and a follow up plan in a complex case such as Mary's.

The potential lack of ward handovers was discussed at length with Oxleas during the findings analysis of a panel meeting: A safeguarding concern was raised by the district nurse attending to Mary on 23rd August 2019 who noted *"Mary in bed, no bedding and Mary's clothes soaked in urine."* Four days later (on 28th August 19) another nurse visited Mary and again noted that she was laying on a wet pad and wet bedsheets. The nurse didn't ask Mary is she had recently had clean bedclothes, so we don't know if Mary had been laying on urine-soaked bedsheets for many days.

In the visit notes on 23rd August 2019, Mary told the nurse that she was *"embarrassed with her son providing personal care"* and she stated that she had *"a sore bottom"*. During the second visit on 28th August 2019 Mary declined for district nurse to check her pressure areas. Mary's son, John, was present in the room when Mary declined to be checked. There was no record of Mary previously declining personal care or being checked. Therefore, what had changed over the five days? Was Mary declining because of John's presence? She wasn't asked. The panel reflected that this was a missed opportunity, and that Mary should have been seen on her own, and sensitively asked about her well-being in relation to concerns raised by the previous nurse to ensure continued safety.

Finally, the nurse on the second visit offered to wash Mary. A member of Mary's family (not Mary) declined the nurses' offer. The outside temperature had reached 28°C in Bexley that day, and temperatures had ranged between 28°C and 33°C between the two visits. there is no indication that Mary was asked directly if she'd like to be cleaned.

After a long discussion, the panel felt that handovers were adequate but that the recommendation should be that nurses follow up with a safeguarding enquiry if they haven't heard back within two days.

Finally, in terms of care, the family noted that they were *"very happy"* with the care Mary received. At times they felt the carers were difficult or dis-respectful to the family, but the care almost always ranged between good to excellent. I saw no evidence to the contrary in the records. In fact, I found all care agencies to be particularly responsive to safeguarding concerns. Whilst the panel avoided the word *"threshold"*, carers appeared to have the correct tolerance level of Mary's environment prior to raising a concern. Mary's health and well-being remained front and centre in the service that they provided.

11.1.1.3 Safeguarding Concerns Raised?

There were multiple safeguarding concerns raised throughout the SAR review period (01st July 2011 to 30th September 2019). Over 90% were raised by care agencies going into Mary's home. Five of the safeguarding concerns raised were progressed to enquiry in January 2012, February 2015, October 2015, November 2017 and January 2019. Mary engaged with the November 2017 safeguarding enquiry at first, opening up about her experiences at home and asking to be rehoused. However, at the following meeting she asked for it to be closed. In the last three safeguarding enquiries raised prior to January 2019; Mary either requested for the enquiry to end, whilst knowing the negative impact her family are having on her life, or denied that the family were having a negative impact. Even with the last one safeguarding enquiry raised in January 2019, Mary was very reluctant to leave the family or for the family to leave her, without the assurance that they would both get appropriate accommodation. She asked the social care assistant and social worker to help with this outcome.

11.1.1.4 Working In Partnership?

There was scant evidence of working in partnership at a meaningful level. There were certainly some good relationships between the agencies involved in Mary's care, but none would achieve the description of a partnership approach. Had there been regular working in partnership on Mary's case, the natural movement would likely have been towards a multi-agency meeting when the safeguarding was raised by Avante in January 2019. Good working partnerships were evident between Avante and the social care assistant; Inspire and the brokerage manager and the social care assistant; and Oxleas and the GP. Partnership working was not evident between the social care assistant and the Oxleas District Nurse team nor the occupational therapist and the District Nurse team. This was particularly apparent in the last two weeks of Mary's life: The social care assistant did not follow up on the safeguarding concern raised by Oxleas district nurses on 23rd August 2019; three further contacts with Mary (2 visits, one phone-call) by the district nurses were not shared with the social care assistant; and a visit by the social care assistant and occupational therapist on 28th August 2019,

where the occupational therapist noted that the air smelt of infection, which was not shared with the district nurses.

11.1.1.5 Evidence Of Making Safeguarding Personal?

In terms of Making Safeguarding Personal, the evidence sought was of a person-centred approach that includes proactive rather than reactive engagement and of a detailed exploration of a person's wishes, feelings, needs and desired outcomes. It involves "*concerned and authoritative curiosity*" characterised by gentle persistence and skilled questioning. What might lie behind a refusal to engage is a key line of enquiry, such as coercive control underlying frequent *"unwise decisions"*.

There was some evidence of Making Safeguarding Personal but it was infrequent and inconsistent, even by the same workers. For example, members of the Adult Social Care team frequently met with Mary at Inspire to ensure she could express her views without any duress from family. However, in April 2019, the social care assistant arranged a meeting with Avante at Mary's home to discuss the open safeguarding raised by Avante in January. Concerns stemmed from the family's negative impact on Mary's safety and well-being by living with her. Mary's daughter-in-law was at home at the time.

During the interview process, I was made aware of the efforts of the occupational therapist, social care assistant and the Head of Service to purchase an adapted caravan for Mary near her son, Ian. This would have enabled Mary to live independently with a care package, close to her son. This option was not discussed with Mary in case it was not approved. This showed real initiative and reflected a prevention strategy in line with Making Safeguarding Personal principles. It was, however, a rare demonstration of preventative action in any of the agencies involved.

The records regularly mentioned *"unwise decisions"* by Mary: the words *"unwise decision"* featured seven times in the ASC IMR. However, the records did not consistently show evidence of informed consent, where Mary had been advised of the potential outcomes of her decision. There was also evidence of Mary not being asked at all, with a decision being made for her based on her previous responses. An example of this is that no-one offered Mary respite when her care package fell through: it was assumed that she would turn it down as she had previously done in January 2018 when her care providers withdrew. The occupational therapist also noted that when she and the social care assistant visited Mary on 28th August, they didn't offer to call the ambulance as they assumed that Mary would not want to go to hospital. These two assumptions were made in the final four weeks of Mary's life. Similarly, the Oxleas District Nurse attending on 28th August 19 did not explain the possible outcome of not tending to Mary's personal needs during their visit – exploring perhaps how long Mary had been sitting on a wet pad, and when her last wash was.

Regarding proportionality, there was no evidence of professionals being intrusive during a safeguarding. However, there was evidence of professionals being absent or less involved in the case when it required more, such as the period following Avante's home care service withdrawal in early August 2019. There was also evidence of Mary being supported during a safeguarding review and her wishes being explored and respected – for example in closing the safeguarding enquiries raised in February 2015, October 2015 and November 2017.

There were efforts to support Mary to report any abuse (Protection). However, her behaviour indicates that she did not sufficiently trust the system to achieve the best outcome for her. For example, in November 2017, Carewatch reported that Mary had disclosed significant neglect and abuse at home to her carer. This was raised as a safeguarding enquiry, and a meeting was set up with Mary at Inspire at the day centre around 10 days later. Mary did not agree with the magnitude of the concerns raised by Carewatch and asked for the safeguarding enquiry to be closed. She asked only to

be supported to move to smaller accommodation with a live-in carer, which she had been requesting since 2012. Whenever safeguarding concerns were raised, Mary would make this request. However, there is no record of professionals *"digging deeper"* into why Mary wanted to move away, and it was assumed by ASC staff that she was *"being a mother"* rather than any kind of coercive control or threat of harm at home.

In terms of accountability, the records evidence that Mary understood the role of everyone involved in her life and so did they. There was transparency throughout.

11.1.2 Information Sharing And Confidentiality

There was no evidence that information was not securely sent and stored by practitioners in this case, and the SAR panel were extremely careful when sharing information, using only secure Egress email services. The Independent Chair has only saved documentation on to a password locked USB. Information has only been used for the SAR process and only an anonymised Executive Summary report will be published due to surviving family.

11.1.3 Previous Safeguarding Adult Reviews

There is a significant number of common themes shared with previous SARs held by BSAB. This has been provided in table format to this report as APPENDIX G.

Common themes reoccurring include:

- Agency response to and engagement with the SAR process, including IMR forms (SAR N and Mrs AB);
- Cross-team working/preventing silos (SAR Mrs BA, SAR Mrs A and SAR Mr K);

- The effects of coercive control on decision making; (SAR Paul); and,
- Attention to mental capacity (SAR Paul and SAR Mr K).

11.1.4 Particular Issues Relating To Ethnicity, Disability, Sexual Orientation Or Faith

Mary was a White British female, who died at home on 4th September 2019 at the age of 63. Neither her sexual orientation nor faith were disclosed. Mary used a wheelchair which she could steer with difficulty using the small amount of movement in her left hand. She had no use of her lower limbs or her right arm. LBB records noted that Mary may have come from a travelling community, following a conversation with the occupational therapist in 2018. However, Mary's son, Ian stated that this was not the case.

There were indications of racial profiling in a couple of instances from LBB ASC staff: Some practitioners related their perception of a travelling family to Mary's unwise decision making, suggesting that perhaps the unwise decisions were partly rooted in a strong sense of family and the men (in this case Mary's sons) being head of the family and in an authority position sufficient to dominate Mary.

11.1.5 Known Research That May Contribute To The Learning

Known research relating to this SAR has been referenced throughout this report when mentioned. Reference sources are also listed in the Bibliography for ease of access.

11.1.6 Participation Of The Family

Mary's family were identified and contacted, despite initial difficulties in contacting the family as they had been rehoused by Bexley local authority. A letter of Invitation to be involved in an Independent Safeguarding Adults Review was sent, and a meeting took place (via video conference) in November 2020 with Mary's son, Ian. At the

meeting, the Independent Chair explained the purpose of the SAR; how it will be conducted and how he may be involved. During the meeting, he agreed to the review taking place and he was consulted on the contents of this report.

As part of this review process, the family also requested the following lines of enquiry/actions were undertaken on their behalf:

1. For the Independent Chair to share with the SAR panel that carers should be mindful that they are going into someone else's home environment, and for LBB to encourage this through the *"Involvement of families"* in the BSAB strategy.
2. That Oxleas provide the family with a written response on what was the possible or likely cause of Mary's purple urine in late August 2019.
3. For the family to receive an update regarding what happened after he and Mary raised a safeguarding concern when Mary's finger was broken by a staff member of London Hire in 2018. The Independent Chair progressed these actions in the November panel meeting and assurances will be sought that these actions have been completed as part of the SAR review process.

These requests have been shared at two panel meetings and were taken for action by senior representatives from the organisations concerned.

12. GLOSSARY

Athlone .....Athlone Care Agency

ASC.....Adult Social Care

Avante.....Avante Care Services

Aquaflow.....Aquaflow

BSAB.....Bexley Safeguarding Adults Board

Bexley Care ....Bexley Care

BITU .....Bexley Integrated Transport Unit

Carewatch.....Carewatch Home Care Services

CCG .....Clinical Commissioning Group

CSC.....Children's Social Care

DASH.....Domestic Abuse, Stalking and Honour

DGT .....Dartford and Gravesham NHS Trust

DWP.....Department for Work and Pensions

EDT.....Emergency Duty Team

EC.....Eleanor Care

EO.....Enquiry Officer

GP.....General Practitioner

HSC.....Haven Social Care

ICM .....Integrated Case Management

Inspire.....Inspire Day Centre

IMR .....Individual Management Reports

KSCP.....Kent Social Care Professionals

LAS .....London Ambulance Service

LCN.....Local Care Network

LBB.....London Borough of Bexley

London Hire ...London Hire Ltd

LGT.....Lewisham and Greenwich NHS Trust

MARAC.....Multi-Agency Risk Assessment Conference

MeSH .....Metro-wide Engagement for Shelter and Housing

MPS.....Metropolitan Police Service

NHS .....National Health Service

OoH.....Out of Hours

OT.....Occupational Therapist

PCTDC .....PCT Diamond Care

RR.....Rapid Response

SAB.....Safeguarding Adult Board

SAR.....Safeguarding Adults Review

SAM .....Safeguarding Adults Manager

SCA.....Social Care Assistant

SW.....Social Worker

13. INDEX OF RECOMMENDATIONS BY AGENCY

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15. APPENDIX A

15.1 Participants In The Review

Participant	Role	Organisation
Angela Johnson	Head of Home Care	Avante Community Support
Eileen McBride	Mental Capacity Act/Deprivation of Liberty Safeguards Lead	Dartford and Gravesham NHS Trust
Karen Upton	Clinical Lead	Bexley Clinical Commissioning Group
Clare Hunter	Designated Nurse for Safeguarding	
Anita Eader	Practice Review & Learning Manager	Bexley Safeguarding Adults Board
Alexandra Gregory	BSAB Coordinator	
Amanda Gillard	Practice Review & Learning Manager	Bexley Safeguarding Children's Board
Deborah Taylor	Centre Manager	Inspire Community Trust
Kadiatu Fofanah	Adult Safeguarding Advisor	Lewisham & Greenwich NHS Trust
Bonny Waterman	Interim Operational Manager	LBB, Adult Social Care
Malcolm Bainsfair	Head of Safeguarding Adults/Principal Social Worker	
Carol Parrott	Interim Adult Social Care and Commissioning Manager	LBB, Brokerage
Corne Van Staden	Services Manager	LBB, Children's Social Care
Deborah Simpson	Domestic Abuse and Sexual Violence Strategy Manager	LBB, Communities
No Representative	-	LBB Housing Services
Sgt Trevor Walton	Safeguarding Lead	The Metropolitan Police Service
Philippa Uren	Designate Nurse for Adult Safeguarding	South East London CCG (Bexley Borough)
Stacy Washington	Head of Safeguarding Adults & Prevent	Oxleas NHS Foundation Trust
Lucy Lord	Independent Chair and SAR Report author	

Individual Conversations: Held with the following practitioners after Mary's family. Individuals are listed below, in alphabetical order based on the organisation they represented.

Participant	Role	Organisation
Ian	Mary's son	Mary's Family
Angela Johnson	Head of Home Care	Avante Community Support
Dawn Dwyer	Branch Manager	
Deborah Taylor	Centre Manager	Inspire Community Trust
Harriet Green	Senior Day Service Officer	
Linda Nadal	Senior Day Service Officer	
Janet Gould	Safeguarding Adult Manager	LBB, Adult Social Care
Teame Ateweberhan	Social Worker	
Jackie Arslan	Social Care Assistant	
Fiona McMullen	Occupational Therapist	
Carol Miles	Senior Occupational Therapist	
Carol Parrott	Interim Adult Social Care and Commissioning Manager	LBB, Brokerage
Corne Van Staden	Services Manager	LBB, Children's Social Care
Patience Idowu	Service Manager MASH, OOH and NRPF	LBB, Children's Social Care
Debee Simpson	Domestic Abuse & Sexual Violence Strategy Manager	LBB, Corporate/cross organisational
Tracey Marling	Senior Allocations Officer	LBB, Housing
Paul Hickford	Manager	LBB, Homelessness Prevention and Advice Service
Sally Daniels-Browne	Housing Officer	
Trude Shaw	Head of Service	LBB, Social Care & Integrated Rehabilitation
Melanie Shaw	Team Leader	Oxleas District Nurse Team
Foluke Ajakiye	Nurse	
Abi Amorighoye	Nurse	
Evelyn Djedji	Nurse	
Nikeru Egege	Nurse	

Jumoke Ibidapo	Nurse	
Joyce Martins	Nurse	
Lisa Middleton	Nurse	
Joy Oghagbon	Nurse	
Linda Orrin	Nurse	
Stacy Washington	Head of Safeguarding Adults & Prevent	Oxleas NHS Foundation Trust

Other Practitioners, Organisations and Researchers that contributed to the SAR Review are, in alphabetical order:

- Lesley Brooker, Resource Officer, Croydon Coroner's Office.
- The British Association of Social Workers in relation to the interpretation of paragraphs 14.81 and 14.82 of the Care and Support Statutory Guidance, and the level of social worker input and supervision in cases where abuse or neglect is suspected.
- Dr Ron Daniels BEM, CEO of UK Sepsis Trust, Executive Board- Global Sepsis Alliance, Clinical Adviser (Sepsis) to WHO and Senior Lecturer- Queen Mary's, London.
- Detective Superintendent Jim Foley Safeguarding lead, SE BCU (Lewisham, Greenwich and Bexley).
- The National SAR Analysis 2020 team (Suzy Braye, Michael Preston-Shoot, Anusree Biswas, Lisa Smith and Dr Adi Cooper) in response to a question relating to case allocation at December 2020 launch event.
- Jane Wells, Director of Nursing, Oxleas NHS Foundation Trust.

16. APPENDIX B

16.1 Terms Of Reference

Safeguarding Adults Review – M (Mary)

1. Background & Context:

This is a very sad case where a woman, to be known as Mary, in her early 60s died in September 2019 whilst in the receipt of care services.

Mary was 63, whose main medical issues were Diabetes and Multiple Sclerosis, had unexpectedly died at home on 04/09/2019.

Original cause of death:

1a sepsis

1b bronchopneumonia and pyelonephritis

1c multiple sclerosis and diabetes mellitus

Mary's son and his family lived in Mary's three-bedroom house which was adapted to meet her mobility and care needs. His partner was her main carer. Family's support for Mary was in addition to the formal care that was put in place by Bexley Council to meet her care needs. Mary's family assisted her with financial management, food preparation and other daily living activities when formal carers were not there.

There was a well-established domestic violence and neglect history in the family, including allegations of financial, physical and psychological abuse of Mary by her son. There was a high turnover of the care agencies that provided Mary with care. On many occasions, they complained about members of Mary's family lifestyles and threatened to withdraw their services and many did. Providers' concerns included

neglect of Mary's nutritional needs by family, alleged strong smell of drugs in the property and unhygienic environment that threatened carer's well-being.

Bexley workers, especially her allocated social care assistant and the OT, have always been involved and worked to find solutions to the complex dynamics in the family.

At the time of her death, Mary did not have a care provider as care agencies refused to take the care package and she was being cared for by family.

This SAR referral has been made because the unexpected death happened in these circumstances and whilst the S42 was still open.

We have not informed the family of this Review but will seek further information from the SAR Panel Members before approaching.

2. Meeting the BSAB duty to conduct a Safeguarding Adults Review:

2.1 The BSAB will take the lead for conducting a SAR when:

- An adult at risk dies and abuse or neglect is known or suspected to be a factor in their death
- An adult at risk has sustained any of the following: a life-threatening injury through abuse or neglect; serious sexual abuse; serious or permanent impairment of development through abuse or neglect

OR

- Where there are multiple victims
- Where the abuse occurred in an institutional setting
- A culture of abuse was identified as a factor in the Enquiry

AND

- The case has given rise to concerns about the way in which local professionals and services worked together to protect and safeguard the adult at risk

The Purpose of a SAR:

In accordance to the Care Act 2014, and the associated statutory guidance, the purpose of this SAR is to:

a) establish lessons to be learned from the case of Mary, in terms of how professionals and organisations worked, both individually and together, to safeguard the adult at risk and prevent harm

b) b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems

c) c) deploy a mechanism for the BSAB to apply lessons learned to service responses for adults at risk across Bexley and to share these lessons at a national level

3. SAR Management:

3. 1 The BSAB was notified of this death on the 26th January 2020 by Social Worker, Teame Ateweberhan, who no longer works for Bexley. The date of death is recorded as 4th September 2019.

The formal notification was discussed at the SAR Sub Group which convened on the 28th January 2020; and a recommendation was made by partners to the Independent Chair, Eleanor Brazil, that this case met the requirements for a SAR. Eleanor agreed the recommendation and wrote to statutory partners and agencies known at the time of death informing them a SAR Review would commence for this case in order to capture the learning.

The 1st SAR Review Meeting is being held on the 9th June 2020, chaired by Lucy Lord, Independent Reviewer. Agencies have been asked to come prepared to talk about their involvement with the victim and/or family so that the scope of the Review can be determined.

Anita Eader, BSAB Practice Review & Learning Manager and Alexandra Gregory, BSAB Coordinator, should be the Review points of contact through bsab@bexley.gov.uk email. The BSAB also uses an electronic Case Review system, and agencies may receive links for forms to be submitted electronically; note: this is a secure system and only the named individuals can access the link.

4. SAR Methodology:

4.1 The Independent Chair of this SAR Panel will oversee the Review process. An Overview Report will be produced and presented to BSAB within agreed timeframes, on the condition that relevant agencies and contributors fulfil their own timeframe expectations. Information gathered will be from agencies identified as having had contact with Mary and family contacts.

4.2 Information will be gathered from Independent Management Reports (IMRs) submitted by agencies having been identified as having relevant contact with Mary. Additional documentation may also be requested by the SAR Chair, if relevant.

4.3 Each IMR will be researched and written by a person working for the agency making the submission and it will be assumed that they will possess the appropriate skills and seniority to analyse and question actions taken by their organisation. However, they should not:

have had any direct involvement with Mary, nor be an immediate line manager of any member of staff whose actions are, or may be, subject to review within the IMR in question.

4.4 Each IMR will include a chronology and analysis of the service provided, during the denoted period covered by the SAR. The IMR will highlight both good and poor practice, and if appropriate, make recommendations for improvement in either agency, or multi-agency working. The IMR will include context relating to issues such as resourcing/ workload/ supervision/ support and training /experience of staff involved.

4.5. Each agency must include the circumstances of their first recorded contact with Mary, in their chronology of their IMR, regardless of the date and scope of the SAR. Any significant incidents that occurred outside the period of the Review period, should also be noted. The chronology must include all information about contact in the Review period.

4.6 Each agency's IMR must contain a comprehensive summary of all information that is relevant to the safeguarding of Mary during the Review period and must include:

- narrative and analysis of their organisation's involvement with Mary
- identification of any lessons learned
- challenges and opportunities
- recommendations for that organisation

4.7 Any issues relevant to equality, for example disability, sexual orientation, culture and/or faith should also be considered by the IMR writer. If none are relevant, a statement to the effect that these have been considered must be included.

4.8 The completed IMR must meet the submission date agreed by the SAR Panel. Each agency must ensure that enough time is available for the IMR to be signed off by a senior manager in the organisation, including return to the author for any amendments or addition required.

4.9 Completed IMRs will be considered at the meeting of the SAR Panel to be held on 4th August 2-4pm. If members of the panel have queries arising an IMR, a meeting will be convened and individual IMR authors will be requested to attend so questions from the Panel can be raised and answered.

4.10 When the IMR information has been agreed by the SAR Panel, the Independent SAR Chair (who is also the Independent Author), will produce a draft Overview Report and draft chronology. The SAR Chair will retain independence from the agencies subject to the Review and will use their independence to discuss the recommendations with the Panel and provide rigor to the recommendations made.

4.11 If necessary, the SAR Chair or members of the panel may seek to request further research/ information to supplement an IMR, to enable better supported independent conclusions about the lessons to be learned from the case of Mary.

4.12 In the spirit of Making Safeguarding Personal, a meeting with the family may be held at the beginning of the process and towards the completion of the first draft. Family views will be sought for inclusion in the Report, should that be the wish of the family and post a written response regarding their agreement to being part of the process.

4.13 The Overview Report will outline:

- A summary of the incident and the risks faced by Mary

- A summary and analysis of the contact and involvement that agencies had with Mary and
- how they worked together, or not as the case maybe, to safeguard Mary
- Any other issues considered as relevant
- Conclusions regarding the above and whether policies and procedures require change to ensure improved adult safeguarding in future
- Recommendations for action that should be taken to improve safeguarding, what should be learned by agencies involved, and how the lessons can be applied.
- If agreed, the outcomes of a consultation meeting with Mary's family in relation to their views

The overview report will assist the panel on completing:

- An action plan, which will set out how agencies will implement recommendations, including: required action, accountability, timescale and what will be different as a result.

4.4 Following feedback from the SAR Panel, an Executive Summary may or may not be produced, and if it is produced, it will not contain any personal or sensitive data.

Executive Summary to be drafted for publication and for learning events.

4.5. A non-redacted draft will be submitted two weeks prior to a further meeting of the SAR Panel, following which agreed changes will be made to the draft. The second draft will be submitted to the Panel, after which a decision will be made whether to submit a final draft to the statutory partners of the BSAB as redacted or non-redacted.

5. Agencies who will be asked to submit IMR reports:

1. Oxleas NHS Trust

2. Lewisham & Greenwich NHS Trust
3. Darent Valley Hospital – DG Trust
4. Inspire Community Trust
5. Avante Community Support
6. LBB Housing Services
7. LBB Adult Social Care - Safeguarding and Commissioning
8. LBB Children's Social Care (Chronology - if needed IMR)
9. The Metropolitan Police (Police Reports needed on all individuals)
10. General Practitioner via Bexley CCG
11. BWA/Solace (Scoping – if needed IMR)

In addition to the above, the family may wish to submit a report of their own or a make a written or verbal contribution to this Review.

6. Action to be taken if there is a failure by agencies to co-operate with a SAR request:

6.1 Any failure to co-operate with this SAR will be reported immediately and directly to the statutory partners of the BSAB.

7. Specific Issues to be Addressed:

7.1 Risk Management:

- Post incident response?
- Any deficits in risk assessment, care, recording, and ward handovers?
- Safeguarding concerns raised?
- Working in partnership?
- Evidence of Making Safeguarding Personal?

7.2 Information sharing and confidentiality:

- All information must be securely sent and stored at all times
- Information will only be used for the SAR process and considerations will be made about publication due to surviving family

7.4 Previous Safeguarding Adult Reviews:

- Are their connections to any previous SARs held by BSAB?

7.5 Particular issues relating to ethnicity, disability, sexual orientation or faith:

- Do any of the above have bearing on this Review?

7.6 Known research that may contribute:

- Is there any known research that may contribute to the learning?

7.7 Participation of the Family:

- Have family members been identified?
- Have they agreed to the Review taking place?
- Have they been advised of the purpose of the SAR; how it will be conducted and how they may be involved?

8. SAR Governance:

8.1 The Independent Chair of the SAR Panel will advise the statutory partners of BSAB regarding emerging findings that may require action by agencies prior to SAR completion, to enable the deployment of change/or agency systems improvement, at the earliest point.

8.2 The Draft Overview Report will be sent to the statutory partners of BSAB prior to listing it as a confidential Board agenda item, in order to ascertain their views, a consequence of which, may be that they request a redraft.

8.3 Once agreed by the SAR Panel, the Overview Report will be presented to the next BSAB for sign off.

8.4 The BSAB will be responsible for the co-ordination of any media management in relation to the SAR in line with their agreed media strategy.

8.5 The BSAB will make the decision about publication of the Overview Report and will record how a decision was made and why.

9. Period the Safeguarding Adults Review will cover and report completion:

The review will cover the period from the first safeguarding concern in 2010 up to the conclusion of the adult safeguarding enquiry. It is expected that the Independent Author/Chair will have completed the report, 6 months following on from commission date, which is approximately the end of December 2020.

10. Parallel Proceses:

There are currently no known parallel processes in relation to this Review, this requires confirmation.

11. Media Strategy:

The BSAB will advise the SAR Panel and its Chair regarding any media strategy that may be required.

12. Legal Advice:

Legal advice from LB Bexley may be sought, at any point during the Review.

17. APPENDIX C

17.1 Evidence Based Model Of Good Practice

The following provides an explanation of the four-domain model, based on the explanation contained within Salford's Adult Safeguarding Board's "SAR Andy", authored by Professor Preston-Shoot (March, 2019). The report is available in full here: https://safeguardingadults.salford.gov.uk/media/1166/sar-report-arfinal-march-2019.pdf

1. First Domain: Direct Practice with the Adult

It is recommended that direct practice with the adult is characterised by the following:

a) A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes;

b) A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills;

c) When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; domestic abuse/coercive control may lie behind refusals to engage;

d) It is helpful to build up a picture of the person's history and that of their familial carers where relevant;

e) Recognition and work to address issues that may underlying "unwise decisions";

f) Recognition of and work to address repetitive patterns or seemingly intractable issues;

g) Comprehensive risk assessments are advised, especially in situations of service refusal;

h) Where possible involvement of family and friends in assessments and care planning;

i) Thorough mental capacity assessments, which include consideration of executive capacity;

j) Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

k) Thorough care plans and regular reviews.

2. Second Domain: Inter-professional and Interagency Collaboration

It is recommended that the work of the team around the adult should comprise:

a) Inter-agency communication and collaboration, coordinated by a lead agency and key worker, which may be termed working together;

b) A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

c) Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

d) Multi-agency meetings that pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options;

e) Use of policies and procedures for working with adults who self-neglect or where there are signs of domestic abuse/coercive control;

f) Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

g) Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

h) Clear and thorough recording of assessments, reviews and decision-making.

3. Third Domain: The Organisation around the Practitioner/Team

It is recommended that the organisations around the team provide:

a) Supervision that promotes reflection and critical analysis of the approach being taken to the case;
b) Support for staff working with people who are hard to engage, resistant and sometimes hostile;
c) Specialist legal and safeguarding advice;
d) Case oversight, including comprehensive commissioning and contract monitoring of service providers, including the preparation of a contingency plan should services fail;
e) Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds.
f) Attention to employee capacity, especially in terms of knowledge and experience. Undertaking a thorough competency review prior to allocation of a complex case, and providing regular specialist and expert, proactive support and guidance in areas of knowledge and competency gaps and growth.

4. Domain Four: The work of the Safeguarding Adult Board

SABs are recommended to consider:

a) The safeguarding efficacy of borough-wide frameworks and multi-disciplinary groups (such as SHIELD, Bexley Care and Bexley CCG);
b) The development, dissemination and auditing of policy and procedural improvements, created in response to weaknesses or gaps noted by the SAR;
c) Workshops on gaps or inefficiencies noted by the SAR in practice and the management of practice with adults.

This model provides a framework to systematically scrutinise the chronology and explore what facilitated good practice and what acted as barriers to good practice.

18. APPENDIX D

18.1 Detailed Chronology

The following is a detailed chronology of the events provided in section 6 of the SAR overview report. Names and identifying information have been removed. However, notes from records have not been changed, which includes acronyms, spelling or grammar.

Date	Chronology Information
07.06.2011	REHAB: Discussion in office with [Name Removed] Social Worker. Expressed concern about home environment, in particular regarding fact that 1 year old child is also living at property. Plan: To re-visit Mary to see if situation with washing machine has improved and to begin to broach subject of home environment and risks involved. To proceed with looking into package of care which may also support family by taking some pressure away from them. [Name Removed] Triage Hub, 07-Jun-2011
10.06.2011	ADMIN - T/c received from [District Nurse] who was extremely concerned as regards to the condition of Mary's home. When she visited the client there was dirty clothes everywhere, dirty nappies all over the side, dog feaces on the floor and food everywhere. Upon the DN visit the son was present, the client stated that her son was the main carer, when the DN asked the son a few question regards to the state of the house etc he was very abusive and said he was not the carer for his mother, his brother was the main carer and that he wanted nothing to do with the assessment. DN did not feel the client was at risk she was concerned at the way the property was presented upon her visit. She would like to highlight these issues to [Name Removed] the allocated worker and for [LBB OT] to contact her A.S.A.P [Name Removed] - DN lakeside health centre - Tel no: [Removed] Message passed to [Name Removed]. RAPID RESPONSE TEAM, 10-Jun-2011
14.06.2011	REHAB: Telephone conversation with District Nurse, [Name Removed] at Lakeside Health Centre [Tel Number Removed]. She advised that she visited Mary on Friday 10th June. When she arrived, Mary was in her riser recliner chair where DN attended to dressing wound. DN advised that she asked Mary how she was coping at home and expressed that it did not appear that she was coping due to the state of the environment. DN then expressed concern about the fact that there is a 1 year old child living in property. At that point Mary apparently called Hayley who was upstairs with John. Hayley came downstairs and DN advised that she was smoking something and wondered whether it was cannabis. DN advised that Hayley did not appear to realise that she was still there and when she saw her she immediately hid what she was smoking behind her. John then apparently came downstairs and apparently there was a heated discussion between him and DN. John told DN that his child had nothing to do with her, DN apparently told him that she has a duty of care to report incident. DN told Mary this. DN advised that another of DN's visited today and did gain access. No problems reported. Discussed with DN that LBB OT aware of situation but that risk is that Mary could refuse access to Rehab service therefore putting her care at risk as well. Proposed plan is

Date	Chronology Information
	for OT to visit with experienced SW on her return from AL. Mary is having regular visits from professionals to the home and any further risk or concern will be highlighted. DN felt this was appropriate but she will update OT of further issues/concerns if they arise. [Name Removed] - Triage Hub, 14-Jun-2011
29.06.2011	REHAB: Telephone conversation with [Name Removed], Housing Officer for Orbit HA [Contact Details Removed]. Advised her of concerns re the environment within the home. [Housing Officer] advised that she knows this family well and has a great deal of input with them in the past. [Housing Officer] reported that the home has been in a terrible state before and she told them that they had to clear it. [Housing Officer] advised that Ian, John and Kyle are all registered as living at property. Ian is carer for his mum. [Housing Officer] advised that she will need to visit in order to check home situation and suggested a joint visit with OT and SW. To await allocation to SW.
04.07.2011	Case has been allocated to [Name Removed] (Social Worker). [Name Removed] - Historic Staff, 04-Jul-2011
05.07.2011	Home visit to see Mary. Staffordshire bull terrier running loose in from garden - growling and barking at me as I approached the property - unable to go to front door. Waited for dog to go indoors as front garden has no fences etc and dog kept coming towards me. Once inside the dog was controlled by Mary who told her to be quiet and sit down. When I heard the dog stop growling I approached the property - the front door was wide open and on one except Mary was in the home. The dog remained settled during the rest of the visit. The downstairs of the property comprises of a lounge, kitchen and shower/Toilet. Every room downstairs had rubbish over the floors (dirty nappies in the hall way, food remnants, cigarette butts, dirty clothes, general rubbish). The living room was very cluttered and one sofa was covered in clothes. There were a large number of flies in the home. The kitchen was very dirty - all surfaces covered in dirty crockery, sink full of dirty crockery, half filled with dirty water. Rubbish on all surfaces. The shower room was also full of rubbish and dirty clothes which were past the state of being washed. They would need to be thrown. The shower is not currently used as access cannot be gained to the shower because of the rubbish and clutter. In my opinion the house is currently not environmentally suitable for a child to live in. Mary's grandchild lives in the home with Mary's son John and his partner and Mary's younger son Ian. I did not go upstairs because the rest of the family live upstairs and Mary only occupies the ground floor. As the other family members were not present I did not have their permission to go upstairs. I discussed the level of cleanliness in the home with Mary. She agreed it was not acceptable. I informed her that unless the home was cleaned up I would have to pass a referral to the children and families team as the home is not environmentally safe for a baby. I asked her if she wanted me to have this discussion with her family or if she wanted to do this. She said she wanted to do it. I agreed to let her do this. I told her that the home needed to be cleaned up by next week and I would come back next week to check it had been done. She agreed to this time scale. Mary is unable to get out of bed or transfer without assistance - she requires hoisting. She says her sons currently hoist her in and out of bed and to the toilet etc. However, she has to remain in bed with no wash or toileting unless they do this

Date	Chronology Information
	for her and she has to wait for them to this. She is often left in bed unwashed and needing the toilet for very long hours even though John and his partner are not working. Ian works and provides care in the evenings. He sleeps in the lounge on the sofa so he is available to toilet her at night if she needs it. He does have a bedroom upstairs. He works as a hairdresser but not full time. In relation to meals she relies on family to provide these but again the provision is haphazard. She had no drinks by her bedside and no means of getting anything if she needed it. On the day of my visit (2pm) she had not been washed or dressed and was in bed in dirty night clothes and had obviously not been washed for at least a few days. She has no means of calling for help in an emergency although she said she was getting a mobile phone. There is no landline. She agreed to have carers in the morning to get her washed and dressed and give her breakfast and again at lunch time to make a sandwich and toilet her. I told her the carers would not be prepared to wash her or make meals whilst the shower room and kitchen are in such a dirty condition. She agreed and again I reiterated the place needs to be cleaned by next Monday. She again agreed. She also agreed to give Inspire day centre a try to get out of the home. She has not left the home since April despite having an electric wheelchair. She cannot get around the home due to the amount of clutter.
13.07.2011	Home visit to see Mary. The home is much tidier and cleaner than before although there is still more that needs doing. Mary has no fridge or freezer as their one broke and they have not been able to replace it. The washing machine is leaking although Mary says that this is because it is not plumbed in properly, not because it is broken. She Also asked if it would be possible for ss to contribute to a skip so they could get rid of all the rubbish in the home. Mary told me that Ian moved out last week. As he was her main carer she urgently needs a care package as previously discussed as John and Hayley are not meeting her care needs even though they live with her. I also discussed how the carers will gain entry and Mary agreed to a key safe. I will ask [Name Removed] (OT) to arrange this. Noted by [Name Removed] Social Worker,
18.07.2011	Holding hours to commence with Carewatch Monday 18/7/11 am see below: From: [Name Removed] Sent: 15 July 2011 10:49 To: [Name Removed] Carewatch Bexley Cc: 'brokerage@carewatchbexley.com' Subject: HOLDING HOURS NEW REFERRAL Mary P143401 Importance: High Further to [Name Removed] telephone call please find attached referral for Mary to commence am Monday 18th July 2011. We have been advised of the following by the Social Worker, [Name Removed] "Mary is totally dependent on others to provide for her adls and personal care. Her son, dil and grandchildren live with her but do not appear to provide adequate care to meet Mary's needs. She is often left in bed in her night clothes and unwashed as the family spend most of their time out of the home and ignoring Mary's needs. They also leave her un toileted for long periods of time with no food or drink to hand. Her younger son was providing more care for her but he moved out of the family home last week. Mary requires hoisting on a standing hoist for all transfers. The home was very dirty and not fit for habitation. The family have attempted to

Date	Chronology Information
	start cleaning up to enable the carers to provide care. The home is still dirty but much improved from previously. " There is a family dog, Staffordshire bull terrier. [Name Removed], Social Worker, has been asked to advise the family to ensure the dog is in another room whilst the carers are carrying out their duties. [Social Worker] will arrange keysafe, once we know we will advise you. [Name Removed/LBB Manager] has asked that you give us feedback on what your carers report. Please confirm receipt. [Name Removed] Administrative Officer Care Audit/Brokerage Team London Borough of Bexley T/N DDI :[Tel No. REMOVED]
20.07.2011	I visited Mary this morning as there were concerns from the carers yesterday. On entering, the floorways are clear. The kitchen is quite messey, there was left over dinner on plates and the tap was dripping in the kitchen. The carers had mentioned that yesterday morning, they had to clean up Dog Pooh before they could put Mary in the shower, but they did say that the family have tidied up a bit. The carers mentioned that the water in the wet room doesn't flow down the drain properly and our carers are getting their feet wet. When the washing machine is on, the water seems to flow back through the back door as it seems the drains are blocked. There is mouldy washing next to the back door and there is washing in a recess in the kitchen. The carers have said that there is only one towel to dry Mary with, and they have also said she doesn't seem to have alot of clean clothes available to change her into, the carers have had to put her back into the pyjama bottoms she wore yesterday. There is alot of flies flying around in the living room, and this is where Mary sleeps and where she sits all day. There is now a key in the Key Safe and we have a record of the number. The fish tank in the living room needs cleaned, the water is nearly black. There is a dog bowl in the kitchen but there is no water in there for it to drink and I don't see any dog food either. [Name Removed] Care Coordinator, Carewatch. Bexley.
25.07.2011	From: [Carewatch] Sent: 25 July 2011 14:04 To: [LBB Manager]; [Social Worker]; [Name Removed]; [Name Removed]; [Name Removed] [Senior Broker] Cc: [removed names of 3 x Carewatch Staff] Subject: Mary P143401 Re: Mary, [Address Removed], I have had some more feedback from my carers. The morning carers have reported over that they are still using the same towel to dry Mary with since last week. They have also said that the family are eating their cereal out of wine glasses, as there doesnt appear to be any bowls, the carers found a plastic bowl to give Mary her breakfast in. There is food everywhere, just left on plates in the kitchen, and they were walking on Coco Pops that had falllen on the floor. The wee girls high chair still had spilled cereral all over it. Mary has no clean clothes to change into, they put on the same pyjamas that she had worn since yesterday. The lunchtime carers reported over that the house is the same state as it was this morning, the family have went out. For lunch, there is ham and chicken roll in this bag, but it is out of date. The carers could only give her 2 pieces of bread and butter, there was nothing else for Mary to eat. The carers have offered to buy her fish and chips for lunch tomorrow. I will await some feedback from yourselves.

Date	Chronology Information
08.08.2011	Discussion with [Name Removed] - Safeguarding Manager re concerns in relation to the living conditions of Mary and the neglect she is suffering from her family who live with her. He suggested this be referred as a safeguarding to facilitate a strategy meeting etc. Discussion with [ASC Manager] who agreed. [Name Removed] Social Worker.
11.08.2011	T/C to [Name Removed] Orbit Housing Officer. She has been involved with the family for a number of years. Things were not too bad when Marys niece was living with her but when John moved in January 2011 he argued with the niece who then moved out. We arranged to do a joint unannounced home visit on Monday morning at 10am (not able to make an appointment as we have no numbers to contact the family on in any case). Social Worker/[Name Removed]
30.08.2011	Email from Carewatch: Hi [Name Removed], Just giving you more updates from our carers regarding situation with Mary. Our carers have reported that the family have tried to make some effort in the last week or so, to tidy up but it seems to have become a mess again. the two dogs where jumping up at the carers, the kids were blocking the area and were playing in Mary's electric wheelchair, there was water all over the floor where the washing machine is not plumbed and daughter in law was screaming at 14 month baby saying 'shut your f***ing whining' the baby was crying for her breakfast, it was nearly 11am. Carers said it was horrifying. While they were hoisting Mary as the hoist ended up hurting Mary's legs as the hoist got pulled and they had to try and navigate through the kids, carers where not able to carry out their duties safely due to this. Daughter in law was only screaming at the kids but not getting them out the way, they were also climbing over Mary while trying to get her up and into hoist. Carers are concerned that there will be accidents waiting to happen, they need additional advice. Many thanks [Name Removed] | Care Co-Ordinator | Carewatch Bexley | First Floor Offices, 2b Devonshire Road, Bexleyheath, Kent. DA6 8DS. Copy sent to [Name Removed], Children and Families Social Worker.
01.09.2011	Joint home visit with [Name Removed] from East Child Care Unit. The house is much cleaner and tidier. [Name Removed] did part of the initial assessment and is returning next week to see them when the children are back at school. She said the upstairs is now much better than when [Orbit Housing Officer] took the photos. The care package is working well for Mary and John said things are much better now. I will continue to monitor the situation for a little while longer (to be discussed in supervision) then close the case. Social Worker/[Name Removed].
30.09.2011	Email sent to [Name Removed], MS Nurse: From: [Name Removed] LBB Community OT Sent: 30 September 2011 13:07 To: [District Nurse] (Oxleas NHS Foundation Trust)' Cc: [Social Worker] Subject: Mary Hi [MS Nurse] Sorry that I haven't replied to your email sooner. I have not seen Mary for a while now but I understand from [Social Worker] that the home is clearer now. The care package is still in place and appears to be working well. Just to update you on my input, I am awaiting installation of a ceiling track hoist in the living room which will be able to be used to transfer Mary from the bed and onto the chair. We

Date	Chronology Information
	have also ordered a different riser recliner chair which is more supportive and promotes a better posture for Mary. With regards to the fridge freezer, I understand that Mary does now have a freezer but no fridge. [Social Worker] has told Mary's son, John, where he could get one from and hopefully he will pursue this. Regards, [Name Removed] Community Occupational Therapist, London Borough of Bexley
30.09.2011	LAS 999 Call Log (CAD 3602) A 999 call was received by our EOC at 18:22 for an ambulance to attend address. It was reported that Mary was experiencing rectal pain. Based on the information provided the call was passed onto NHS Direct.
11.10.2011	Telephone message left for John advising that will be visiting at 1pm today with lift engineer. LBB OT home visit with Mary. On arrival Ian and Hayley were just leaving property. They both advised that Mary was well. Hayley advised OT that she had concerns about a particular carer who visits on Saturdays only and has asked that she doesn't visit again. She advised that this carer was always on her phone whilst on call to Mary. Advised that this will be reported back to [Social Worker]. There were 2 carers from Care Watch present in property and were taking Mary to the toilet. One of the carers advised that she had just spoken with Ian and Hayley about the key safe being left open with the key visible. She advised that this has happened on a number of occasions. OT observed Ian put the key back in the key safe before he left property. Carer also advised that Mary is now not sitting in her wheelchair as she had an 'accident' in this about 3 weeks ago and seat has not been cleaned by family. Carers reported that Mary often has no clean clothes and that the shower does not drain away (drain is blocked with hair). Observed Mary in standing hoist. Positioning was worse that on initial assessment and sling was riding up her back. Her right arm was not supported. Provision of a ceiling track hoist will resolve this problem but this will not be immediate. Discussed provision of suitable shower chair which will go over clos-o-mat. OT to investigate reclining shower chair. Mary has no method of calling anyone in case of emergency. OT to investigate possibility of concessionary phone. The home environment was in a better state from previous visit. The living room floor was relatively clear (except for a plastic frisbee that one of the dogs had destroyed). There was a plastic box filled with children's toys. There was no evidence of dog excrement or soiled nappies. Hayley and Ian returned briefly during visit. She advised that she is pregnant (due early June 2012) and they are trying to sort the house out. Issues raised/discussed with Mary: 1) Shower chair: OT to investigate provision of reclining shower chair (19") suitable for over clos-omat. 2) Mary advised that she has lost her cutlery. To organise replacement set (large ultralite) and ahelping hand. 3) Intercom is broken (handset has been removed/fallen off). Mary was struggling to operate handset. Key safe in place for access. 4) Mary has no method of calling anyone in case of emergency. Family have not given her a mobile phone and they cannot afford a phone line into the property, therefore cannot have BELL. To investigate concessionary phone. 5) Mary enquired about benefits. To liaise with [Social Worker] regarding this.

Date	Chronology Information
	6) OT to liaise with Orbit regarding drains (shower is blocked with hair). Still getting water on floor asdrains have not been sorted regarding washing machine. 7) OT to liaise with Orbit regarding through floor lift and kitchen. Mary would like the lift removed as not used now. The kitchen was adapted for wheelchair use but she is now unable to use it and family would like it reinstated for ambulant use. 8) Moving and handling: standing hoist not offering level of support now needed. To consider replacement with mobile hoist and shower chair until ceiling track hoist installed.
18.10.2011	Assessment visit Re Concessionary telephone. Mary was at home during the visit. Mary has MS and is a wheelchair user and hoisted for all transfers,client has minimal use in her left hand and unable to use r/hand. Client has carers a/m to assist with personal care and lunch time to heat a meal. Clients home is shared with her son and his partner plus 2 children and pets. Mary says that she is very left on her own in the home that there is usually somebody there. Son does not have permanent employment and only works on odd days. Client did have a telephone in the past but was unable to pay the bill, telephone was cut off, sky hd has also been cutoff due to non payment..Client does get the DLA. Unfortunately client does not meet the criteria for concessionary telephone have informed [Community OT] who made the refferal. [Name Removed].
18.10.2011	HI [Name Removed], Thank you for your email. I did visit Mary yesterday and she said that you were going out to see her. I am quite surprised at what Mary has told you about her family often being at home as this does not seem to be the case at all! She is often alone and during these times has no means of calling anyone in an emergency. As you can see on CF21 there is a long history of problems/issues with this family and my feelings are that we should be setting Mary up with a support mechanism that has no dependency upon her family. I have copied [Social Worker] in on this email as she is also involved. I wonder whether this case could be relooked at in light of my email as I do have great concerns about this ladies lack of means of contacting anyone in an emergency. Regards [Community OT]
20.10.2011	T/call from [Name Removed] Carewatch care agency wanting to speak to [Social Worker] urgently. [Carewatch] reported the morning carer did her visit today and a relative had been aggressive towards the carer today. Another carer is due to go in at lunch time and [Carewatch] needs to speak to [Social Worker] regarding this as it is ongoing issue.
	Duty call as [Name Removed], allocated social worker was away from the office till this afternoon. T/C to John client's son on [Telephone Number Removed], to enquire what had happened with the carer this morning. John said he was woken up by the loud voice of his mum's carer requesting for towel for his mum. on getting downstairs he said the carer was making comments about his children and the cat being on the sofa. also said carer commented about washing up not being done. John said he found these comments offensive and believes the carer must have come in with a "hump" which ought not to be brought to work. he said he felt insulted by the comments and had asked the carer to leave his house. After speaking with John he agreed for carers to come to the house to carry out his mum's care needs as per careplan and he agreed to keep away from carers when they attend. T/c to Carewatch, [Name Removed] was on lunch hence i spoke with

Date	Chronology Information
	[Name Removed] narrating the above version from John. i informed [Name Removed] that if it were true then the carer ought to have reported her concerns through the appropriate channels not directly with clients or their family. carers should also resume this afternoon as per original careplan. Holly will inform her manager and ensure carers go in to meet client's care needs even if carers are changed.
	T/C from [Social Worker] to advise that Carewatch have informed her that they have no carers that are willing to visit client as her son is being verbally abusive and intimidating, therefore [Social Worker] has asked if we can change providers. Discussed with senior broker [Name Removed], who has previously met with client and her family and [Name Removed] is going to arrange a visit to discuss ongoing problems.
22.10.2011	11PAC168861 22/10/2011 On Saturday 22nd October 2011 Police attended the subjects home address to conduct a Section 18 search after the subjects uncle was arrested for possession of class B substance with the intent to supply. The subject's uncle has lived at the address for two weeks but does not permanently reside there. The search was negative for anything connected to the offence or any other offence. The property was unkept, dirty with tools and rubbish on the floor, there was old food on the table that was also covered in rubbish. The grand mother is ill and sleeps in the living room (asleep on police arrival) with medication out on a bedside table also in the living room. The children appeared happy and healthy to look at.
16.11.2011	LAS 999 Call Log (CAD 1178) A 999 call was received by our EOC at 10:26 for an ambulance to attend address 1. It was reported by a carer that Mary's legs had gave way and she was unable to get up. Mary needed assistance, she had no injuries. It was deemed that an ambulance was not needed and the call was referral to Mary's GP who would deal, with no time period given.
	GP - Telephone encounter with ambulance service. Patient keeps falling. They assisted in helping her. No injury but they requested a Doctor to visit.
23.11.2011	[Name Removed] from Brokerage called today, carers are wanting to pull out for all the same reasons as in the past, no clean towels, family not cooperation. I informed [Name Removed] that [Social Worker] will contact her on her return to work, from previous observation it seems things are happening on this case. - Case note by [Social Worker's Manager]
28.11.2011	T/call from [Name Removed] Carewatch agency wanting to speak to [Social Worker] urgently as the carers are now refusing to go into client to provide a service. The clients dogs are jumping on the carers and messing their uniforms. There is dog mess everywhere around the property and even in clients shower. [Carewatch] would like a call back from [Social Worker] to what to do as the lunch time carer refusing to go in.
	Email to Carewatch Hi [Name Removed], Please continue to cover services for Mary and finish after the am call tomorrow 29.11.11 as agreed on the phone today. Thank you for all your support. Regards, [Name Removed], LBB Acting Senior Care Broker ----------

Date	Chronology Information
	From: [Name Removed]@carewatchbexley.com Sent: 28 November 2011 12:13 To: [3 x Names Removed for LBB Brokerage] Subject: Hi, Just to let you know that Carewatch are no longer able to provide carers for Mary. There have been ongoing issues in regards to the very poor environment and I am now concerned for the carers safety. Our Last visit was this morning. If you require any further information, please do not hesitate to email or contact me. Regards, [Name Removed] | Care Manager
29.11.2011	Athlone commence delivery of Mary's home care package.
20.01.2012	REHAB: Telephone call on mobile from Prism engineer. They are on site about to fit ceiling track hoist but layout of room has been changed from original plan. Agreed to call in. Visit to Mary. x2 engineers/fitters from Prism on site with Mary and Hayley. Acorra chair has been put in far corner of living room, diagonally opposite position of chair on survey. Engineer established layout of H frame system to ensure pick up points for chair, bed and wheelchair. Hayley expressed that she did not feel the hoist was necessary and that it would be unsightly. Ian then phoned and asked to speak with OT. OT spoke with Ian. He advised that he had said that he did not want the ceiling track hoist. Advised that this was quite some time ago and further discussions with his mother established that it was a good idea and that Mary had agreed to it. Ian did not agree with this. Ian said that all the equipment in the home is making it look more like a hospital than a home. Advised that his mother needs the equipment on site. Ian felt that the standing hoist was satisfactory and if sling positioned correctly his mother has good position. Advised Ian that as his mothers upper body strength deteriorates it may be unsafe for her to continue using this hoist. Ian expressed that the equipment was making his Mum more disabled as she does not have to put the effort in and has become lazy. He quoted an example that she now has to use a straw to drink from. Advised Ian that this is because of her condition and the fact that it is deteriorating. Ian disagreed and said that he was not stupid and had read up on it. Ian refused for ceiling track hoist to be fitted therefore Prism left site. Ian has said he would like to meet with Community OT.
31.01.2012	Notes from Safeguarding meeting 31/01/2012: [Name Removed] asked for clarification from [Social Worker], with regards to what form of neglect Mary had experienced. [Social Worker] stated that Mary had experienced forms of neglect, as she never has any money, not alot of food, and does not have a mobile phone. [Community OT] stated that she feels this is a real issue, as Mary has no way of contacting anybody if an emergency arose. There is no intercom, and if an intercom is fitted, it gets broken. Mary said that she is never left on her own in the property, which [Community OT] stated was untrue. Mary is sometimes left in the property with the young children. [Social Worker] said that Mary is left all day in bed, with no food or drink. Mary will not ask family members for anything, as she does not want to be a burden on them. [Social Worker] feels that Mary is not scared of her family, but does not want to impose on them. Mary, does have capacity she understands and is aware of circumstances.

Date	Chronology Information
15.03.2012	Safeguarding meeting - 15th March 2012 1. Financial Abuse – there were concerns that the family were living at the home and not contributing the food bills, fuel costs etc. 2. No clean clothes or towels available to carers when they are caring for client. 3. No food in home and therefore lack of food and good nutrition for Mary. 4. Children being left in Mary's care when she is not able to assist them or care for them. 5. Hoist installation being refused by family. Other Concerns 1. Washing Machine was still broken preventing carers from doing any laundry. 2. Standing Hoist still being used when this may not now be the safest way to transfer Mary. 3. Mary is not able to call anyone for assistance as the phone has been cut off and she has no link line. Action Points and outcome:- 1. [Community OT] to speak to Mary about hoist at home again 2. [Community OT] to speak to Mary about transfers and dressing/undressing in lounge and try to work out how to avoid this. 3. Link Line to be ordered when phone has been installed- [Social Worker] 4. [Social Worker] to email Children and Families Team with concerns re children being left with Mary who can not care for them. 5. [Social Worker] to check with carers regarding lack of clean towels, clothes and food in home to establish if this is still a concern or if this has now been resolved. 6. [Social Worker] to monitor with carers Mary's nutritional intake. Conclude Safeguarding 1. Neglect from family- Substantiated • No food • No clean clothes • No clean towels • Poor environment 2. Hoist being refused by family- Not Substantiated as client has capacity, understand hoist refusal and is refusing hoist. There was no evidence to suggest that Mary was involved in these meetings and no advocate was employed on her behalf. However, these issues were continually discussed with Mary in an individual basis away from the home environment and at the home with her family present. Mary's views and the family's were listen to at all times as documented in the case notes on Liquid Logic.
15.03.2012	Received urgent documents from [Social Worker] at ILTN requesting an increase in services as Mary requires hoisting for transfers therefore longer time is needed. The following services have been validated for Mary: 45 mins am x 7 days x 2 carers for personal care 30 mins x 7 days x 2 carers lunch 30 mins pm x 7 x 2 carers ptb. The above services to maintain clients safety and welling whilst in the community. [Social Worker] has been advised with the following: Please could you provide the Care Brokerage Team with the following documents: RAS; Update the Care Plan; Put on CF21 Activity of arranging services assigned to BROKER. Documents passed to the Brokerage Team for services to be processed.
19.03.2012	T/c to commissioning to confirm that Marys day care will start tomorrow. TC to Hayley to inform of this - no reply so text her to inform of this. T/C to Athlone care

Date	Chronology Information
	to inform that they will need to be at Marys in the morning for 8am to get her ready in time for transport and to cancel the lunch time calls on Tuesdays. I asked if they were still having issues with no clean towels, clothes etc and they said they were. I asked that they inform us each time there is a problem like this so we can keep a log.
20.03.2012	Mary commences attending Inspire Day Centre. 06/02/2012, following January Safeguarding meeting, [Social Worker] suggests offering Mary a trial at Inspire. Mary attends as a guest on 06 March and then commences one day a week from 20th March 2012.
10.04.2012	Inspire records: Call from social worker regarding extra days and recliner not working.
15.05.2012	REHAB: Email received from Care Agency reporting problems with moving and handling as a consequence of the bed control needing to be replaced. Telephone conversation with Amina but she was in meeting so agreed to call OT back to discuss further: Dear [Senior Broker], Please note below of the carers feedback regarding [Mary's] Service. The carers have raised concerns that Mary bed is too low when carry out personal care and transferring Mary to the commode. Carers are complaining of back pain. There is a high risk for Mary injuring herself when carers are transferring her. Mary has informed the coordinator that she has reported to the OT team that the bed is too low but she is still waiting to have a response back from the OT team regarding the bed. Can you please look into the above issue as soon as possible as there Is a Health and safety issue. The coordinator has explained to the family and Mary that the carers cannot lift Mary, but Mary has refused to wear incontinence pads until the above issue can be resolved. Kind Regards, [Name Removed] Branch Manager, Athlone Care
12.07.2012	Carers reporting that they were hurting their backs, so agency requested for Bexley to find another provider. Brokerage team noted that these moving and handling issues could have been resolved with installation of a ceiling track hoist being fitted at the property, however Mary's family (and latterly Mary) refused to have a ceiling track hoist installed at the property. Eventually the agency gave notice and handed back the provision on 12/07/2012
12.07.2012	Kent Social Care Professionals commence delivery of daily home care package.
30.07.2012	Home visit to see Mary. Hayley was at the home. Hayley, John and the children have now moved out into a house of their own. Kyle and Ian have moved back in. Mary is happy with her carers, they come at reasonable times and she was looking clean and well groomed. The house was also looking cleaner and tidier than I have ever seen it. The dogs have also gone (they went with Hayley and John). Completed the financial assessment form. Discussed children... Notes by [Social Worker]
23.08.2012	Updated information received from [Social Worker] at ILTN requesting an increase in service for client, these had been presented at the CAT Management Meeting.

Date	Chronology Information
	Panel have validated the following increase in services for client: 1hr am x 7 days x 2 carers personal care 30 mins x 7 days x 2 carers for lunch 30 mins pm x 7 days x 2 carers put to bed services. Panel have declined the 4th call as client is not doubly incontinent and has no risk of skin breakdown therefore does not meet the FACS criteria. The above services will maintain clients safety and wellbeing whilst in the community. [Social Worker] has been advised with the following. Please could you provide the Care Brokerage Team with the following documents: Update the Care Plan RAS Put on CF21 Activity of arranging services, type CHOICE AND PLANNING, assigned to BROKER. Documents passed to the Brokerage Team for services to be processed. **Copy of the paperork handed to the Commissioning Team for a decision to be made regards the request for an additional day care service**
27.09.2012	T/C yesterday from Mary. She is agian requesting a 4th call - she is having to wait from lunch time to 9pm to go to the toilet and is often now wet. this will cause her skin to break down as she is wheelchair bound and requires hoisting. She does not understand how social services are telling her she is not eligable for a 4th toileting call taking into account she requires hoisting for toileting. She is angry that she is being made to wet herself and sit in wet pads which is very uindignifed as well as being uncomfortable. she has requested I again apply for a teatime call to toilet her. I will put the case back through cap again. Mary has also said that she want to move from her house to a 2 bedroom bungalow. Ian will move with her to be her carer and she has phoned the housing dept for a form. she now has the form and would like me to come and help her complete it. I told her to take it to Insprie tomorrow along with documents that can be copied and I will try to come and see her. I explained that I am on duty so may not get there tomorrow. She has still not heard about an extra day at inspire. T/C to commissioning. The papers were sent to them on 23/8/12 - [Name Removed] will check to see what is happening with the application and get back to me.
20.10.2012	LAS 999 Call Log (CAD 1042) and PRF A 999 call was received by our EOC at 06:56 for an ambulance to attend address 1. It was reported that Mary had fallen out of a hoist and incurred a leg and hip injury. It was further reported that carers were on scene. On arrival of the ambulance staff they have documented that Mary was on the floor, she had slipped from a hoist, she had no injuries. Mary was assisted to her feet and lowered into her wheelchair. Mary declined to be conveyed to hospital as she had no in injuries. Following the ambulance staffs assessment Mary was left in care of her carers with the advice ring back again if needed. 19/03/2014.
22.10.2012	The Multi Disciplinary Management Plan within Inspire's notes and completed by [Social Worker] rates Mary as very high risk/need and that “the family often neglect her care”.
23.10.2012	Documents received from [Social Worker] at ILTN is requesting services for client. These have been presented at the CAT Management Meeting. Clients medical conditions are Multiple Sclerosis. Panel have agreed the following increases in services due to clients health

Date	Chronology Information
	deteriorating. 60mins x 7 x 2 carers -AM 30mins x 5 x 2 carers -Lunch (not Tue or thurs as at Daycare) 15mins x 5 x 2 carers -Tea (not Tue or thurs as at Daycare) 30mins x 7 x 2 carers -PM Day care - Whitehall x 2 days a week (Tue & Thur) The above services will maintain clients safety and wellbeing whilst in the community. [Social Worker] has been advised with the following. Please could you provide the Care Brokerage Team with the following documents: Update the Care Plan RAS Put on CF21 Activity of arranging services, type CHOICE AND PLANNING, assigned to BROKER. Documents passed to the Brokerage Team for services to be processed.
10.01.2013	Call from [Name Removed] at Kent SCP. Asked for moving and handling assessment to be carried out as 2 carers are struggling with transfers with existing hoist. Email sent to [Social Worker] as she is the allocated worker
28.03.2013	28-Mar-2013 Liquid Logic notes "Kent SCP informed LBB Contact Centre that there are many people living at address and a dog kept in a cage in the bedroom and another dog who is allowed to "do his business" everywhere. REQUEST:- Client's son's have moved into client's house, one of them with his partner and the other with his partner and 3 or 4 kids, a cat which does not get fed and 2 dogs. One of the dogs is locked in upstairs in a cage, the other dog is just left to his own devices to do his business all over the house, including the shower room. Sons have refused to allow to have a ceiling hoist which will make client's transfers a lot easier. Both are verbally abusive to carers. House stinks of cannabis. Carers are at the point now where they can't even find her clothes as there are piles of dirty, clean, damp and wet clothes everywhere, washing up has been left to build up until there is nothing to use, toys everywhere etc. Client was getting very agitated this morning as carers were having difficulty doing their job amongst all the mess. Carers have now refused to go back in there, Kent SCP will be getting their managers to go until something can be sorted out.".
29.03.2013	SAFEGUARDING INITIAL RESPONSE: The concerns raised by the carers are not new issues and have been dealt with in the past and things improved when John and Hayley moved out with the children. The previous safeguarding investigations resulted in Mary attending day centre 3 times a week as part of the protection plan. However, in relation to the unsanitary conditions in the home, the smoking of cannabis, the refusal to have a ceiling hoist and verbal abuse towards the carers, Mary was fully aware of these issues, has capacity to make decisions about these issues and to date has refused to either ask her family to leave or ask them to clean up the home. However, these issues will again be impacting on the children now living back in the home so I have instructed brokerage to contact the care agency and tell them put though a referral to Children and Families. I will visit Mary at the day centre to discuss the issues again and then probably abandon the safeguarding as Mary will most likely refuse to allow the investigation to continue as she would

Date	Chronology Information
	rather have her family staying with her than move out or send them away. [Social Worker]
05.04.2013	Children's Social Services - Safeguarding Strategy Discussion, held on 05-Apr-2013. Initial Assessment concerns - poor home environment, drug use, poor attendance and parental aggressive behaviour. Proceed to Core Assessment. 05-Apr-2013 - Unannounced home visit. John refused to let workers in the house. Slammed the door, left the baby in the house and followed workers to their car. He was aggressive and shouted. Second home visit carried out with Police, children were seen, no concerns noted.
09.04.2013	Call from [Name Removed], manager of care agency to report their 2 carers have fled the house after being verbally abused by Client's son (John?) and after finding the house in a disgusting state with the Excrement of 2 dogs on floors and shower drain blocked. There were also 2 young children seen walking around in the filth. The son is reported to have screamed in the carers face various threats, expletives as he was beside himself with anger after being contacted by Childrens services today. Both carers have left and refusing to go back as they feel unsafe. Caller said these were the last carers willing to visit this lady due to the state of the house and number of people living there. Mary who has MS needs to be hoisted onto the toilet then into bed. There have been other problems which have been reported concerning Cannabis and keys taken out of Keysafe. Caller said she and the other manager [Name Removed] would visit to PTB tonight but only with Police back up. I called Police and requested a Welfare visit with Carers to ensure their safety and also to check on the welfare of the children in the house. CAD 8055 police agreed to liaise with Care agency on 01322 470070 care agency informed of plan. LBB Emergency Duty Team (EDT)
10.04.2013	My earlier recording was lost due to CF21 being down for maint. I recorded and saved the following; 21.00 last night [Care Agency] called to say Police had not yet been intouch so they have visited Mary and PTB. Caller said the house was much cleaner than when she was last there and the son had arrived when they did with a bag of clean washing from the local Launderette. the baby was seen to be asleep in the Pram and the dog mess had been clened up. There was no sign of Cannabis seen either. The son John was appologetic to [Care Worker] about shouting at the carers earlier. It would appear that appart from the verbal abuse the other concerns reported to me were historic. [Care Worker] has called the Police and told them they were no longer required. The Police called at 22.00 and I repeated they were no longer needed and they called again at 7..00 am to be told again to cancel the Welfare visit. Appoligies for lateness of report but system was down till after 9.00 after which I was not available.
10.04.2013	T/c from [Care Brokerage Manager]. The care agency are threatening to pull out because John was very verbally abusive to the carers and chased them out of the home. The family had been visited by the Children's team and refused them entry. They returned the next day with police and were allowed in but had cleaned up the dog mess and tidied up etc. John then became very angry with the carers as he believed that it was them who 'set children and families onto them'. I informed [Care Brokerage Manager] that I would visit Mary tomorrow at Inspire and then possibly go and talk to John. I will tell Mary that we are going to have problems with providing care for Mary if the home continues to be an environmental

Date	Chronology Information
	problem and also if John is going to be abusive. If this is the case she is going to have to decide if she stays in the home and sorts John out (children and families should actually be doing this anyway) or we move her into alternative accommodation without her family - her choice. [Senior Broker] will ask the care agency (KSCP) to continue until I have 'read the riot act' to John and Mary. Noted by Social Worker.
11.04.2013	T/C from [Senior Broker] to inform me that she has asked PCT Diamond care to take over the care package and it will start on Monday. T/C to Mary whilst she was at Inspire Day centre. She knew I was phoning about John. She denied there was dog mess in the home and said John and the four children were staying until they found somewhere else to live. I told her it was unacceptable for John to verbally abuse the carers although I did understand he was very upset because he had been informed that it was the carers who reported the situation to the Children's team. I informed Mary that the care agency was pulling out and a new one starting on Monday. She was OK with that. She asked me to visit next week so I booked to visit her at home on Tuesday at 10.30. She wanted me to visit at home, not at inspire. I told her I would want to see John and Hayley to discuss the issues. [Social Worker]
15.04.2013	PCT Diamond Care to take over the care package starting Monday, 15 April 2013.
16.04.2013	Call from Diamond care to report client has refused to allow carers to wash her in bed. Caller said carers have been told by SS not to use Hoist as sling is too small and therefore unsafe. I authorised carers leave the property. For info and follow up. Emergemcy Duty Team.
17.04.2013	Home visit to see Mary. Also saw Hayley and Ian. As previously stated, the issues in relation to the state of the home and the attitude of the family to carers are the same as those previously investigated. Mary is happy with the care being provided by her and the living conditions etc and does not want a safeguarding investigation to continue. She is fully aware that the carers have issues with the state of the home at times and also with her family on occasion but does not want to address these issues in a formal way. I talked to Hayley and Ian and my observations of the condition of the property is that it is much better than previously. It is much cleaner and less cluttered and the family are making attempts to keep it this way. These issues will continue to be raised periodically by care agencies, particularly as Mary condition deteriorates but as long as she has capacity (and she does have full capacity) it is her choice to live with her family with these issues. I am therefore abandoning the safeguarding referral as Mary has not consented to an investigation. Noted by Social Worker.
12.06.2013	Agency have reported difficulties they had this morning gaining access to client and abuse from son. The manager wanted assurance that the carers could return and there would be no problems. I have contacted son Ian and he assured me that the carers would be able to get in and there would be no interference from his brother. Agency have confirmed that the visit has taken place and there were no problems. It has been identified that there is no food to provide breakfast for client, this is a regular occurance. I will report to [Social Worker]. Noted by Senior Broker.

Date	Chronology Information
12.08.2013	CLOSING SUMMARY by Social Worker: A number of safeguarding referral have been received about the living conditions in the home and the level of care being provided by the family. These issues have been addressed over the last few years and whilst the living conditions have improved greatly there remain concerns. However, Mary has capacity to make decisions about her life, care and living conditions and has refused to consent to any SG investigations following the initial SG investigations a couple of years ago. Mary has a full care package of 4 calls a day and inspire day centre 3 days a week. At this point in time there is no further support required from adult social care social work. It appears that the Children and Families team are involved again with John and Hayley and the children but this does not indicate that we need to remain involved at this point as the issues are around the children, not Mary. Sg abandoned and case closed to CCE.
30.08.2013	Son (Ian) calls Orbit - Subject: Tenancy Management: Moving in date; residents son called to ask how res can get a move to a smaller property. I advised that they would need to sign up to homeswapper or regiser with local authority. Taken from Orbit records.
01.01.2014	Police National Computer records - One Possible record of VIOLENT, DRUGS but showing a different address (2014), Believe this the same person. Has a Non Molestation against him.
10.01.2014	Orbit records note: "******Fortunately Ian informed me that he has taken his mother to son #2's home (in Essex) where she is safe for the short term foreseeable future******Additional information:Ian was very helpful and understanding with the situation. He did however say that son #3 used to bully his mother and was often in trouble resulting in visits from the Police. Ian took action and removed his bother from the property before Christmas. He is also getting an injunction against his brother from contacting his mother. I got the impression that the current situation with the meter defect has direct link to son #3's behaviour. This may explain the position EDF took with this callout. Recommendation: [Name Removed] - I'm not sure if the electrical problems to this property are on your radar. [Name Removed] advised that MITIE are booked on the 22nd Jan to carry out a test. Obviously recent events mean arrangement for a test and subsequent work will have to be brought forward as an emergency. I told Ian that somebody would call him [Telephone Number Removed] or his partner [Details Removed] on Monday to arrange access for MITIE. [Name removed] - if you could free up an electrician for Monday please. [Name Removed] - I think it might be worth asking the Neighbourhood Officer to call Ian to further enquire on his mother's welfare. Ian seemed very genuine on the phone but I suspect there is a back story to this case involving ongoing ASB from son #3 that we may be aware of. The condition of the property may have suffered as a result. I called Ian back at 8:45pm and he was happy with ORBIT's outlined approach. Hopefully the above makes sense. Call me if you need further detail. Note on CRM. [Name Removed] Duty Officer
15.04.2014	[Care Agency] rang to report carers had called at the home and the client has a staffordshore terrier who will not let the carers get near her. The dog is usually upstairs but today it was downstairs. The carers left and will return later when the dog has calmed down. [Care Agency] asked me to call, however i tried on several occasions and no one answered. [Telephone Number Removed]. Note Emergency Duty Team.

Date	Chronology Information
01.12.2014	PCT Diamond withdraw services as they were unable to provide carers that were willing to go in to the home.
02.12.2014	Inspire commence delivery of home care package.
02.12.2014	Call from [Name Removed] @Inspire as they provide clients personal care. Has a standing hoist and a moving hoist . [Name Removed] says that Mary is not suitable for a standing hoist at all and the moving hoist is old and needs servicing as it can just stop working . Also a general O/T assessment is needed for this client . Says that the rails in the bathroom are rusty and there is a hole in the floor which cause an issue with her chair.
01.02.2015	Inspire raise concerns re drug use in the home of Grandmother where the children were residing; verbal abuse of the children; broken glass left on the lounge floor for two weeks; neglected home conditions; overcrowding; physical impact on the children of parental cannabis use. Case progressed to Assessment. Concerns not substantiated aside from the over-crowding. Case closed.
24.02.2015	Telephone conversation with [Name Removed] Safeguarding Adults Coordinator at Inspire. -Concerns that the client may be being coerced and financially abused by her family. Young family members sleeping on her floor; preventing access to her lift; being obstructive re charging of her hoist which to date the carers are managing still to do. Significant verbal aggression towards client, not yet clear if also towards client. ACTION AGREED - [Inspire] will telephone the detailed concerns to the contact centre. Will ask the contact centre to make it clear in the referral that neither the client nor the family are aware of the referral. There must be no contact with the family or the client prior to discussion with the alerter and a multi- agency discussion on risk management. Current level of Risk to Client - There does not appear with the information available to be an immediate risk of any significantharm occurring but there may be risk of ongoing financial, emotional harm and a risk of physical harm if the hoist is not able to be charged. 24-Feb-2015 17:16
25.02.2015	Telephone conversation with [Name Removed] at Inspire with [Name Removed] Safeguarding Adults Coordinator Complex Team East. Urgent Safeguarding Alert. Client has carers 3 times a day and she comes to the Day Centre at Inspire twice a week. Over the last few weeks problems within the household have been escalating from shouting and swearing to verbal threats. The family are preventing care of the client by refusing to plug in the hoist and when the carers do this they are getting abuse from the family members and the client is getting upset. Family members in the home are using drugs and alcohol and this not making the care environment safe. The other day there were complete strangers lying on the floor near her. Family don't want the carers to give the client the full dose of her painkillers. This morning the carers went in and received verbal threats. Carers can no longer attend to this client as it is unsafe to do so. Family members, John (the son) and Hayley (partner), take money from her purse. They say it's to buy groceries, but there is no food in the fridge. The family members are also restricting

Date	Chronology Information
	her from eating chocolate. A previous carer has also been assaulted by this family. Medical Conditions: MS, Diabetes, other conditions unknown. 25-Feb-2014 12:32
25.02.2015	Brokerage have informed that carers form Inspire are withdrawing their care as from today, as they are sustaining unacceptable levels of verbal abuse, which could also escalate to physical abuse and intimidation. I have noted that [Name Removed] has put on a case note yesterday regarding this case. Apparently the house also is in a poor condition, a son has just moved back in to the property, who has not been supportive and there are dogs also on site. [Name Removed] - Safeguarding Adults Co-ordinator. Telephone conversation with [Name Removed] at Inspire. (as above - 24-Feb-2015 17:16) Noted by [Name Removed], Social Worker, Complex Care East Team
26.02.2015	[Social Worker] contacted Mary directly regarding the concerns raised and recorded “In relation to Mary's capacity, I have known and worked with her and the family for a number of years and she has always had the mental capacity to make decisions about all aspects of her life including care, who stays in her home and her right to family life even if this impinges on her ability to receive care. Having talked to her again today I remain of the opinion that she still retains this mental capacity”. “I have to say in my experience of the family their day to day language always included a lot of swearing and they are very loud so it can be intimidating even if this is not the intention”. “I have no concerns that Mary was answering under duress because Hayley was present. The family have always been very open and honest in their dealings with me and have freely admitted when they have lost their temper and been aggressive. Hayley and Mary both feel that the carers in this instance have reported the concerns as a result of Hayley challenging them on staying in the house once they have finished their duties. Mary was very clear in her wish to continue having the same carers and agency and was upset at the thought of changing carers as she said she likes all the girls. She also kept saying she didn't want to get them into trouble. Hayley also said she wanted the care agency to keep providing the care and could see no real reason as to why they were withdrawing. I asked both Hayley and Mary if they needed care to resume today as it was unlikely we would be able to do this. Hayley stated they would do whatever was needed for Mary until care was reinstated”. [Social Worker] concluded “Having listened to Mary and Hayley's view of the incidents and concerns, and being aware of previous family history and safeguarding investigations in my opinion the safeguarding concerns are not substantiated. However, the issue in relation to the family being abusive and aggressive towards the carer is an ongoing issue. It appears that the reasoning for the family using abusive language could be valid but their approach to dealing with it is the issue. this is always going to be the case because this is how they communicate with each other in their everyday lives and see no problem despite this issue being addressed on numerous occasions by many professionals including myself”. The safeguarding was closed at the clients request, and the care package was reinstated.
02.03.2015	Email from Ian to LBB Brokerage - "Here is a email that i have passed on to the care company that has been looking after my mum i am very unhappy with the care provided and the malicious comments that have been mad about us to the council and other parties i am very unhappy with the situation that these carers are allowed to freely to do under no real supervision and i don't feel they have had

Date	Chronology Information
	sufficient training at all and due to family in the business i do feel that have made a professional issue into their own personal vendetta i feel this very manipulative over people that are disabled and quite wrong for them to use the system and their authority against people. Ian."
18.03.2015	Aquaflow Commence delivery of Care Package - Email Sent: 17 March 2015 11:35 To: 'AQUAFLO' Subject: NEW REFERRALS Importance: High Hi [Name Removed] Further to our telephone conversation please find attached 2 referrals for x 2 carers. Mary – to commence tomorrow Wednesday 18 th March with a.m. call . Please confirm receipt. Thank you. [Name Removed] Choice & Planning Co-ordinator Brokerage Audit and Review Team
26.03.2015	Spoke to customer who is in a wheelchair. She said that she has never had to pay anything before and would contact HB. She has her son, daughter-in-law and five grandchildren living with her. Says that HB don't know this. Said she cannot pay anything as she has no money. Advised her to contact JHB. Left statement and calling card. Orbit records.
13.04.2015	From: Bexley Aquaflo [mailto:bexley.aquaflo@aquaflocare.com] Sent: 13 April 2015 10:08 To: [Broker] Cc: [Senior Borker] Subject: RE: AVAILAbilITY Hi [Broker], This is an update to Mary's care package, started on Wednesday 18/03/2015 with AM call. I will like to inform you that the allocate time for her Lunch and PTB call is not sufficient because client spent more time in the toilet and request the carers to wait till she finish. So carers have to wait change, and transfer her back to her seat/bed. I have observed this myself whenever I cover shift with one of the carer. The environment appears unsuitable for the carers to work with it due to the use of hoist and transferring client. For example, the bathroom is untidy, the house floods, she sleeps in the living room with the dog on her bed and it unhealthy. We are concern about Mary 's home environment and her well-being. We have also reported on the 09/04/2015 that her hoist appears to be faulty because sometimes it work properly and sometimes it does not work. We are told that one of the team from the repairing will visit her but no specific time or date was given. Please I will really appreciate your immediate reply regarding this matter. Presently, the carers are really struggling using the hoist and maintaining all calls in the AM, Lunch, Teatime and PTB. The carers have reported to the office they cannot continue this package because of health and safety reason; they are complaining of their back.

Date	Chronology Information
22.04.2015	From: Aquaflo Bexley [mailto:bexley.aquaflo@aquaflocare.com] Sent: 22 April 2015 11:03 To: [Name Removed], Brokerage TeamSubject: MaryHi [Brokerage],Good morning [Name Removed], just to let you know that the hoist has not been replaced and carers are struggling using it. It been almost two weeks now, and carers are holding back from visiting this client. Sometimes I do cover up for this client, and I've also sustained a back injury. This client refuses to have a bed wash as she wants to have a proper shower and this is becoming an impossible task to do. As carers are pulling back from this package, we would be forced to drop this package, due to health and safety issues. At this present moment we don't have double up capacity and we are really struggling. The issue regarding the hoist has been on for the past few weeks, and nothing has been done to resolve the problem. Secondly, this morning 22.04.15 at 07.00am, the daughter in-law asked me if any of my carers has picked up her younger sister's iphone. Personally I felt offended, on the same spot of my discussion with her I mentioned to her that that I will contact both carers that attended the call time yesterday and get back to her this afternoon. I have contact the two carers, and they confirmed to me that they have not seen the phone neither have they taken it. They only went there to do their put to bed call and went back home. Right now the two carers cannot be sent back there due to this allegation; in addition to this we are short of staff to maintain the double up call for Mary. I will appreciate your immediate response to this matter, please confirm receipt of this email. Many Thanks, [Name Removed], Aquaflo Care Company
24.04.2015	Hi [Broker], Sorry for the late reply, we do not had anything about the hoist. Please may I inform you that we are seriously struggling with this package due to health and safety reason, I [Name Removed] have to cover this package with another care coordinator from the office. I live very far in Essex and I can not continue to cover the package with my care coordination. At the moment, I do not have a capacity to continue this package. Please I will really appreciate if you can look into this matter as soon as possible. Please confirm receipts of this email. Many thanks, [Name Removed], Aquaflo Care Company
27.04.2015	From: Bexley Aquaflo [mailto:bexley.aquaflo@aquaflocare.com] Sent: 27 April 2015 13:37 To: [Broker] Subject: RE: Mary Hi [Name Removed], This is an update on above client, no hoist has been delivered, and at the moment is a struggling maintaining this package due to carers refusing to return to the care package. On Friday 24/04/2015, at about 19:30, client has not yet got her replaced hoist yet again, called the Rapid Respond team and Bexley council for an update of the hoist but nobody to report to. Client's son had to transfer her from her mobile chair with the damage hoist unto the toilet sit. Client's son also stated that we cannot manage the hoist because it is not working properly. He also transferred her into her mobile chair unto the bed by carrying the client. We are concern about the safety of both client and her son. We noticed that the method of transferring was not safe for both. I will appreciate if client can be re-asses due to her needs, the environment and the also to see the state where client's sleeps.

Date	Chronology Information
	On 25/04/2015 at 08:00, we got in and told her we can't use the lifting hoist but we can give a bed wash; client burst into tears and appeared very upset. We had to stop and ask her why and she said we should stop the bed wash; we immediately stopped and dressed her up. We have both strain our back from transferring her using the lifting hoist because the bed need to be change and also she wants to sit on her mobile chair. We transferred her from her bed with lifting hoist into her mobile chair; we gave her porridge with a cup of hot chocolate and medication prompted. We went in for lunch call on 25/4/15, client needed to use the toilet, we can only used the lifting hoist to put her into her mobile chair and she moved herself into the toilet, this was so much an effort because her corridors were too narrow. We are concern about this client because she needs to use the toilet and needs her hoist as soon as possible. This morning I got a call from the carer who double- up with me calling in sick in the early hour of this morning and complained of her back after working on this package over the weekend. Based on this issue, I and my manager have to leave the office to do the double-up for above client. We can't continue to close the office in order to attend to the client. Please I will need you to understand that is been a struggle maintaining the care package. This morning as you know, client declined bed wash and she was very upset about it and burst into tears again. We persuade to wash her face and used a wipe to do her personal care. We dressed her up on bed and used the lifting hoist which is uncomfortable for client while transferring into her mobile chair. Client cannot use the toilet because hoist is not working. Client also declined the use of pad. Client stated that she has not been visited by either social service or a physiotherapist for the past three years. We can't continue with this care package due to short of carers who has been on this package and have a strain in their back as a result of hoist not working for the past three weeks. We have reported this issue about the hoist and up till now client has not yet got a replaced or repaired hoist. At the moment, three staff of ours has been stopped from working (two carers and Field/Care Coordinator) these are the main carers for Mary. Therefore, we do not have capacity to maintain double-up package till we recruit more carers in that area. I will inform you about the hoist after the visit this afternoon. Please we need a reply urgently, we can't continue with this package. Many thanks, [Name Removed]
29.04.2015	From: [Name Removed] Sent: 28 April 2015 13:45 To: 'Bexley Aquaflo' Subject: RE: Mary Hi [Name Removed], I have cover Mary with another provider from Thursday 30/04/2015 am, your last call will be Pm on Wednesday 29/04/2015. Please confirm receipt of this email Many Thanks [Name Removed] Senior Broker, Care Brokerage
30.04.2015	Haven Social Care commence home care package delivery.
05.05.2015	Client continuing record, Brokerage contacted for change of carers as the did not attend Monday due to dogs not being put away, Mary tearful. {Inspire notes)

Date	Chronology Information
16.06.2015	Subject: Tenancy Management: Adding tenant to tenancy; Transferred resident through to [Name Removed] re : Daughter in law and 5 children have moved into property.
12.07.2015	I hereby confirm that Haven Social Care will carry on providing care service for Mary. Kind Regards. [Name Removed] Care Coordinator Haven Social Care. Sent 10th July. Previously Haven Social Care were going to withdraw from the care pacakge on 12th July.
15.09.2015	Inpsire - Client continuing record, call made to catheter nurse, Orbit housing called, regarding daughter in law being added to tenancy, couldn't as over crowded, new boiler needed and Mary concerned house will be to big/expensive if the family move out.
	Orbit - Subject: Tenancy Management: Adding tenant to tenancy; The residents Daughter.
06.10.2015	Safeguarding concern raised in Oct 2015 by Inspire Day Care. The Day Centre reported the following concerns: Mary arrived at the Day Centre not positioned properly in her wheelchair and Mary looked unkempt. Following a call to the Care Agency further concerns were raised by the carers, no clean clothes or bed linen where available, no food for breakfast and no money for food at the Day Centre. The case was allocated to [Name Removed] Social Worker as Enquiry Officer and [Name Removed] Senior Social Worker as the SAM. A conversation was had with Mary regarding the concerns that has been raised and a meeting was held at Inspire Day Care with a family member was also present. Mary's capacity was also addressed and confirmed that she had capacity at this time regarding the concerns raised about lack of food at the property and money for the day centre. The outcome of the enquiry was as follows: [Social Worker] states "Mary does not want any further enquiry made as she is happy at home with her family and has denied all allegations made by the care agency (Haven Care Agency) and day centre (Inspire). As a result she does not want this enquiry to continue because she is fine and the allegations are untrue." Mary considered that Hayley did her best. Hayley had also explained that she shopped small and often so some days there would be no food as she would be due to shop that day.
22.12.2015	Increase in day care agreed by panel, passed to [Name Removed] Respite & Day Care Assistant, to process
24.02.2016	Email sent sent by Central Care team to OT as follows: - Hi [Name Removed], Please see email below from Inspire. Thanks. "Hi. FYI My name is [Name Removed] and I am duty worker at Inspire today. One of the service users (Mary) has come in today, and stated that she is wearing her last continence pad, and could we give her some from here. We have previously given her 2 packs, and have supported her to phone Continence Services and the District Nurses. Mary currently has no working phone, so I have asked the continence nurse to contact me here at the centre, so I can pass on the messages. I believe she is waiting for a follow up appointment to get on the rolling scheme for delivery of

Date	Chronology Information
	pads. When I asked if she could purchase any pads until she got a delivery, she said that she had no money to do this. She often comes into the centre with no money on her, and so clocks up a bill for her lunch here. I understand that her daughter in law deals with her money at home. Could this please be looked into and chased up, as we cannot keep supplying her with pads, and if she doesn't get a working mobile, she will have no means to book any appointments. I feel she may be getting neglected in certain areas of her care. We have sent her home with a third pack of pads. Many Thanks, [Name Removed], Day Service Officer, Inspire Community Trust.
01.04.2016	From:[Name Removed], London Hire Ltd Sent: 01 April 2016 12:05 To: [Name Removed] LBB Triage Team Subject: Mary Hi [Name Removed], what we spoke about on the phone money missing Mary's family are saying they gave Mary £10 pound this morning put it in her bag when Mary got on the bus she ask the passenger Assistant to have a look in her bag no money in bag. The passenger assistant went back to the house to ask a family member one of the family came out to the bus to see Mary started shouting at Mary saying you're always losing money, Family member said this is all I have gave her £3 pound and a bank card shouting a pin code really fast no one understanding what the pin code was. Thank you, {Name Removed] London Hire Ltd Action From Triage: Contacted [Name Removed] who raised the alert to get more information. She reports that the concern was raised by London Hire and she reported issue to Commissioning Team but was asked to raise a safeguarding alert. I have attempted a call to [Name Removed] from London Hire but missed him, a voice message left on his phone to ring back. Case is open to [Name Removed], Moving & Handling OT whom case is been discussed with. [Moving & Handling OT] knows the family very well and he would do a follow up on the above issue. Case would not be raised as a safeguarding at this time, It would be link to existing case for [Moving & Handling OT] to follow up and he would raise an alert if he has any concerns
17.05.2016	TELEPHONE CALL With both tenant and tenants occupant Hayley regarding an incident of ASB witnessed by myself today and reported by their neighbour. I warned tenant that the behaviour of her visitors to her property today is not accepted and is classed as anti-social behaviour which in turn could have an effect on her tenancy. Hayley said she had just come back from shopping and had told the boys of for their behaviour. I explained to the tenant that I had been on the phone with her noeighbour when one of her vsiitors had knocked on the door. I listened in on the conversation and the visitor became abusive and intimidating saying he could do whatever he wanted because he had the permission of John, tenants son. I explained to the tenant that the tenancy is in her name and her name only and therefore she is responsible for the behaviour of any occupants or visitors to her property. I said I would be sending a letter out today as a warning regarding the behaviour. [Orbit]

Date	Chronology Information
23.06.2016	23/06/2016 -24/06/2016 admitted to Rowan Ward Darent Valley Hospital. Mary attended for Cystoscopy and Supra Public Catheter admission. She was in for less than 24hrs, she recovered well.
05.07.2016	DN IMR notes: 05.07.2016 onwards: Following suprapubic catheter insertion there are multiple calls to DN service for bypassing catheter, urinary tract infections and suprapubic site infections. Also, regular need of bladder wash outs and skin assessments.
19.07.2016	Subject: Tenancy Management: Adding tenant to tenancy; daughter in law [Orbit MIS-AMS records]
16.09.2016	Tenant's daughter in law came in and handed a letter for add occupant- to add daughter in law and her chilred. she only bought the daughter in laws ID. I have asked her to bring the childrens ID. she will be bringing them in. [Orbit MIS-AMS records]
31.10.2016	Merlin report received relating to police officers executing a search warrant in the family home under sec 23 MDA; however no drugs were found in the property except the cannabis joint owned by father. The whole house has been described as filthy and very messy, dirty clothes and toys are everywhere, floor, tables and surface seem to be covered with leftovers and dirty dishes. Toilet and bathroom were described as disgusting, unhygienic and filthy, as was the kitchen. Leftovers were left in every part of the house. All the beds in the house were filthy with dirty bed sheets and kids sleeping on the mattresses covered in plastic foil with no blankets underneath. [Name Removed] has asthma - which could be heard straight away - yet house is dirty and her father was smoking cigarettes in the presence of [Name Removed] and her siblings. C&F undertaken which did not identify safeguarding concerns for the children.
21.11.2016 - 23.11.2016	URGENT SOCIAL WORK INPUT requested (23-Nov-2016 12:38). Liquid Logic notes: Client's services were provided by Haven Care, due to serious issues raised and a whistle blow a new provider had to be sourced as a matter of urgency, the new provider Eleanor Care took over the care from Monday 21/11 at very short notice. Due to confidentiality the agency were advised not to contact the client prior to taking over the package. Eleanor Care have identified so many issues which has now resulted in all carers refusing to attend to client. The issues raised are that the front door is broken so carers were asked to wait until a family member climbed out of the window to be able to let them in, there are lots of children and adults sitting around while the carers are trying to carry out personal care to the client, they are making the carers feel very uncomfortable and threatened, there is nothing clean to wash and change client, there are dogs running about the home and getting under the carers feet. The agency have no other carers to attend, historically this client has had lots of agency changes due to the issues with family. Can I please request urgent Social Work in-put as this lady will be without care after the lunch call today. 23-Nov-2016 12:38 Triage Outcome Decision: T/c to Ian (son) he confirmed [Senior Broker] had been in touch and he was aware the new agency could be starting tonight. He advised he had called Orbit and notified them that the door was not secure and they should be fixing this in the next 4 hours. Ian was agreeable to putting the dogs in a room when the carers visit and was aware it may take some time for carers to get to know Mary and the family. Suggested if the

Date	Chronology Information
	door is not fixed to leave it ajar when carers visit so they do not feel anxious that they can not get out. He advised he did not see the point of the family leaving when personal care was undertaken since they all help Mary with this. Mary is able to advise if she wants the family to leave the room. Ian was aware I would be passing the case over for allocation to a Social Worker to oversee the start of the care package to prevent care from being stopped in the future. High Priority for allocation to Social Worker on an urgent basis to work with the family and care agency to address any issues regarding the property to ensure care does not break down in the future.
24.11.2016	T/c to Ian (son) he confirmed [Senior Broker] had been in touch and he was aware the new agency could be starting tonight. High Priority for allocation to Social Worker on an urgent basis to work with the family and care agency to address any issues regarding the property to ensure care does not break down in the future. Case to be passed to Complex Care East as discussed with [Triage Duty Senior].
16.12.2016	Administration NOS DN letter- for positive UTI. abx done, sent to chemist, msg left for pt to ring reception - District Nurse requesting antibiotic for UTI, prescription sent promptly.
18.03.2017	LAS 999 Call Log (CAD 4189) and PRF A 999 call was received by our EOC at 21:15 from a district nurse for an ambulance to attend address 1. It was reported that Mary had a blocked suprapubic catheter and had dark and smelly urine. On arrival of the ambulance staff they have documented that Mary's catheter had been bypassing since the previous day the district nurse had tried to unblock it without success. Following the ambulance staffs assessment Mary was conveyed to Darent Valley Hospital where a handover of care was provided to the hospital staff.
05.05.2017	Carewatch Safeguarding Concern. Email received from [Name Removed] of Carewatch regarding issues carers are facing with client's addiction, unruly dogs and poor home environment. Email passed to a senior who will speak to client's son Ian to address issues raised. Tel call made to [Name Removed] at Carewatch informing her of current action.
26.07.2017	Email from Care watch highlighting concerns about: -Lack of toiletries in the home -broken microwave -dirty dishes left in the sink -lack of food shopping -Smell of cannabis on the house Care watch advised they had discussed concerns with Mary and she confirmed she is smoking in the property. After coming back from Mary home, we had a message left from the daughter-in-law saying:- "she wasn't happy, she mentioned that there is always shampoo and conditioner in the house. If there isn't any downstairs she will always have some upstairs and that she is happy to go and get them for the carers. Regarding the smell of cannabis - it is Mary that smokes this, but never inside the property - they always take Mary out into the garden as she doesn't want it smoked around her children". Carewatch following these conversations- the concerns still remain and no action has been taken. Social Worker discussed concerns with [Senior Broker]. [Senior Broker] advised that

Date	Chronology Information
	these are ongoing concerns. [Senior Broker] advised Mary has capacity so to discuss concerns with her. [Senior Broker] said what normally happens is concerns are raised- family address them and then it improves for a period of time. [Senior Broker] advised Mary is difficult to contact, so recommended speak to her at day centre. Checked support plan- Mary attends inspire day centre every Tuesday, Thursday and Friday. 27.07.2017 T/C to inspire day centre- I was advised Mary was having lunch and to call back later. T/C x2 no response- message left stating i'm trying to contact Mary 28.07.2017 T/C x3 no response- message left stating i'm trying to contact Mary 1.08.2017- Contacted Mary at Inspire day centre to discuss concerns- Mary was aware of concerns and advised she is going to buy a new microwave. Mary advised she will discuss concerns with her family to get them addressed. Mary had capacity and understood the risk that if concerns remain carers may not be able to provide the support she requires. Agreed I will speak to Mary on Thursday 3.08.2017 at Inspire day centre to find out if she has spoken to family and addressed concerns. Mary denied concerns about the lack of food in the property. T/C to Carewatch spoke to [Name removed]- Carer - I advised I had spoken to Mary about concerns and asked that she gets her family to address concerns. I explained i will call Mary back on Thursday to find out if she has had a discussion with family and if there are any problems will see if Mary consents to me speaking to her family on her behalf. I explained Mary has capacity and understands the risks so Bexley Social Services are limited in what action we can take. [Liquid Logic Notes by LBB Triage]
10.08.2017	TRIAGE OUTCOME DECISION- Following [Name Removed] (Social Worker) conversation with Mary on the 01/08/17, I followed up with Mary to ensure the concerns have been addressed. T.C to Mary at Inspire Day centre. [Name Removed] (Inspire day centre manager) was present. Mary was happy with this. Mary could recall the conversation with [Social Worker] and when asked about the microwave Mary advised she will be purchasing a new one when she next goes shopping very soon. I asked Mary about the toiletries and these are now down stairs and easily access to the carers. I asked Mary about the cannabis and she advised she no longer smokes inside. Mary is aware that there is a health and safety risk to carers if she continues to smoke indoors. Mary advised her daughter in law Hayley every Tuesday and Friday when Mary is at the day centre. I advised the concerns have been addressed and Mary agreed. Mary is happy to let the care agency know the outcome of the safeguarding alert. I advised Mary to contact social services if she has any concerns in the future. T.C to [Name Removed]- Care Watch Bexley. I have advised [Name Removed] that the concerns have been addressed. [Name Removed] advised that she visited yesterday and there was still no working microwave. I advised Mary had told me she has not got round to buying one yet. I advised that the carers needs to communicate with Mary if they have any concerns. Care agency to inform Social services if they still have concerns. Care agency to continue to prompt Mary to get

Date	Chronology Information
	a new microwave if the family do not arrange this. PLAN- Safeguarding enquiry to be closed as concerns have been addressed. Care agency to speak to client/family if the microwave is not replaced. Care agency to contact SS if any future concerns.
21.08.2017	CareWatch raises Safeguarding Concern. "Mary lives with her family and on the 19 th and 20 th of August they left to go away for the weekend. We were not informed of this and Mary does not have a working mobile phone or a link line. Therefore had no form of contact if any issues were to arise. Carers also informed us that there was lack of food in the house. On the 19 th and 20 th August Mary was having to live off cornflakes, ryvita and beans on toast." Plan to set up LinkLine - Closed Case due to not being contacted back - I tried to contact client through agency, could not get through and sent a letter to client's address, I have not heard anything back.
29.08.2017	T/C to Inspire Day Centre to discuss concerns about lack of mobile with Mary. Mary advised she is waiting for a new chip for her mobile. Mary said she is getting a landline set up soon. Discussed Linkline, Mary would like this. Agreed to contact her on Thursday 31.08.2017 to undertake referral. Mary asked for keysafe to be installed, Mary lives in Orbit property in a house. I advised we will need Orbit's permission to set this up. Mary was advised it may take some time to get keysafe installed. T/C to Orbit Housing to request key safe for Mary. Orbit advised they will install this but need to send a letter to Mary first to get written permission. T/C to [Name Removed] Inspire day centre to ask if she can explain to Mary, I can not undertake telecare assessment without landline number. [Name Removed] thinks the landline is being installed today. I advised Orbit will install a keysafe.
27.09.2017	I have had an Email from the transport team stating "Just to inform you that Mary won't be attending Inspire today due to not having any money at the moment" I have passed this information to [Name Removed] as she is completing a CAT annual care plan review on 04/10/2017.
10.10.2017	Have not heard from client, contacted Inspire multiple times and sent a letter to client's address stating that I have tried to make contact to discuss the service with her and presented my direct dial on the letter on, sent 14/09. Closed Case. Noted by Triage.
01.11.2017	Safeguarding concern raised in Nov 2017 by Care Watch – Bexley. The care agency reported the following concerns: Mary reported that she no longer wished to live with her family, she was only being given £100 a month out of her benefits, no food in the fridge and not being included in family meals, unable to be showered as there was often dog faeces in the shower room and no clean towels for P/C. The case was allocated to [Name Removed] SW CCT as EO and [Name Removed] SSW as SAM. Mary was assessed has having capacity “Mary demonstrated understanding of the concerns raised, she was able to retain the information provided and weigh the information to communicate her decision”. Mary was visited at the day centre to enable her to be interviewed alone and then again at the family home with her daughter in law present [Social Worker/EO] stated the following “Mary demonstrated understanding of the concerns raised, she was able

Date	Chronology Information
	to retain the information provided and responded with coherent information as well as come with a solution of how she should be supported to minimize the long-term risks. Mary was clearly able to express that she does not view her daughter in-law, Hayley's action to be putting her at risk of significant harm as she has been very supportive in ensuring her care needs are met. However, she acknowledged the limitation around how her finances are being managed and having eight close family members living with is not how she wishes to continue living. Therefore, she does not wish the concerns to proceed to a full safeguarding enquiry rather she wishes to be supported to downsize to a smaller property where she would live alone, and this will help her level independence and make her feel in control of her environment and managing her affairs. This will also reduce the chances of safeguarding concerns being raised". The outcome of the enquiry was as follows: Social Worker recommends - To close the safeguarding as Mary does not wish for it to proceed further and she is capacitated to do so. To support Mary to complete housing application form. Case to be allocated for a needs assessment to help identify Mary's long term care needs and a suitable care package.
09.11.2017	T/c received from Mary stating that she really wants to move. She stated that the situation is not good in her house. Her son John is shouting/moaning at her which is making her feel uncomfortable. She wants to live on her own with a live in carer. Mary stated that she doesn't feel at risk, but said she would alert social services or agency carer if she does. Agreed to pass message over to allocated worker.
14.11.2017	Screeners received email from Carewatch Bexley highlighting their concerns about medication management for client - email has been uploaded to client's documents for reference: Triage Hub Action: T/c [Name Removed], Carewatch who confirmed that carers reported the incident to her on 12/11/17 pm - she then spoke to Mary who declined contacting the GP because she said that she felt fine. Mary took some responsibility for the incident as she had forgotten that she had taken this medication and asked a family member to dispense it again. [Carewatch] confirmed that her medication is in a blister pack - so family member should have noticed that she had already taken it. [Carewatch] also said that lights had not been working in the kitchen, so carers were unable to prepare Mary's meals - she has spoken to the daughter and this matter has now been resolved. [Carewatch] also raised concern that there are rats at the property - she was unable to confirm if they are inside or out. Agreed to alert allocated SW of these concerns. She is due to visit Mary tomorrow morning. Triage Hub Outcome Decision: Referral link to be reassigned to [Name Removed], allocated SW, CCE.
17.11.2017	Carewatch raise safeguarding - son swearing, hit something - didn't know what it was. Apologised, and then started again. Agressive behaviour. Carers felt unsafe. Noted children at property. T/c Carewatch, [Name Removed] had left for the day. Spoke to [Name Removed] and advised that concerns raised are regarding the wellbeing of children in the property and referral should have been passed to children's services. Advised her that I am unable to do this as referral is from themselves.

Date	Chronology Information
	I agreed to contact Children's Services to establish if the children are open to their service. T/c to Children Services Admin and was advised that children have been closed to Children's Services since May and was advised that Care Agency should complete a new referral form. T/c Carewatch, spoke to [Name Removed] and advised her that she would need to make a new referral. I provided her with email address for new referrals and contact telephone number. [Name Removed] agreed to refer directly to Children Social Services. Triage Hub Outcome Decision: In view of the above, concerns raised are related to the grandchildren and care agency have be advised to make a new referral to Children Services. Mary is currently being supported by SW in CCE as part of a Section 42 Safeguarding Investigation.
27.12.2017	Administration NOS DN reports ?uti, unable to get sample. abx cover and rpt dipstick post abx. admin informed. - GP Notes
04.01.2018	January 2018 the case was allocated to [Name Removed] Social Care Assistant, Complex Care Team to complete a needs assessment. Needs assessment and Moving and Handing Assessment completed.
18.01.2018	In May 2017 the agency contacted the brokers to report: issues with drugs; the dogs being present in the home were unruly; the general condition of the home environment being very poor; that there were no clean towels, toiletries or clothes for Mary, which was making it very difficult to provide Mary with the support and care that she needs to address her basic needs. The agency also advised that there was a lack of food to give to Mary, plus there were dirty dishes everywhere and the microwave which they used to heat food, when it was available, was broken. In August 2017 John and his family went away for the weekend. They had left Mary with no food, nor a working phone that she could use to contact someone in an emergency, if she needed assistance. The agency raised a safeguarding in November 2017 with concerns that Mary was being neglected and financially abused by her family. Following this the agency handed back the care package as were afraid of any repercussions from the John following them making these reports.
19.01.2018	Commissioning asked to find suitable emergency respite placement for Mary however no paperwork on the system that can be used. Following on from discussion with Social Worker who has spoken with client who has capacity and does not want to go into respite. Commissioning to stand down for looking at placement for client and social worker to go and meet with client to sign statement confirming this.
	Visit to Mary at Inspire Day Centre to ascertain her capacity, her wishes, feelings and view about going into a temporary accommodation as it has been very difficult to find a care provider that will provide her care at home due to the family threatening behaviour towards carers. We explained to Mary the reason for our visit and she understood. She was asked how she will manage since the care agencies are refusing to send their carers to provide her care due to the threatening behaviour of her family. She denied that the carers were threatened by her family and said that the incident happened a while ago and it was only [Carer Name Removed] that was asked not to return to her home. During the meeting Mary was asked if she required an advocate to support her and she said no that she

Date	Chronology Information
	is fine. Mary refused to go into a care home on a temporary basis until Wosley House is ready and made a decision to return home and that her family will support her. She was asked how her personal care and toileting will be met and she that Hayley or her son John will help her as well as changing the Urinary Bag (Catheter). A Mental Capacity Assessment will be completed by [Social Care Assistant] to show the rationale of decision made by Mary. Mary was assessed to have the mental capacity to make a decision in relation to her care and support needs and she was able to understand the information provided, options considered, retain the information long enough to make a decision, communicate her decision in a clear manner. She was able to tell us that if she is not supported with personal care she will be dirty, have infection and skin damage. This was witnessed by [Social Care Assistant] and [Inspire Manager] as well as [Social WOrker] on a 2nd visit with [Social Care Assistant]. As a result Mary and her family signed a written statement to say that she will be supported until she is placed at Wosley House. Options Considered: *For Mary to go into Wosley House with enhance care package double handed and full body hoist to be provided by the store after Occupational Therapist Moving and Handling Assessment *For Mary to go into Meadowview till Wosley House was equipped with moving and handling equipment and enhance care package *For Mary to into a care home on a temporary basis until Wosley House was ready Mary declined the temporary placement in a care home and made a decision to return home until Wosley House is ready and she was aware of the risk she was taking to return home. Agreed Action Plan: [Social Worker] to complete Mental Capacity Assessment Day Care to be increase Mary to be placed at Wosley House on a temporary basis OT Moving and Handling Assessment to be completed Full Body Hoist Equipment to be provided [Social Worker] to complete her needs assessment [Social Worker] to liaise with Housing Depart to speed up Mary's Housing Application
22.01.2018	I rang Mary on 22 Jan '18 to see how she was and how things have been over the weekend. Mary said everything was fine. I asked if she had been able to have a shower and she said she had one on Saturday and one on Sunday. I asked if she had had a shower today and she said she would be having one later today. I advised Mary that I would probably visit her later just to check she's ok. Mary asked if new carers were coming and I explained that Brokerage have been unable to find any care agency that will come to the house. Mary then explained that her son John moved out yesterday, until Hayley has been rehoused. Social Care Assistant
	I visited Mary on 22 Jan '18 with [Name Removed], Social Worker in Complex Care East, to check how she has been getting on, since the care package was withdrawn on 18 Jan '18. Mary looked relaxed and happy and said she had a shower on Saturday and Sunday. Mary advised that John has left the property yesterday of his own accord and will stay away until the family have been rehoused. I asked where John would be staying and Hayley said he would be at a friend's house. Hayley also explained that John would need to come back to the house to visit the children. Personal Care Hayley explained that Mary's other son, Ian, would now be helping her to shower Mary. I asked Mary if she was happy with this and she said yes as he has done it before. Wolsley House. I asked Mary if she was still happy to go to Wolsley House and she said yes. Mary asked if she would need her quilt and if there was a television there. I said I would check with the manager and let her know. Hayley,

Date	Chronology Information
	the daughter in law, asked if she could visit on day 1 to ensure that Mary has everything she needs and said she would do some shopping for her. Day Centre If possible, Mary would like to attend the Day Centre on Wednesdays, with a view to attending every day if possible. Mary currently attends the Day Centre 3 days a week - ie. Tuesday, Thursday and Friday.
25.01.2018	New POC -Avante Community Support Hello team, Thank you for accepting this care package. Please find attached the referral form. Please note the CCA is not currently available and will be forwarded asap. You agreed to commence on Thursday 25th January with PM call. Kind regards [Name Removed] Brokerage.
26.02.2018	I received a call from [Name Removed] at Avante (Telephone Number Removed) on 26 Feb '18 to explain that when Mary is having a full body wash there are other family members down the other end of the lounge and the other day her son had a friend round, who was also in the lounge at this time. I explained that I will speak to Hayley (the son's partner) and ask them if it is possible to get a screen to give Mary some privacy. I have contacted Hayley on 26 Feb '18 and currently it is not possible to connect to either the home number or her mobile number. After speaking to a couple of professionals here I advised [Avante] to advise the carers to ask Mary each time they are providing personal care, if she wishes them to ask the family to leave the room. They should document that each time they visit. I tried to contact Mary and Hayley on the home number and mobile number and neither phone was answered and there was no facility to leave a message. Noted by Social Care Assistant.
06.03.2018	On 6 March '18 I visited Mary at Inspire Day Centre with [Name Removed], Social Worker Complex Care East. The reason for the visit is because the care agency had raised concerns about her having personal care at one end of the lounge, whilst other family members were at the other end of the lounge. Mary assured us that she was happy with this arrangement and did not want her family to be asked to leave whilst personal care was taking place. I asked Mary if she would use a screen in the lounge to give her some privacy and she said she would. However, Mary advised that she or the family would not be able to afford to buy one. As this is not an item OT provide, the alternative is to purchase one from a charity shop. I will look into this as an option. Mary advised us of the following: - Her son John and his partner Hayley will be moving to the coast in the next few months. - The through floor lift has not worked for some years. - Orbit have done the electrics ie. rewired the sockets downstairs, but now the shower does not work. I agreed to chase up Orbit on her behalf. - Her mattress has a lose connection and she was advised to contact the District Nurses.- Mary would like her shower chair returned from Wolsley House. However, on checking with them this item had been returned to Stores. Noted by Social Care Assistant.

Date	Chronology Information
26.04.2018	Client continuing record, spoke to [Social Care Assistant] and [Triage Hub Coordinator] re: Mary's Shower Chair. [Triage Hub Coordinator] will speak to Community OT team as new assessment may need to be carried our. The Shower Chair went back to stores.[Triage Hub Coordinator] was not been able to track this down. Email on file re: Shower Chair - 27/04. Signed [Inspire Day Services Officer].
26.04.2018	Client continuing record, supported Mary to make phone calls. Rang DWP. Mary has had her benefit ESA suspended as she did not make the appointment on 24/04/2018 at 11 o'clock. DWP will ring Mary on Tuesday 1st May at 2pm on Inspire telephone. Rang beds, will visit Mary on 26/04/2018 at 4pm to check the bed as it is not working properly. Signed [Inspire Day Services Officer].
28.04.2018	Avante undertake a telephone review of their services with Mary on 28/04/2018,
30.04.2018	[Name Removed] from Avante called to advise that carers over the weekend have been expected to cook hot meals in an overnwithout a handle, the lining coming out and an unreadable temperature dial. There is no microwave. The carers are in the interim continuing with the hot meals but this is putting the carer's at risk and can not continue. Supervision notes: Mary still wants to move and is involved with housing. [Social Care Assistant] to contact housing to ascertain current situation and progress with housing.
01.05.2018	Appointment made to visit Mary on 01 05 18 @ 1.15pm with Avante carers (arranged through [Name Removed] at Avante Care) OT has been unable to contact client or her family using the contact numbers on Liquid Logic OT will address missing shower chair, and check to ensure that chair issued to Mary in 2017 (Wealdon Rehab - Raz Shower chair) still meets her needs. If appropriate, replacement chair will be ordered. Social Work - [Social Care Assistant] notified of visit.
	Home Visit undertaken by OT. Notes as follows: Home Visit Mary spends her day in her wheelchair. Double handed carer is in place to complete Mary's personal care needs. Mary is hoisted form her chair onto the profiling bed for her care to be given. Issues raised on the visit are: 1. Shower chair - Mary's Raz shower chair had been inadvertently returned to Inspire Stores, when he replacement at Wolsey House did not go ahead in January 2018. Mary has had Avante care since January 2018, and had not been taken into the shower room between January and May 2018. The shower room is in disrepair, with the drop down rails, shower seat showing signs of excessive rusting, plus the flooring to the shower room was ripped at the doorway and in the centre of the room. The carers report that they have visited in the past and fecal excrement has been found in the bathroom. This has been reported as being due to the dogs in the home using the shower room as a toileting area. The shower area is not usable as the floor seals have been breached and present as a hazard. Mary reports she has applied for re-housing and is hoping to be offered a sheltered housing scheme, or supported living. her family (son, daughter in law and grandson would be housed separately). Case discussed with Comminuty OT Manager, [Name Removed], and agreement reached that at this stage a replacement shower chair re-order should be placed on hold until either Mary is rehoused, or Orbit repair the flooring to the shower room.

Date	Chronology Information
	2. Bed positioning Mary presented with flaccidity of both arms, and she has limited functional use or ability to reposition her arms once she is in bed. The carers use a rolled up pillow to support one of Mary's arms in a functional position in bed, the other arm is positioned using a large 'teddy bear'. Whilst this enable Mary to have her arms close to her body they are uneven and placing strain and poor positioning on her shoulders and neck Suitable positioning pad/blocks to be investigated..Lejrelet roll may be suitable.
02.05.2018	[Name Removed] from Avante [Telephone Number Removed] called for [Social Care Assistant]. [Avante] reported carers have been to client, they have reported a broken oven door; they spotted a rat in the kitchen; dog faeces and dog urine on towel in the bathroom, this was the towel they used for personal care on the client!. Email to [Social Care Assistant] for info
01.06.2018	Client continuing record, supported Mary in having a DWP telephone interview and also a telephone call to Orbit Housing. Signed [Inspire Day Services Officer]
07.06.2018	OT Visits property - Daughter in Law unable to open front door as Mary has key and has locked. Has been climbing in and out of the window. Discusses Sling Damage, Bathroom Floor repair status, Shower Chair situation and Postural Support. Consideration regarding re-ordering shower chair will be undertaken once bathroon floor repaired.
14.06.2018	Supervision Notes: [Social Care Assistant] to visit Mary urgently to discuss issues with the environment, and what she would like to do moving forward. Feed back to senior and we discuss next steps. No record of Social Care Assistant (or any LBB representative) visiting Mary prior to visit by OT to Mary at Day Centre on 7th August 2018, and by Social Care Assistant on 20th August to discuss accident that occurred on way to Day Centre on 16th August. Meeting to discuss issues re: environment took place on 13/09/2018 at Day Centre.
14.06.2018	Community Occupational Therapist undertakes Housing Application status check with Bexley Housing Allocations Service. Allocations Assistant notes in final email on 18/06/18 in email trail that "we are in the process of reassessing the application. Currently the chances of being helped are very low, but I cannot take account of the outcome of the reassessment. Sorry, I have also seen that Mary started filling out the online housing application form but only got as far as completing the household section. No online form has yet been submitted. Mary would need to go back in and complete the application form and submit the necessary documents, details of which are given on the website. We have applications from younger family members but Mary is not included."
22.06.2018	Client continuing record, "Email sent to [Social Care Assistant] - copy on file. Rang DLA, Mary's money should be in by 25/06/2018. Stopped by PIP because a form was not completed in time. Family responsible for filling in forms according to [Social Care Assistant]." Signed [Inspire Say Services Officer]
11.07.2018	Failed encounter NOS X2 - PARAMEDIC TO DO VISIT TODAY
16.07.2018	During case dicussion with Supervisor, noted that Mary still wishes to move to a property. [Social Care Assistant] has reported that Mary would require a live in

Date	Chronology Information
	carer due to the level of night time needs. Social Care Assistant has been advised to complete a CHC checklist.
06.08.2018 & 07.08.2018	Voice mail message to OT from [Name Removed] (Avante) regarding Mary's ongoing needs. 1. Bathroom floor repair - OT has made two appointments for the flooring to be renewed in the bathroom, via Orbit Housing. The family have not enabled access for the contractors to go in. Until the flooring is replaced OT is unable to replace the shower chair. 2. Rehousing - Housing allocations report that Mary has started an online Rehousing application, but has not completed the process. Mary is requesting supported housing. 3. Bed repair - Avante have reported concerns about the bed, and the carers state there are wires visible. Access, Avante Care reports, has not been granted for the bed to be repaired. Action: Call returned to [Name Removed] at Avante Care, followed up by email message. Email sent to [Social Care Assistant] requesting discussion about taking this issue forward. There is no record on Liquid Logic relating to email sent from OT to SCA or of action taken following discussion.
	SCA makes two calls to Mary: one where a message is given to [Name Removed] at Inspire to pass a message on to Mary and one leaving a message on a mobile for Mary. Both messages ask Mary to make calls to fix current issues (ring Stores/ask your family to ring stores to arrange access for the bed to be fixed) and ring Orbit to get the bathroom floor fixed. Ring [Name Removed] for updates on housing application. No regard given to Mary's ability to undertake these actions.
16.08.2018	LAS 999 Call Log (CAD 2861) and PRF A 999 call was received by our EOC at 17:07 for an ambulance to attend address 1. It was reported that Mary had damaged her hand which was bleeding, had bent her finger back and there was an obvious deformity. It was further reported that Mary was an MS patient. On arrival of the ambulance staff they have documented that at 08:30 this morning Mary's carer was in control of her electronic wheelchair and crushed Mary's hand between the door frame and the arm rest of the wheelchair, the carers continued with the journey and took Mary to the day care centre. Mary's son was informed of the incident and attended the day care centre and took Mary to Erith Urgent Care Centre who advised that she needed to go to Queen Elizabeth Hospital for an x-ray and that she was to go home and request an ambulance to take her. On examination Mary had a deep laceration at the base of her right little finger which required closure. Mary had limited movement. Following the ambulance staffs assessment Mary was conveyed to Darent Valley Hospital where a handover of care was provided to the hospital staff.
20.08.2018	Home Visit by SCA to Mary on 20 Aug '18 to see how she was following an incident involving a cut to her hand. Mary advised me of the following: [Name Removed] from Transport injured my index finger on my right hand, when wheeling me out of the front door at approx. 8.30am on 16 Aug '18. My finger was dressed at Inspire Day Centre, by [Name Removed] at approx. 1.45-2pm that day. The finger was cleaned up and a plaster was put on it. [Name Removed] was then told to "Leave it". Apparently the Day Centre advised Transport

Date	Chronology Information
	that they shouldn't have brought Mary in after having injured her finger. Ian (son) asked Transport to take Mary to Erith Hospital that afternoon and that he would follow. Once at Erith Hospital Mary was advised to go to hospital. Mary went home and called an ambulance at approx. 4.30-4.45pm. Mary was taken to Darenth Valley Hospital, where she had an x ray which confirmed it was broken, she also had butterfly stitches to a cut across the base of the inside of her index finger. Mary and her family, ie. John (son) and Hayley (son's partner) asked for this to be raised as a safeguarding. I also carried out a CHC Checklist. I spoke to [Name Removed], Senior Social Worker, [Name Removed], Adult Safeguarding Officer and [Name Removed], Interim Quality Assurance Officer and it was decided that this can be case managed and it is not a safeguarding.
22.08.2018	22/08/2018 Mary did not attend her outpatient's appointment
05.09.2018	(Note): PDF could not be sent as no email set for household.
13.09.2018	SCA visited Mary at the Day Centre on 13 Sept '18, to discuss her housing options. SCA notes: "I advised Mary that I had a meeting with Gill Cross, Housing, on 11 Sept '18 and discussed the following with Mary: • It is not possible to rehouse Mary because she is in a fully adapted property. • The overcrowding is because she has allowed it to happen. • Mary's request to move is 'choice' rather than 'need'. • Mary's family have no current housing application with Bexley. • For the above reasons it is not possible to move Mary and leave the family in the current house. • Housing are not able to move Mary and make the family homeless at the same time. As this is inevitable, Housing are not able to do this. • The family would need to meet the criteria of having lived in the borough for a minimum of 5 years in order to make a housing application. • Mary would need a fully adapted property if she moved and there are currently 11 people on the waiting list. As they get 2 done every 6 months, it would take approx. 3 years if Mary was added to this list. • If both names were on the tenancy then Mary can be moved on medical grounds. However, this is thought not to be the case. • If there are any rent arrears, there is no way they can be moved. • We talked about which people were occupying the bedrooms in her 3 bedroom property and were advised of the following: First bedroom - John (son), Hayley (partner) and [Name Removed] (grandson aged 3) Second bedroom - [Name Removed] (granddaughter aged 16) Third bedroom - [Name Removed] (granddaughter aged 8) & [Name Removed] (granddaughter aged 6) I was advised that [Name Removed] will not share her bedroom with [Name Removed] (granddaughter aged 18), so [Name Removed] sleeps on the sofa in the lounge. Mary was very disappointed that she cannot be rehoused at this time and it was explained that a lot of work has been done with housing to try to achieve her wishes. Mary acknowledged this and asked if I could find out the following:

Date	Chronology Information
	• Mary would like to know if she can approach another Housing Association. I said that I would ask on her behalf, however, all housing requests usually get channelled through the Council's Housing Dept. • Mary also asked if it was possible to get a private rented property that was fully adapted. I advised Mary that I would ask someone in Private Sector Leasing. Unbeknown to Mary that following this meeting the Occupational Therapist and Social Care Assistant had made enquiries into Bexley purchasing an adapted caravan in Essex for Mary to be near her son Ian and to live independently. This was an option that Bexley considered seriously as it was deemed that it would be cost effective in the long term and achieve the desired outcome expressed by Mary in terms of living nearer to her son in Essex. The Occupational Therapist had identified a suitable caravan but sadly Mary passed away before it was discussed with her.
17.09.2018	Supervision Notes by Senior Social Worker: Social Care Assistant has got advice from housing regarding Mary being rehoused and this has been fed back to Mary that she will not be rehoused. However, Social Care Assistant still needs to visit the family to discuss the housing situation as it appears that the house is overcrowded.
20.09.2018	Blocked catheter, DN visit to washout not successful so re catheterised, message to GP regards UTI as urine cloudy.
28.09.2018	Client continuing record, called in to DN regarding sores on Mary's right buttock. Cut off every time. Rang surgery as concerned that will lead to further problems. Given DN's email. Sent DN email and applied Proshield. Signed [Inspire Day Centre Officer]
28.09.2018	[Social Care Assistant] visited Mary on 28 Sept '18 at the Inspire Day Centre as she was contacted by [Name Removed], Community Support Services Manager, to say that Mary had come into the Day Centre upset. [Name Removed] and I saw Mary and discussed the following: Home life - Mary was upset as [Name Removed], one of her granddaughters told her this morning that she should be in a home. Mary said she now wants to live on her own. Mary understands that in order to do this, she needs to ask the family to leave. Overcrowding - Mary is aware that the house is currently overcrowded as there are 8 people living in a 3 bed property. I will visit Mary and Hayley (son's partner) at home at 10am on Monday, 1 Oct '18, to discuss this and find out what the family's plans are for moving. Mary asked me to invite Ian (son) to the meeting and I have contacted him and he said he will be present. Bed Sore - Inspire Day Centre noticed a bed sore at the top of Mary's right leg when they changed her today and applied Proshield at approx. 11.30am. District Nurses visit and will treat accordingly.
01.10.2018	Screeners received a call from the client's son Ian. He said that [Social Care Assistant] had a meeting with his mother today and that [Social Care Assistant] wanted to visit the client on her own. However, Ian informed me that his other brother was going to be at home today. I tried contacting [Social Care Assistant] but she had been away from her desk for 5 minutes. I left a message with [Name Removed] who was going to try to phone [Social Care Assistant] to let her know

Date	Chronology Information
	just in case she wanted to cancel the meeting. Notified [Social Care Assistant] NFA for Screeners.
01.10.2018	SCA Visit Notes from Liquid Logic : "On 1 Oct '18 I visited Mary with [Name Removed], Social Worker in Complex Care. Hayley (son's partner) was also present. We discussed the following: Housing - I asked Hayley how she was getting on with her housing application. Hayley explained that she had seen Bexley Housing in May '18 and that she had been asked to come in with Mary, which was not possible due to Mary's health condition. [Social Worker] suggested that Hayley take a video of Mary, to explain that she was evicting the family. This would enable Hayley to apply for housing under the 'homeless' criteria. Housing Waiting List - I explained to Hayley that she would need to live in the area for 5 years in order to meet the criteria for joining the Housing Waiting List. Hayley confirmed that she had been in Bexley for 4 years, as at Sept '14 and that her daughter, [Name Removed], started school in the borough on 5 Sept '14. Offer of Support - I explained to Hayley that there was no completed application and that I would support her at the Civic Offices to make an application. I also explained that Hayley would need to bring in supporting documents, as outlined on the letter from Housing that she showed us. On leaving I advised Mary that I would be away from 4-10 Oct '18 and that if she wants to see me at the Day Centre, where she will be able to talk away from the family, I am happy to visit her."
02.10.2018	OT visited Mary at Inspire Day Service today (02 10 18) Issues discussed: Housing - Mary discussed the meeting she had yesterday with [Social Care Assistant] and [Social Worker]. Mary is aware her rehousing application will not proceed at this time, and if she wants a live-in carer she will need to evict her family. Mary states her family are aware of this. Mary states they need their own place and that she needs her own space. As Mary will now being staying on her current address, the level access shower, which is in a poor state of repair due to holes and rips in the reduced slip flooring, cracked wall tiles and rusting rails and fittings, will need to be refurbished. Housing contacted to check if this can be done through a Disabled Facilities Grant application of if it will be the responsibility of Orbit HA
19.10.2018	Telephone encounter called number on phone consult screen answered by son who is at work. tried calling other 3 numbers - not working, no voice mail tried to call son again- voice mail left to ring us back with alternate numbers- contact Mary
27.11.2018	OT visited Mary at Inspire Day Centre. Discussed planned bathroom refurb. Mary advised that she has informed her family that they would need to leave, however she stated that her preference continues to be that she moves to a new property and to have a live in carer in a new home. OT stated that the Housing Department has raised the fact that Mary's current property, once the bathroom has been repaired, is already fully adapted to meet her needs, and the prospect of being rehoused in the foreseeable future would be unlikely. OT Discussed rehousing situation with [Social Care Assistant], who conferred that Mary will be staying at [Address removed].

Date	Chronology Information
30.11.2018	Supervision with [Safeguarding Adult Manager] - SUPERVISION - [Social Care Assistant] to meet with Mary and explain that she is unlikely to be a priority to be rehoused as her property is already adapted to meet her needs. [Social Care Assistant] to discuss that moving to a 2 bedroom property would not automatically mean that she would be agreed for a live in carer and get agreement for a further grant for adaptations.
18.12.2018	Visit completed by OT to Mary at Inspire Day services Disabled Facilities Grant application form discussed and signed by Mary today. The original form had not been completed by the family. Without the application the bathroom refurbishment cannot proceed. Letter from DWP is also required to confirm that Mary is in receipt of ESA. Call made to DWP with Mary in the room to discuss 1. Confirmation letter of benefit award. This will be sent to Mary's home address, as DWP will not send to any other address other than an appointee. 2. Prepaid envelope given to Mary for her to forward the letter on receipt form DWP 3. Mary has also agreed for a copy of the letter to be held at Inspire Day Services on her notes,as a record 4. Mary is also changing her DLA benefit to a PI and is awaiting an assessment of her needs.The application was put into the DWP on 21/11/18 and the process can take 6- 8 weeks. Mary is concerned as she has had her benefit payments have stopped until such time that a decision is made about her claim. 5. DFG application is being held with [Name Removed], Grants Team, until the benefit confimationletter has sent through The grant will not proceed until all confirmation documents of Mary's income, have been received.
28.12.2018	Home visit Hx 3/7 of non productive cough with temp. Pt saw the DN last Wednesday who were querying a UTI but no Abx given, ? UTI ? Chest infection. O/E chest clear, no wheeze no crackles. Pyrexic 37.7 Tacy 109 RR18 SP02 97%. plan - Pt discussed with [GP] and Abx prescribed. Advised- if things worsen over the weekend call 111 or 999
07.01.2019	Failed encounter NOS x 5 at various intervals- HV Please
08.01.2019	OT notes that Mary has not yet submitted information form the DWP in respect of her income and benefit entitlement, so grant application is unable to move forward. Email sent to [Name Removed] at Inspire Day Services to ask if she could prompt Mary when she next attends the centre. Prepaid envelop has been provided for Mary to return the information.
22.01.2019	Letter received Clinical Letter Queen Marys Hospital Urology
22.01.2019	Client continuing record, phone call to Hayley asking if she could bring money down. She won't be able to come until this afternoon as she is waiting for someone for their bathroom. Signed [Inspire Day Services Officer]
30.01.2019	Safeguarding concern raised on 30 January 2019 by Avante Care Agency – BexleyThe care agency reported the following concerns:The referrer advised that the client's home is in a bad state, which includes dog mess and urine on the floor. There often appears to be no food for the client.There are no pillows on the client's bed. The carer's often find that the client's sheets are on the floor, covered in urine

Date	Chronology Information
	from the dogs.The carers are refusing to attend as the dogs are not locked away when the carers are trying to attend to the client.The smell of cannabis is strong in the property that carers are getting headaches.The client's son broke the client's bed approximately 15/01/2019. The client's son had cut the hydraulics.The case was allocated to [Social Worker] Complex Team East as Enquiry Officer and [Safeguarding Adults Manager] Senior Social Worker as SAM.[Social Worker] stated the following: Mary was met at the day centre she attends to ensure she expresses her views without any duress from family. She was met with [Social Care Assistant], who she is very familiar with. Mary advised, yes she has issues with her family living with her, but she did not want to discuss details of the issues apart from saying they need to have their own place. She said she did not want them to be homeless by her asking them to leave and wondered if social services can help with housing them or moving her to a different place, so the family can live in her three bedroom house on their own.The concerns raised about her family's behaviour were read out to her. But she was focused on discussing accommodation.As this is a concern about her family, I advised Mary that she will need an advocate to ensure that her best interests are upheld throughout the enquiry and that she should not be under any duress from anyone. I assured her that the advocate will work to represent her interests and with her wishes at the centre. Mary was adamant that she did not need an advocate. She said what she needed was help with finding the family a place of their own to live.Social Worker notes - "[Name Removed] is a social care assistant in my team (Complex Care) who has been working with the family very closely since March 2018 to deal with Mary's care needs. [Social Care Assistant] knows Mary and the family very well.[Social Care Assistant]'s view of the family is that although they were outwardly a 'dysfunctional family', Mary remained connected with them and they were a closely knit family. Mary did not want this disintegrated and they were all working to maintain the network. [Social Care Assistant] advised the only way to resolve the ongoing issues was to assist them and finding ways for Mary to live safely and happily in her place. [Social Care Assistant] acknowledges the family could be "messy" but saw the bond between them and was working towards alleviating their situation for Mary".The view of the family at this time was "Son and daughter-in-law advised they are not managing things at the home well, but they are doing their best given the issues they have as a family with their own children to care for. But they deny a deliberate neglect of their mother"The outcome of the enquiry was as follows:[Social Worker] concludes the follow: "There was no question the allegation of neglect by family is substantiated; but given that Mary was not keen to lose the family connection and did not want her son's family to go through further difficulties as a result of being evicted from her place and she had mental capacity and clearly voiced that, made it difficult to think about alternative measures. But the fact that she had a care package in place and Social Care Assistant and the OT have regularly worked with Mary and the family to address these issues also meant that the impact of any neglectful act by family was being minimised and kept in check".
08.02.2019	CR 3902145/19 Drug search at the home address, evidence of cannabis use and some cannabis found. Research has been completed and family known to police, This is the second warrant been executed at this address last one being 2016, the grandmother lives with the family and it has been stated that she is bedbound but

Date	Chronology Information
	unknown why but it is her that takes the drugs namely Cannabis. Father is known for drugs.
12.02.2019	12/02/2019 @11:52 am letter to GP to inform him that Mary did not attend her out patient's Urology Dept. appointment at Queen Marys Hospital in Sidcup. It was a choose and book appointment, therefore she will require a referral back if required.
13.02.2019	Written to re: OT Report - CURRENT HOUSING: Mary lives in a 3 bedroom property belonging to L&Q. She lives with her son, his wife and their 4 children. Originally she lived there with her husband (now deceased) and her children. The children left home but her son returned to care for her. There is ramped access to the property with a long lounge, kitchen and level access bathroom adaptation on the ground floor and the 3 bedrooms and bathroom on the first floor. There is a vertical lift in situ but she reports this is no longer working and she prefers to be at ground floor level near her bathroom. PRESENTING PROBLEMS: Mary is set up downstairs at one end of the lounge with a hospital bed and hoist. She has a mobile shower seat to take her into the shower-room. However the turns from the lounge and into the shower-room are quite hard. The shower-room is in a poor state of repair and she reports that Orbit have promised to refurbish this. The shower-room is also relatively small in size for an adaptation and it can be difficult to manoeuvre her in this area. Mary mobilises in a powered chair which tilts and therefore is considerably longer than a standard wheelchair and needs more space to turn in. She has carers attend 3 times a day for personal care and meals. Her daughter-in-law also helps care for her and deals with some household activities and assists with paperwork etc. The property is severely overcrowded and lacking space. PROPOSED SOLUTIONS: Although the property had been adapted in the past for Mary these adaptations need upgrading to meet her current needs. ADDITIONAL COMMENTS / INFO: Her daughter-in–law would like to be closer to her family who are based in [Removed]. She currently has an application for housing registered with [Local Authority in Another Area]. The son and his family are a 4 bedroom need on their own. In the event of her son and family moving Mary would be severely under-occupying the property. Her preference is to move to ground floor accommodation (ideally a bungalow) and to be assessed for a 'live-in' carer. The Care Agencies have threatened to withdraw service from Mary due to issues with the son. Therefore she is at risk of a breakdown in care arrangements. Mary attends the Day Centre at Inspire Community Trust 2 days a week but expressed an interest in attending more days. She failed to attend an assessment for her PIP and has had to start this process again. Currently she is not in receipt of PIP. OBSERVATIONS: Mary spends her day in her powered chair and was seated in this during the assessment. There was limited floor space for her to move about in this. She expressed a strong desire to live independently from family. RECOMMENDATIONS: Mary has significant health problems that cause severe functional problems in her home. Although the property was adapted for her years ago these adaptations need upgrading to meet her current needs. She is at risk of a breakdown in care arrangements with the threat of Care Agencies withdrawing. If the son and family move to [Removed] she will also be under-occupying. It would be appropriate for her to be able to bid for wheelchair adapted properties so as to

Date	Chronology Information
	avoid the aforementioned situations. She would need to have an updated assessment of need to see if she qualified for 24hr care which would determine the bedroom size needed. Band 2 Mobility A
	Home Visit (MeSH OT) with [Name Removed] from MESH. [Name Removed] to refer to Environmental Health as she suspects the family are statutorily overcrowded.
26.02.2019	Client continuing record, spoke to DWP re: PIP. Supported Mary to contact DWP today regarding her PIP claim. Mary spoke to an Operative at the DWP. Told Mary that a letter had been sent to her home address on 16/01/2019. Mary gave Inspire's contact number to contact her on the days she attends. Call had been made for re-consideration and letter will be sent back out to Mary. Needs to obtain an SSCS1 form and send back to appeals. Now speaking to Case Manager who is going to get the decision to be re-looked at. Signed [Inspire Centre Manager]
01.03.2019	Client continuing record, Mary brought in a letter dated 16/01/2019 which she received this week. I think this is a copy of the letter she did not receive stating the decision around her PIP has not changed. Mary also had a SSC S1 Form on her. I advised Mary to get her family to complete the SSCS1 Form with her this weekend. The family will have all her benefit details at home which may be needed for the form. Will assist Mary next week if family are unable to do. Signed [Inspire Day Service Officer]
07.03.2019	Outright Possession Order letter from Orbit. Overdue rent of £1,324.51.
12.03.2019	We have been trying to get her on the HR as an under occupier, I believe [Name Removed] visited her at the day centre to get her HR application done, we have been waiting for her to follow through with supporting docs, or even her ID would be sufficient. The other issue is that she has her son & dtr in law + 5 children staying with her and they are a 4 bed need on their own, when I spoke to the family about 6 months ago the daughter in law advised they had has applied to [Name Removed] council as she has family there, but I did an approach check, and they has not heard of them? OT report says the family have now made an approach... it's very unlikely that another borough are going to pick the family up, so we may be faced to 2 families being homeless here. [Name Removed] – OT report stated 13/2/19 she needs a Mob A property. One bed, are you in agreement that we should active this HR app and look for a direct offer of a Mob A property for Mary? there is the other issue of why the rent arears has a crewed, this could hinder another offer even if we are lucky enough to find one. [Senior Housing Allocations Officer]
13.03.2019	OT - Discussed case in supervision and agreed action: client now on rehousing list therefore refurbishment of bathroom adapts is on hold. Grants team informed not to proceed with bathroom refurbishment works as Mary has been placed on rehousing list. Work is currently out to tender, and permission to proceed is awaiting Orbit Housing's go-ahead [*Note: This is not actually the case, Housing confirm that they are still waiting for documentation via email on 26 July 2019 to OT*]

Date	Chronology Information
15.03.2019	Client continuing record, supported Mary to contact DWP regarding her claim. Still waiting for re-consideration (6-9 weeks) Spoke to Karen who confirmed the above (26/02/2019) Signed [Inspire Centre Manager]
19.03.2019	19/3/2019 - We raised concerns with Social Care Assistant regarding Mary living arrangements, as a family member was smoking, what carers believed was marijuana, when they were present. We also raised concerns that children were present the time. At the same time we raised concerns regarding lack of food for carers to provide Mary with meals, animals in the property and dog urine being on the bathroom floor.
19.03.2019	Review of progress towards outcomes - Mary selects Communication Needs, Personal Care Needs, Food Nutrition Needs and Social/Emotional Needs as "Fully Achieved" and Mobility and Handling Needs and General Health Needs as "Partly Achieved". Under further actions to achieve outstanding actions: under General Health the record states "some deterioration in hands curling up. Mary to contact Physician or GP for referral for splints/slings. Mental well-being is ok. Best practice is keep monitoring Mary when at centre. Under Mobility notes state "To encourage 'Mary' to use splints..seeing consultant Dr Silva 01/05/2019. Sees once a year. 'Mary' likes him, he is helpful. Mary feels listened to by him. Under Food and Drink, notes state "Some issues with money (PIP) so 'Mary' owes for meals. Once PIP is reinstates, 'Mary' will pay her bill. Best practice for 'Mary' to have a regular source of money when at Inspire. Signed by Mary and Assessor [Name Removed]. Next of next review: September 2019.
19.03.2019	(Note from Housing): [Name Removed] & [Name Removed], Hi Both, Please see below. [Social Care Assistant] from Adult SS came over today enquiring about her client who is facing eviction. They have stated she cannot come in to take an application so was wondering if we could see her so I was wondering if you could attend Sal to take an application. SS have advised that you should not attend alone as the situation can be quite volatile. She has her son living with her (not on the tenancy) and he can be quite a barrier and is perhaps the cause of her rent arrears! [Social Care Assistant] has asked if you could let her know when you are planning on attending so that they can let the client know as opposed to you just turning up on the doorstep. Arrears appear to be minimal, SS state that there have been problems with transferring her from DLA to PIP and some suspensions involved so this is where the arrears may have come from. She has applied on the HWL but it is still pending as they do not have a copy of her ID, so if you are able to get that information whilst there then it would be helpful if you can give a copy of her ID to the allocations team. Thanks [Name Removed].
19.03.2019	[Senior Housing Allocations Officer] (Note): I have sent another letter out requesting ID, have stated its needed urgently now, we have been asking for this since September 18, as our chat yesterday we will active her on HR once her ID has come in, [Name Removed] is the responsible user as case is still with Mesh. [Name Removed] – FYI I have set a reminder for 4 weeks to check on this application.
20.03.2019	[Name Removed] at Inspire has been supporting Mary with PIP payment delays. As the Mary is in receipt of other benefits she is not deemed priority regarding PIP. PIP have been advised to contact Mary at the Day Centre on Tuesdays and Fridays as

Date	Chronology Information
	they can support her with the phone calls. PIP made a home visit and was turned away by the son, hence the subsequent delay
21.03.2019	Subject: FW: Mary - LL2604 - Orbit Possession Order Hi [Name Removed], [Name Removed] and I are going to visit this house this afternoon, before hand can you contact someone at Orbit to discuss the eviction please and ask how much the current rent arrears are, she is an under occupier but her violent son has moved his family in, she is at possession order stage but needs a move, can you feed back to me before 2pm if possible what Orbits current position is. Also if they have a BC or passport on file photocopied if they could possibly send it over, they may refuse so not crucial. Client Mary [Address Removed] Thanks [Name Removed]
25.03.2019	[Housing Team] (Note): email received from Orbit as follows;_ Good afternoon Thank you for your email, further to our recent conversation. The consent given by Mary to give information to yourselves has been noted in our records. Just to confirm, the court granted Orbit an Outright Possession Order on the 05/03/19 after 28 days, i.e. on the 02/04/19. Her arrears are currently £723.45 plus court costs of £325.00 and there is a rent shortfall of £30.50 per week. We understand our customer to be very vulnerable and we can see Bexley are working with her to resolve the issue as soon as possible. In the circumstances, we will agree to hold off from applying for an eviction warrant until the 30/04/19 at this time. Could you give us an update please at that time so we can then review the situation. Regards [Name Removed] (The above is In response to email below sent 25/03/2019) With reference to our conversation re the above client, I have attached the consent to share, She was visited in her property last week and we are requesting you hold off with the eviction process, we will either clear the arrears or move her to a more suitable property, but assessments of her needs need to be made, please can you confirm that this is acceptable whilst her case is looked into and all assessments carried out. Also she could not provide a Birth Certificate or passport, please could you provide us with a copy of either one that was used at sign up just to speed up the process.
11.04.2019	The arrears and court costs were repaid in full on the 11/04/19, following receipt of £1,129.53 by a debit card transaction. The source of funds is not known.
29.04.2019	Social Care Assistant joint visit at home on 29 April '19 with [Name Removed] and [Name Removed] from Avante Care Agency. Discussed safeguarding concerns raised by carers. Lack of food reported by carers; Ferrets in the bathroom; Dog urine and faeces in the bathroom reported by carers; Lack of privacy for personal care; Ceiling track hoist; Bathroom flooring and tiling; Water bottle for the wheelchair - to be able to access a drink independently. Shampoo caps. Tenancy - On leaving the property, Hayley (partner of Mary's son John), advised me that they will now be staying at the property and having their names added to the tenancy.
	Mary was given actions to improve issues discussed but case history indicates that she had little agency to affect and maintain permanent improvements. There is no evidence that the family's ongoing neglect and abuse of Mary was considered during this meeting. The daughter in law was in the house during the meeting. Such meetings were often undertaken at Inspire to allow Mary to speak freely. This did not happen on this occasion. Practitioners to consider the effect of coercive

Date	Chronology Information
	control on an individuals' decision making and ability to affect change in their environment/personal circumstances. Where domestic abuse is suspected, victims should always be seen in a safe place which encourages the victim to speak freely and without fear of repercussions from the potential perpetrator(s).
02.05.2019	Patient had limited use of her upper limbs and she relies on her carers to feed her, she is able to steer her wheel chair with her left hand, she was considering to downsizing her three bedroom house to a flat with a live in carer. she had a supra-pubic catheter that is changed every couple of weeks, she get lots of sediment, this can sometimes happen if there is dehydration or infection as mentioned in the letter sent 03.05.2019.
16.05.2019	From:[Senior Housing Advisor] Sent: 16 May 2019 09:24 To: [Social Care Assistant]; [Senior Housing Allocations Officer]; Community OT; [Housing MeSH Representative]. Subject: RE: 61398 Mary [Address Removed] 19/07/1956 Pending enquiries Hi yes I will discuss this with MESH and get a meeting arranged. [2 Names Removed] please can you ring me to discuss this, thanks [Name Removed]
20.05.2019	Blocked catheter, DN visit to washout not successful so re catheterised. Incident reported of granddaughter shouting at Mary who was requesting equipment for DN but daughter on phone, resolved by team manager.
21.05.2019	Splinting Exercise Plan - regular exercises completed with support from Inspire Day Services Officer between 21/05/2019 - 30/07/2019. No issues.
22.05.2019	Medication Administration Record Audit Sheet completed for April
22.05.2019	Client continuing record, Inspire Day Services Officer notes have observed Mary over last few days and Mary seems to be coping much better with the controls on her electric wheelchair. To keep monitoring the situation.
30.05.2019	MESH team to arrange meeting with social care (Social Care Assistant and Occupational Therapist) to look at the wider issues surrounding Mary's housing needs. Mary has reported to staff at Inspire Day service that Orbit Housing have agreed to add her son and his family to the household on her tenancy agreement. This would mean that Mary is no longer underoccupying and may not be eligible to continue with her rehousing application If Mary is to stay in her property then the bathroom refurbishment would need to be completed. If she is to remain on the rehousing list, then refurbishment of the bathroom would be cancelled. Action To await outcome of Metro-wide Engagement for Shelter & Housing (MESH) meeting
04.06.2019	Failed encounter - message left on answer machine @12:40 for pt to call back anytime before 1pm today or tomorrow to discuss request.
06.06.2019	We had regular communication with the District Nurses between 6th June 2019 and 3rd August 2019 re bypassing of catheter, dates contact made were made were on 06/06, 18/06, 19/06, 13/07, 21/07, 26/07 x 2 calls, 02/08, 03/08. (GP records)
07.06.2019	Client continuing record, Supported Mary to ring DLA on 0800 121 4600. Explained she now needs to call PIP as now receiving this since claim on 20/06/2018. Rang 0800 121 4433. No reply. Signed Inspire Day Services Officer.

Date	Chronology Information
04.07.2019	6 month review on the 04/07/2019. The Care Plan was also updated and additional visits made as required.
04.07.2019	4th July 2019 - concerns were raised by Avante with Social Care Assistant regarding lack of food for Mary and having no toiletries for carers to use for Mary during personal care. Also shared that Avante's Field Care Officer visited on the 4th July 2019 to resolve an issue regarding evening medication and whilst present Mary had advised her that she had not had a meal for 3 days, Hayley, daughter in law had had taken her phone away and that she had not seen any post and the last time she had seen a bank statement was a year ago.
	Following an issue with medication and a prescription for Mary to take a tablet at tea time, Avante Home Care & Support made contact with the pharmacy on 4th July 2019 to see if it was possible for the tablet to be administered during the night visit as Mary did not have a tea visit in place. It was agreed this was possible and the prescription was changed to administer during the night visit.
18.07.2019	Action - OT to follow up current housing situation and rehousing application. Joint visit completed by OT and SCA. Mary was at home with her daughter in law, Hayley. Mary's son, John, was also at home but did not participate in the visit. Discussed issues of not having enough money at Day Centre, not having sifficient food in the house. Wendy Lett Slide sheets, Bed Handset Control and Bathroom Refurbishment. OT asked Mary if she had removed herself from the rehousing list (following Housing OT recommendation in Jan/Feb 2019) as adaptation would not proceed if her rehousing application was still current. Mary was unable to remember of she had asked to be removed from the housing list. Action - OT to follow up current housing situation and rehousing application. Mary assigned various actions to resolve recurring issues and Hayley responds directly to some of the concerns raised (eg lack of food/Mary's access to money). Son John is at the property during the visit. Details as follows: Joint visit by Occupational Therapist completed with Social Care Assistant: Mary was at home with her daughter in law, Hayley. Mary's son, John, was also at home but did not participate in the visit Issues raised: 1. Inspire report that Mary has not had sufficient money to pay for her meals when she attends the Day service. Hayley reports that Mary does have money with her when she goes to the day service, but she spends it on items brought in by other attendees who are selling goods. Action - it was suggested to Mary that she ensures she has enough money for her meals first, as concerns have been raised by staff at Inspire, about her managing and maintaining her nutrition. This would not prevent Mary spending her money on whatever she wants to buy, but her priority needs to be her nutrition first. 2. Carers report there has been insufficient food in the home Hayley reports there now food in the home, and that Mary does not go hungry, as both Mary and Hayley have capacity to make their own decision, the contents of the kitchen were not observed by OT and SCA. 3. Wendy Lett slide sheets Mary has been requesting an additional set of the Wendy Lett sheets/slide system Mary has been issued with 4 x base sheets and 5 x top sheets since 2017 She has also reported she has a set of Liko slide sheets (pre-dates current TCES records)

Date	Chronology Information
	Hayley found two base sheets in the laundry and two top sheets. Action - Mary has been advised that OT will be unable to issue further Wendy Letts at this time. 4. Bed handset control Mary reports she is unable to manage the handset on the bed. Mary has no functional use in her right arm, and very limited thumb opposition in her left. She is unable to manage the handset. Mary is able to tilt her head towards her shoulder on the right-hand side. She demonstrated a good range of head control on her right side, (lateral flexion) limited on her left. OT had discussed options with Apex who have been unable to advise on an alternative control for the bed. Action - Environmental Control system discussed with Mary, who has agreed that a referral can be made to the NHS for an assessment. 5. Bathroom refurbishment Hayley reports that Orbit have carried out an asbestos check in preparation of the bathroom refurbishment. OT asked Mary if she had removed herself from the rehousing list (following Housing OT recommendation in Jan/Feb 2019) as adaptation would not proceed if her rehousing application was still current. Mary was unable to remember if she had asked to be removed from the housing list Action - OT to follow up current housing situation and rehousing application.
22.07.2019	Avante send a further concern through to request a joint visit re concerns with the dogs not being put away and carers feeling uncomfortable and concerned when providing care. This included concerns that there was no food in the house, carers were not allowed to use the kettle to heat up water, no washing items egg. Soap or body wash, no deodorant and the family having takeaways every night and not offering Mary any food.
26.07.2019	Email to Occupational Therapist from Senior Housing Allocations Officer: Following on from our chat this morning just to confirm Mary is not on the HR as we have not been able to take an accurate application from her with regards to the family set up, amongst other things. As a way forward I think we should contact orbit and ask for an occupancy check and see of the Tenancy is still in sole name of Mary, I'm sure it will be. If as you say some of the older extended family have moved on, so not extremely overcrowded, and Mary is happy to stay put as the property is suitable for her needs, pending upgrade of the adapted bathroom, then that's fine, all will be resolved. I will send the e-mail to Orbit today. If she does want to be rehoused on her own then we will have to have a conversation with her possibly while she is at the day centre, so she can feel free to say what she wants with out judgement, the consequences would be that her family would need to find their own accommodation, as you say her son is working as a plasterer so can look to private rent or get Housing support & advise from homeless team. It would not be possible for the family to stay in the 3 bed house on their own, the most that Mary could have done is inform Orbit that they are part of the HH, they would have no rights to tenure. Hope this all make sense, I will come back asap with info from Orbit.
26.07.2019	Email from LBB Housing to Orbit: RE: Occupancy check and tenure advise HR61398 - Hi That's Great thank you. Could we have the relationship to the tenant and dates of birth please, the reason I ask is that we may have housed one of these HH members recently and want to check it's the same person.

Date	Chronology Information
02.08.2019	Client continuing record, Rang [Brokerage Manager]. Mary would like her 45 minute care call put up to 1 hour at a time. Also a carer once a week when money comes to go shopping. [Brokerage Manager] will look at changing the two care calls am and pm. A referral will need to be made for a shopper. Rang GP for a repeat prescription of painkillers and creams. Mary rang GP at home on Monday re: sling and adding Sudocreme to prescription. Look for a dentist. Signed Inspire Day Services Officer
03.08.2019	Blocked catheter, DN visit to washout
05.08.2019	Social Care Assistant rang [Name Removed], Deputy Manager at Avante, (Tel: REMOVED) on 5 Aug '19 to arrange a joint home visit to see Mary to discuss the following issues: Large dog not tied up No food in the house Carers not being allowed to use the kettle for hot water No washing items eg. soap or body wash No deoderant Family having takeaways every night and not offering food to Mary. [Name Removed] and I will be visiting Mary at 10am on Monday, 12 Aug '19, and have discussed that we will need a follow up joint home visit to see if these issues have been resolved.
06.08.2019	Client continuing record, support Mary to ring Brokerage Manager and Social Care Assistant. Both were unavailable. Signed [Inspire Day Services Officer]
09.08.2019	Care agency visit QDS to provide personal care for Mary. While at the home on the evening of 8/9/19 carers witnessed Mary's son having a physical altercation with a visitor to Mary's home. Following the incident the carers reported that Mary's son threatened them verbally to not report the incident to the police. Carers reported this to their manager and the care agency then withdrew support. A referral was made to rapid response by the care agency to source an alternative care agency – but nil found to cover with immediate effect. Rapid response document that they had liaised with Mary and her family and were informed that both would be happy for the family to provide Mary with personal care until a new care agency could be sourced.
10.08.2019	Telephone call received on 10th August 2019 by Branch Manager DD from Out of hours call receiver to advise that an incident had occurred at the night visit on Friday 9th August 2019. The Out of Hours receiver had been made aware on arrival for her shift that carers [Names Removed] had called the OOH call receiver on Friday evening to advise them that whilst in providing carer for Service User Mary a visitor had arrived to the house which led to Service users Mary son fighting with the visitor in the house and a pregnant relative was also involved and the carers were witness to the incident and one carer was physically pushed against a door during the fight. The carers were sworn at and told to leave the property which they did. They pulled up in their car further down the road to telephone the office to advise them what had happened and the son of Service User had followed them out shouting that they should not even think about calling the police as they would see what happened next. Both carers were scared by the incident and both advised that they would never return to the property following the incident. They were requested to document the events of the incident and bring to the office.
10.08.2019	Referral from Bexley Out of Hours states that Avante need urgent contact regarding Mary. Telephone call was made to Avante caller [Name Removed], incident of

Date	Chronology Information
	09/08 explained. Carer did not report incident until now. Mary has TDS package of care with Avante. Avante said the AM and Lunch time call was completed and no issue was reported by the carers . However, the evening carers is refusing to go back to the address. Avante said incident report was completed and forwarded to their manager. Out of Hours Social Worker advised Avante to inform Mary of incident and find out if family is able to cover the PM call while they are looking for another carer for the PM call. Action taken: Out of Hours Social Worker call client home to discuss the incident and also to find out if she is safe to remain at home following the incident reported. No reply and no facility to leave a message. Out of Hours Social Worker to case notify allocated worker. Noted by Out of Hours Social Worker.
10.08.2019	Decision made by Head of Home Care not to call the Police so as not to exacerbate the situation nor put carers at risk.
10.08.2019	Agency (Avante) concerns regarding witness safety/anonymity.
11.08.2019	T/C Avante Care Agency, Out of Hours Social Worker spoke to [Name Removed] (Avante Manager). Avante Manager reported that they have pulled the carer out from providing Mary with care and plan to hand over the care package back to social service on Monday 12/08/19. Out of Hours Social Worker made several telephone call/email to other care agency, to arrange the care package so Mary can receive support over the weekend but no luck. Out of Hours Social Worker spoke to Mary and explained to her that the care agency has pulled out following the incident that happened in her house on Friday 09/08/19., and as a result, social service will need time to sort for a new care agency. Mary said she understand and she is happy for her family to support her until Monday 12/08/19. Noted by Out of Hours Social Worker
11.08.2019	Follow up on referral received today re: Care Company. Care company said they contacted social services yesterday. Out of Hours Social Worker contacted Hayley, who reported that no carer attended the address this morning to support. Out of Hours Social Worker informed Hayley that RRT attempted to contact family on phone several times yesterday, but there was no reply. Out of Hours Social Worker also informed Hayley that the out of hour worker spoke to Mary grandson regarding the issue. Out of Hours Social Worker explained to Hayley that RRT attempted to sort for a new provider with no success. Hayley said she is happy to care for Mary over the weekend, provided another provider is sort within the shortest possible time. Hayley said she has kids. Hayley want the care to be sorted out asap. Out of Hours Social Worker informed Hayley that the allocated worker will contact her to discuss a way forward. Plan action: Out of Hours Social Worker to case notify allocated worker. Case is now NFA to RRT. Noted by Out of Hours Social Worker
12.08.2019	Concerns raised by Out of Hours workers. Emailed concerns onto allocated worker - [Social Care Assistant] to look into. At this time Triage will be taking no further action. 12-Aug-2019 10:05
12.08.2019	Avante Manager had a discussion with the Commissioning Manager from Bexley Social Services on 12th August 2019 regarding the incident and we were requested to email to advise that we were giving notice with immediate effect. An email was

Date	Chronology Information
	sent as requested and information regarding the incident reiterated in the email as Bexley were requesting that we continue with the package of care as the son had telephoned them to apologise and informed them he would be moving into a caravan so therefore our problem/concern would not be an issue moving forward. Branch Manager DD advised that we would not be providing the care package moving forward and was requested to confirm this in an email, which was completed. .
12.08.2019	Occupational Therapist attends property for joint visit which Avante has cancelled. OT has not been notified of cancellation and was unaware of the events on 09/08/19. OT continues with visit alone. OT enquired if carers had been this morning as Mary was still in bed, she had not had her personal care needs attended to and she had not eaten or drunk anything that morning (OT visit was at 10am). Hayley fed back the events that had happened on Friday 9th Aug. OT has asked Mary to consider what she would see as the solution to her housing and to clearly state what she would like to do about her housing position. Hayley reported that they are still not on the rehousing list with Bexley although she reports he has made several applications. OT notes Action - "To discuss with Social Care Assistant.
12.08.2019	Commissioning Manager contacted Avante and advised them that they could not just stop providing care to Mary due to her vulnerability. Avante advised they would not be sending anymore carers to Mary. Commissioning Manager asked team to source another provider.
14.08.2019	14/08/2019 @23:28 Mary was bought into hospital by ambulance, she was being washed and the supra pubic catheter had come out. Past medical history noted as MS, type two diabetes mellitus and high cholesterol. Discharged back home after urology consultant inserted Catheter
	Son unintentionally pulled out suprapubic catheter when giving personal care, Mary attended A&E; urinary catheter inserted while in A&E.
15.08.2019	Discharge summary report Discharge Summary/Report Darent Valley Hospital A E
20.08.2019	Inspire call [Brokerage Manager] re: 'Mary's' home situation. Avante have pulled out of caring for Mary even though apology has been sent by son, re: careers letting in boyfriend to Mary's granddaughter who then caused an uncomfortable situation with John (Mary's son) Avante do not want to discuss this. Explained to [Brokerage Manager], Mary is not attending centre as not able to get her up in time for transport. [Brokerage Manager] to contact [Social Care Assistant]. Signed Inspire Day Centre Officer.
23.08.2019	Mary calls single point of access 12:05. Bypassing catheter. Day team visit and report the following: Granddaughter present throughout DN visit, was on phone for entirety. Mary in bed, no bedding and Mary's clothes soaked in urine. No spare catheters at the home, HCP [Name Removed] requests a colleague to bring one to the home, while waiting HCP gives personal care to Mary and discusses current situation. HCP reports that Mary's personal hygiene was poor and she had a variety of foods in her hair and on her body and clothes. No drinks within Mary's reach noted by HCP, also noted that Mary's tongue and lips very dry with film on the front of her teeth – drink offered and accepted.

Date	Chronology Information
	Mary informed HCP that her care agency stopped visiting and her son now provides all personal care. Mary reported she was embarrassed with her son providing personal care, particularly if her bowels had been opened and stated that she had "a sore bottom". Buttocks checked – category one pressure area noted and photo taken with consent. Advice given to off load pressure and apply barrier creams. Mary reported to HCP that she no longer attended her day centre three times per week, as her son worked 9-5 daily and no one else could get her ready for the transport in time, therefore could no longer attend. Catheter supplied by HCP's colleague and inserted with no issues – urine draining freely. Concerns discussed with team manager and HCP completed safeguarding adult referral and sent to Council via Screeners.
27.08.2019	Safeguarding Alert: SPC received a Safeguarding Alert for the client. This has been uploaded into client's documents. From the alert- "I visited today there was no sheet on the bed. Mary informed me that she has no carers now as there was an altercation with the son so she is no longer having personal care. This is being done by the son and sometimes the daughter he works from morning till 5pm. She is no longer going to the day centre as there is no one to get her ready and in her wheelchair to go. She had a supra pubic catheter but said that when her son was washing her he caught it and pulled it out they couldn't get it back so the site had sealed and she went to hospital and had an urethra; catheter inserted. This had 15mls in a 10ml balloon. She has a mark on her right buttock which may be from the pad. " TRIAGE HUB OUTCOME DECISION Safeguarding referral received from Nurse [Name Removed] with concerns that family are neglecting her needs. Case is open to [Social Care Assistant] and SG allocated to Social Worker. Therefore will link to existing safeguarding and notify both workers to follow up. Social Worker notes: I discussed this with [Social Care Assistant] who noted the Brokerage Team is working to move Mary to Direct Payments, where the family will purchase a care service directly. This is because Brokerage is having difficulties to secure a provider for this case. 27-Aug-2019 16:11
27.08.2019	[Brokerage Manager] receives call from Inspire to alert that Mary has not attended Day Centre for three weeks. Send internal email to follow up - From: [Commissioning Manager] Sent: 27 August 2019 16:16 To: [Social Care Assistant]; BrokerageComTeam <BrokerageCommissioningTeam@bexley.gov.uk> Cc: [Head of Operations] Subject: Re : Mary LL 2604 Hi – I have just had a call from Inspire to say that Mary has not attended Day Centre for 3 weeks now and transport will no longer have her on the pick up route unless they have confirmation that she will be attending. Brokerage what is happening with this care package ? have we not allocated an agency yet ? [Social Care Assistant] are you following this case up… Am just a little worried that we are relying on family support for this Lady and there has been a history of neglect and other issues. Mary has always enjoyed her days at the Centre so feel she is being deprived. Transport have stopped calling because family do not have Mary up and ready to go. Can you please update on the situation. Many thanks. Kind Regards, [Interim Adult Social Care and Commissioning Manager].... Brokerage

Date	Chronology Information
	team [Name Removed] responds - "Choice and Planning are actively looking but the agencies we approach who they haven't already had, say no once they are aware of the history, [Social Care Assistant] is aware I spoke to her on Friday and about her not attending day centre too. I gave [Social Care Assistant] the details in regards to them having the DP and the funds being managed." [Commissioning Manager] responds: "Thank you [Name Removed]. [Head of Operations] can I make you aware of this. Apologies if you are already aware. This Lady's care needs are very high."
27.08.2019	Mary's son called into single point of access at 12:29 to report that Mary's urine was "purple" in colour, but catheter not blocked and no pain expressed. Advice given to increased fluids and monitor and to call back if not resolving.
28.08.2019	SCA and OT carry out welfare visit with Mary at home as Mary has not been able to attend Inspire as she was not ready in the mornings for the transport to take her. Summary: Agreement reached that whilst Bexley had been unable to source an agency that was in agreement to visit this property due to previous issues in the home/family over the years, that efforts would continue to find a care agency that a a minimum would attend to Mary's needs on the days she attends Inspire Day Services. Contact had been made by family (Ian) during this appointment to alert the DN's of Mary catheter care needs and concerns over her tissue viability. Mary looked well and made no complaints about her food/drink provision. However it is appreciated that she may not wish to comment about the family's care provision whilst there were present. Mary, confirmed by Hayley and Ian, reported that she was experiencing pain on her back. Hayley and Ian reported that the area was red.
	Full Liquid Logic entered on to the system by the OT at 8pm on 4th September 2019 is as follows: Visit with Social Care Assistant Appointment time 1:30pm At the time of the unannounced visit, Mary was still in bed. Present: Mary – client; Hayley – daughter in law; Ian – son; Occupational Therapist Bexley Council; Social Care Assistant] Bexley Council Issues raised: Toileting Her pad and catheter bag were visible. The pad was observed to be damp, and Mary explained that she had experienced a number of times where the indwelling catheter was back flowing and that today was one of the occasions. She also reported a reaction to the latex in the catheter where the bag and urine had turned purple. This had been reported to the DN's, however no report had been made to them that particular day. Mary, confirmed by Hayley and Ian, reported that she was experiencing pain on her back. Hayley and Ian reported that the area was red Hayley also reported that Mary's urine was dark in colour and had white 'threads' of matter/tissue in her urine. Action: Ian contacted the DN's whilst [Occupational Therapist] and [Social Care Assistant] were on site to request a visit to resolve Mary's toileting needs. Care needs Care provision had not been resolved following the departure of Avante, due to the events that took place on their call on the 9th August. Mary has therefore been reliant on Hayley, John and the family to make sure her

Date	Chronology Information
	care needs were being addressed. John and Ian have been assisting with her personal care, alongside Hayley. Hayley reports that should would not be able to get Mary ready for transport times on the day centre days by herself (Mary was requiring double handed care) Mary has not been able to attend Day Care since the 9th August Mary would like to be able to go back to Inspire Day Service Action To seek care agency that would be able to come in to ensure that Mary is at a minimum be bale to attend Inspire Day care. If this is achieved, then her ongoing care needs can be checked whilst work to source an agency who are willing and able to provide care provision is identified. (Other agencies operating for Bexley clients have all withdrawn their services over the years due to the family's behaviours) Nutrition Mary looked well and made no complaints about her food/drink provision. However it is appreciated that she may not wish to comment about the family's care provision whilst there were present, which reinforces the need to ensure that Mary is able to regularly attend her Day Service provision where any issues can be monitored. Ian stated is mother was eating a lot of chocolate that was not suitable for her due to her diabetes Options about other types of food provision (Wiltshire Farm foods – Appettio) were also raised with the family and Mary. Presentation Mary had the base 'Wendy Lett' slide sheet in place, but no top sheet was observed. She was wearing a tee shirt and an incontinence pad. She was talking, articulate and appropriate to time and place, and was able to discuss her situation. Summary Agreement reached that whilst Bexley had been unable to source an agency that was in agreement to visit this property due to previous issues in the home/family over the years, that efforts would continue to find a care agency that a a minimum would attend to Mary's needs on the days she attends Inspire Day Services. Contact had been made by family (Ian) during this appointment to alert the DN's of Mary catheter care needs and concerns over her tissue viability.
28.08.2019	Mary calls into day team late in the day, so referral passed to OOH service for bypassing catheter. On OOH arrival Mary informs them that catheter bypassing since yesterday. Mary was reported to be laying on a wet pad and wet bedsheets, when discussed with family member at the home, stated that they would change the clothes, pad and bedding once the bypassing had stopped. Family member declined for OOH HCPs to give personal care to Mary, stating she would after the visit. Mary declined for OOH HCP's to check her pressure areas. Bladder irrigation performed and was successful so catheter was not changed.
30.08.2019	Failed encounter - message left on answer machine @14:50pm for pt to call back and speak to clinician re: symptoms. Called twice. (GP records)
01.09.2019	Daughter-in-law reported that she was expecting a GP to visit as they had "spoken to the surgery about a possible urine infection in the week". HCP and Nurse both reported strong odour to urine, catheter changed and drained urine. Buttocks checked by HCP and Nurse, reported to be healing and less red. Mary asked if she

Date	Chronology Information
	would reach her drinks on table in front of her – replied no, her family help her. HCP noted that Mary's mouth was very dry. Mary confirmed that carers had not yet been reinstated 09:16:00
02.09.2019	Telephone encounter daughter. SP catheter came out 2w ago and changed to urethral one in a&e. was by- passing and dn changed catheter y/day. dn said urine smelly. pt has been having burning pain when pu.no fever/vomit/abdo pain. e+d finefor abx. call again if not better.
04.09.2019	19FOU006980 Sudden Death 04/09/2019 On 04/09/2019 at approximately 02:40hours, officers received a call from LAS (CAD 000686/04SEP19) in regards to a medical defib request at [Address Removed]. Upon arrival LAS L150 + L151 was on scene and confirmed life extinct at 02:51 hours of: Mary DOB [Removed/1956] Death was not suspicious. No signs of injury on deceased, No signs of unlocked doors/windows, family present and found deceased. Hayley confirmed she left Mary sleeping, snoring in her bed in the living room at approximately 00:00hours on 04.09.19. At approximately 01:00hours, Hayley went downstairs to the kitchen to make her baby a bottle. She went into check on Mary which was when she noticed Mary was not breathing and was ice cold. This was when she called LAS. Hayley confirmed Mary has been suffering from a water infection for the past week and has had very sharp pains and her urine was very dark. The doctors prescribed Mary with tablets to help with her water infection on MONDAY 2ND SEPTEMBER however failed to physically see her in person. Officers carried out a body check on Mary and there was no body injuries

19. APPENDIX E

19.1 Report Findings And Recommendations Table

The following is the findings and recommendations table developed by the SAR Panel in this review following the review of the chronology and analysis of the learnings. SAR Mary Findings and Recommendations are provided in Sections 8 and 9 of the Overview Report, categorised under the Four Domain Analytic Framework for Safeguarding Adult Reviews. This table enables the reader to see both the Findings and the Recommendations under each analysis theme, which assists in connecting the recommendation to the finding if required.

19.2 Domain A: The Adult – Direct Practice With Mary

1) Theme: Recognising and Responding to Specific Forms of Abuse and Neglect

a) Sub theme: Domestic Abuse

Finding Summary: Domestic abuse of adults with care and support needs was under-recognised and under-reported. No agency completed a DASH risk assessment or discussed concerns with a domestic abuse specialist. Practitioners lacked an understanding of the nature and forms of domestic abuse.

Agency	Finding	Recommendation
Avante	Avante's carers raised six safeguarding concerns describing abusive behaviours of the family towards Mary but did not use the term domestic abuse nor follow a domestic abuse response pathway.	Training: BSAB to be assured that examples of domestic abuse features in all member's safeguarding

GP	Multiple failed encounters and difficulty in contacting the patient directly could be a sign of domestic abuse. No action was taken to explore this possibility.	training, to ensure that staff can recognise and appropriately respond to domestic abuse. (*Note LBB runs free Domestic Abuse awareness and DASH training which is available to any professional needing to access this*). (Similar to finding in SAR Paul (2020)). BSAB to be assured that all its member and commissioned agency staff complete domestic abuse training, to an appropriate level and complete refresher training on a rolling basis. BSAB representatives support LBB's Domestic Abuse Champion programme. Ensure all LBB staff allocated complex and/or open S42 safeguarding enquiries have appropriate level of domestic abuse training. LBB to circulate regular briefings on good practice regarding all forms of abuse, particularly those highlighted by the Care Act 2014 within adult safeguarding, such as domestic abuse. CCG to task all health agencies to undertake an audit of non-attendance in patient records and update relevant procedures to consider non-attendance as a sign of domestic abuse, including actions to take if signs are evident. Follow up to confirm completion within given timeframe.
Inspire	Economic abuse – and its effect on Mary - was recognised by staff but not considered as domestic abuse. No action was taken.	
LBB ASC	Different Social Workers named domestic abuse in the case notes between 2012 – 2019 but no action is taken. No DASH risk assessment is completed. No member of the team contacts the Housing IDVA / Council base IDVAs nor the Domestic Abuse & Sexual Violence Strategy Manager to explore any additional support for Mary and her case. Social Care Assistant (SCA) described the family as "incapable of following the rules" and Mary as strong-minded. The SCA noted that they never saw domestic abuse; shouting/swearing, hitting, and they considered the family as "outwardly dysfunctional and messy". The Safeguarding Adult Manager (SAM) over-seeing the safeguarding enquiry, who was also the SCA's supervisor, noted that Mary was just being a Mum looking after her children. Domestic abuse was not recognised, nor accepted by either the SCA or the SAM. As a result, practices to safeguard Mary from domestic abuse/coercive control were not explored or implemented.	
LBB Housing and MeSH	Civica notes that the son is violent and concerns of over-crowding (possible indicator of economic abuse). Two members of the homelessness prevention team attend for safety. Neither the Housing IDVA nor the Domestic Abuse and Sexual Violence Strategy Manager are made aware of this case. The Adult Social Care Team are not connected to the Housing IDVA to help explore additional options in Mary's case.	
Orbit	Mary was consistently in arrears between 2014-2019. Records note "violent son", "volatile son", family's concerns about son's behaviour, including getting an injunction to prevent contact with Mary, and the "need to move Mary to a place of safety due to violence from her son". No action was taken by Orbit.	
Oxleas	Emotional abuse witnessed in May 2019 whilst at property. When nurse challenged the behaviour, perpetrator formally complained to Oxleas. Opportunity to communicate concerns/raise a safeguarding with LBB was missed.	

Sub theme: Self-Neglect – Hoarding

Finding Summary: Mary's Home was cluttered with evidence of hoarding. This was first noted by the Social Worker in 2011 and again by same Social Worker in 2013. No investigation or assessment was undertaken to determine whether any form of abuse was taking place.

Agency	Finding	Recommendation
Avante LBB ASC Orbit Oxleas Family	Mary's home was cluttered with evidence of hoarding. The family noted that Mary liked everything around her and that as a result her living space was cluttered and messy. They noted that Mary would purchase Avon products at Inspire which she would not use nor gift but hoarded in the living room and bedrooms. Inspire also noted that Mary would regularly buy (and then owe for) Avon products. The family also shared how Mary liked to look and smell nice, and really enjoyed being pampered. Multiple carers described the house as dirty, filthy, messy, and cluttered. No investigation was undertaken into the reasons for the clutter and mess to determine whether any form of abuse was taking place. This is a similar finding to SAR Mr K (2017) and BSAB's Self Neglect and Hoarding Toolkit for practitioners which was launched in March 2018.	Audit and Training BSAB to be assured that all agencies will fully engage in partnership working to achieve the best outcome for people who hoard or self-neglect.

Theme: Assessing and Meeting needs

Sub theme: Safeguarding Action – Referral & Response

Finding Summary: Agencies followed safeguarding referral processes. However, the local authority safeguarding enquiry case leads did not consistently take a person-centred approach nor always follow Making Safeguarding Personal principles.

Agency	Finding	Recommendation
Avante	Good practice: Staff were tenacious and compassionate, raising multiple concerns (six recorded/five in the last nine months of Mary's life) to the local authority regarding Mary's well-being to the local authority and being determined to improve Mary's living environment.	Avante to continue to encourage staff to raise concerns.
LBB ASC	Discussed safeguarding concerns relating to family's behaviour in front of members of the family at Mary's home was not in line with Making safeguarding Personal principles, ensuring privacy from others in Mary's network, particularly when the safeguarding related to the family.	LBB to seek assurance and measurable evidence (e.g .training/increased supervision) from teams of practitioners' knowledge, skills and confidence in leading safeguarding enquiries and of their understanding on the Care Act and the six Making Safeguarding Personal principles. LBB ASC to be assured that staff are alert to whole environment and seasonal factors that will affect vulnerable adults within a safeguarding enquiry.
Oxleas	Oxleas Out of Hours Health Care Professional (OoH HCP) visiting Mary on 28.08.19 for catheter issues and suspected UTI. UTI not checked for as in previous visit, bladder irrigation completed in lounge where Mary sleeps. Son in room watching TV throughout. Nurse offers to clean Mary but family member declines. Mary declines OoH HCP's to check her pressure areas. A safeguarding had been raised by Oxleas five days prior (23.08.19). The SAR review panel reviewed Oxleas' process for recording and communicating safeguarding concerns across the nursing team and were satisfied with the process. They did however recommend that Oxleas ensures that nurses formally are recording what they have done/are doing to keep the person safe after each visit. During this review process, LBB and Oxleas representatives on the SAR panel noted the work to develop elements of shared record keeping between Oxleas and LBB will assist	Oxleas to run a report and dip test cases where a safeguarding concern has been raised to be assured that safeguarding conversations are happening between nurses, and that actions taken/planned to keep the subject safe are being recorded in progress notes. LBB to be assured that its process for responding to safeguarding concerns is helping to build stronger safeguarding connections and relationships between agencies.

Agency	Finding	Recommendation
	with inter-agency communication and collaborative responses to safeguarding concerns.	BSAB to be assured that all health and social care professionals are alert to whole environment, including seasonal factors, that will affect vulnerable adults where there are safeguarding concerns.

Sub theme: Risk Awareness & Assessment

Finding Summary: The risk assessment completed by the local authority as part of the Section 42 Safeguarding Enquiry open from the end of January 2019 was inadequate. Further, the risk assessment was not reviewed or revised whilst the safeguarding was open, despite significant factors changing in Mary's case, such as the risk of eviction and the care agency's withdrawal of their daily care package.

Agency	Finding	Recommendation
LBB ASC	The risk assessment completed as part of the Safeguarding Plan lacked SMART objectives and was not revisited when Mary's circumstances changed. None of the staff involved in the safeguarding enquiry (SAM, SW/EO, SCA nor OT) recognised the extent of the risk posed to Mary when her formal carers were no longer attending. This was one of the three key services that safeguarded Mary against abuse or neglect. This lack of recognition was possibly due to the failure of the Support Plan not being clearly noted as a risk in the Safeguarding Plan signed off in January 2019. There was a failure to link together factors in Mary's situation which had the potential to increase risk. A risk assessment with clear risk mitigation actions and checks would have minimised risks to Mary of abuse and neglect at this time. The SCA and the Brokerage team noted that the family had provided care before, albeit for a shorter	LLB to update Safeguarding Planning form to require Enquiry Officer to record Specific, Measurable, Achievable, Realistic and Timebound objectives, and to be clear on the desired outcomes, including how planned actions will safeguard against abuse or neglect. The Planning form should also be clear on the need to be regularly reviewed and revisited whenever there is a change in the adult's circumstances, including changes to their Support Plan.

Agency	Finding	Recommendation
	period and in different circumstances. Brokerage felt they could have been more involved in the Safeguarding Plan. The risk tolerance in this case was possibly assisted by the 'rule of optimism' by the view that the family had coped previously.	

Sub theme: Working with families and significant others

Finding Summary: The Care Act is clear on the need to safeguard carers. Mary's family was abandoned to care for Mary whilst LBB worked to fill gap in care package. The family asked for another provider to be secured as soon as possible. No Carers Assessment was completed. Agencies were also rarely observed to "Think Family" in relation to others living in the same household as Mary.

Agency	Finding	Recommendation
Avante/Care Agencies	The family noted that some carers were committed and compassionate, showing tenacity and flexibility to work to meet Mary's needs in their family home. Other carers were "just doing a job". They asked that carers are mindful that they are working in someone else's home and raise concerns with the family in the first instance. This aligns with BSAB strategic priority to promote working with family members to involve them to reduce risks to individuals and to enhance support for them. Direct multi-agency work with the family may have improved Mary's situation and the environment for care givers and all community-based agencies providing support.	Avante to involve families in the safe delivery of their service whilst ensuring that the individual remains at the centre of their efforts.
LBB ASC	The family were abandoned by the local authority to care for Mary without support. Hayley said she was happy to care for Mary over the weekend, provided another provider was "sorted within the shortest possible time". Hayley stated on the call that she had children (other caring responsibilities) and re-iterated that they wanted the care package to be sorted out asap.	LBB reviews it processes relating to families providing interim support for adults with high care and support needs to ensure process is clear, with sign off at SAM level or higher. This is similar to the Duty of Care to Carers finding in SAR Paul (2019): the safeguarding

Agency	Finding	Recommendation
	No carer's assessment was completed, nor was the wellbeing of Mary's familial carers considered. *The primary family carer (Hayley) was in her third trimester of pregnancy/had a new-born baby in the last two weeks of Mary's life. It was the school summer holidays (children at home from school) and the temperature reached up to 33degC in the August when Mary was without formal care. The family were not proactively contacted to ascertain how they were coping. There is no evidence that the family agreed to covering the care support package for longer than the weekend after the carers withdrew.* The Local Authority has a duty of care to familial carers made clear in the Care Act guidance (Section 14.2, 2020) and must do an assessment for any carer who they think may need support now, or in the future. The wellbeing principle applies equally to adults with care and support needs and their carers. The "Pan London" Safeguarding Adults' Procedures further notes the importance of assessment, itself referring to the ADASS publication, Carers and Safeguarding Adults – Working Together to improve outcomes (2011). The assessment would help ascertain the presence of health and care needs that exceed the carer's ability to meet; the extent to which carers understand their actions and their impact on the person supported and the nature and extent of any financial difficulties; including any surrounding the management of money of person supported.	of carers (Family members providing care and support) to be identified in all safeguarding training. Safeguarding considers the whole family and wellbeing principles are applied. Training should provide examples in practice. At each stage the Local Authority should be providing oversight and guidance.)
LBB ASC	Good practice: The SCA offered to assist family with their Bexley Housing application to move them out of Mary's house to help improve Mary's living environment. Good understanding of history and evidence of thinking flexibly.	-

Sub theme: Responding to Characteristics of the Individual

Finding Summary: Mary had MS and her health was noted by health professionals to be deteriorating. She had extremely limited use of her left arm. She required additional support to complete forms, write letters/emails or to make/take phone calls. She could not rely on her family for this support. No support was given by the local authority to source or signpost support when this need was expressed by Mary and Inspire.

Agency	Finding	Recommendation
Inspire	Good practice: Personalised and strong continuity of support over many years from three dedicated members of the staff team who were committed to supporting Mary whilst at the Day Centre in filling forms, making calls and being as independent as possible. This included a significant level of support to help Mary increase usage of her left hand. She wanted to be able to drink independently, which may indicate her need to take control of her own hydration needs. Panel members described Inspire as Mary's refuge.	-
LBB ASC	Mary was unable to fill in forms without assistance. Complex forms often required information from home and significant time to complete. Inspire supported at the Day Centre but Mary needed someone to work with her at home on the rare occasion complex forms needed completion (such as housing allocation forms and PIP). Panel members representing LBB ASC noted that the Social Care Assistant has a duty to maximise people's income. This forms part of Adult Social; Care's prevention offer, where clients can be referred for support to complete forms, particularly around housing. Mary's experience is common and a national issue: PIP is not an easy benefit to claim successfully. According to the DWP's latest statistics released on 28 July 2020, just 44% of new claims for personal independence payment have been successful where the claimant is not terminally ill. The success rate for DLA to PIP transfers is currently 72%. A panel member signposted the SAR Chair to speak to Bexley's Bridging the Gap founder and CEO, Gerry Kenny, who in turn signposted to the following website for information and support Personal Independence Payment (PIP) (benefitsandwork.co.uk).	LBB to reinforce social care option of commissioning external support for clients to complete processes to access statutory benefits or housing and/or to manage debt. Possibly an "Appointee" service. Review what Community based/charitable services are available locally to provide an Appointee type service and signpost. For example, DWP provide home visits to assist with form completion. BSAB to consider a joint letter from the National Network for SAB Chairs to the Secretary of State for Work and Pensions, to

Agency	Finding	Recommendation
	Being declined for the Personal Independence Payment (PIP) was cited as a stress factor within Bexley's Safeguarding Adult Board's SAR Paul. Information and / or a response was requested from the DWP but no response was supplied.	request improvements in PIP claim process, using evidence from recent SAR findings.
LBB ASC	All agencies supporting Mary had significant difficulty contacting her via letter, phone or email. None raised their concerns with the local authority. This was first raised by the ASC Social Worker in 2011, and raised in safeguarding concerns since. It was however never resolved and exacerbated issues such as arranging repairs to the property and risk of eviction for rental arrears.	Review options available to Social Workers to provide vulnerable clients with their own personal means to make a phone call and ensure Social Workers/Social Care Assistants are aware of these.

Theme: Making Safeguarding Personal: Finding the Person

Sub theme: Reluctance to Engage.

Finding Summary: LBB ASC practitioners failed to make safeguarding personal (Empowerment): choice was not given, instead response was assumed.

Agency	Finding	Recommendation
LBB ASC	LBB ASC (SW/SCA/OT) did not offer respite when Mary's Support Package fell through in August 2019 as assumed Mary would decline as she had done in the past. *Care Act Guidance notes that when an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time.* On a previous occasion when Mary declined respite in January 2018 during a gap in home care, a visit was made to Mary to ascertain her mental capacity, ensure she	LBB ASC be assured that practice is clear that all safeguarding options are explored with the subject of a safeguarding concern whenever there is a choice to be made, and that practitioners document asking and the client's response each time a choice is made.

Agency	Finding	Recommendation
	understood the risks of being cared for by her family, and she was asked to sign a written statement noting that she was aware of the risks. The process in 2018 was led by a Social Worker, the process in 2019 was led by a Social Care Assistant.	
LBB ASC	Assumed Mary's response to option of going to the hospital as Mary had declined in the past. *The OT noted that from the moment they walked in that there was a distinctive urine infection smell in the room and that Mary's nightie was visibly soiled. John had been providing personal care. SCA and OT encouraged Ian to call Doctor and District Nurse. Ian called the DN and the DNs visited that evening. OT/SCA didn't consider calling the LAS to take Mary to hospital as Mary hated hospitals and [they assumed that Mary] wouldn't have consented to ringing them. Need to involve Mary in decision making – must speak to person in first instance.*	
LBB ASC	Good practice, offering advocate and recording of conversation. Social worker offered Mary an advocate in January 2019 when Safeguarding enquiry was discussed at Inspire Day Centre (away from family).	-
LBB Out of Hours Adult Social Care	Good practice: In line with Making Safeguarding personal, Out of Hours Social Worker ensured that they spoke directly with Mary to confirm that she understood the situation and that she was happy for her family to provide care over the weekend until Monday 12th August, as had previously been discussed with Mary's daughter in law. This was clearly recorded on the local authority's shared case management system Liquid Logic.	
Oxleas	During the DN's visit on 28th August, the nurse offered to clean Mary, as she was laying on a wet pad and wet bedsheets. The family member refused the offer. In line with Making Safeguarding Personal principles, there is no indication that Mary was asked if she'd like to be cleaned.	Ensure practice is clear that whenever there is a choice to be made in relation to a client's health and/or care needs, and be assured that practitioners record asking and the client's response each time a choice is made.

Theme: Practitioner Attributes

Sub Theme: Legal Literacy

Finding Summary: Agencies supporting Mary with her housing did not evidence knowledge or use of legal powers and duties in relation to over-crowding.

Agency	Finding	Recommendation
LBB Housing and MeSH	Only LBB's Senior Housing Allocations Manager undertook action to ask Orbit for a tenancy check as over-crowding was suspected. The MeSH OT raised concerns of over-crowding following a visit prior to this request. The Adult Social Care team knew how many people were residing at the property and could be asked. Housing requested a simple tool to calculate is a property is over-crowded. The concerns raised by the MeSH OT should have been escalated to ensure the council was meeting its legal obligations under Homes Act (2018) /Housing Act (1985).	Ensure LBB Housing team are clear on their options when they suspect that a property is over-crowded/unfit for habitation or for which they have environmental concerns. Recommend creation of a tool to assist the team in assessing overcrowding.
Orbit Housing	No action taken on multiple records of reported over-crowding in Mary's house. In 2015, records show that daughter-in-law had moved in with partner and five children. Later records noted that Mary was no longer able to get up to a bedroom due to her family moving in upstairs. No action was taken in relation to the over-crowding and the affect that Mary's family was having on her safety and wellbeing. There are clear legal obligations for Landlords under Homes Act (2018) and Housing Act (1985).	Orbit to provide BSAB with assurance that it is undertaking tenancy checks when over-crowding is suspected or recorded, and that it is meeting its statutory duties in line with the Homes Act and Housing Act in relation to over-crowding.

Sub Theme: Attention to mental capacity

Finding Summary: Respecting Mary's decision-making rights where she was assumed to have mental capacity discouraged the caseworker from engaging Mary in dialogue about the consequences of what practitioners consistently described as *unwise decision*s.

Agency	Finding	Recommendation
LBB ASC	Respecting Mary's decision-making rights where she was assumed to have mental capacity discouraged LBB ASC (SW, SCA and OT) from engaging Mary in dialogue about the risks and potential consequences of what practitioners consistently described as unwise decisions. There is no evidence of a formal mental capacity test after January 2018, undertaken by a Social Worker with support from the SCA. Nor was there a discussion with Mary relating to the potential risks of her choices after this date. Practitioners reflected that they had not considered the potential effect of coercive control/domestic abuse on Mary's decision-making capacity and that they may have become desensitised to the case. The panel felt that this was a common issue across the borough and so the related recommendation is in under Domain D: SAB Governance.	Recommendation relating to this finding is in Domain D: SAB Governance. Intended outcome of recommendation for LBB is: Training leads to improved use of mental capacity assessments, which includes consideration of domestic abuse/coercive control on decision making. This is a similar recommendation to SAR Paul (2020) and Sar Mr K (2017).

19.3 Domain B: The Team Around The Adult – Interagency Working

Theme: Information Sharing

Sub Theme: Record sharing

Finding Summary: Different recording systems and levels of access impeded interagency communication and information flow.

Agency	Finding	Recommendation
LBB Adult Social Care,	Connect Care is not effectively linking health and social care so that information can be shared between services across Bexley. There is significant evidence throughout this	BSAB to review progress of systems integration/read across (Bexley Connect Care and

Agency	Finding	Recommendation
Oxleas, GP, DGT & LGT	case of health and social care services not being joined up and practitioners cannot easily read across on safeguarding information. LBB ASC were unaware of Mary's hospital visit following an issue caused by Mary's son's personal care of her. This would have been picked up by the formal care agency (Avante) had they been providing support at that time. GPs continue to have standalone systems (a national issue) which no not integrate/share information with any other systems and cannot access Rio. Expert health representatives on the panel noted that GPs therefore rely on others to update them on safeguarding enquiries or concerns. *There is a continued need to improve communication and ways of working between social care teams and health services is recognised in the recent "System of Systems" review by the South East London, CCG. It further notes that GPs are a key partner and their inclusion in will reduce gaps in care pathways.*	Coordinate my Care) to seek assurance that policies and procedures are up to date, staff are being supported to adopt new systems/processes, supervisors are encouraging good practice, training is being offered and taken up by staff and audit/spot checks are happening to help embed new practices. *This is part of Bexley's "System of Systems" Endorsed by South East London CCG on 20.07.2020 and/or Our Healthier South East London Recovery Plan, October 2020 – approved at the SE London CCG Board meeting of 05.11.2020.*
Oxleas and Local Authority	Oxleas District Nurse team cannot see any LBB information on Connect Care. GP and other hospital information is accessible but no information on social care or safeguarding can be accessed. Staff raise safeguarding concerns in Rio. Oxleas use this information to pull together an iFox report which is used to provide safeguarding reports to the CCG. Oxleas staff in Greenwich can access social care information, but this is not the case in Bexley. This impedes partnership working in safeguarding.	

Sub Theme: Information flow

Finding Summary: Interagency information flow was inconsistent where flow required practitioners to take proactive action.

Agency	Finding	Recommendation
GP / Oxleas	On multiple occasions the GP noted that they had no record of actions taken by Oxleas nurses when attending to the patient. GPs cannot access any shared information and use standalone systems. They rely on others to proactively update them and add notes directly to their own standalone system as necessary. The panel noted that a more formal mechanism is required and suggested replicating the model of Multi-Disciplinary Teams in Care Homes.	GP and Oxleas co-develop a pro-forma form for district nurses to add to client health records that GPs can access.
CCG		CCG consider revising care home NHS MDT model to deliver comprehensive health and social care in the community in partnership with LBB.
Inspire	Good practice: Tenacity attending to Mary's health and wellbeing whilst at the centre included arranging transport for healthcare appointments, sending information to GP/District Nurses relating to sores management, assisting Mary to contact Social Care Assistant and Brokerage an LBB for changes to her care package and support with issues arising. High level of inter-agency information sharing (with Mary's consent) to meet Mary's care and support needs through proactive staff action (i.e. not reliant on IT systems)	-
Orbit	LBB relationship with Orbit is weak. Communication channel with Orbit is slow, inefficient, and at times, ineffectual.	Orbit to develop agreed protocols and Service Level Agreements with all Bexley Social Housing providers relating to working together effectively. Orbit to ensure named Safeguarding lead at Orbit is known to Adult Social Care team and dedicated safeguarding email address supplied for safeguarding concerns. LBB Housing to consider reviving Housing Provider Forums to improve communication and assist all members in their continuous improvement processes.

Agency	Finding	Recommendation
Oxleas, LBB Rapid Response and LBB Brokerage	Oxleas have a nursing service to provide emergency care at home. The panel considered whether this service could have been explored for Mary whilst a new care agency was secured. However, this would risk creating an expectation for nurses to take on a social care role and add strain on an emergency support service. As care agency withdrawal was a known risk, contingency plans could have been developed in advance. If no alternative was possible at the time that carers withdrew, offering respite to a potential place of safety was likely the best option, and documenting Mary's informed response.	BSAB to note panel exploration of an alternative emergency care option in this case.

Theme: Safeguarding Processes

Finding Summary: There was no interagency safeguarding action taken as a result of the open safeguarding enquiry because no agency external to LBB ASC was aware of the open safeguarding or involved in the safeguarding plan. Internal council departments were also unaware and were not involved. Further, there were multiple isolated incidences of safeguarding practice being inefficient or ineffective across most agencies.

Agency	Finding	Recommendation
Avante and LBB ASC	Proactive action undertaken by SCA to improve Mary's home environment with Avante's support following the safeguarding raised by Avante in January 2019. However, no joint safeguarding plans or risk assessments were created nor were actions discussed with Mary to improve issues formally followed up.	*Related recommendation is in Domain B: Case Coordination below, relating to working together and effective co-planning.*
Avante and LBB ASC	At no point were Avante aware that their Safeguarding Concerns in January 2019 led to the opening of a Section 42 safeguarding enquiry which was open when Mary' died in September 2019.	LBB to assure that safeguarding concerns are acted upon within 48 hours and that referrers are updated on action taken because of their referral.
LBB ASC	Family raised a safeguarding concern following an incident of a worker from London Hire Ltd breaking Mary's finger when moving her to the Inspire transport bus. Family	

Agency	Finding	Recommendation
	was not contacted with an update. Actions were requested of London Hire Ltd and copied to BITU by SCA in August 2018 but these were not acted upon. There was no follow up by the SCA/BITU. Family requested an update as part of this SAR process.	LBB to consider updating safeguarding process to oblige LBB Adult Social Care to contact referral organisation, to encourage multi-agency working and to strengthen communication channels, even if no action is planned because of the safeguarding concern(s) raised.
LBB Triage	Safeguarding sent 23.08.19 at 17:00 by Oxleas, Screeners action four days later at 16:11 on 27.08.19. (Bank Holiday weekend in between). Oxleas receive no update of what happened in response to their safeguarding concern. During the SAR Review process, it was noted that safeguarding referrals are now responded to within 48 hours acknowledging receipt, and shortly thereafter an update is provided to the referrer on actions taken/planned: Oxleas confirmed that this is their experience of the system and that it had greatly improved.	
CCG	Mary had multiple missed appointments. Mary was on the Integrated Case Management programme in Bexley which aimed to bring together range of professionals from across adult social care, physical health, mental health, primary care to support primary care clinicians with patients requiring whole-system support. Mary was known to be entirely dependent on others to attend her health appointments. There is no evidence of the GP/DGT checking for an open safeguarding or informing the local authority of missed appointments or of any proactive contact with the local authority. There is no evidence that the GP contacted the district nurses to ask if they had any concerns, as nurses were known to visit Mary frequently for catheter care. There is no evidence of GP referring Mary back to the Urology Dept after her last missed appointment in February 2019. Professional curiosity by GP lacking. Panel noted that there is a good process for children but that follow up on non-attendance by adults does not currently receive the same level of scrutiny.	CCG to oversee the development of a standard borough-wide process for following up on failed encounters. Ensure that the process includes consideration of the patient's personal circumstances (Making Safeguarding Personal) (e.g. checking if on ICM programme/evidence of domestic abuse/recent mental capacity assessment/reliance on others to attend) and a duty to inform the local authority when failed encounter levels raise concerns. *Similar to earlier recommendation under section 10.1.1.1.* Improve communication with other services supporting ICM patients and ensure important information (such as missed appointments) is shared. Develop a process for ICM cases that captures a new safeguarding enquiry and ensures it is

Agency	Finding	Recommendation
		discussed at the next Local Care Network (LCN) meeting, with input invited from the Social Worker supporting the client. Bexley Care to ensure distribution of information on how to refer cases into the Local Care Network meetings across all Social Care and Health networks, including domiciliary care and care homes.
LBB ASC	Triage add new safeguarding raised by Oxleas on 23.08.2019 to existing safeguarding and requested follow up by SW and SCA. SW and SCA did not respond to Oxleas. If had been treated as new safeguarding, referrer would have received an update within 48 hours. However, as safeguarding concern was added to existing, this practice was by-passed, and Triage requested ASC to "follow up" instead. This led to a lack of clarity for ASC relating to who/what to follow up and as a result the referrer was not contacted.	LBB Triage/Screeners to review process on when to add a safeguarding concern to an existing safeguarding enquiry.
London Ambulance Service	Missed opportunity following incident of carer breaking Mary's finger when moving her in August 2018.	London Ambulance Service to ensure staff know how to raise safeguarding concerns via Screeners.
Orbit	SW raised concerns to Orbit re: drugs use at the property and over-crowding, Orbit staff raised safeguarding concerns internally in March 2019. No action was taken, and no response was given to SW. Orbit acknowledge that they did not follow their local safeguarding procedure in this case.	Orbit provide BSAB with current safeguarding policy and provides assurances to BSAB that staff understand and consistently follow policy. Orbit build relationships with key departments within Bexley council to enhance multi-agency safeguarding.

Agency	Finding	Recommendation
Oxleas	Nurses did not check for UTI or contact the GP directly to prescribe anti-biotics, as they had done on previous occasions when a UTI was suspected (16.12.2016, 27.12.2017 and 20.09.2018). UTIs are common where patients are dehydrated. Mary's health records note that she was frequently dehydrated: a common feature of neglect. The family stated that they expected the same on this occasion. Family called DN team on 27.08.19 regarding suspected UTI and were advised to increase liquids and call if no improvement. Family called Bexley's Single Point of Access on 28.08.19 and asked for a nurse to attend. On his call, Ian raised concerns about filaments in urine and its purple colour. Oxleas notes state that "Mary calls into day team late in the day, so referral passed on to OoH service for by-passing catheter." According to Oxleas' Level 3 Desk Top Review of the unexpected death, Mary's family were expected to contact the GP. However, this was not made clear to the family and was different to the family's previous experience. GP notes no inbound call from family in August but notes a failed encounter outbound call on 30.08.2019 to the family and a call with the daughter-in-law on 02.09.2019. During the review process, the SAR review panel were informed by Oxleas' Head of Nursing that "Purple Urine Syndrome" can be an indication of acute kidney injury.	Where there is a safeguarding concern – including concerns relating to family input into the care - Oxleas to have a process to ensure that the family/carer has called GP when advised to do so. Oxleas to mirror safeguarding process for children: when safeguarding raised, to ensure see client on their own.

Theme: Case Co-ordination

Sub Theme: Failure to engage a multi-agency approach

Finding Summary: Silo working by the LBB ASC led to missed opportunities to engage a multidisciplinary/multi-agency approach and a failure to develop and share risk plans and mitigation actions.

Agency	Finding	Recommendation
LBB ASC	Outside of the safeguarding process, there was a failure to engage a multi-disciplinary approach to support Mary and a failure to develop shared risk assessment and risk mitigation actions. The ASC focussed on Mary's care package and housing and did not consider health services supporting Mary as part of their ongoing risk and safeguarding management. The absence of shared risk assessment and a shared perspective on what intervention was therefore needed led to a failure to explore the legal powers and duties available to all agencies. The ASC did not engage a multi-disciplinary approach within the safeguarding process in progress between January 2019 and the date of Mary's death. Panel members suggested that perhaps staff do not feel supported or empowered to call MDT meetings for a safeguarding case.	LBB to be assured that SAMs are ensuring that case workers consider multi-agency approaches in their case management. This includes community/non-commissioned/non-statutory services (such as charities). LL to ensure Adults Social Care staff, including SWs, EOs and SAMs, are confident and supported at a senior level to call Multi-disciplinary team meetings to manage complex safeguarding cases.

Sub Theme: Leadership

Finding Summary: The lead practitioner did not take the lead on a coordinated, interagency approach to understanding and meeting Mary's needs nor in responding to the final safeguarding enquiry.

Agency	Finding	Recommendation
LBB ASC	The SCA was given responsibility and ownership for the management of the risks presented by the individual, but the absence of inter-agency case management meant that there was no coordinated approach to understanding the full risk picture and agreeing a shared strategy that could then be monitored by a lead practitioner. The SCA was not directed nor encouraged to consider the whole team around an adult as seen in children's services.	*Recommendation relating to SAM and Supervision Support covered in following section: Domain C – The Organisation around the professional team*

Sub Theme: Use of multidisciplinary meetings and complex case management frameworks

Finding Summary: The lead practitioner did not build multi-agency case management relationships or employ multi-agency management activities or processes.

Agency	Finding	Recommendation
LBB ASC	The lack of inter-agency case management outside when there was no safeguarding open meant that networks and partnerships were not already established and embedded as part of usual case management. Multiagency complex case and high-risk forums are available in Bexley but there was a failure to use these for multiagency consultation and case coordination. The local authority has already planned training and regular practice review meetings to address this.	SAB to seek assurance of use of frameworks for complex case management by LBB's Adult Social Care teams.
LBB ASC		LBB to ensure practitioners are able to use LBB's complex case management tools, and are encouraged to hold and attend colleagues' complex case management meetings.

19.4 Domain C: The Agencies Around The Team – Organisational Behaviour

Organisational behaviour in the agencies involved contributed to the practice observed in both direct work with the individual and in interagency working in Domains A and B above.

Theme: Workload pressures

Finding Summary: Two of the three practitioner involved in managing the Safeguarding Enquiry reported workload pressures.

Agency	Finding	Recommendation
LBB ASC	The SCA and SAM reported that they were under increased pressure with high complex caseloads and duties, the SCA noted that there was not enough time to work closely with complex families. The risk of poor decision making, inability to focus on case issues and incomplete process adherence is high in such circumstances. This also impacted upon the SCA's ability to engage in preventive rather than reactive interventions such as; timely commissioning of care and support; time to read case histories; communications with other agencies; attendance at/setting up multiagency meetings; time to reflect; time to build relationships and the timeliness and progress of safeguarding actions. Historically, high Social Worker caseloads had led to safeguarding enquiries being allocated to the Social Care Assistant rather than to a Social Worker supported by a Social Care Assistant. At interview, the SCA stated that they were managing 40-50 complex cases and was allocated all cases like Social Workers except for those with a Court of Protection order. Without close guidance and support, this practice risks placing staff in to positions which require an enhanced knowledge and sensitivity to safeguarding law and practice beyond their capabilities or competencies. The SAM and SW both felt that the SCA was capable of leading on the safeguarding enquiry, however the safeguarding practice noted across this case does not evidence this.	LBB reviews safeguarding processes with staff to make them as user friendly as possible. Review use of automated processes wherever possible, such as automated diarised follow ups for a Safeguarding Plan review, or where a client is without a service in their Support Plan. LBB ensures SAMs have sufficient time within their workplans to give additional complex case support along with regular supervision to staff working on complex cases, to reflect on their role, review seemingly intractable issues in cases and apply a wider lens on all their work. *This is perhaps the Principal Social Worker's regular practice forum meetings?* LBB Social Workers/Social Care Assistants encouraged to express when they feel they have unsafe caseloads and to work with management to find solutions to address.

Theme: Staffing

Finding Summary: An unqualified social care practitioner was managing a complex case. The SAR panel agreed that was not necessarily an issue, but that this finding combined with a lack of oversight, supervision, planning, quality assurance/competency framework and multi-agency/disciplinary approach, this finding is relevant.

Agency	Finding	Recommendation
LBB ASC	The staff member assigned the case had insufficient training and proactive support to manage a case of this complexity. The consistently poor level of safeguarding practice in line with local and Pan-London procedures and statutory guidance and principles reflects poor knowledge and understanding. The gap in supervision and management support is addressed under the theme Supervision and Support below.	LBB to be assured that all complex case workers are adequately trained and that regular reviews are completed to monitor staff competence.

Theme: Supervision and Support

Finding Summary: Supervision and support was irregular, light touch, and not at the level required for a case of this complexity.

Agency	Finding	Recommendation
LBB ASC	A complex case with five previous safeguarding concerns was allocated to social care assistant with no evidence of a competency assessment, additional training, or enhanced/reflective supervision support. The Social Care Assistant continued to lead on the case following the opening of the sixth safeguarding enquiry in 2019. It contained safeguarding issues that had featured in the case since the first safeguarding concern in 2011. Concerns of familial neglect featured prominently in each one. These issues had not been resolved by previous Social Workers assigned to the case. The SCA had three supervision meetings over the nine months that the safeguarding was open between January and September 2019. Only one action was raised over that period: on 4 February 2019, the SCA was directed to arrange a joint visit to Mary with Avante and the OT. This meeting was carried out 12 weeks later at Mary's home on 29th April. There is no mention of the Social Worker in the Liquid Logic case notes and no formal support was provided to the SCA by the Social Worker to manage the safeguarding plan for which they was the Enquiry Officer. There was a lack of supervisory scrutiny, challenge or reflective review of the approach taken over many years. Consideration of legal/alternative options or escalation within	LBB to review the case allocation process to include a formal competency assurance framework that reflects case complexity, including appropriate levels of management support, reflective supervision and training for staff. LBB to develop and make available resources which assist supervisors with reflective supervision with their staff. Managers at all levels to promote a 'learning culture' with an ethos in which reflective practice and self-questioning are accepted and actively promoted. Research in Practice have recently developed this reflective practice resource to draw upon, which builds on this earlier resource from 2017.

Agency	Finding	Recommendation
	LBB was missed. The panel noted that SAMs and Social Workers have a "*professional responsibility to support unqualified staff when they delegate a case to them*". They recommended that responsibility for open safeguarding enquiries is made clear to SAMs, and that SAMs feel confident to put responsibility, actions and timeframes on other professionals under their shared statutory safeguarding duty. The panel noted that for such a protracted high-risk case, with repeating patterns of the same issues from first recorded safeguarding by LBB Social Worker in July 2011, the lack of supervisory oversight was *"striking".*	LBB ASC to undertake an audit of case with open Adult safeguarding enquiries to be assured that Social Workers are active in their management and that Safeguarding policies and procedures are being followed.
LBB ASC	Staff in LBB ASC and in Brokerage noted that they were likely desensitised to the risks in Mary's case. During interview, the Adult Social Care SW, SCA and SAM also noted that this case was not unique and that they had several live cases which they considered more complex than Mary's. The panel agreed that in complex care cases, such as Mary's case, the SAM needs to provide a level of challenge to the Social Worker/allocated case worker. LBB representatives on the SAR Panel noted challenge is not currently carried out often enough and is an area of improvement.	LBB Supervisors are reminded to be alert to desensitisation. Inclusion of risk of desensitisation in relevant LBB procedure, with checklist of indicators to assist managers in early identification and response. LBB Practitioners and their managers should routinely play 'devil's advocate' in considering alternative actions, explanations, or hypotheses. LBB Supervisors to provide a safe but challenging space to oversee and review cases, with sufficient time afforded to complex cases. LBB to review LBB's Clinical Supervision process and dip test sample of Adult Social Care team and/or undertake an anonymous staff survey to measure and evaluate efficacy.
LBB ASC	Supervisory management lines were fractured.	*Resolved*

Agency	Finding	Recommendation
	The SAM who signed off on the Safeguarding Plan was the direct supervisor of the SCA but not the Social Worker who was the Enquiry Officer for the Section 42 enquiry. The Social Worker reported to a different SAM and had no supervision discussion of this case. There were no additional cross-team meetings in relation to this case. This issue has already been identified by LBB Adult Social Care and now the SAM supervisor of the EO in a section 42 enquiry signs off on and oversees the safeguarding process in line with the Pan-London Safeguarding Policy and Procedures.	

Theme: Management oversight and leadership

Finding Summary: Management oversight and leadership was well below the level required for this protracted and complex case.

Agency	Finding	Recommendation
LBB ASC	There was an absence of management oversight in the decision to accept, and continue to accept, Mary's family as an adequate alternative to the formal care package. The SAM and the Social Worker were not adequately sighted on the situation and as such there was no assertive leadership instructing the SCA to carry out a welfare check on Mary. This was particularly concerning given the open safeguarding which relied upon the Support Plan to reduce the risk of neglect. There is a noticeable gap of 15 days (12.08.19 – 27.08.19) where there are no Liquid Logic notes on Mary's case record. After the care agency withdrew on 10.08.2019, the SCA leading on the case management first spoke to the family on 28.08.19 during an unannounced visit. The visit was undertaken due to the safeguarding concern raised by Oxleas (23.08.2019) and an email from Brokerage Manager (27.08.2019) raising concerns as Mary had not attended the Day Centre for three weeks. The Brokerage Manager noted that they knew that Mary was vulnerable, and that the Day Centre was an important part of Mary's safety plan, which is why they escalated their concerns to	LBB to explore/develop means to escalate cases where protracted high risk exists involving a capacity vulnerable adult – possible use of case examples in practice development forums.

Agency	Finding	Recommendation
	Bexley's Operations Manager and to the Social Care Assistant managing Mary's case. The Independent Chair and panel concluded that there was a significant lack of safeguarding action over this period.	
LBB ASC	Adherence to the Safeguarding Process and oversight of the Safeguarding Plan was inadequate: The Social Worker/EO responsible for the Section 42 Safeguarding Enquiry had very little involvement in the case after the Safeguarding Plan was signed off in February 2019. Their name features in the notes just once after this date in August 2019 following the safeguarding concern raised by Oxleas. Actions within the safeguarding plan were vague, immeasurable and not greatly different to the approach taken since 2011. The panel noted that the team had lapsed into "chipping away" at issues with task-oriented interventions rather than a whole-case approach. They noted that potentially unconscious bias was present with the assumption that Mary would refuse to engage with any new approach. There were no dates or deadlines withing the Safeguarding Plan and no date of sign off by the SAM. No risk assessment was completed. There was no oversight or ongoing monitoring of actions per the duties of the EO and SAM described in the local safeguarding policy and procedure. There was no formal review, the Pan London Procedures recommend a formal review at least every three months. The SAM / EO did not schedule a multi-agency meeting. The Pan-London safeguarding policy is clear on the need for the SAM to consider convening a multi-agency planning group dependent upon the complexity of an enquiry. It also states that the EO should be confident and understand what is required. The independent Chair and panel felt that a case of this complexity required a multi-disciplinary team across all agencies supporting Mary and that the EO's understanding of actions required for the enquiry was not evident. The three key elements of Mary's Support Plan which helped safeguard Mary from neglect were not clearly stated in the Safeguarding Plan. Doing so may have provided a	SAB to seek assurance on the consideration and use of multi-agency involvement in all complex cases open to Adult Social Care, regardless of whether they are being progressed under S42 of the Care Act. LBB to be assured that SAMs/EOs consider the need for a multi-agency meeting in every new Safeguarding Enquiry. Review current Safeguarding Enquiry Flowchart within Pan London Safeguarding Procedure (p69) and revise locally to include need to complete risk assessments and to develop and action interim safeguarding plans which are Specific, Measurable, Action-oriented, Relevant and Time-bound (SMART). For eg, Haringey Section 42 Enquiry flowchart which builds upon the Pan-London policy and procedure. Consider clarity of expectations within local Safeguarding Process/Forms for Social Workers (EO), SAMs and any other staff with allocated responsibilities.

Agency	Finding	Recommendation
	reminder to staff allocated to the enquiry to protect these services and for contingency plans to be made prior to any element failing. Safeguarding and contingency planning for the home care package would have been particularly beneficial as there had been ten changes of domiciliary care provider who had withdrawn their services due to issues with Mary's family, and issues with Mary's family's behaviour had featured in every safeguarding concern raised, including that which was open at the time. Following the care provider's withdrawal, the Support Plan was no longer intact which formed a significant element of the Safeguarding Plan. The Safeguarding Plan was not revisited or reviewed at this time, nor was a risk assessment undertaken. The local safeguarding policy does not stipulate the need to revisit the Safeguarding Plan when an ongoing risk mitigating (often the Support Plan) activity fails. However, it should be evident that risk needs to be reviewed whenever an aspect of the Support Plan fails, in line with the Care Planning process detailed in The Care Act statutory guidance (2020), regardless of whether a safeguarding enquiry is open at that time.	Training for SAMs to complement the revised Safeguarding Process, ensuring that the elements for action are SMART. Trigger/reminder in system where safeguarding is recorded for regular action reviews and a formal review at least every three months. [Completed]

Theme: Lack / Shortage of Services

Finding Summary: The pan-London issue of housing stock supply was a consistent barrier to progress throughout the full review period of this case.

Agency	Finding	Recommendation
LBB Housing	The pan-London issue of housing stock supply was a consistent issue in this case. Mary expressed her desire to move to a 2-bedroom bungalow with a live-in carer from 2011 to her death. Mary and her son Ian attempted many avenues to secure a bungalow. However, in 2015, her younger son, daughter in law, and their 3 children moved in, with two further older children living in the property on occasion. From then on, Mary's efforts to move were impeded by her concern that by doing so, she would render her	BSAB to note hidden effects of housing shortages in London – including the hidden homelessness of a young family in Bexley.

Agency	Finding	Recommendation
	grandchildren homeless. Mary sought assurance from professionals that this would not occur, but professionals consistently noted short housing stock and long waiting lists and advised that as her house was adapted to her needs, would not be priority. This finding evidences the often-hidden effects of the lack of affordable housing in London. Practitioners agreed that although Mary's housing situation did not cause her death, had she attained her desire to move to a two-bed bungalow, the issues relating to her home environment, carers withdrawing and familial neglect were far less likely.	

Theme: Organisational Structure

Sub theme: Organisational practice silos

Finding Summary: The disconnect between adult social care and children's social care, evidenced in previous Bexley SARs and a common national feature, was present throughout the case. Additionally, there was poor joined-up working between LBB Housing and the Adult Social Care team, with lengthy periods of time passing with no progress made on Mary being added to Bexley's housing register. There was however good practice in terms of seeking cross-organisational support when the LBB OT involved in Mary's case undertook internal enquiries to fund the purchase of a fully adapted caravan for Mary. A fully adapted caravan had been identified and a discussion was underway with senior LBB executives to approve the purchase in principle prior to sharing the idea with Mary. The panel noted that this showed initiative and a change in thinking which created a solution to a seemingly intractable, seven-year problem.

Agency	Finding	Recommendation
LBB Adult and	Disconnect between Adults and Children's Social Care:	LBB to consider joint training/practice "Think Family" sessions sharing good practice for ASC and CSC staff.

Agency	Finding	Recommendation
Children's Social Care	LBB staff raised concerns about current cross team referral process which is currently four pages long. Staff felt this was un-necessarily long for a first contact form and hindered cross-team communication. During interview, practitioners noted that ASC and CSC cannot see information from the other's section of Liquid Logic. The SCA and SAM did note that cross team communication has improved, thanks in part to a change in team structure where SAMs support the staff in CSC and ASC. The SW (EO) noted that the safeguarding forms now also include a question about children being involved which prompts ASC to "Think Family". Did not "Think Family" and share information: ASC did not advise CSC that a safeguarding enquiry had been opened in a household where children are living and were previously subject to Child in Need plans (November 2017 and January 2019). CSC did not speak to Adult Social Care prior to closing a children welfare review case closed in May 2017. Case notes record that Mary is supported by Adult Social Care. On day after CSC's final visit, Carewatch raised a safeguarding concern.	Review LBB cross referral process for safeguarding. Consider Liquid Logic notification process that pre-populates key information to be shared. BSAB seek assurances that CSC policy is to check in with ASC re: any current concerns relating to adults living in the same property prior to closing a case.
LBB ASC	Mary's housing request was no further forwards more than eight years after she first shared her wishes as part of a safeguarding enquiry in 2011. LBB ASC did not advise LBB Housing or MeSH team of the open Section 42 safeguarding enquiry and explore whether there were any avenues to expedite Mary's housing request. During the interview process, LBB Housing representatives shared concerns about the number of previous safeguarding enquiries and the reports of domestic abuse on both Liquid Logic and the Housing system Civica. Housing Allocations spoke of instances of getting up and going to talk to members of ASC. This practice of direct communication with colleagues often led to progress but emails continued to be the primary method of contact.	LBB Senior Managers to encourage telephone and face to face communication between Adult Social Care and Housing, as well as cross team conversations and 'task and finish' type meetings to progress long standing safeguarding/Support Plan issues tied to housing.

Agency	Finding	Recommendation
Police	Failure to Think Family when drugs are found at property on three occasions in 2012, 2016 and 2019. There were at least four minors living in the property. Other adults in the house had previous record of drug usage. Other adults seen smoking cannabis by carers. Police representative on the SAR review panel noted that it looks like the relevant protocols regarding children at the scene of a crime were not followed. Therefore, the presence of children was not noted, which led to no specific action/recording relating to the children's safety and wellbeing. Re: The final drug search in 2019, Children's services had no case open to the family at the time, Adults ASC however had an open S42. ASC had not informed CSC of the open safeguarding with children living at the property. The completion of a Merlin record would have helped bring in LBB's Children's Social Care team to the case and increased the likelihood of ASC and CSC working together to respond to the family's needs (including housing).	Recommunicate need across Police Force to Think Family during a drugs raid at a property, and to follow due process in relation to reporting children present (e.g. completion of a 101 book or a Merlin Pack).

Sub theme: Information system structure silos

Finding Summary: Current LBB internal systems integration is not providing LBB practitioners with the safeguarding information they need in a timely and effective way.

Agency	Finding	Recommendation
LBB Housing / MeSH & Adult Social Care	Current system integration is ineffectual. An open safeguarding cannot be seen in Civica. Housing must open Liquid Logic separately. This means that for Housing to be aware of a safeguarding enquiry, they must either proactively log in to Liquid and read the notes or be directly informed.	LBB to ensure all LBB IT systems show where a person is subject to a safeguarding enquiry. Ensure key safeguarding information is easy for council staff to access in their daily role.

Theme: Organisational Systems

Sub theme: Policies and Procedures

Finding Summary: LBB Brokerage commissioning processes could be improved to escalate gaps in care packages to management and Oxleas safeguarding process could be improved by adding a step to follow up where there has been no response to a safeguarding concern raised. Organisational policies and procedures across the agencies involved were mostly effective. Minor adjustments, in the spirit of continuous improvement, would improve future safeguarding practice across Bexley.

Agency	Finding	Recommendation
LBB Brokerage	Significant time passed before the gap in Mary's Home Care came to the attention of Brokerage Management from an external source (Inspire). No increased priority status/escalation was applied to a case with an open S42, nor where the gap is a significant aspect of a client's Safeguarding Plan being managed as part of the safeguarding enquiry.	LBB Brokerage to develop and apply escalation procedure for unfilled care packages: daily SAM, EO and Brokerage management update of any unfilled care packages where there is an open safeguarding.
LBB Brokerage	The Care Agency was able to immediately withdraw without a notice period nor providing any interim solution.	LBB Brokerage to consider legal support to add a notice period for Care contracts in line with provider and local authority statutory obligations under the Care Act, Sections 18-20.
LBB Brokerage	There was no contingency plan for when/if Avante withdrew. It was recorded on Liquid Logic in January 2019 that Avante were the last care agency option for Mary when Avante raised a safeguarding concern. Brokerage could be prepared for similar incidences with a contingency plan. This would also be useful for Out of Hours response teams where incidents occur in complex cases outside of working hours.	LBB Brokerage to undertake an audit of current cases to identify residents *with an open safeguarding enquiry* whose Support Plan is at risk of breaking down. Adult Social Care to then ensure LBB works with these residents to agree a Safety Plan / Contingency Plan should usual care arrangements fail with support from Brokerage.

Agency	Finding	Recommendation
		Develop a Risk Assessment report/process that can be run to complete the above rolling check on a regular basis. Consider system automated flag on case file when high numbers of providers have withdrawn from providing support to a client, to highlight cases that need additional attention and/or a different approach. Brokerage to develop a de-escalation process for agencies in crisis and early identification and formal response to cases where agencies are at risk of withdrawing.
LBB ASC	Mary's son allegedly intentionally damaged Mary's care equipment (e.g. cutting hydraulics in her bed). Equipment was fixed/replaced. No further action was taken. Son's behaviour continued to cause issues with Mary's home care providers, and many withdrew services due to his behaviour. This was an opportunity to challenge his behaviour and demonstrate the detrimental effect of his actions on Mary.	LBB to develop and communicate a clear procedure relating to the 'intentional' damage of council property whilst in a private dwelling for staff to follow.
LBB Equipment Stores	Shower Chair returned to stores by Manager of Worsley House after Mary did not attend Respite in January 2018. Shower Chair was subsequently lost/possibly reallocated. As a result, Mary didn't have a shower at home from January 2018 to her death on 4th September 2019. Mary stated that she liked to " have a shower daily" in the Safeguarding documentation raised in November 2017.	Review LBB stores booking in process and ensure policy includes not loaning out equipment that is not part of stores inventory. Ensure policy includes process for investigating source of unknown equipment and signing in to stores.

Agency	Finding	Recommendation
	Mary's family confirmed that Mary did not have a shower over this period. This was due to not having a shower chair and her bathroom being unfit for her use. A daily shower was not part of the Avante's care package. Updates to her bathroom were stalled due to her request to be rehoused. Mary strongly disliked being bed-washed and much preferred a shower. In an account from Aquaflo (carers) in 2015, Mary was reported to be very upset and cried when she was only able to be bed-washed. The fact that this element of her daily life was never restored undeniably had a detrimental effect on Mary's quality of life.	Ensure staff understand and follow stock management policies.
LBB Housing	Complex housing processes – ASC staff felt housing policies created a significant barrier and prevented a meaningful intervention in Mary's case. No evidence of Housing asking for additional information from Adult Social Care which may have increased re-housing priority/expedited the process such as *safeguarding concerns/open S42/domestic abuse*.	LBB Housing to ensure ASC and Housing teams are clear on options available to expedite/treat differently/provide specialist support for Housing applications in situations such as Mary's. (e.g. discussing with Housing IDVA). Representatives from Housing and Adult Social Care develop a checklist for housing to complete when working with ASC on housing allocations for vulnerable clients.
LBB Housing	LBB ASC understood Case Closed to mean no further action, where-as in LBB Housing is means *inactive awaiting action from outside of Housing.*	LBB Housing to input in to LBB Glossary of terms underway in Bexley per action noted in SAR Mrs A (2018).
LBB Housing/MeSH	There was no identifiable change to prioritisation of Mary's housing application following MeSH, OT concerns raised following their home visit to Mary on 13.02.2019. MeSH OT's notes included mention of "violent son", over-crowding, need for updating and risk of care-package breakdown.	LBB Housing/MeSH team to ensure process following formal MeSH OT review includes updating Social Care lead on next steps/process and likely timeframes.

Agency	Finding	Recommendation
LBB Out of Hours Adult Social Care	No evidence of Out of Hours Social Workers checking for an open safeguarding enquiry on Liquid Logic regarding family's suitability to provide care over the weekend.	LBB to be assured that OoH SW/Rapid Response check for open safeguarding enquiry when responding to a case development, to ensure any decision made is informed as possible, and that senior management are involved or informed where necessary.
LBB Social Care Teams	Coroner's Office note that "When a new case is allocated to our Coroner's officer they would only know if it was a safeguarding issue if the deceased's GP was noted or if it was on the police database". In this case, neither Police nor GP were aware of open S42. Coroner (Case Officer) does not contact local authority to check for an open safeguarding enquiry. Social Worker was slow in contacting coroner to note concerns regarding the death and did not mention possibility of a SAR. Case was closed before local authority contact. Post-mortem completed 10th September.	Local Authority develops and embeds a process for case workers to notify the Coroner as soon as they are aware that a client has died when there is an open Safeguarding Enquiry. Local Authority provides South London Coroner's office with Single Point of Contact for enquiries.
Orbit	Orbit's Safeguarding process was not followed on two occasions in early 2019 when Mary's last safeguarding enquiry was open as she was at risk of eviction: An internal Safeguarding Concern raised on 7th March 2019 by Orbit's Income and Collection Recovery team. Orbit acknowledged that this safeguarding received no response and did not follow Orbit's policy and procedures. LBB were unaware of the concern raised. Orbit have taken action to ensure their staff understand and follow their safeguarding policy. LBB's Social Worker raised concerns on 25th February 2019 relating to the over-crowding and drugs at the property. Notes state that referrer did not leave their name, but a record of The Social Worker's call with contact details was in Orbit's Customer Service Centre notes on its Customer Management System. Social Worker was not contacted in relation to the concerns raised.	*The recommendation relating to this finding is covered in Domain B: Interagency working above*.
Orbit	There was an over-reliance on telephone calls and letters instead of home visits prior to the eventual court ordered Outright Possession Order. Orbit noted that it had	Orbit to review tenant contact policy to ensure process is Equality Act (2010) compliant and does

Agency	Finding	Recommendation
	"exhausted internal procedures" and possession proceedings were started. Consideration was not given to Mary's personal circumstances nor of accessibility of Orbit's communication channels for people with protected characteristics, in Mary's case – disability.	not disadvantage people with protected characteristics.
Oxleas	Oxleas District Nurses followed their Safeguarding Policy, which is based on the Pan-London safeguarding policy and procedure, when they sent their safeguarding concern to the local authority via Screeners on 23.08.2019. The current procedure does not indicate the need to follow up. However, Oxleas representatives acknowledge the important principles of safeguarding within The Care Act relating to the need for each professional and organisation to do everything they can to ensure that adults at risk are protected from abuse, harm and neglect. Oxleas have therefore undertaken to update the policy to include a follow up process if there is no response from the local authority within 48 hours of the safeguarding being raised as a result of the findings of this SAR. Panel members suggested reflecting safeguarding management models used elsewhere in health settings in the borough, such as a central admin role to assist in the follow up of safeguarding concerns, to minimise the burden on front-line practitioners and to assist with central data collection, measurement and evaluation.	Oxleas to work with the local authority to develop and agree a simple follow up process to help progress safeguarding concerns raised and encourage professional knowledge sharing across the health and social care to improve safeguarding practice. Once agreed, Oxleas safeguarding policy will be updated accordingly. Oxleas to consider a system to centrally capture the number and status of safeguarding concerns raised by Oxleas to local authority for measurement and evaluation.
Oxleas	From the start of 2019 (eight months) there are 17 notes of 'blocked catheter' on Mary's Rio health records and at least two bladder wash outs. Oxleas noted that this was common for Mary, and relatively common for patients with MS. In Mary's case, there is no evidence that health practitioners sought to identify and minimise the root cause of Mary's recurrent catheter issues.	Oxleas DN team to consider developing a process where-by multiple call outs for catheter issues triggers a multi-disciplinary team (MDT) meeting to review possible root causes and preventative action which could reduce the prevalence of issues that require call outs. Where a patient who has MS is having recurring catheter issues, Oxleas to ensure that an MS specialist nurse is consulted to make sure that

Agency	Finding	Recommendation
		medication is correct, and that the medication will minimise the risk of bladder issues.
Oxleas	The Oxleas District Nurse team acknowledged within their own reflective practice review following Mary's death that nurses should have taken Mary's temperature or carried our a urine test at one of the three visits made to Mary when a UTI was suspected. They noted that a raised temperature is an early indicator of sepsis and of escalating UTI, and that this would have assisted in earlier identification and response. The panel was informed that the nurse attending to Mary on 23.08.2019, and who subsequently raised a safeguarding concern, had known Mary for a long time. As such it was possible that the nurse had become used Mary's experiencing UTIs and blocked catheters (unconscious bias), and instead of following the NICE guidance on suspected UTIs, the nurse recommended that the family called the GP for antibiotics.	Oxleas DN teams ensure vital signs are recorded, in particular temperature, and report to GP if outside usual parameters when attending patients with suspected urinary tract infection.
Oxleas	On 27.08.2019 Mary's son, Ian, called the District Nurses as they usually did for catheter related healthcare. Ian called the number for the newly established Single Point of Contact (SPOC), hoping to arrange a home visit. The call was passed to the district nurse team, who advised to increase fluids and to monitor. No home visit was arranged. Three days earlier, a senior nurse had raised a safeguarding concern via Screeners to the local authority. At that time Oxleas were trialling use of telephone rather than direct visits and adjusting follow up visits to safeguarding cases only. Mary's case was not flagged as a safeguarding case as no response had been received from the local authority. Oxleas noted that w*ithout confirmation from LBB safeguarding team, which would have gone into Rio notes, District Nurses looking in notes would not have seen if LBB had opened an enquiry or had one open already.* The call handler was not expected to check for an open S42 on Liquid Logic/Connect Care or on Mary's recent case notes in Rio where he/she would have seen that a senior nurse had raised a safeguarding concern three days earlier.	Oxleas to consider prioritisation of home visits where there is a safeguarding concern, including where a nurse has raised a concern and is awaiting a response from the local authority.

Agency	Finding	Recommendation
	The panel supported the prioritisation of home visits where there is a safeguarding concern, and recommended that this includes cases where a nurse has raised a safeguarding concern to the local authority, and it is awaiting a response from the local authority (i.e. open), to close the risk of an escalating safeguarding issue during the local authority's response timeframe.	

Theme: Record Keeping

Finding Summary: There were instances of poor record keeping at LBB which hindered safeguarding management.

Agency	Finding	Recommendation
LBB Brokerage	In August 2019, four key communications were not logged on Mary's case records: two safeguarding concerns raised by Inspire in August 2019 relating to Mary's continued non-attendance at the Day Centre, and two requests from Mary: one for a personal shopper for "when the money comes in", and one for additional Home Care time. Only the second safeguarding concern was shared via email on 27.08.2019 to the Social Care Assistant. The Social Worker (EO) and the SAM were not included on the recipient list.	Ensure LBB teams are clear about requirement to record all case relevant information on Liquid Logic.
LBB ASC	Liquid Logic notes were added up to a week after activities such as the last home visit to Mary by the SCA and OT on 28.08.19 before Mary's death, which was input on the evening 04.09.2019 after Mary's death. Some key meetings – such as the Safeguarding meeting with Mary in January 2019 to discuss the Safeguarding Concern and an email from LBB Social Worker to Orbit Housing to raise concerns in February 2019 – were not recorded on Liquid Logic.	LBB to recirculate the policy on the maximum number of days within which notes are to be added to Liquid Logic. Ensure LBB teams are clear about requirement to record all case relevant information on Liquid Logic. Supervisors/Managers to oversee/regularly spot check and remind staff.

Agency	Finding	Recommendation

19.5 Domain D: SAB Governance

Theme: Policy and Procedures

Finding Summary: There was no evidence of Police contact with the local authority to ascertain if there was an open safeguarding enquiry prior to recording the case as non-suspicious.

Agency	Finding	Recommendation
BSAB	The Police were unable to provide records of a process undertaken to rule out Mary's death as suspicious, such as a Sudden Death / Unexpected Death process that the officers completed (e.g. the "*ABC*" process via College of Policing). Mary had a long history of safeguarding concerns, and neglect. The local authority had a Section 42 enquiry open at the time. Body worn cameras were not used by the officers in this case. Whilst activation of body worn cameras is not mandatory when attending an unexpected death, Principle 5 of the College of Policing's Body Worn Video Guidance (2014), advises that the tendency should be towards recording incidents rather than not. Police forces in other regions (such as Merseyside Police) recommend in their local policies that unexplained deaths are 'scenes' should be captured, although officers are trusted and empowered in accordance with Force Strategy, to use discretion as to whether or not they believe it is important to record the scene. In this case, the number and type of prior incidents at this address, should have led to the attending officers activating their body worn camera.	BSAB to be assured that when attending an unexpected death, Police procedures are to contact the local authority to ascertain if there is an open Safeguarding/any concerns of neglect/abuse prior to recording a case as non-suspicious. This assists in ensuring that the Coroner does not close the case prior to the local authority's decision to commission a SAR/DHR. BSAB to be provided with Police force policy and/or procedure to provide clarity on the usage of body worn camera when attending an unexpected death.

Theme: SAR Process

Finding Summary: The consistency of attendance by the SAR Panel members and their commitment to the meetings was exemplary. The process greatly benefitted from the same people attending each month and feeding into the process in-between meetings. In terms of the paperwork: IMR Authors in the SAR process grappled with the IMR process and the quality of some IMRs suffered as a result.

Agency	Finding	Recommendation
BSAB	Whilst there was strong co-operation from most agencies involved in the SAR process, co-operation with the SAR was difficult to obtain from Orbit Housing Association.	Review measures available to it for seeking compliance with Section 45, Care Act 2014, where an organisation fails to fulfil their statutory duty to provide information.
BSAB	No IMRs were completed fully in line with The Care Act Guidance. Important information was missing and discovered through reading all case notes or during interviews. Practitioners directly involved in supporting Mary authored IMRs, chronologies were missed, key information was missing, and many were submitted late. Orbit's submission, on its own template, was partly submitted on 24.11.2020. Key information, including the appendices noted in the submission, were still outstanding at the point of drafting findings in early December. Orbit's IMR contained unique information which was of importance to the findings and learnings. Panel members fed back on their frustrations with the IMR form and requested that the form be revisited with the SAR subgroup. Training is planned for 03.03.2021 to cover IMRs which are in line with the six safeguarding principles thanks to changes in record keeping process which now reflect Care Act record keeping and six safeguarding principles.	SAB to revisit the IMR form and completion process with the SAR sub-group and GPs/GPs representative. SAB to be assured that all IMR Authors understand the information and process required to complete the form. SAB to be assured that managers signing off on IMRs have a checklist of what a good IMR looks like, including SMART recommendations. SAB to consider offering a pre-IMR briefing so that IMR Authors understand the methodology and what organisational involvement is expected.

Theme: Bexley SAB's role in improving practice

Sub theme: Training and Awareness Raising

Finding Summary: Practitioners would benefit from reminders of existing or the development of new training in relation to:

Mental Capacity, and its value in opening up alternative lines of professional responsibility and options. The panel noted that a lot more work is needed to go through some of the nuanced arrangements around mental capacity assessment, such as the effects of coercive control.

Sepsis Awareness, with the benefit of hindsight, Mary was at high risk of Sepsis given the combination of circumstances towards the end of her life. Nationally, Sepsis is the most common cause of death recorded by the Coroner in SARs, and therefore it would be prudent to revisit Sepsis Awareness training across the borough.

Agency	Finding	Recommendation
BSAB	Mental Capacity. Practitioners noted that Mary has mental capacity without recording how they came to this conclusion. No assessment was undertaken by LBB after January 2018. The Neurologist assessed that Mary's cognition was reasonable on 2 May 2019, however there is no record of the test undertaken not any further notes on file. The panel noted that it is too easy to assume or even determine that someone is making a capacitous "unwise decision". Exploring mental capacity, which would include considering coercion or other external influences affecting someone's ability to decide at that time, would open alternative lines of professional responsibility and options. The	BSAB to provide Mental Capacity Training – revisiting the Mental-Capacity-Toolkit-14.12.2018.pdf safeguardingadultsinbexley.com). Attention to Mental Capacity in cases where Domestic Abuse is recognised or suspected.

Agency	Finding	Recommendation
	panel noted that a lot more work is needed to go through some of the nuanced arrangements around mental capacity assessment.	Coercive Control is recognised as hindering a person's ability to make "wise choices". (R. Thiara 2019, L. Pike 2018, LGA/ADASS Guidance 2018.).
BSAB	Sepsis Awareness Sepsis is UTIs are common in MS patients with catheters (80%). Mary had frequent UTIs. Sepsis is commonly underlain by a UTI. Research shows that MS likely dulls the symptoms of a UTI and Sepsis. There is no evidence of a health professional being concerned about the increased risk of Sepsis for someone like Mary with recurring UTIs, Catheter issues, MS and frequently neglected without formal care provision. Bexley CCG did some work on Sepsis in 2018. Public Health England did some work on Sepsis and Gran Negative Sepsis on catheters, but this work has ceased. The work included the increased risk of Sepsis underlay by a UTI where there is dehydration, neglect and frailty. There are tools such as National Early Warning Score (NEWS2) used in the NHS. Preston-Shoot et al (2020) found that Sepsis was the most common cause of death recorded by the Coroner in SARs. He is due to be presenting health related findings to a meeting of the Safeguarding Adults National Network (SANN) in January 2021. The SAR Panel agreed that this is a bigger issue across Bexley that should come out of the Health and Wellbeing Board as this affects all residents in Bexley.	Bexley Health and Wellbeing Board to progress awareness programme on Sepsis, including the prevalence of UTIs with catheters. *UK Sepsis Trust Founder/Executive Director, Dr Ron Daniels BEM, has expressed an interest in supporting Bexley with this work.*
BSAB	Information on Bexley's Principal Social Worker(s) is not publically available. The principal social worker should be visible across the organisation, from elected members and senior management, through to frontline social workers, people who use services and carers. Local authorities should therefore ensure that the role is located where it can have the most impact and profile.	BSAB to ensure details of Bexley's Principal Social Worker(s) are available on LBB intranet, clear on LBB org charts/phone listing, and externally on-line where the role can have the most impact and profile.
BSAB	Avante did not report a crime to the Police: Violent incident in the home on 09.08.19 when carers on site. Carers opened the door to the alleged protagonist. A pregnant	BSAB to commission a borough-wide communication on the need to report crime, in

Agency	Finding	Recommendation
	woman and carer were physically involved, children present and there were continued threats to carers. Avante were concerned about witness safety. *Note that many carers/front line workers live in the same area as the families they support, and some are known to the families outside of work through shared community connections.* Two members of LBB's Out of Hours support team, an Adult Social Care Social Worker and a Rapid Response team member, separately speak to Avante about the violent incident. Neither advise Avante to report the incident to the Police. Staff did not note the local authority's policy of "We don't not report crime". Avante expected to be told if there was a policy or local authority expectation to report crime. In this case, where children were also witnesses, there is a wider public interest duty to safeguard the children. Since the incident, Avante has updated the relevant policy to include the duty to report crime to the Police and notification of relevant senior employees. The panel felt this was a cross-brough issue and therefore the recommendation should be for a cross-borough awareness raising activity to improve crime reporting.	partnership with Police. The aim of the campaign is to educate all statutory and statutory commissioned agencies on how to report crime and options relating to witness safety and anonymity.

20. APPENDIX F

20.1 Changes In Care Agency Over Review Period

#	Agency	Start Date	End Date	Reason For Ending Contract	Total Days Commissioned	Days Between Contracts
1	Carewatch	18.07.2011	29.09.2011	The family had exhausted the carers who were willing to go into the property to support Mary due to home environment and John's behaviour.	73	-
2	Athlone	30.09.2011	12.07.2012	Carers starting to report that they were hurting their backs, so agency requested for Bexley to find another provider. These moving and handling issues could have been resolved with installation of a ceiling track hoist being fitted at the property, however Mary's family (and latterly Mary) refused to have a ceiling track hoist installed at the property. Eventually the agency gave notice and handed back the provision.	286	0
3	Kent Social Care Professionals	12.07.2012	14.04.2013	KSCP handed back the care package when John was verbally abusive to the carers, resulting in them fleeing the property. The carers had raised issues about the deterioration in the state of the property, describing that they were having to avoid dog faeces, as the dogs seemed not to be house trained. There were also problems with the shower room drain overflowing, dirty dishes piled up and reports that people in the home were smoking cannabis around the carers when they were trying to attend to Mary.	276	0
4	PCT Diamond	15.04.2013	01.12.2014	Issues were being reported by the agency of John “screaming and shouting” at the carers because they had to knock on the door because the key had gone missing from keysafe. The lack of key in the keysafe meant that the carers could not let themselves in as usual	595	0

#	Agency	Start Date	End Date	Reason For Ending Contract	Total Days Commissioned	Days Between Contracts
				using the key. The agency continued to provide support to Mary until December 2014 when they were unable to provide carers that were willing to go into the home.		
5	Inspire	02.12.2014	24.02.2015	Reported moving and handling difficulties, where they said that the hoist was unsuitable, and the workers were struggling to transfer Mary. They reported verbal aggression from John and described difficulties providing the support to Mary due to their being younger members of the family sleeping on the floor in the lounge where Mary was set up in a microenvironment This made it difficult to put the hoist on charge and to be able to carry out their duties in attending to Mary's needs. On 24th February 2015 they handed the care package back following reports that John had been very verbally aggressive to the carers.	84	0
6	JC Michael	18.03.2015	29.04.2015	The agency reported issues with the general condition of the home, a leak in the bathroom resulting in puddles of water, the hoist not working properly and carers hurting their backs whilst trying to provide support to Mary. They were struggling to get carers to go in to the home and provide support.	42	21

#	Agency	Start Date	End Date	Reason For Ending Contract	Total Days Commissioned	Days Between Contracts
7	Haven Social Care	30.04.2015	21.11.2016	First requested to hand back the care package 12th July 2015 reporting issues with family and advising that the property generally was in a poor state. On this occasion, the issues were addressed and resolved; John and his partner (Hayley) agreed to ensure the areas that the carers had to use were clean and tidy and they would keep the dogs and the children out of the way while they carried out their duties. Consequently, Haven care agreed to continue to provide the care. The agency decided to terminate their care as the carers had raised some serious issues of neglect against the family regarding there being a lack of food to give to Mary and were concerned for safety; carers were buying milk and bread to give Mary something to eat.	571	0
8	Eleanor Care	21.11.2016	24.11.2016	Eleanor Care only provided a care package for three days from 21.11.2016 to 24.11.2016. The agency reported that the carers could not work safely due to the dogs running around and jumping at carers. They also said that there were young children running around the room whilst they were trying to attend to Mary. The agency further advised that the front door was broken, which meant that the carers felt unsafe in the environment because the door could not be opened from the inside, and they did not like feeling trapped in the environment that they found themselves in.	3	0

#	Agency	Start Date	End Date	Reason For Ending Contract	Total Days Commissioned	Days Between Contracts
9	Carewatch	24.11.2016	18.01.2018	In May 2017, Carewatch contacted the brokers to report: issues with drugs; the dogs being present in the home were unruly; the general condition of the home environment being very poor; that there were no clean towels, toiletries or clothes for Mary, which was making it very difficult to provide Mary with the support and care that she needed to address her basic needs. The agency also advised that there was a lack of food to give to Mary, plus there were dirty dishes everywhere and the microwave which they used to heat food, when it was available, was broken. In August 2017 Mary's son (John) and his family went away for the weekend. They had left Mary with no food, nor a working phone that she could use to contact someone in an emergency, if she needed assistance. The agency raised a safeguarding in November 2017 with concerns that Mary was being neglected and financially abused by her family. Following this the agency handed back the care package as were afraid of any repercussions from John following them making these reports.	420	0
10	Avante	25.01.2018	09.08.2019	After raising multiple concerns similar to previous agencies, one of which led to an S42 safeguarding enquiry in January 2019 (which was open when Mary died), the agency handed back the contract after a violent incident. The carers had let somebody into the property who then attacked John. After being challenged by John about letting the man come into the property, the carers left the property, and reported that John had chased them to their car and was being verbally aggressive and threatening towards them because of what had happened. Avante noted that they had a duty of care to their staff, and as such withdrew their services.	561	6

Mary

#	Agency	Start Date	End Date	Reason For Ending Contract	Total Days Commissioned	Days Between Contracts
11	No formal care	10.08.2019	04.09.2019	Mary was without a domiciliary care package between 10.08.2019 - 04.09.2019. Mary died in the early hours of the morning of 04.09.2019.	25	-

21. APPENDIX G

21.1 Previous Bexley SAR Reviews With Similar Findings To SAR Mary

Theme	Learning	Recommendation	Source
Responding to coercive control	The impact of coercive and controlling behaviours on decision making to be considered.	Familial domestic abuse examples to be explored within safeguarding training to ensure that all agencies can recognise familial abuse.	SAR PAUL (2020)
Responding to coercive control	Coercive and controlling behaviours are the impact on autonomous decision making to be considered.	The potential impact of coercive and controlling behaviours affecting a person's ability to make autonomous decisions should be explored in all safeguarding interventions that involve domestic abuse, including familial domestic abuse. Training and briefing regarding decision making and autonomous to be provided in the most accessible format across all agencies.	
Personalisation	The accessibility of services. Sending letters to someone who cannot read them or respond to them means that some of the most vulnerable people will be denied access to services. This is not the first time that this matter has been identified in a local Safeguarding Adults Review, it should be highlighted as National Learning.	All assessment processes to consider the accessibility of services. If audits suggest that letters are routinely sent to those who unable to access the service for some other reason then, an equality impact assessment covering accessibility to services should be conducted as a multi-agency event. Access to services is an aspect of reasonable adjustment under the Equality Act 2010. All agencies should be reassured that they have supported equitable access to services.	
Attention to Mental Capacity	A wide variety of practitioners would benefit by these proportionate and sensitive capacity assessments being shared as examples of good	Capacity assessment recording to be shared as examples of good practice across all agencies. Although Bexley are working hard on capacity	

Theme	Learning	Recommendation	Source
	practice. A full and detailed explanation is not always required for every situation, enough evidence to provide a rationale is a more proportionate response. It would be useful to look at this and then consider the impact of trauma on a person's executive functioning. If found to lack capacity the ethics involved in best interest decision making can be complex as to remove power and control from someone who has suffered from trauma, loss and a lack of power and control may not be the best way forward.	across the partnership, some examples of proportionate assessment where a full report is not required would be helpful for everyday use.	
Attention to Mental Capacity	It is recognised that when someone suffers from traumatic incidents there can be sensory things that continue to trigger distress (Somatic markers similar to Post Traumatic Stress). When suffering trauma, the area of the brain affected is the executive functioning that governs chronology, date and time, self-care, impulse control, risk assessment and future planning. This would most often affect a person's ability to weigh up information which is required to deem someone as having mental capacity to make that decision. Panel members recognised the importance of this form of assessment in understanding whether a person can make decisions. This form of assessment is difficult to achieve, as the person can describe a course of action and / or a rationale, however, they may struggle to employ the	Panel members and Board members to reflect upon who would be expected to conduct such complex capacity assessments (Understand the impact of executive functioning on a person's ability to make a decision).	

Theme	Learning	Recommendation	Source
	actions, or to have insight into their own abilities. Panel members identified the current local and national struggle to get all agencies to conduct simplistic capacity assessments and that this may be too much to expect. This is a repeat theme in Safeguarding Adult Reviews conducted in the case of self-neglect, self-harm / suicidal ideation, hoarding, homelessness, abuse or neglect. Panel members discussing the understanding of executive function in assessing capacity recognised that even if the person were to be found by the assessor as lacking capacity to make these decisions, it is rare that it would be in that persons best interests to force a course of action that would remove further power and control away from the individual displaying symptoms of trauma. Nevertheless, the rationale in some cases is more defensible and evidence based. It is worth noting that a person who lacks capacity to make a decision is not making an informed choice and therefore the best interest decision is required but must be proportionate and balanced.		
Case coordination	... a more coordinated approach across safeguarding would have been beneficial.	To share good practice examples in a manner that is accessible to all practitioners. (See recommendations about safeguarding, information sharing and Local Authority overview of outcomes).	

Theme	Learning	Recommendation	Source
Case coordination	A coordinated multi agency response for safeguarding purposes would have been valuable. The coordination of support and services, recognition of the history of trauma and the impact on the whole family, capacity assessments and applicable legislation discussed to ensure a lead agency in safeguarding responses would have provided a clear picture of the complexities involved.	Multi-agency safeguarding responses with a lead agency identified and oversight, guidance provided by the Local Authority in safeguarding situations.	
Whole Family	Safeguarding measures are to consider the whole family.	Safeguarding considers the whole family and wellbeing principles are applied. Training should provide examples in practice. At each stage the Local Authority should be providing oversight and guidance.	
Whole Family/Carer Assessment	Where family members are providing support to meet an identified need or to maintain wellbeing then they should be informed about the responsibility to identity to services is they are struggling to meet the identified need. All identified needs including those met by family care providers should be identified on care and support plans.	To ensure that all mental health and ASC staff recognise the importance of up to date care and support planning that supports family care providers, but also holds them accountable for meeting needs or reporting concerns.	
Responding to domestic abuse	The complexities of familial domestic abuse and risk factors to be explored in all safeguarding cases involving family members.	For domestic abuse services and ASC to monitor recognition and response of familial domestic abuse and risk assessment management.	
Safeguarding Process	The Care Act requires agencies to be reassured of the safety and wellbeing of a person / family and to seek advice, support, guidance and	Ensure safeguarding concerns are followed up.	

Theme	Learning	Recommendation	Source
	oversight from the Local Authority. The question is where all agencies reassured of safety and wellbeing and if not, what actions would be taken moving into the future.		
Safeguarding Process	Avante, and Nurses did not raise or follow up safeguarding.	BSAB seeks assurance from all relevant agencies in this review, that agencies are confident that statutory duties are being deployed and met under the Care Act, in relation to making appropriate safeguarding referrals.	SAR N (2020)
Commissioning/Managing reviews	That all parties involved in a SAR have a legal obligation under s45 of the Care Act 2014, to supply information on request from a Safeguarding Adults Board, if that party is likely to have information relevant to the Board's functions, and therefore such a request places that person under a duty to disclose. In this case it could be argued that that duty was not met.	This is a matter going forward for both Orbit Housing and BSAB.	
Safeguarding Process	-	Any agency working with an adult where they have concerns about ongoing risk should contact adult social care to ask for a multi-disciplinary meeting to review the risk and the care plan.	SAR VICTORIA (2020)
Commissioning/Managing reviews	Issues with IMR process.	Training in completing scoping forms and IMR to be offered to all agencies. Agencies to ensure that staff who worked closely with the client are involved in the process.	SAR Ms AB (2019)

Theme	Learning	Recommendation	Source
Cross-team working / Preventing silos	Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would also be responsible for the S42 Enquiry.	Undertake research and audit of safeguarding responses to and from domestic abuse across both Adults and Children's services to ensure LA oversight. AND Ensure joint Safeguarding Enquiries (Between Adults and Children's Services) are undertaken in coordination with the police for families where mental health and domestic abuse concerns are raised, irrespective of whether they are raised first with only one agency initially/To continue practicing, 'Think Family' when safeguarding concerns are raised across all service areas; regardless of first point of contact to ensure this finding can be satisfied.	SAR Mrs BA (2019)
Safeguarding/MDT		Consider setting up an integrated MASH (Multi Agency Safeguarding Hub) Service, to triage referrals to either Adults or Children's Safeguarding (or both, working together).	
Information Sharing/Systems (H&SC)		Improve systems for information sharing between primary health care, social care and (specialist mental health care where risks of suicide are identified).	
Cross-team working / preventing silos	Housing using terms unfamiliar to, and thereby mis-interpreted by) ASC.	Incorporate Glossary of terminology used across sectors including Courts, Probation, Housing and other health and social care services; this is not limited to terms but also processes.	SAR Mrs A (2018)

Theme	Learning	Recommendation	Source
Safeguarding Process	In order for services to understand what the concerns are a more formal system of escalation needs to be in place in organisations.	BSAB to emphasise and agree an Escalation Process to follow with regards to care and support needs and risks to safeguarding and BSAB Audit to have evidence provided against partner's policies/procedures.	
Safeguarding Requirements	All agencies need to understand the importance of their statutory requirements under the Care Act 2014 and to ensure this is managed locally at a senior level and through the Board representative.	BSAB Toolkit updates and cascading.	
Personalisation	Agencies should consider all options of communication with patients and understand 'writing to' as least beneficial method of communication.	Noted and to ensure service user safety and risk addressed in Bexley Care re-design.	
Cross-team working / preventing silos	Work on uncoordinated parallel lines	Liquid Logic read-across Adult's/Children's services.	SAR Mr K (2017)
Management oversight/Supervision & Preventing Silos		Robust District Nurse daily handovers, supervisions and team meetings (Oxleas).	
Information Sharing / MDT & Interagency working	Failures of Communication / Organisations should ensure collaborative working across Adult Social Care, Children's Social Care and Community Based Health services (including: GPs, District Nurse, and Physiotherapists), agreeing Joint Referral Pathways and Information Sharing Protocols.	Local Care Networks - No silo working, robust MDT working in conjunction with Primary Care, voluntary sector, Bexley Council, Oxleas services bespoke care to individual need.	

Theme	Learning	Recommendation	Source
Leadership	Lack of Leadership and Coordination.		
Management oversight/Supervision	Failure of escalation and challenge to poorer service standards.		
Cross-team working / Preventing silos / Think Family	Failure to "Think Family".	Consideration to be given to briefing sessions for Adults and Children's Services on referring to and navigating each other's services AND the BSCB and BSAB will organise quarterly meetings on issues which impact on both adults and children's services. These meetings to involve key managers from partner agencies.	
Use Legal Rules/Legal Literacy	Legal Literacy.		
Attention to Mental Capacity	Mental Capacity.	Ensure staff across adult's and children's services have access to guidance on mental capacity and the significance when a person appears to be making 'unwise decisions'.	
Understanding and responding to specific forms of abuse and neglect	Collective omission of 'the mundane and the obvious' (desensitised) / All relevant staff should be competent to manage safeguarding adult referrals including self-neglect and challenging behaviours when working with hard-to-reach groups.	Review current training provision to ensure it adequately supports staff to recognise self-neglect and safeguard adults.	