Safeguarding Adult Review

Ms B

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1. Decision to Hold A SAR

The decision to hold a Safeguarding Adult review was made by the Ealing Safeguarding Board SAR Sub Group (previously known as the Practice review and Audit Subgroup) in October 2023.

2. Summary of Events

1. Ms B was a 40-year-old woman who lived in the community with her 80-year-old father who we refer to in this report as Mr B. Ms B had a long history of support from mental health services dating back to 2002.

2. Ms B had a diagnosis of treatment resistance schizophrenia. She was previously offered high levels of medication but was never admitted to psychiatric hospital as she did not require care in an acute inpatient unit. The main contact was with mental health integrated network team (MINT) psychiatrist with appointments taking place every three to five months.

3. Ms B was supported by her mother and father over many years and most recently by her father alone as her mother sadly died in 2013. Over the years a number of services and support were offered including the opportunity to live in supported accommodation, but all these offers were declined by Ms B who was assessed as having capacity in respect of her accommodation and mental health care and support needs. It has proved impossible to identify a record of this capacity decision.

4. In 2020 Ms B's father [Mr B] unfortunately was diagnosed and began to receive treatment for cancer. On April 28th 2022 Mr B contacted Ms B's psychiatrist to ask for an assessment of care and support needs under Section 9 of the Care Act 2014 for his daughter as he was undergoing treatment and unlikely to be able to provide support. Mr B went into Hospital for treatment in April 2022.

5. An occupational therapist (OT) visited Ms B on the 6th of May 2022, the OT recommended that a care package be implemented and made referral to Adult Social Care. A social worker assessed Ms B in Mr B's presence, on the 7th of June 2022 and recommended a care package but this was never implemented.

6. Following a visit by neighbours who had concerns for Ms B's welfare Ms B, the police called, and Ms B was found deceased in the house on the 16th of July 2022. She was found unkempt within an untidy and dirty house with a large number of beer cans in the living room and kitchen.

7. The body was found to be decomposed and the cause of death is still to be determined. The level of decomposition is consistent with the week of the 16th of July being the hottest days in London's history.

8. Subsequently Mr B was discharged from Hospital into the house which was in a poor state and sadly Mr B deceased in March 2023. Contact was made with Ms B's relatives, but they declined involvement in this review.

3. Legislative Context

1. The care arrangements for Ms B and Mr B are subject to the **Care Act (2014**) in respect of assessment of need and care provision and safeguarding.

2. **Article 8 of the Human Rights Act 1998** also applies in the context of Ms B rights human rights.

3. **The Mental Capacity Act (2005)** also applies in the contact of Ms Bs rights and decision making.

4. As a user of Mental Health Services Ms B's care was subject to **NHS Guidance on Care Co-ordination**. In 2020 the NHS Guidance emphasised the need for people to be supported by shared decision making which reflected the appropriate support arrangements for people. This was strengthened in the latest Guidance Dialogue +, which indicates that **Each person has a single, named care coordinator.**

4. The Methodology used in the SAR

This SAR utilises the basic approach within the SAR in rapid time methodology developed by SCIE. The internal management reviews from each organisation were used to identify key lines of inquiry and a full chronology was developed from the records of each of the agencies.

From early analysis it was clear that the engagement of services with Ms B were characterised in 3 distinct phases. An NHS phase, an adult social care phase where the Care Act Assessment was being completed and then the wellbeing visits from the reablement service. The Chair of the Safeguarding Board added an additional key line of inquiry when it became clear that Mr B had been discharged from hospital back to the house, which was in the same state of disrepair that was evident when Ms B was found deceased.

Due to the relatively linear nature of these key lines, 4 learning events were held with each of the professional groups individually.

The Key Learning Lines of Enquiry were agreed with the Performance, Audit and Review (PAR) Subgroup
SAR Key Lines of Enquiry (KLOE)

1. **There was a carers assessment undertaken for Ms B's father in May 2014.**

   What were the health and social care arrangements for Ms B from 2014?

   What support arrangements were put in place for Ms B's father following the carers assessment in 2014?

2. **Ms B's father contacted the psychiatrist on 28th April 2022, advising of his hospital admission. There was an assessment by the OT on 6th May 2022 and a further assessment by the social worker on 7th May 2022.**

   What actions occurred following the contact by Ms B's father on 28th April 2022?

3. **What actions occurred following the visit by Independent Living Services (ILS) on 12th July 2022.**

"Page 20,Universal personalised care-implementing the comprehensive model. NHS England ,January 2019. https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

4. **Were appropriate procedures followed regarding the care of the body of the deceased?**

This point has been addressed following a conversation with the Coroner's Office who indicated that the body had decomposed as a result of very high temperatures in London that week

To make the task more manageable the Review was then broken down into three phases

Phase 1: Covered the period between February 2020 until April 2022 when support was being provided by WLNHS Trust.

Phase 2: Covered the period where a Care Act assessment and care package was being put in place for Ms B by Adult Social Care – Mental Health Social Work between 28th of April 2022 and 16th of July 2022

Phase 3: Covered the period when the Adult Social Care ILS Reablement service visited and spoke to MS B but did not take any action in respect of her needs on the 12th and 13th of July 2022.

The following process was followed during the Review

For Phase 1, a learning event was held on the 5th of March 2024 with health colleagues to discuss the key lines of inquiry.

For Phase 2, two Learning events meetings were held with the mental health social work team on the 25th of January 2024 and a further meeting on the 23rd of February 2024 with the Council Mental Health Service lead employed by Adult Social Care and the Principal Social Worker.

For Phase 3, a meeting was held with the manager of the Ealing Adult Social Care

ILS reablement team the 18th of January 2024.

In Phase 3 , there was a further e-mail exchange with the service manager for hospitals in late February to explore the arrangements for the discharge of Mr B from hospital and how the conditions in the house were managed prior to discharge.

There was full and unimpeded discussion in all of the meetings and the emphasis was for participants to reflect on their learning post the events and to detail what process improvements had already been made and any suggestion they had for future developments.

5. Chronology

This Chronology is based on the verbatim case notes that were made by the agencies at the time.

Key to Agencies involved in the case

West London NHS Trust (Mental Health Integrated Network Team)(WLNHST)

Met Police

London Ambulance Trust (LAS)

Independent Living Service (ILS) Adult Social Care, Ealing Council

MH Social Work Team (MH Social Work Team)Ealing Council

Until October 2021 the Mental Health Social work team was integrated with the West London NHS MINT Team.

	Phase 1		
	Feb 2020	**WLNHST**	Face to face review by Psychiatrist.
	July 2020	**WLNHST**	Review by phone due to Covid restrictions, father receiving treatment for cancer and worried about Ms B's care, she does not attend to any household chores.
	09/07/2020	**WLNHST SAR Update**	Telephone Call by Nurse Mr B said Ms B was sleeping when he answered her mobile phone. He reported that her sleep patterns were irregular, as she frequently goes to bed late at night and sleeps during the day. He confirmed Ms B's adherence to her medication, and he exhibited hesitancy in increasing the dosage. Mr B believed Ms B's mental state to be stable, and she consistently heard voices at and engaged in loud conversations at home. The OT discussed concerns regarding Mr B's status as the primary carer and his impending chemotherapy with her supervisor; Ms B was scheduled to be reviewed by the OT.
	12/08/2020	**WLNHST SAR Update**	Telephone Call by Consultant Psychiatrist Mr B answered Ms B's phone and stated that he was in good health and did not require assistance at home.
	Nov 2020	**WLNHST**	Medical review, Ms B agreed to OT assessment
	Feb 2021	**WLNHST**	Ms B did not attend appointment
	07/06/21	**WLNHST SAR Update**	Telephone Call by Consultant Psychiatrist Ms B disclosed that the results of the tests for her father's bowel operation were scheduled to be available the following week. Further chemotherapy might be necessary for him. Ms B reported that she spends time watching television, consumes a few units of alcohol on a daily basis, and did not hear voices, although she did chuckle frequently to herself.
	02/11/2021	**WLNHST MOR addition**	The patient had an OPA with her Consultant via telephone. Her medication was reviewed, she reported that the voices she heard were fainter and she reported that she was not interested in joining any OT activities. A plan was made for a follow up Out Patient Appointment in 5 months and she was to continue with her current medication.
	25/04/2022	**WLNHST**	Medical phone review, no response On 25 April 2022, an Outpatient Appointment was arranged, and the patient was contacted but she did not pick up the phone. The appointment was rearranged for 28 April and on 28 April 2022 the patients father called to report that he was going to go into hospital for cancer treatment and raised a concern that his daughter would be at home on her own. Following this call the Consultant referred the patient to the Local Authority requesting a package of care to support her whilst her father was in hospital.
	28/04/2022	**WLNHST**	Call from father that he has been in Charing Cross hospital for 3 weeks and is worried about Ms B being on her own, wants help to be put in place. Email forwarded by psychiatrist to MH Social Work Team based in Adult Social Care.

	Phase 2		
	28/04/2022	**MH Social Work Team**	The consultant made the referral to the MH Social Work Team, for consideration for support via package of care, after her father / carer (Mr B) contacted him to advise that he was in hospital. The Duty Senior screened the referral. LBE (London Borough of Ealing) centralised Duty Worker attempted to contact Ms B on her home and mobile number. There was no answer, and both numbers went to voicemail. a left a message on the landline.
	29/04/2022, 03/05/2022, 04/05/2022	**WLNHST**	Calls by Social Workers go unanswered
	03/05/2022	**MH Social Work Team**	(Following the bank holiday weekend) the duty social worker again attempted to contact Ms B. The Duty Senior asked that further attempts be made to contact Ms B and also her father in hospital.
	06/05/2022	**WLNHST**	OT assessment at home, not bathing, not leaving the house for a month, home cluttered, medication had run out and there was delay in delivery, self-neglect. Twice daily package of care to support with washing, dressing, meal prep, medication management, blitz clean, referral to link worker/befriending service made.
	06/05/2022	**MH Social Work Team**	A home visit was undertaken by an Occupational Therapist, said that Ms B was willing to agree to a package of care and providing further information on her needs and how to contact Ms B. Her assessment was recorded in Rio and an email was sent to the LBE Duty Inbox.
	06/05/2022	**MH Social Work Team**	Upon reviewing clinical records on Rio, during the visit on 6 May 2022 by an Occupational Therapist, there were concerns regarding Ms mental state she was suffering with negative and positive symptoms (signs of self-neglect, low mood and paranoia and delusions) e.g. disclosed that the devil has stopped her from having a wash and that her father has passed away in hospital and the devil has taken over from him and returned to her home to bully her, the devil won't let her wash and threw out her underwear.''
	09/05/2022	**MH Social Work Team**	Care Act Assessment was assigned to a social worker to undertake a Care Act Assessment who was allocated the case on her return to work on 10 May 2022. 11/05/2022 Allocated to SW on Mosaic
	13/05/2022	**WLNHST**	Call from father to enquire about updates, still in hospital.
	17/05/2022	**WLNHST**	Call from father to enquire about updates, OT checked with social work duty – unable to confirm. Allocated worker details shared with father.
	24/05/2022	**ILS - Adult Social Care Ealing**	Discharge to access referral from Charing Cross Hospital as Mr B had been admitted to hospital, his background was that he had cancer of bowel/rectum and had been admitted with dizziness and postural drop, reduced oral intake, small bowel obstruction. The Discharge to Assess form stated his next of kin was his daughter Ms B. 30/05/2022 a follow up referral was sent by Ealing Community Partners Discharge to Assess Team requesting a Social Services Occupational Therapy referral stating he would benefit from a stair lift.
	31/05/2022	**MH Social Work Team**	T/ C to B, no response left a message for her to contact her father called to arrange for a visit on Tuesday 7/6/22@12.30pm Plan. Care Act Assessment visit on Tuesday 7/6/22@ 12.30pm

	31/05/2022	**WLNHST**	Call from Social Worker to arrange care act assessment for 7th June
	07/06/2022	**MH Social Work Team**	Home visit by Social Worker to complete care act assessment, father was at home without support of his own. Call made to social care to request support for father. Recommendation of once daily visit to Ms B. The social worker completed the Care Act Assessment. T/C to Ealing Adult Social Care Spoke with Manager who informed me that a referral was made but they were not sure how Mr B was discharge home without ward staff chasing up to see that the requested service was in place this she stated was an unsafe discharge Manager informed. me that she will chase up the referral and get some service put in place
	7/06/2022	**ILS - Adult Social Care Ealing**	Follow up from the social worker/Mint Team to the Reablement Service stating Mr B had been discharged from hospital with a stoma insitu and needed support.
	08/06/2022	**WLNHST MOR addition**	A letter was sent by a peer support worker to the patient on 08 June 2022 as an introduction as a referral had been made to them for support. Contact details for Avenue House, SPA, the Samaritans and 6 social centres were sent. In the letter the peer support worker identified that the referral was accepted, and that the patient was on the waiting list and would be contacted as soon as possible with an appointment.
	15/06/2022	**ILS - Adult Social Care Ealing**	A telephone assessment took place by the Reablement Service and Mr B confirmed he lived with his daughter who had mental health needs and was unable to support him and he requested support with cleaning and a Reablement Referral was made for a further Wellbeing visit and assessment and District Nurse referral.
	16/06/2022	**MH Social Work Team**	Overview Assessment sent to Team Manager Authorised.
	17/06/2022	**LAS**	CAD 2354 An ambulance was requested at 10:47 to attend Mr B at address 1. It was reported that he was very weak, dizzy/lightheaded and his heart was racing. It was further reported that he was a Cancer patient at Charing Cross. An ambulance attended and following their assessment Ms B father was conveyed to Charing Cross Hospital where a handover of care was provided to the hospital staff. The ambulance staff have documented that he became emotional due to his health and having no assistance at home (he was a carer for his daughter according to his Health Records records). He consented to a Wellbeing referral being submitted. *We are unable to confirm at the present time if a Wellbeing referral was submitted.*
	17/06/2022	**MH Social Work Team**	Overview Assessment to Service Manager -Authorised.
	28/06/2022	**MH Social Work Team**	Support Plan completed. Package of care support with prompting and attending to Ms B personal care ensuring that she is appropriately dressed and prompting her to take her medication Support to keep the house clean
	29/06/2022	**MH Social Work Team**	Support Plan Approved by Team Manager.

	06/07/2022	**MH Social Work Team**	Case taken to funding panel on 6th July where it was authorised. PoC did not commence.
	12/07/2022	**MH Social Work Team**	Brokerage referral to Brokerage homecare by the Social Worker
	12/07/2022	**MH Social Work Team**	ILS Reablement (council) visited the property on 12th July and spoke with Ms B.
	Phase 3		
	12/07/2022	**ILS - Adult Social Care Ealing**	A wellbeing check was conducted by ILS Reablement, and Ms B advised that Mr B was in hospital and his date of discharge was not known. Carers observed the front door was open propped up by 5 crates of beer and there were empty cans and boxes of cigarettes, the home environment required significant cleaning.
	12/07/22	**MH Social Work Team**	At the Wellbeing visit for Mr B on 12th July 2022 '' –it has been recorded that daughter Ms B answered and informed that Mr B is still in hospital with no known discharge date. Carer informed that door was open, propped with 5 crates of beer. Ms B was sitting on the sofa with 10 empty cans around her and boxes of cigarettes. have a pet cat. Home environment requires significant cleaning and tidying. advised carer to leave. Case was closed to Reablement as customer is in hospital.
	12/07/2022	**ILS - Adult Social Care Ealing**	A further Discharge to Assess was received, and the case was allocated, and preparations were made for discharge which included a key safe and package of care arranged.
	13/07/2022	**From Met Police incident records**	Neighbours informed L (a neighbour) that on WEDNESDAY 13TH JULY 2022 approximately 06:30 noticed that Ms B' front door was wide open. At around 21:00 hrs L (Neighbour)attended address and found Ms B sat upright on the sofa, calm but very drunk. They asked her if she had been eating, which she said she had, where Mr B was, to which she replied that he was in hospital and had been for the past 2 weeks, and if Ms B would like to be escorted upstairs, which she declined.
	14/07/2022	**From Met Police incident records**	L(Neighbour) attended at 07:00 hrs on THURSDAY 14TH JULY 2022, knocked on the front door and called through the letterbox but received no reply, then left thinking that Ms B had gone to bed to sleep off the alcohol.
	16/07/2022	**LAS**	An ambulance was requested at 21:01 to attend Ms B at address 1. It was reported that she was not breathing, had gone blue and looked deceased.
	18/07/2022	**WLNHST**	Information from Mr B that Ms B was deceased, no details known
	18/07/2022	**ILS - Adult Social Care Ealing**	Mr B did not return home and on the 18/07/2022 police informed they had found Ms B deceased at the home address by neighbours after they had been alerted by Mr B that he was not able to contact his daughter whilst he was in hospital.

6. Results of the Learning Sessions based on the 3 key phases of the Chronology

Phase 1: When WLNHST were co-ordinating care for Ms B (from February 2020 until April 28th 2022)

Phase 1 Key Issue 1

Key Line of Enquiry: How did WLNHST ensure that it is duties under the Care Act, Care Programme or Mental Capacity Act were met?

Response: The meeting identified that the Psychiatrist had been in regular contact with Ms B and her parents over many years. The NHS participants were comfortable that the caring relationship between Ms B and Mr B was appropriate and ensured that Ms B's rights and needs were being realised. Ms B was asked regularly if she would want to be referred to Social Care or have a care co-ordinator, but she always refused. There had been face to face contact with Ms B with the Psychiatrist in February 2020 and all seemed ok. The legislation does require that the processes of consent and decision making should be formally recorded, and there appears to be limited documentary evidence in this case.

Phase 1 Key Issue 2

Key Line of Enquiry*: What steps did West London NHS Trust take to ensure that care was provided*

Response: It was identified that it had become more difficult to secure the appointment of a care coordinator in such cases and that this was a material factor in this case. It was also identified that due to changes in the way that services are now organised there were fewer health led social opportunities Ms B had valued in the past.

Phase 1 Key Issue 3

Key Line of Enquiry*: On two occasions the need for an OT visit was identified, but did not happen on 09/07/2020 and 23/11/2020, it is particularly worrying that Mr B raised concerns re coping yet this did not translate into action. This was a missed opportunity to actually see what the state of the property was like. There was also a third point on 2/11/21 when the Consultant's t/c identified that Mr B was undergoing chemotherapy where OT was considered but not pursued , due to Ms B's refusal.*

Response: There was recognition that if Ms B had had the support of a care coordinator that the missed opportunities provided by the potential occupational therapy contact could have been utilised. The two potential OT visits could have acted as the trigger for an earlier referral to social care, particularly as this was the point at which Mr B's cancer diagnosis and subsequent treatment was clearly beginning to impact on his caring capacity. In these circumstances it would have also been possible to explore Ms B's reasons more fully for refusing care and also the opportunity to discuss her care needs in the context of her father's medical condition. The need for contingency planning to cover carer breakdown was also agreed.

Phase 1 Key Issue 4

Key Line of Enquiry*: Ms B would appear to have had Care Act eligible needs for many years , but there appears to have no formal assessment under the Care Act until Mr B contacted the Psychiatrist in April 2022 when the situation reached a crisis.*

Response: The meeting with health colleagues identified that there should have been an earlier referral to social care, but this was compromised by the availability of care coordinators within the NHS Trust. As has been stated previously colleagues identified that referral to social care had been suggested to Ms B and her father, but she had refused. It was recognised that the provision of social care would have been beneficial, and it is likely that if a care coordinator had been allocated then the ensuing negotiation may have had a successful outcome. Given this finding on the central role that is accorded to care coordinators there needs to be a full review of the role and its interface with the local authority and Care Act

responsibilities . A critical component of this review needs to be clarity as to the roles of professionals where a care coordinator is not allocated, as there was a clear inference that professionals struggle with capacity to coordinate in the absence of a dedicated coordinator. It is possible that earlier provision of a social care package might have improved the lives of Ms B and her father. It is also the case that Mr B's clinical condition might have affected his caring abilities, and this should have triggered a discussion re support.

Phase 2: Where a Care Act assessment and care package was being put in place for Ms B by Adult Social Care – Mental Health Social Work (events between 28th of April 2022 and 16th July 2022)

Phase 2: Key issue 1

Key Line of Enquiry: *On April 28th 2022 Mr B called WLNHST to ask for a referral to Social Services to be made. This was acted on promptly by the NHS and included a visit by an OT on the 6th of May 2022. The Care Act assessment was assigned to a Social Worker working for the Council on the 9th of May 2022 , but delays in process meant that no care was put in place prior to Ms B's Death.*

Response: All Social Care staff were clear that the conduct of the assessment, care plan and delay in implementation were unacceptable and whilst not necessarily causing Ms B's ,death would have led to Ms B not receiving the care that she required and also consented to. The matter of consent here is critical as prior to April 2022 all offers of support had been refused and so the opportunity to constructively engage with someone who was clearly affected by neglect were missed. This will have caused great distress and anxiety to both Ms B and her father and might have been a turning point in her life.

Throughout this SAR assurance has been received from adult social care managers that there has been robust reflection on the circumstances that led to the delay in completion and approval of the care after assessment and subsequent care provision.

From September 2022 the following actions were put in place

- Interagency MDT and risk assessment policies and procedures. Complex cases are considered for joint assessment.
- A monthly case audit process led by the Principal Social worker.
- All allocated cases are discussed and actions to be taken are brought back to allocations panel after 2 weeks. This is part of the Allocations and Complex case pathway.
- Funding panel decisions and recommendations are recorded by the Panel Administrator and are brought back to the Panel for update after 6 weeks.
- A full QA process for case work is being implemented in early 2024.

These measures, if robustly implemented and monitored will reduce the risk of the delays that occurred in this case in prioritisation of completion of Care Act assessments, preparation of support plans and practical implementation of support services. The issue of social work practice also arises, and the Principal Social Worker has been very clear that measures have been taken to create a more robust framework for ensuring that practice is optimal.

Phase 3: When the Adult Social Care ILS Reablement service visited and spoke to MS B but did not take any action in respect of her needs (12/13th July 2023)

Phase 3 Key Issue 1

Key Line of Enquiry: *How effective was the process for undertaking Wellbeing checks.*

The Council needs to strengthen its checking arrangements when Wellbeing checks find evidence of potential risk. Referring parties must also ensure that the information is clear.

Response: The Council has reorganised the process for Wellbeing checks. The ILS Reablement service ceased to carry out wellbeing checks in October 2023 and the Social Services Intake team are now responsible for them.

Phase 3 Key Issue 2

Key Line of Enquiry: *The form and manner of recording and access to data systems and alerts needs to be reviewed to ensure fail-safe oversight is in place, to ensure that even when risk is implied , but not visible, it is capable of being quantified. This might include a formal requirement to keep all self-neglect/ hoarding cases open until the referrer has been fed back to.*

Response : At the time of the Wellbeing visit to Mr B in July 2022 the procedure was that the service would not routinely feedback to the referrer as the required decision was whether the person required reablement or not. The process prior to this time was that Reablement would routinely feedback , but this was changed. Between April 2023 and October 2023, the feedback for the wellbeing checks was screened by the ILS Reablement Assessment Team (social workers, OT's) for any next steps required. Wellbeing checks for any new service user are now the responsibility of the originating team. This means that oversight is stronger as all parts of the process are managed within the same team.

Phase 3 Key Issue 3

Key Line of Enquiry: *It is also clear that the discharge information for Mr B's discharge in June /July 2022 did not specify his caring responsibilities strongly enough. I have not explored this in this SAR as it is not a significant issue as mental health services were well aware of the relationship and Mr B's admission. However, I would suggest that as part of the review identified above particular focus should be placed on Hospital Discharge information flow, particularly on risk*.

Response: The Manager agreed that the information flows need to be improved as if the relationship between Ms B and Mr B had been more explicit and the risk more clearly identified then action would have been taken. It is worth noting that the social worker referred Mr B to ILS Reablement on the 7th of June 2022 for his needs not Ms B's. This action was a very positive attempt to ensure that Mr B's needs were met , but it did not alert to the risks facing Ms B, hence an unintentionally missed opportunity. This issue is more robustly addressed in Key Issue 4 below.

Phase 3 Key Issue 4

Key Line of Enquiry :*What measures were taken after Ms B's death to prepare the home for Mr B's discharge and what information was shared about Mr B's needs?*

Response: The records on the MOSAIC IT system are readily available with subject headings which are easily accessible to workers and management.

On allocation of a case, workers review the previous records made before them to contribute to their involvement in the case highlighting issues such as risk to lone working, home visits, customer preferences. Records are time stamped the age of the record is available to establish their validity and relevance.

There are clear business rules within teams on the terms of involvement and allocation of work. If a team is involved in a piece of work another team will not work on it at the same time except in exceptional circumstances and this is signed off by a team manager.

The ILS Reablement team has implemented a policy to bring any concerns to management on return from home visits for risk assessment and possible allocation and a note is entered on the case file.

Any cases where a worker recognises risk or clutter this will be brought to the attention of the relevant team manager to make the appropriate decision to progress to support the customer or to close the case.

All support requested has to have management oversight and authorisation recorded before service is implemented. Whereas prior to this, staff were able to implement care at home without management sign off simply based on their judgement.

There is a weekly case audit undertaken via a resource allocation panel. Any new services provided in that week are scrutinised to pick up concerns or quality issues. These are undertaken every Wednesday.

Team managers and senior practitioners are now held accountable for workers cases with the expectation of the inclusion of a summary on the file confirming they are aware of the circumstances surrounding the case and the service implemented before it gets to the Head of Service for sign off.

Phase 3 Key Issue 5

Key Line of Enquiry: The issues below were identified in the Reablement IMR. Closer working with Mental Health/Mint Social Worker and Hospital Homeward Team was necessary. The Care Act assessment of Ms B determined she required a care package to support her. carers assessments were also necessary, and Mr B also requested and required support because of his health needs,

1. Police CJSM reports were usually received much later, after the event. Whilst they pertained to Ms B, they should also have been documented on her father's case file as they would have possibly given more background and insight into their situation as a unit (Think Family).

Response: They do not appear to have been fully implemented by Adult Services and so will be included in the SAR actions.

7. Findings

1. It is clear that the consultant psychiatrist had a long and constructive engagement with both Ms B and her father. The evident rapport that existed would appear to have ensured that Ms B's Wellbeing and Mr B's role as a carer were supported.

2. When Mr B asked for support for his daughter the response from the psychiatrist and the health team was rapid and appropriate.

3. The assessment undertaken by the NHS occupational therapist in May 2022 was also thorough and detailed and contained enough information to signify risk and urgency when referred to social care.
4. However, during Phase One, it has been recognised that there could have been an earlier referral to social care in late 2020.

5. Whilst in discussions with health colleagues the rationale for the limited consideration of a multi-agency approach was attributed to the lack of care coordinators. There has been a missed opportunity to explore Ms B's individual identity, and to consider and record this There is no doubt that a caring relationship existed between Ms B and her father but the Care Act , Human Rights act and Mental Capacity Act require us to treat people as individuals in the first instance and once individual capacity and preferences have been identified, ensure that people's desire for relationships is respected. No information has been made available that gives that individual perspective.

6. There were several occasions in the period July 2020 to July 2022 where Mr B was undergoing treatment where Mr B's decreasing capacity to care for his daughter should have been explored. This has been recognised by NHS colleagues as a potentially missed opportunity. It is also important to note that when the NHS OT assessed Ms B in May 2022 Ms B agreed for a support package to be put in place.

7. Whilst the response of the NHS in April 2022 was very timely, it was primarily a referral to social care, the opportunity to undertake a full review of Ms B's needs and that of her father was not initiated at this time.

8. Whilst there were some missed opportunities during the period that Ms B was receiving care from the NHS alone, the most significant omission was the failure to put in place a care package for Ms B , following the referral to mental health social work in April 2022.

9. The Phase Two analysis addresses events from April 2022 until the 12th of July 2022. During this time, a Care Act Assessment for Ms B was requested and arranged but the resultant care package was not implemented. The likely impact of this omission has been explored earlier , the focus needs to on the steps taken to ensure that such an omission should not be repeated.

10. The assurances provided for Phase 2 address many of the systems failures that led to this omission, but the Council will need to ensure that those systems are routinely monitored to give assurance that the processes are working.

11. Again, when the issues of the reablement visit and what preparations were made for Mr B's discharge from hospital (Phase 3) were examined, a similar list of process and procedural flaws were highlighted. These changes are listed in Phase 3 above. Adult Social Care have now provided assurance that these processes have been reviewed and the appropriate changes/quality assurance measures have been implemented.

12. It is positive that the social worker who assessed Ms B on the 7th of June 2022 ,then made a referral to the ILS service for reablement support.
13. There was however a missed opportunity when the ILS Reablement made the Wellbeing visit on the 12th of July 2022.The reasons for this and the significant changes that have been made since these events, are detailed in the Phase 3 exploration.

14. The missed opportunity to identify the issues of neglect of Ms B when the Ambulance Service transported Mr B to hospital on the 17th of June 2022, was also a missed opportunity. This practice needs further challenge with London Ambulance Service and the subsequent remediation measures need to be monitored by the Safeguarding Adult Board.

15. There is little documented evidence that Mr B was offered support in his own right either as a Carer or to consider his potential own needs, given his known health conditions. Discussions with Health colleagues recognised that identifying contingency plans for such carers is particularly important.

16. It has been identified above that there was no visible exploration of Ms B's wishes desires or capacity, so it is hard to reach any firm conclusions as to whether the service is provided to Ms B or her father in his caring capacity were appropriate. The absence of this assurance framework is again a significant deficit across the NHS and Adult Social Care community and runs contrary to the Care Act and NHS guidance.

17. The issue of potential neglect also does not appear to have been considered at any stage of Ms B's care. It is evident that Ms B was seen by the consultant psychiatrist at a review in February 2020 and that the regular telephone conversations that were undertaken did not indicate cause for concern. However, the regular refusal of offers of support coupled with a lack of first-person information does indicate a potential risk of neglect.

8. Recommendations

1. **West London NHS Trust (Mental Health Integrated Network Team)** needs to **review** the arrangements for **Care Co-ordination** to ensure that appropriate support is given to services users and carers. This review also needs to ensure that triggers for Care Act assessments and neglect/safeguarding responses /referrals are specified, and actions monitored. Assurance of this being implemented should be shared with the SAB. This needs to be particularly focused on people who decline services and who are supported by informal carers whose capacity to care may be compromised.

2. **West London NHS Trust (Mental Health Integrated Network Team) needs to review processes** to ensure that the **Individuals views, decisions and capacity** are clearly recorded and that where the person's capacity needs to be considered that this is also recorded. The policy also needs to highlight the situations where it is appropriate to use relatives to gain views and what protections need to put in place to support the individual.

3. **Across all agencies, if people consistently refuse the offer of support this refusal should be reviewed and escalated for Multi agency safeguarding consideration**. The Ealing Neglect and Self Neglect pathways which was published in April 2022 has guidance on capacity and referral. These policies apply to all agencies and the **Safeguarding Board should be assured that these processes are operating effectively**.

4. **Ealing Council** should provide assurance to the SAB that there are processes in place to quality assure care management decisions. This should include
   - Monitoring response times and ensuring that high risk cases are appropriately responded to.
   - Ensuring that hospital discharge processes capture all available information.
   - Ensuring that wellbeing visits are effective and that risks are accurately identified and appropriately escalated.
   - Ensuring that Interagency MDT and risk assessment policies and procedures are effective.

5. The Ealing Safeguarding Adult Board should lead a review of the process for recording and processing Police referrals to ensure that they are consistently appropriately visible to those who require access.

6. The Safeguarding Adult Board also needs **to seek assurance from the London Ambulance Service** that if the signs of neglect are present that these signs are reported to Social Care.

7. **All agencies** need to record where the lead responsibility lies, when more than one agency is involved with an individual or a family.