7-minute Learning Summary

Safeguarding Adult Review – Evelyn

Richmond and Wandsworth Safeguarding Adults Board

Case Summary

The Richmond and Wandsworth Safeguarding Adults Board (RWSAB) undertook a Safeguarding Adult Review on Evelyn in order to understand how agencies might work together in future to support people who appear to have social care and health needs but move frequently and refuse, or their family refuses, assessments and support.

Evelyn was a 75-year-old Black British/ African-Caribbean woman who was a retired midwife. Evelyn had two sons, Simon, who had a Lasting Power of Attorney for Evelyn's care and welfare, and Ted. There were multiple concerns about how well Evelyn's health and care needs were being met by her family but attempts to intervene and to offer support were rejected. Evelyn was moved regularly by her family between three addresses in three different boroughs, seemingly to avoid contact with services and attended at least eight different hospitals, some of which were private, from which she was often discharged by her family against medical advice. Evelyn left the UK with one of her sons in March 2019 and died later in a care home on a Caribbean Island.

Summary findings

1. **The impact on Evelyn of decisions made on her behalf by her family was not recognised.**

- Evelyn was frequently found trapped in her home, or wandering outside, in distress, There were concerns that Evelyn was being neglected, did not have heating, and moved between three local authority areas. Evelyn had physical health needs, mental health needs and care and support needs but despite all this, decisions made by her family to refuse interventions and treatment were not challenged.

- Care Act assessments were offered but were not made and it appears that professionals were often given enough assurance by Evelyn's family that her needs were being, or would be, met so that they withdrew. This was despite accumulating evidence to the contrary.

2. **Frequent moves made it difficult, but there was insufficient inter-agency communication and joint working to meet Evelyn's needs.**

- There was a lack of joint working across boroughs and lack of clarity about what to do once Evelyn had moved from one borough to another. There appears to have been a very slow recognition that Evelyn's regular moves from place to place might be a safeguarding concern. Attempts were made by different boroughs at different times to initiate action, but no shared understanding of Evelyn's circumstances was formed. There was a lack of information sharing between hospitals, which meant that patterns of attendance and discharge were not identified.

3. **Safeguarding referrals were made but no action was taken**

- There was a belief that if neglect was not deliberate, then it did not meet the criteria for an enquiry under section 42 of the Care Act. Assurances given by Evelyn's family that Evelyn's needs were being met went unchallenged and contact with Evelyn and her family was at times difficult to establish. Evelyn moved frequently and sometimes her family were not clear about where she was. All these factors made making safeguarding enquiries more difficult.

4. **There was insufficient engagement with Evelyn's family and there was insufficient professional curiosity or responsibility in exploring Evelyn's circumstances.**

- Evelyn's family relationships were also not fully understood. Evelyn's family could be very resistant, forceful and intimidating. At different times, Evelyn's family was considered to be a protective factor, to be neglecting Evelyn, or to be preventing her needs from being met. There appeared to be a lack of recognition that Evelyn's wellbeing was not being promoted. Family members No Carer's Assessment was offered and no input from an outside specialist agency such as a Carers Centre was sought.

Lessons

1. Be careful when you close a safeguarding case because someone has moved out of your area, and you don't know where they have gone. If you are concerned about someone's safety then contact an organisation that works across local authority or health areas, such as the ambulance service or the police, in case the person comes to their attention.
2. Think Family. Consider and respond to the need of all family members in all your assessments and interventions. Does anyone involved have mental health needs, use drugs or alcohol, experience or cause domestic violence and abuse? Are there other organisations that you can ask to be involved? Are there family members that you can work with?
3. Don't assume that someone's family will always be a protective factor. Despite whatever assurances you receive, think about the person's wellbeing: what is their life like and is their wellbeing promoted? If you need support when working with a hard to engage family, consider using your local Carer's Centre to provide an independent voice and to offer support to the family.
4. Always read a client's history of contacts with your organisation. Remember that multiple hospital admissions can be a warning sign that someone's situation is deteriorating. Look for patterns and repeating themes. These might help you to identify concerns that require intervention.
5. Check that a relative or representative actually has the Lasting Powers of Attorney (or Deputyship) they claim to have, as soon as possible. Ask to see evidence that each page is stamped by the OPG (Office of the Public Guardian). You can also check on the OPG website. If someone does not appear to be discharging their responsibilities correctly and are not acting in the person's best interests, then report your concerns to the OPG.
6. If someone you are concerned about refuses your involvement or that of other services, but appears to be at risk of harm or abuse, or their wellbeing is not being promoted, then be curious about why? Are they being coerced, controlled or unduly influenced? Are they afraid of the loss of close relationships, do they fear repercussions from the person who is coercing or controlling them? Remember that they may lack the mental capacity to make decisions to protect themselves or to about whether to ask for help, because of these fears or because of the influence, coercion and control of others. Do you need to intervene to protect their Human Rights, do you need to apply to the Court of Protection?