RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW 'Evelyn'

2021

Review Report Written by Patrick Hopkinson

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SAFEGUARDING ADULT REVIEW – EVELYN

Richmond and Wandsworth Safeguarding Adults Board

1. Introduction

1.1. 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. Evelyn left the UK with Simon on 02nd March 2019 and died of a heart attack on 31st May 2019 in a care home in Jamaica.

1.2. Prior to this, Evelyn had been the subject of at least 34 safeguarding referrals from the London Ambulance Service and the Metropolitan Police, made to four London Boroughs over a 2-year period. Most of the safeguarding concerns highlighted that Evelyn was found confused and in a neglected state in, or away from, her home. Contact with Simon at the time of these events suggested that he was distrustful of statutory services and was unwilling to facilitate medical or social care services for his mother. Despite this, Evelyn was left in his care.

1.3. Evelyn attended at least six hospitals but there was pattern of discharge against medical advice and of not being assisted by Simon to attend follow-up appointments. When Simon was encouraged to allow his mother to receive treatment, he said that he had a Lasting Power of Attorney for health and welfare and that he was her decision maker.

1.4. Evelyn's primary address was understood to be in Hillingdon, where she was ordinarily resident. However, she was known to live with her son Simon in Richmond. She also lived with her other son, Ted, in Enfield from time to time. Evelyn was moved from borough to borough regularly. A Section 42 enquiry was also begun by Kensington and Chelsea in March 2019 regarding Evelyn's discharge from Chelsea and Westminster hospital, although by this time Evelyn had left the country, and was closed in April 2019.

1.5. No assessment of Evelyn's needs under the Care Act appears to have been made by any of the local authorities, although one was offered by Richmond but was refused by Simon.

2. SAFEGUARDING ADULT REVIEWS

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

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

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

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

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

2.2. The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

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

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.4. The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-final-.pdf

2.5. All RWSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.6. This case was referred to the SAR Sub-group of the RWSAB by a Richmond Social Worker in August 2019 and considered for a Safeguarding Adults Review at the meeting on 02/09/2019.

2.7. The SAR Sub-group considered this case as meeting the criteria for a SAR, and the SAB Executive ratified this on 25/09/2019. RWSAB approached Hillingdon SAB and Council, who were happy to participate in a Richmond-led review on this complex case.

2.8. The following organisations were involved in this Safeguarding Adults Review

- London Borough of Richmond Upon Thames
- London Borough of Hillingdon
- London Borough of Enfield

- London Ambulance Service
- Metropolitan Police West Area BCU
- Chelsea and Westminster NHS Foundation Trust
- NHS South-West London CCG

2.9. For brevity, the London Boroughs involved in this review will be referred to as Richmond, Hillingdon and Enfield.

2.10. A SAR panel was formed of representatives from these organisations and teams and agreed terms of reference to guide the review. The terms of reference were for the review to consider:

- The impact of cross-borough/ BCU coordination and information sharing.
- The impact of assumptions about carer responsibilities especially in the absence of carers assessment.
- The challenge of working with people who are difficult for services to engage with.
- The challenge of interventions when family members are resisting the involvement of services.

2.11. SAR Panel members provided chronologies and reflective Individual Management Reviews of their involvement with Evelyn and answered specific questions and provided additional information as required.

2.12. Two Multi-Agency Practitioner Learning Event was held, one of which was for health staff who had been unattended the first event. These Practitioner Learning Events were attended by staff who had worked directly with Evelyn or her family, or had made decision about them, and assisted in developing an understanding of the approaches taken, the challenges faced, the opportunities missed and ways in which practice could be further developed.

2.13. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Richmond and Wandsworth Safeguarding Adults Board, or its partner agencies or any of the other local authorities involved in this review.

2.14. Evelyn's family were notified of this review but did not respond.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology provided by agencies covered the period from 4th February 2015 – 28th January 2020, which was after Evelyn had left the country and had died in Jamaica**.** The following is a summary of key events.

3.2. Between 4th February 2015 and 14th March 2018, concerns arose about Evelyn in the London Borough of Hillingdon. These included nine contacts with the police in what appears in hindsight to have been a slow increase in Evelyn's mental distress. For example, on 4th February 2015, Evelyn

contacted the police about what may have been a bogus telephone call to her home. On 21st October 2017, Evelyn was reported to be shouting at a neighbour over the garden fence. On 17th January 2018, Evelyn told the police that intruders in her house were hiding in her kitchen and on 18th January that her medication had been stolen. Evelyn appears to have been ordinarily resident in Hillingdon, living in a house that she owned.

3.3. On 19th January 2018, Evelyn was admitted to Hillingdon Hospital Accident and Emergency Department by the London Ambulance Service for a "check-up" following reports to the police by neighbours that she was shouting that she could not get out of the house. One of Evelyn's sons also attended and was given information to arrange support for Evelyn. After follow up from Hillingdon Social Services, Evelyn's son, Ted, confirmed that Evelyn did not need help.

3.4. Ted repeated this on 7th February 2018, when Evelyn was found outside by the police and appeared to be lost. On 8th February 2018, after Evelyn had flagged down a passing motorist, claiming that her things had been stolen and she was locked in the house, the police attended Evelyn's Hillingdon home and found the house hoarded with newspapers, the toilet and bathroom unfit for use, and the cooker not working. Hillingdon Social Services tried to contact Ted but with no success.

3.5. On 9th March 2018, the police attended again following reports that Evelyn was knocking on neighbours' doors. Evelyn was alone and the police were concerned that the hot water and heating was off. There were a number of notes tacked to doors and cupboards directing Evelyn to the location of her room, the bathroom, and the toilet. The police contacted one of Evelyn's sons who attended and explained that "the doctors messed her medications and this is the result." Hillingdon Social Services followed up between 9th and 12th March 2018 and, on 12th were informed that Evelyn was in Ealing Hospital, and subsequently they closed contact with Evelyn.

3.6. On 18th April 2018 a neighbour alerted the police that Evelyn had been banging on his door saying that they had stolen her children. This was followed up by Hillingdon Social Services who spoke to Evelyn's son, Simon, the following day. Simon said Evelyn did not need help, and again the contact was closed.

3.7. On 2nd May 2018 the police were called by neighbours to Evelyn's Hillingdon home and the ambulance service attended. They were concerned that Evelyn had dementia (this appears to have been the first mention of the potentially explanatory diagnosis). Evelyn's son, Simon, however arrived and refuted this. The ambulance crew determined that Evelyn lacked mental capacity and took her to Hillingdon Hospital, against the wishes of Simon who was described as obstructive. The house had been found to be dirty and unsanitary with soiled clothes and rotten food. The police asked Simon what he thought of his mother's living conditions and he said that he could not see a problem with them. The London Ambulance Service raised a safeguarding concern with Hillingdon Social Services that Evelyn was being neglected. This was not progressed to an enquiry under Section 42 of the Care Act 2014 because there was not enough evidence that Simon was neglecting his mother.

3.8. On 25th May 2018, Evelyn attended Chelsea and Westminster hospital Accident and Emergency for abdominal pain. She was discharged home (attendance at the Chelsea and Westminster Hospital suggests that she was in the London Borough of Richmond at her son, Simon's, home at the time) to follow up with her GP if there were any further problems.

3.9. On 15th June 2018 the London Ambulance Service was called to Evelyn's assistance again. A member of the public had heard someone screaming inside Evelyn's home in Hillingdon and could see Evelyn inside half naked. Evelyn appeared confused (handing various item through the letter box which she believed to be keys) and said that she wanted help. The police attended but did not force entry since Evelyn's life did not appear to be at risk. However, the police contacted Evelyn's son who stated that his mother was fine and should be left alone. The neighbours were lying, and Evelyn had now had carers for some time. Evelyn's son would not attend to let the police or ambulance crew in and would sue if entry was forced. The police had attended Evelyn previously and contacted her GP surgery but found that she was no longer registered with them.

3.10. The police and ambulance crew's records referred to carers being present and contact with their care agency (which confirmed that it has started providing a service the previous day) who had details of Evelyn's new GP, who was then contacted. This GP was very concerned about Evelyn 's general health and decline and about her son's behaviour and attitude and had notified Hillingdon Social Services of this and would do so again. The ambulance crew raised a safeguarding concern with Hillingdon Social Services.

3.11. On 4th July 2018 Evelyn's GP raised a safeguarding concern with the London Borough of Richmond that Evelyn was being neglected by her son and that he was moving her to different boroughs and presenting her to random hospitals that were not connected. Richmond Social Services contacted Hillingdon Social Services to ask if they had similar concerns. Hillingdon contacted Evelyn's son who said that Evelyn had a twice a day package of care privately funded, and that he would let them know if she needed anything else. Hillingdon closed the contact.

3.12. On 11th July 2018 Evelyn was taken by ambulance crew to Hillingdon Hospital after being found in Uxbridge High Street disorientated and complaining of head pain. It appears that Evelyn was discharged home following this.

3.13. On 18th July 2018 an ambulance and the police were called after reports of Evelyn leaning out of a window, confused and distressed and described as suffering from dementia. The ambulance crew contacted the care agency who said that Simon had refused to give the key safe code (which he also refused to give to the police) and had stopped the care package the previous day. The ambulance crew also contacted Evelyn's GP who said that she was waiting for a joint meeting with social workers because Evelyn was now known to social services in Richmond, Hillingdon and Enfield. Evelyn refused to attend hospital and the ambulance raised a safeguarding concern with the local authority (borough not specified but assume that it was Hillingdon).

3.14. On 14th August 2018, Evelyn attended Chelsea and Westminster Accident and Emergency with long-term occasional swelling of one of her legs.

3.15. On 23rd August 2018 police were called to what appears to have been Evelyn's son Ted's home in the London Borough of Enfield by a neighbour. Evelyn appeared confused said that she lived at this address in Enfield but was without house keys and otherwise reluctant to speak. The police were concerned for Evelyn's safety and stayed with her until her son, Ted, arrived home. Their Merlin report was reviewed by the Enfield MASH and sent to Hillingdon Social Services, which reviewed the Merin report and returned to Enfield since the concern had arisen there.

3.16. On 4th September 2018 police were called to the address in Richmond (believed to be the home of VE's son Simon) since a passer-by was worried about Evelyn who was knocking at the window. The police report was reviewed by the MASH and sent to adult social care (borough not specified).

3.17. On 11th September 2018 Hillingdon received notification that Enfield had been asked to offer a care assessment to Evelyn.

3.18. Between 26th and 28th September 2018 there was an email exchange between Richmond and Hillingdon where it appears Hillingdon shared safeguarding concerns raised with them since 2015. It is not clear why Enfield was not also involved in this exchange.

3.19. On 2nd October 2018 police were called to the Enfield address. Evelyn was alone at the property and police were concerned that Evelyn could be danger to herself as she was confused, and her memory was poor. The police report was reviewed by MASH and sent to adult social services (borough not specified).

3.20. Between 17th and 22nd October Richmond Adult Social Services tried to contact Evelyn at the Richmond address and sent a letter to the Enfield address, advising that a safeguarding concern was open and offering a Care Act assessment. On 26th October Richmond decided to close the safeguarding concern because there had been no response from Evelyn or her sons.

3.21. On 30th October the police were called as Evelyn had been found in the street confused and she was taken back to the Enfield address. The police report was reviewed by the Enfield MASH and sent to Adult Social Services (borough not specified).

3.22. On 14th November 2018, Evelyn attended Accident and Emergency at St Mary's Hospital with chest pain. She was accompanied by Simon. Evelyn was reported to have made paranoid statements which her son agreed with. Evelyn was seen by a psychiatric liaison nurse and discharged home as there was no acute mental health risk, but further clinical assessments were required. Evelyn's GP was notified.

3.23. On 4th January 2019 the London Ambulance Service Safeguarding Lead contacted Richmond Social Services and said she would arrange a

professionals meeting with the police and the three boroughs to share information about Evelyn. Subsequently, this meeting was held on 22nd January 2019. Richmond attended, but it is noted that the other partner agencies did not. No further action appears to have been agreed following this meeting.

3.24. On 11th January 2019 Evelyn was found in the street in Hillingdon and was hypothermic. She refused to go to hospital and police "used their powers under the Mental Capacity Act" to take her to Hillingdon hospital by the ambulance service and then she was discharged home. The police reported this to the MASH, which notified Hillingdon adult social services

3.25. On 15th January 2019 Evelyn was found in the street again and was re-admitted to Hillingdon Hospital. A safeguarding concern was raised with Hillingdon, a new s42 enquiry begun and a strategy meeting was held on 17th January 2019. It was agreed that Richmond Social Services would complete a welfare check to the address in Richmond (where Evelyn's son Simon lived) within two weeks and that another care agency would report back to Richmond if there were any concerns.

3.26. On 15th January 2019 Evelyn was transferred from Hillingdon Hospital to the Clementine Churchill Hospital (a private hospital), where she was admitted with confusion and was treated for a possible urinary tract infection. At this stage, the Deprivation of Liberty safeguards provisions under the Mental Capacity Act were used to keep Evelyn in hospital. On 18th January 2019, the Clementine Churchill Hospital sent Richmond Response and Rehabilitation Team (an integrated health and social care service for adults) a notice to assess Evelyn prior to her discharge home. No assessment appears to have been made before Evelyn was returned home by 21st January 2019.

3.27. Evelyn attended the West Middlesex hospital on 22nd January 2019, accompanied by her son Simon, for a steroid injection in her knee.

3.28. On 27th January 2019, Evelyn attended Chelsea and Westminster Accident and Emergency Department from the Richmond address with a leg swelling. The report of this attendance back to Evelyn's GP advised that she be referred to a memory clinic since there was, "marked cognitive decline". It was also noted that Evelyn had been seen previously at the Royal Brompton hospital (a private hospital) for "cardiology/nephrology and Care of the Elderly".

3.29. The Richmond Response and Rehabilitation Team tried to contact Evelyn and her son Simon by telephone but despite leaving voice messages received no reply. They closed the case on 12th February 2019 due to no response.

3.30. On 6th February 2019 Evelyn was conveyed by ambulance crew to Chelsea and Westminster hospital (at Simon's request, despite the West Middlesex Hospital being closer) following a report that she had collapsed or fallen at the address in Richmond. Simon was reported to have refused to give ambulance staff Evelyn's medical history, saying that he would speak only to a doctor. Simon was also described as being obstructive at the hospital.

Against medical advice Simon discharged Evelyn, using his Lasting Power of Attorney for her care and welfare. This does not appear to have been challenged as not being in Evelyn's best interests.

3.31. On 8th February 2019 police were called by neighbours to the Enfield address. Evelyn was confused and could not find her keys. The police report was reviewed by MASH and sent to adult social services (borough not specified). On the same day following a request from the London Borough of Richmond, the London Borough of Hillingdon referred Simon to the Office of the Public Guardian in response to concerns that Simon was not using the LPA in Evelyn's best interests.

3.32. On 28th February a professionals meeting attended by the ambulance service, Hillingdon and Richmond Boroughs was held and a decision was made for Richmond to complete a welfare check and raise a safeguarding concern.

3.33. On the same day, Evelyn attended Chelsea and Westminster Hospital Accident and Emergency since she had appeared confused and agitated during a urology outpatient appointment there. Simon is reported to have said that Evelyn was agitated because she was scared. Evelyn did not allow any investigations or checks in Accident and Emergency and when asked about Evelyn's memory problems, Simon replied that the GP was taking care of this. Simon is noted to have said that he was Evelyn's main carer, lived with her and asked friends to look after her when he was at work. He did not think that he needed further help. Simon took Evelyn home against medical advice and without investigation. The Urology consultant expressed safeguarding concerns that Evelyn needed more care at home but concluded in discussion with a social worker (borough not specified) that there were no grounds to ask Evelyn to return to the hospital. The discharge summary stated that, "We would be grateful if the GP could organise a joint home visit along with Social Services to assess home situation and potential need for support at home".

3.34. On 1st March 2019 Richmond and Hillingdon boroughs agreed to share information between themselves about Evelyn to reduce the risk and impact of possible neglect and harm.

3.35. On 2nd March 2019 Evelyn and Simon flew to Jamaica.

3.36. On 4th March 2019 Hillingdon and Richmond agreed to work together. There was an on-going safeguarding enquiry by Richmond, and Hillingdon had recently opened its own Section 42 enquiry. It was agreed that Richmond was to work with health services to enquire into safeguarding concerns regarding hospital discharges without medical care and would liaise with the Office of the Public Guardian to seek revocation of Simon's Lasting Power of Attorney by the Court of Protection. At this stage neither local authority was aware that Evelyn and Simon had left the country. The police discovered this on 7th March 2019.

3.37. Following police enquiries it was found that Evelyn died in a care home in Jamaica on 31st May 2019.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1. General Points

4.1.1. The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 “Type of Reviews” describes a number of “methodological” requirements and related shortcomings of SARs, which can be summarised as following (following my discussions with the lead author of the report)

4.1.2. SARs should connect their findings and proposals to an evidence base. There is, for example, a lot of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.1.3. SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discretely. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.1.4. SARs should be analytical. There is too much description and not enough analysis.

4.1.5. SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.1.6. Consequently, a study was made of the practice evidence and legal context to provide an analytical framework for understanding Evelyn’s circumstances, including neglect, repeated hospital admissions, working with families, some of which might be avoidant or obstructive and working across different local authority areas.

4.2. Learning from other Safeguarding Adults Reviews

4.2.1. A search was made for SARs on similar topics, namely difficult to engage family members who may be making decisions that are not in the best interests of an adult at risk of abuse and the involvement of multiple agencies across multiple boroughs. This has involved internet searches and an analysis of the 118 entries in the SCIE (Social Care Institute for Excellence SAR library), 112 of which are SARs, but no other SARs that match these criteria has been found.

4.2.2. Some SARs, however, concern related topics and these include the financial abuse of a parent by a son (number 107 Swindon Honor SAR report no date.pdf) and neglect due to the inability to care for each other in co-dependent couples (as an example number 111 Nottingham Mr and Mrs G SAR overview report Dec 2015.pdf and https://www.leicester.gov.uk/media/186453/mary-and-graham-overview-report-safeguarding-adults-review.pdf).

4.2.3. Other SARs feature circumstances that were more similar to those present in the case of Evelyn but their analysis of these is limited. The Safeguarding Adults Review of the circumstances concerning Mrs Y, published in December 2016 by City and Hackney Safeguarding Board (number 55 in the SCIE SAR library) raised the matter of "Mrs. Y and her family not engaging with vital services" but did not make any recommendations for, or offer any guidance on, how services should respond to this.

4.2.4. Similarly, the Report of the Learning Together Safeguarding Adults Review Into The Case Of Mrs H, published by the West Berkshire Safeguarding Adults Board in July 2016 (number 23 in the SCIE SAR library) featured a family member's reluctance to accept services. The Learning Review did not explore this further.

4.3. Evidence from research

1.1. Repeated hospital admissions

4.3.1. Evelyn was attended at least eight hospitals on at least 13 occasions between January 2018 and January 2019. These were:

4.3.2. On 19th January 2018: Hillingdon Hospital Accident and Emergency Department for a "check-up" following reports that Evelyn was shouting that she could not get out of the house.

4.3.3. On 12th March 2018: Ealing Hospital. Evelyn was confused and was generally feeling unwell. Evelyn was transferred to St Mary's Hospital and discharged home from there.

4.3.4. On 13th May 2018: Hillingdon Hospital. The ambulance crew raised a safeguarding concern that Simon was neglecting Evelyn.

4.3.5. On 25th May 2018: Chelsea and Westminster hospital Accident and Emergency for abdominal pain.

4.3.6. On 14th August 2018: Chelsea and Westminster Accident and Emergency with long-term occasional swelling of one of Evelyn's legs.

4.3.7. On 14th November 2018, St Mary's Hospital Accident and Emergency with chest pain. Evelyn was seen by a psychiatric liaison nurse and discharge home as there was no acute mental health risk, but further clinical assessments were required.

4.3.8. On 11th January 2019: Hillingdon Hospital. Police raised a safeguarding concern that Evelyn was being hypothermic and neglected at home.

4.3.9. On 15th January 2019: Following admission to Hillingdon Hospital on 11th January, transferred to the Clementine Churchill Hospital (private). Evelyn was discharged from there hospital on 23rd January 2019.

4.3.10. On 21st January 2019: West Middlesex Hospital on for a steroid injection in her knee.

4.3.11. On 27th January 2019: Chelsea and Westminster Accident and Emergency with leg swelling. During this visit the hospital had noted that Evelyn had been seen at the Royal Brompton hospital (private) for "cardiology/nephrology and Care of Elderly".

4.3.12. On 6th February 2019: Chelsea and Westminster Hospital following a report she had collapsed/fallen.

4.3.13. On 14th February 2019: Moorfields Hospital.

4.3.14. On 28th February 2019: Chelsea and Westminster Hospital following a urology appointment. Simon took Evelyn home against medical advice and without investigation.

4.3.15. Attendance at hospital was occasioned by treatment for physical illnesses, predominantly at the Chelsea and Westminster Hospital, and as result of concerns by emergency services (police and ambulance crews) about Evelyn's health and welfare. Attendance at hospital appears to have resulted in two admissions (to Ealing/ St Mary's Hospitals in March 2018 and to Hillingdon/ Clementine Churchill Hospitals in January 2019. None of Evelyn's hospital admissions were planned.

4.3.16. Previous Safeguarding Adults Reviews, for example, that of Ms H and Ms I (London Borough of Tower Hamlets, 2020) have identified that repeated emergency department hospital admissions are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018). A recent Richmond and Wandsworth SAR following the death of John and published in 2021 found that John had been admitted unplanned to hospital eight times in less than 1.5 years. During the last seven months of his life John was in hospital at least once each month. Evelyn has attended hospital seven times in the last two months before she moved to Jamaica. This would seem to confirm that frequent, unplanned hospital admissions are a warning sign, although in Evelyn's case this pattern was perhaps less clear since she attended five different hospitals for different reasons.

4.3.17. In addition to being a potential warning sign, for some adults at risk of abuse or neglect, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014). In Evelyn's case, a number of safeguarding concerns were raised by emergency services about the circumstances that led to Evelyn's hospital attendance. One safeguarding concern was raised by a hospital nurse at Hillingdon Hospital on 15th January 2019 to Hillingdon Social Services. This followed Evelyn's admission there on 11th January. This was linked to an existing concern already raised by the police, whose attendance that day had resulted in Evelyn's admission to hospital.

4.3.18. Hospital admissions also provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions (Boutin-Foster et al, 2005; Gersons, 1990). This was made more challenging due to the transitory nature of Evelyn's presence in different local authority areas, but it does not appear that Evelyn's hospital attendances resulted in a recognition of the

need to assess and rethink the effectiveness of current approaches until January 2019. On 17th January, following the safeguarding concern raised by the hospital and the police on 15th January, a strategy meeting was held at which it was agreed that Richmond Social Services would carry out a welfare check and on 4th March when Hillingdon and Richmond agreed to work together and agreed an action plan. Prior to this the attempt by the London Ambulance Service to coordinate a multi-agency, cross-borough professionals meeting on 4th January 2019 had only been attended by Richmond Social Services.

4.4. Evidence from practice

4.5. Domestic Abuse and Coercion and Control.

4.5.1. Domestic Violence and Abuse was included (along with self-neglect and modern-day slavery) to the categories of adult safeguarding in the Care Act 2014 and includes, “including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence”. Consequently, domestic abuse was as adult safeguarding concern during the time period covered by this safeguarding adults review and included a broad range of abuse.

4.5.2. Despite entering statute after the period of time covered by this review, the Domestic Abuse Act (2021) defines abusive behaviour as consisting of any of the following carried out by one person towards another if they are over the age of 16 years old and are personally connected:

- physical or sexual abuse.
- violent or threatening behaviour.
- controlling or coercive behaviour.
- economic abuse
- psychological, emotional or other abuse.

4.5.3. Of particular relevance for the events described in this SAR, are controlling or coercive behaviour and psychological, emotional or other abuse.

4.5.4. The Government definition of controlling and of coercive behaviour is given in two parts as follows:

4.5.5. **Controlling behaviour:** *A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

4.5.6. **Coercive behaviour:** *An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

4.5.7. Domestic abuse is often considered in the context of intimate partner violence, but the Domestic Abuse Act is clear that its definition of being personally connected includes relatives.

4.5.8. There is little evidence that the presence of controlling or coercive behaviour in Evelyn's life, whether intended or not, was explored. People with mental health difficulties (which can include the dementia like condition that Evelyn often presented with) are more likely to experience domestic abuse than the general population (Rodway, et al, 2014). Evelyn also had a number of long-standing physical health problems and people with chronic physical health problems are also at increased risk of domestic abuse compared to people without chronic physical health problems (Khalifeh et al 2015). These characteristics might have triggered further exploration of the impact on Evelyn's circumstance. Despite efforts made by Evelyn's family, it is reasonably clear that Evelyn's wellbeing was not being promoted, which appears to have been recognised at the joint meeting 17th January 2019 when the London Borough of Richmond agreed to make a welfare visit to Evelyn.

4.5.9. Recognising domestic abuse, whether intended or not, can be a challenge for practitioners since its effects can readily be ascribed to other causes, which are often sufficiently explanatory to rule out further investigation. Whilst there is no evidence that Evelyn was being physically abused, the impact that reluctance to engage with services and frequent moves from borough to borough had on her wellbeing does not appear to have been recognised until March 2019.

4.6. Working with family carers

4.6.1. The ADASS (Association of Directors of Adult Social Services) Advice Note Carers and Safeguarding Adults –Working Together to Improve Outcomes was published in 2011. Whilst this provides useful guidance on working with carers (family or "informal" - although this term tends to underplay the significance and importance of their role – rather than paid carers), it predates the Care Act 2014 or its statutory guidance and is not always consistent with it (featuring a primordial iteration of the principles of adult safeguarding for instance).

4.6.2. The LGA (Local Government Association)/ ADASS "Adult safeguarding and domestic abuse: A guide to support practitioners and managers" second edition was revised in October 2014 and so references the Care Act Statutory guidance in its initial form (the statutory guidance is subject to regular updates).

4.6.3. This LGA guidance does identify the presence of domestic abuse within families and within the relationships between family carers and those they care for, and draws attention to the influences of coercive and controlling behaviours upon decisions and upon willingness to disclose what is happening. It also provides definitions of coercion and of control. It does not, however, demonstrate and operationalise these in a way that would assist in practitioners in identifying the presence of coercion and control in situations similar to Evelyn's.

4.6.4. The case of Southend-On-Sea Borough Council v Meyers [2019] (EWHC 399 (Fam)) is also useful in highlighting the duty to act in accordance with the Human Rights Act to protect life when working with families that resist interference from statutory services. The provision of necessary care and support to Mr Meyers by Southend-On-Sea Borough Council was prevented by his son with whom he lived. Mr Meyers had made a mentally capacitous decision that he would not leave his home even if this meant that he would not receive the support he required.

4.6.5. Concerned about Mr Meyers' wellbeing and welfare, Southend-On-Sea Borough Council presented to the case to the High Court under the principle of inherent jurisdiction (essentially, the principle that the High Court can hear any case put before it). The judge considered that Mr Meyers' son was, *"…needy, irrational, frequently out of control as well as manifestly emotionally dependent on a father who, despite the alarming history of this case, he obviously loves. [The son's] influence on his father is insidious and pervasive. It triggers Mr Meyers's sense of duty, guilt, love and responsibility…The consequence is to disable Mr Meyers from making a truly informed decision which impacts directly on his health and survival.*

4.6.6. The judge ruled that Mr Meyers and his son should be separated in order to allow care to be provided to Mr Meyers and concluded that, "*The essence of [Mr Meyes'] vulnerability is, in fact, his entirely dysfunctional relationship with his son ... Mr Meyers, I am satisfied, is entirely capable of and has the capacity ... for determining where he wishes to reside and with whom. ... I instinctively recoil from intervening in the decision making of a capacitious adult ... Here Mr Meyers' life requires to be protected and I consider that, ultimately, the State has an obligation to do so*".

4.6.7. The relevance of this judgement to Evelyn is that it highlights how Human Rights Act based approaches can be used to intervene in complex family situations. In particular, it also demonstrates the need to consider how family relationships that contain elements of coercion and control, whether intended or not, can impact on the ability of family members to make decisions: despite asking for help when distressed, Evelyn seems to have then refused interventions or treatment, often when her sons were with her.

4.7. Cross-borough safeguarding arrangements

4.7.1. Section 4.3.10 of the London Multi-Agency Adult Safeguarding Policy and Procedures describes arrangements for "Cross-boundary and inter-authority adult safeguarding enquiries. It sets out, "*the rule for managing safeguarding enquiries is that the Local Authority area where the abuse occurred has the responsibility to carry out the duties under Section 42 Care Act 2014, but there should be close liaison with the placing authority*" (p.59).

4.7.2. The Policy and Procedure appears to consider cross boundary safeguarding from the perspective of commissioned services and does not offer guidance on safeguarding concerns in family or informal settings.

4.7.3. The London Child Protection procedures does, however, consider "Families Moving Across Local Authority Boundaries" (section 6) and states that responsibility for safeguarding arrangements should remain for a short

period of time with the local authority in which the concerns first arose in circumstances when protection plans are in place or when an assessment or enquiry has begun but has not been completed. Such an arrangement for adults might be useful in the context of this safeguarding adults review.

4.8. Care Act assessments

4.8.1. Section 1 of the Care Act (2014) states that, "*The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being*". A definition of well-being is provided (see appendix 1) but for the purposes of this review, it is sufficient to note that well-being includes personal dignity (including treatment of the individual with respect); physical and mental health and emotional well-being; and suitability of living accommodation.

4.8.2. Section 9 of the Care Act (2014) states that where is appears to a local authority that an adult may have needs for care and support, the authority must assess (a) whether the adult does have needs for care and support, and (b) if the adult does, what those needs are.

4.8.3. If an adult refuses an assessment, then under Section 11, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or neglect. This includes self-neglect. There are other circumstances in which assessment must be made despite refusal, which are not relevant to this SAR.

4.8.4. This Care Act duty applies regardless of the authority's view of (a) the level of the adult's needs for care and support, or (b) the level of the adult's financial resources.

4.8.5. The Care Act also empowers local authorities to meet urgent needs without an assessment (section 19, Care Act 2014).

4.8.6. Assessments of Evelyn's needs were considered and offered by both Hillingdon Social Services and by Richmond Social Services, but these were refused on the basis that Evelyn did not need support or that her care needs were being met in other ways. Only from January 2019 was there a recognition that Evelyn's needs may have not been met

4.8.7. If an adult refuses an assessment, then under Section 11, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or neglect. This includes self-neglect. There are other circumstances in which assessment must be made despite refusal, which are not relevant to this SAR. There does not appear to have been consistent exploration of Evelyn's mental capacity to refuse an assessment and help or to consider whether or not her sons were acting in Evelyn's best interests.

4.9. Mental Capacity Act

4.9.1. The Mental Capacity Act and its guidance sets out the principles and the administrative process for assessing mental capacity. There were few assessments of Evelyn's mental capacity but she was kept in hospital in January 2019 using Deprivation of Liberty Safeguards and her son, Simon, had a Lasting Power of Attorney to make decisions about Evelyn's health and welfare on her behalf. These suggest that there was a recognition that Evelyn lacked the mental capacity to make certain decisions. General guidance about the MCA and Best Interest decisions is shown at Appendix 2.

4.9.2. The legal framework for making decisions on another's behalf includes the principles that decisions must be least restrictive on independence and liberty and must be made in a person's best interests. The legal framework also allows scrutiny and challenge of the decisions that can be made on someone's behalf. It is clear that certain professionals recognised that the decisions made by Evelyn's sons were not always in her best interests and might cause Evelyn harm. Despite this, no action appears to have been taken to challenge Simon's Lasting Power of Attorney until 8th February 2019 when at the London Borough of Richmond's request, the London Borough of Hillingdon referred Simon to the Office of the Public Guardian in response to concerns that Simon was not using the LPA in Evelyn's best interests.

5. THEMATIC ANALYSIS AND FINDINGS

5.1. Using this research and practice evidence-base it is possible to identify a number of analytical themes. These include the recognition and response of services to Evelyn's needs and the way that agencies worked together and communicated with each other.

5.2. Sharing information across boroughs and between services

5.2.1. Evelyn moved location regularly throughout the period covered by the chronology (4th February 2015 – 28th January 2020). Evelyn was present, often temporarily, in at least three London Boroughs (Richmond, Ealing and Hillingdon). It would appear that these were the locations of her own home and of those of her two sons.

5.2.2. The following is a table of the dates when Evelyn was known to be in a specific location by the police, the London Ambulance Service or a local authority.

Date	London Borough
09/01/18	Hillingdon
22/05/18	Ealing
30/05/18	Richmond
15/06/18	Hillingdon
18/07/18	Hillingdon
04/09/18	Richmond
02/10/18	Ealing
30/10/18	Ealing
11/01/19	Hillingdon
15/01/19	Hillingdon

08/02/19	Ealing

5.2.3. Evelyn appears to have moved regularly but with no pattern. She appears to have been most frequently found in Hillingdon, which is likely to have been the location of her own home and where she seems to have spent the most time, although she may also have spent prolonged periods in Ealing.

5.2.4. Evelyn also appears to have attended at least eight hospitals (Clementine Churchill; West Middlesex; Royal Brompton; Ealing; St Mary's Hospital; Chelsea and Westminster, Hillingdon and Moorfields). Little information was provided following Evelyn's stays in the private Brompton and Churchill Hospitals. Practitioners considered it is likely that Evelyn had been referred to these by a GP rather than have accessed them directly so there would be an audit trail for the reasons for admission. Evelyn was transferred to the Churchill Hospital from Hillingdon Hospital.

5.2.5. Practitioners identified that the attendance at different hospitals had made the sharing of information more difficult There were also communication and coordination difficulties presented by transfers between hospitals. For example, on 14th March 2018 Ealing Hospital issued a Section 2 request for an assessment by Hillingdon Social Services before Evelyn's discharge home. Evelyn had been transferred to St Mary's Hospital for an operation and this so this request for an assessment was kept open since it was anticipated that Evelyn would return to Ealing Hospital first. However, on 27th March 2018 Evelyn's son (Ted) explained to the Hillingdon worker that Evelyn had been discharged home the previous week from St Mary's Hospital and was being cared for at home. The allocated worker spoke to Evelyn, who confirmed that she did not require any support. The request for an assessment was consequently closed that day. As a result, an opportunity to assess Evelyn in hospital, away from her family and the chances this might have offered to understand her circumstances and to consider other interventions was missed.

5.2.6. There were unresolved challenges for practitioners in developing an accurate understanding, and history, of events and in accepting responsibility for making decisions and for taking action. Evelyn would move to another borough or attend another hospital before actions could be taken and so practitioners believed that they no longer held responsibility. This could also be compounded by processes that hampered information sharing and made joint working across boundaries somewhat arduous. For example, on 4th July 2018, Evelyn's GP raised a safeguarding concern with Richmond Social Services. This reported that Evelyn was being neglected by her son and was living in hoarded conditions. The GP was also concerned that Evelyn's son was moving his mother to different boroughs and presenting her to different hospitals. This analysis by the GP seems to have been quite accurate.

5.2.7. As part of its consequent enquiry, Richmond Social Services contacted Hillingdon Social Services the next day to confirm Evelyn's primary residential address. The outcome was that Richmond Social Services was asked by Hillingdon Social Care Direct staff member to send the request to Hillingdon Social Care Direct by email and the contact was closed. Whilst emails might provide audit trails and the ability to formalise responses, this

approach also introduced delay and a process for professional-to-professional discussion might be useful in situations like this.

5.2.8. On the following day, 6th July 2018, a Richmond Social Services duty worker contacted Hillingdon again (with the concerns raised by the GP: hoarding in the property and her son obstructing intervention and request any information on similar concerns that Hillingdon might be aware of. Following this, a Hillingdon triage worker made enquiries and found that a psycho-geriatrician, used by Evelyn's son Simon, had recommended that Evelyn's medication be reviewed by her GP. Evelyn's son said that he would inform Hillingdon if there were other services that he may feel are needed in due course and was privately funding care twice a day. This contact was then closed. This enquiry does not appear to have comprehended all the points raised by the GP.

5.2.9. There does not appear to have been joint debate between Richmond and Hillingdon or with the GP about the GP's concerns or any sharing of patterns or previous episodes which might have led to reconsideration of the information that the triage worker had been given by Evelyn's son. On 5th October 2018, Richmond suggested a meeting with Hillingdon which was declined by Hillingdon since it judged that a meeting would not achieve anything and instead, Richmond and Hillingdon agreed to update each other.

5.2.10. On 26th October 2018, Richmond Social Services finally closed its safeguarding involvement since there had been no response or contact with Evelyn or her sons since the safeguarding concern had been raised in July 2018

5.2.11. Whilst there were attempts at cross borough and multi-agency communication and cooperation these were inconsistent and were not fully developed until Evelyn left the country. This reveals a need to further develop information sharing protocols for cross-borough working.

5.3. Powers and responsibility to make decisions on another adult's behalf.

5.3.1. Evelyn and Simon refused offers of services and the reasons for this were not always explored. Practitioners recognised that, for example, nurses will discharge a patient into the care of their family but that the success of this should be followed up afterwards. This was not always done if the family gave sufficient, convincing assurance that they could manage. Family members are often assumed to be protective factors, in that they will alert services if there are problems and will also act to prevent harm or neglect. Sometimes, however, this is an overly optimistic view and practitioners need to be curious enough to enquire further into how protective family members actually are.

5.3.2. For example, on 27th January 2019, whilst Evelyn was in the Chelsea and Westminster Hospital, an OT (Occupational Therapist) met Evelyn and her son and noted that Evelyn lived on the ground floor with her son in a maisonette and received three care calls per day. Evelyn's son said that the carers did not do much and the OT noted that the reasons for the package of care were unknown. Evelyn's son reported no concerns with Evelyn's cognition or memory but the OT noted that cognitive deficits were evident.

Evelyn was described as disorientated to place, to be seeking assurance from her son throughout and too tired to take part in the bed transfer assessment. The OT and Evelyn's son discussed equipment options but these were declined. The OT concluded that Evelyn was now medically fit for discharge but would require OT assessment for this discharge. Evelyn agreed to a brief mobility assessment. The OT appears to have been satisfied that Evelyn's needs would be met by her son and the care workers.

5.3.3. There was a developing pattern in which Simon seemed to be interfering in Evelyn's treatment in a way that was not in her best interests. Simon had refused to allow entry to the both the police and the ambulance service on 15th June 2018 and on 7th February 2019 Evelyn had collapsed at home and was taken to the Chelsea and Westminster Hospital. Evelyn's GP was informed that, Simon, "…was noted to be difficult during London Ambulance Service care and also obstructive during Evelyn's care in Accident and Emergency". Simon refused to let Evelyn have a chest X ray as it was " too much radiation" and would "give her cancer" despite appearing to understand that the X ray was to rule out a chest infection. Instead, Simon was insistent that Evelyn have a CT urogram (a computerised imaging of the urinary tract, which involves the use of radioactive dye) as he believed that Evelyn's kidneys were the cause of her health problems, despite medical advice that Evelyn's current kidney function made this unsafe. Evelyn's son refused to stay and Evelyn self-discharged.

5.3.4. Simon claimed that he had a LPA (Lasting Power of Attorney) for Evelyn's health and welfare and on 6th February 2019, Simon's LPA had been used to discharge Evelyn from hospital against medical advice. Despite making some decisions on Evelyn's behalf that were not always in her best interests (including discharge from hospital or refusal of offers of support) these decisions were rarely challenged.

5.3.5. This only seems to have been recognised when on 28th February 2019, a professionals meeting was held and attended by London Ambulance Service, Hillingdon and Richmond. Evelyn had attended six different hospitals over past few weeks and had been discharged on 12th February 2019 by Simon against medical advice using his LPA for care and welfare.

5.3.6. The outcome of this meeting was to complete a welfare check and raise a safeguarding concern. Later that day, it was discovered that Evelyn was in Chelsea and Westminster A&E following a urology outpatient appointment. The medical team suspected that Evelyn had a fractured hip, but Simon took her home against medical advice and without further investigation.

5.3.7. A cross borough agreement to contest Simon's LPA was reached on 4th March 2019 but this was too late to have effect since Evelyn had left the country on 2nd March 2019. If this had been recognised earlier, then there may have been more opportunity to revoke the LPA and intervene to safeguard Evelyn and to promote her wellbeing.

5.3.8. There would seem to be a need for greater legal literacy especially about mental capacity and the circumstances in which someone can make a decision on another's behalf and the powers a person might hold to do this. This includes how these powers can be confirmed and the circumstances in

which, and how, they might be challenged when they do not appear to have been used to make decisions in another person best interests or to be putting them at risk of harm.

5.4. Responses to safeguarding concerns

5.4.1. Thirty-four safeguarding concerns were raised but these do not appear to have led to completed enquiries. One of the reasons for this and for no further action was that there was insufficient evidence that Simon was intentionally abusing or neglecting Evelyn. On reflection, practitioners recognised that even if there is no suggestion of deliberate harm being caused, safeguarding enquires and interventions can be useful (and can be made either under s42 or as “other” enquiries) if there are concerns that someone is being harmed or neglected. On other occasions no action was taken because Evelyn had moved to another address. Practitioners considered that some of these moves were made to avoid their enquiries. For example, the considered that Simon transferred Evelyn from Hillingdon Hospital to the private Clementine Churchill Hospital on 15th January 2019 in response to the safeguarding enquires that Hillingdon Hospital has begun to make. On other occasions there were difficulties making contact with Evelyn and with hers sons.

5.4.2. Some safeguarding concerns were also not reported. Practitioners considered that this may have been because these concerns were about how well Evelyn’s care needs were being met rather than that she was being abused or neglected. The impact of neglect was missed: even if Evelyn’s son was not intentionally neglecting Evelyn her then an intervention should still have been made. On reflection, practitioners recognised the need to consider what Evelyn’s life was like and whether or not her wellbeing was being promoted. Neglect does not need to be deliberate for it to be a safeguarding concern. There is a collective need to develop safeguarding approaches further to include interventions when care needs are not being met rather than just when there are concerns about wilful abuse and neglect.

5.4.3. The term “safeguarding” may also have different meanings for different professionals particularly in health services where the term is used independently of its statutory connotations in the Care Act. For example, on 28th February 2019, a medical doctor at the Chelsea and Westminster Hospital noted an “Impression” that, "There is a Safeguarding issue here with regards to potentially requiring more care at home. Concerns relayed to Consultant (A and E) and Registrar". This use of the term “safeguarding” appears not to have been intended to indicate a reasonable suspicion that Evelyn was being abused or neglected but rather a more general concern how best her care needs could be met. Consequently, this was not raised formally as a safeguarding concern with the local authority.

5.4.4. Another factor, found in other SARs, was that the recognition that a new approach and decisive action was required came too late. On 4th March 2019 the boroughs of Richmond and Hillingdon agree to work together and to share information to reduce the risk of harm to Evelyn and this became a safeguarding enquiry under s42 of the Care Act. Unknown to both boroughs, however, Evelyn had left the country on 2nd March 2019. The s42 enquiry remained open until 9th September 2019.

5.4.5. Perhaps exacerbated by the number of boroughs and organisations involved, the London Ambulance Service appears to have been the only agency that identified a pattern of safeguarding concerns. This was, however, recognised too late to have a meaningful impact since the meeting the London Ambulance Service had organised on 22nd January 2019 was only attended by the London Richmond. This meeting, if fully attended, might have provided an opportunity to share information, reconsider approaches and decide on action, which otherwise did not take place until the meeting on 4th March 2019 after Evelyn and Simon had left the country.

5.4.6. There were two contacts with the care agency commissioned by Simon on 15th July and 18th July 2018 by the London Ambulance Service, but these do not appear to have been used to find out more about their experience of providing support to Evelyn, either to gauge the extent of her care and support needs or to find out more about how she was being treated and what her life was like.

5.4.7. There does not appear to have been consideration of whether or not Evelyn was experiencing other forms of abuse, for example, financial abuse and no attempts to check how Evelyn was managing her finances seems to have been made. Simon had a Lasting Power of Attorney for Evelyn's care and welfare, but it does not appear that any checks were made on powers to make financial decisions on her behalf.

5.5. Recognition and assessment of needs and diagnosis.

5.5.1. Interventions offered to Evelyn by adult social services were often refused. Assessments under the Care Act were offered but were refused (by whom is not always recorded) and it does not appear that an assessment of need was made. For example, Evelyn told the London Borough of Hillingdon on 10th May 2017 that she did not need help, did not want strangers in the house, was a self-funder and did not want an assessment. Following discharge home directly from St Mary's Hospital following an operation, on 27th March 2018 Evelyn told Hillingdon that she did not require support. There does not appear to have been any consideration of the extent to which Evelyn's decision to refuse an assessment was mental capacitous, especially in the context of the evident distress and confusion that had brought her to the attention of services in the first place.

5.5.2. The need to work across-boroughs seems to have impacted on making an assessment of Evelyn's needs. For example, on 11th September 2018 Enfield notified Hillingdon that it would offer a Care Act assessment to Evelyn but this does not seem to have progressed and was not followed up after Evelyn moved. On 28/09/18, the Hillingdon Safeguarding team confirmed that Evelyn had not received a Care Act assessment. Simon, however, seems to have privately organised care for Evelyn at home at times.

5.5.3. It also became apparent that Evelyn showed symptoms of dementia, but Simon and Ted refuted this and also that Evelyn may have any other mental health difficulties. There is no evidence that a formal diagnosis was made apart from a mini assessment (referred to in a conversation between the

police and London Borough of Hillingdon on 2nd May 2018 following Evelyn's admission to hospital which showed signs of early onset dementia).

5.5.4. Evelyn also had several physical health problems and injuries (spinal cord compression; falls; "a bleed on the brain" referred to by Evelyn's son Simon on 4th May 2018). These received treatment as necessary but no pattern or link between them appears to have been sought or made.

5.5.5. Overall there was a gap in knowledge across all the organisations working with Evelyn about her needs in the context of the safeguarding concerns and other factors such as the moves between different boroughs, attendance at multiple hospitals and claims by Evelyn's sons about how any care needs were met.

5.6. Responding to family involvement

5.6.1. Accounts given by practitioners suggest that Simon could be very assertive, and that junior staff in particular could be intimidated by him into not challenging his decisions. Simon also made threats that he would take legal action to prevent interference with Evelyn. This does not appear to have been resolved, although it appears that the London Borough of Richmond did begin to pursue this in February 2019, but Evelyn left the country on 2nd March 2019.

5.6.2. There appears to have been little consideration, by any of the agencies involved and across the different boroughs, of the extent to which Evelyn's family's desire for her to remain in her own home (or in their homes) might be detrimental to her wellbeing. although by it seems that Richmond seems to have begun to recognise this just before Evelyn left the country The family's motivations for wanting Evelyn to remain at home do not appear to have been explored.

5.6.3. Ted, Evelyn's other son, seems to have been less involved and to have deferred to Simon. He was not considered to be an alternative voice in Evelyn's life or someone who could intercede. Richmond tried to contact Ted on several occasions, but he never responded to telephone calls and voicemail messages.

5.6.4. There is a need for curiosity to enquire about how well family members can meet the needs of adults in their care. There is no evidence that a Carers Assessment, under the Care Act, was offered or conducted or advice given to contact the local Carers Centre. Attempts were made by social care staff in Richmond to meet Simon on numerous occasions, but he declined invitations. Instead, Simon made complaints about the social care staff's interference, some of those made against Richmond were investigated by the Local Government Ombudsman, which found no evidence of fault in Richmond's actions.

5.6.5. Work with the Carers Centre might have helped to identify different approaches that could be used to engage with Evelyn, Simon and Ted. The Carers Centre might also have worked as an experienced intermediary and even have challenged Simon and Ted from a skilled and non-statutory perspective. There was also no evidence that an independent advocate was

considered to support Evelyn. This might also have helped to provide an independent voice in what was becoming a dialogue between professional and Evelyn's sons.

5.6.6. A "Think Family" approach might also have provided further insights into family dynamics. This approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016) and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners:

a) Consider and respond to the needs of the whole family; including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions

b) Work jointly with family members as well as with different agencies to meet needs

c) Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

5.6.7. Such an approach may have led to greater consideration of Evelyn's relationship with her sons and how interventions could have been formulated to assist all the family. There may also have been other relatives who could have been involved as intermediaries, as authority figures or to offer additional help and support. There does not appear to have been much curiosity about Evelyn's sons, including their ages, occupations and whether there were any partners or other family members.

5.6.8. Practitioners recognised that there was a need to co-produce work with carers but also to recognise potential indicators of "misguided zealousness" or coercive control in families. Doing this would require professional standards and assertiveness in responding to carers who are not able to provide the necessary support, or who are coercive and controlling. Practitioners suggested that the chronologies used in children's services, and which were not used to adult services, help to build up an understanding of persistently present themes and patterns. Chronologies such as these might be useful in adult services.

5.7. Cultural factors

5.7.1. The recent Richmond and Wandsworth SAR of David identified how biases and assumptions, both unconscious and in judgement, may influence professional decision making and risk assessments. There was no evidence of overt discrimination against Evelyn or her sons in the evidence analysed, or in the practitioner interviews and learning sessions that formed part of this review. However, it was brought to the reviewer's attention that Simon had complained, after Evelyn had left the country, that enquiries into her circumstances were racially motivated. Managing different perspectives on what constitutes acceptable standards in which to live, and how best needs can be met and how past experiences might impact on perceptions of the

motivations of professionals and the functions and approaches of different organisations can be challenging.

5.7.2. There does not appear to have been consideration of why Simon, in particular, seemed so oppositional towards attempts by services to intervene to support and treat Evelyn and as a consequence, the approaches taken did not adapt to meet his needs. Exploration of his expectations and his experiences of previous contact with institutions might have been useful. This was further exacerbated by the complaints that Simon. The result as that Simon became considered, to an extent accurately, as a problem and one which remained unresolved. This had the consequence of locating any difficulties in him and seems to have hampered consideration that Simon's opposition might be consequence of the approaches taken by the various organisations involved and Simon's perception of their roles and motivations.

5.8. Changes made since 2019

5.8.1. Due to the time elapsed between awareness of Evelyn's death in Jamaica and the completion of this SAR, it is important to recognise that changes have already been made.

5.8.2. Richmond has updated its local adult safeguarding procedures to include Repeated Safeguarding Concerns to include conducting risk assessments and making safeguarding plans patterns of similar concerns have been identified. If the adult at risk does not engage with services, then a professionals' meeting will be held to decide what approached and actions to take. All organisations in the borough of Richmond which are covered by these procedures are responsible for recording and noting patterns of concern and may be asked to share and analyse information and contribute to a multi-agency response.

5.8.3. In considering how to respond to repeated concerns the following factors need to be considered:

- The safety of the adult who the concern is about.
- Mental capacity and ability of the individual's support networks to raise the concern, or to increase support to meet outcomes of safeguarding concerns.
- Wishes of the adult at risk and impact of the concern on them.
- Impact on important relationships.
- The level of risk identified.

5.8.4. Additionally, Richmond held a webinar for adult social service staff on how to recognise and respond to disguised compliance and their own unconscious biases.

5.8.5. The London Ambulance Service has introduced a new adult safeguarding concerns escalation process. This requires that local authorities are alerted to potential patterns of abuse or neglect when three or more safeguarding concerns have been raised by the ambulance service about an individual within any six-month period.

6. SUMMARY OF THEMES

6.1. A number of factors were present which the published research and practice evidence links with poor outcomes. For example, Evelyn had repeat hospital admissions, yet it appears patterns were not responded to and none of the admissions led to a change in the approach taken by services. This was hampered by attendances at different hospitals.

6.2. No individual workers or agencies took responsibility for coordinating approaches to assessing and meeting Evelyn's needs until February 2019. This was similarly hampered by regular moves from one local authority area to another.

6.3. Whilst many adult safeguarding concerns were raised, few led to action or intervention, again hampered to an extent by frequent moves. There was little inter-agency communication, although attempts had been made by Richmond to liaise with Hillington in 2018. Simon and Ted's wishes for their mother to remain in her own home (and in theirs), with their support, were rarely challenged and were given priority over ensuring that Evelyn's needs were met. There was a lack of recognition of how the desire to support Evelyn at home might prevent her needs from being met, with a detrimental impact on her wellbeing.

6.4. Professionals did not show curiosity when being given assurance by Evelyn's family members that her needs were being met or that she did not have needs. There may have been an element of "disguised compliance", or perhaps more accurately "feigned compliance", in which professionals were told what they wanted to hear in order to prevent them from enquiring further.

6.5. Simon's ability to make decisions on Evelyn's behalf went unchallenged despite growing evidence that these decisions were objectively rarely in her best interests.

7. CONCLUSIONS

The following conclusions are drawn from the thematic analysis and more widely from other safeguarding adults reviews.

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

7.1.1. Despite the evidence available that Evelyn had physical health needs, mental health needs and care and support needs, decisions made by her sons to refuse interventions were not challenged. Evelyn was discharged from hospital against medical advice on multiple occasions and was not receiving support. This was despite a historical and current picture of Evelyn being found trapped in her home in distress, wandering outside in distress, being neglected, not having heating (and at one point being described as hypothermic) and moving between three local authority areas.

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

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

7.2.1. There was a lack of clarity about, and joint working across boroughs, on what action to take once Evelyn had moved out of a local authority area. Attempts were made by different boroughs at different times to initiate this but because of their irregular individual contact with Evelyn the importance of this was not recognised and no shared picture was formed. There was no overt reference to Ordinary Residence, nor to the London Multi-Agency Adult Safeguarding Policy and Procedures for guidance on responsibility and, until March 2019, no comprehensive joint working to intervene. There appears to have been a very slow recognition amongst services that Evelyn's regular moves from place to place might in themselves be a safeguarding concern, despite this having been identified by a GP in 2018.

7.2.2. Similarly, there was a lack of information sharing between hospitals, which meant that patterns of attendance were not identified, and which meant that any interventions (such as to challenge decisions made on Evelyn's behalf which were not in her best interests; to admit for fuller medical assessment etc) were not formulated or made.

7.3. Safeguarding referrals were made but no action was taken

7.3.1. It appears that most safeguarding concerns raised about Evelyn led to no decisive action. This was partly explained by a misapprehension that if neglect was not deliberate then it did not meet the criteria for an enquiry under section 42 of the Care Act. Another reason was the unchallenged assurances given by Evelyn's sons that Evelyn's needs were being met. Contact with Evelyn and her sons was at times difficult to establish, Evelyn moved frequently and sometimes her sons were not clear about where she was. All of these factors made making safeguarding enquiries more difficult.

7.3.2. The local authority is the lead agency for adult safeguarding under the Care Act and must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

7.3.3. Whilst there was uncertainty about whether Evelyn was being neglected, the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (commonly known as "other" enquiries) and interventions where the three-part test is not met but where there is sufficient concern that someone may come to harm. It is likely that Evelyn met at least the criteria for a non-statutory adult safeguarding enquiry from 2018 onwards

and either this or a s42 enquiry might have led to an earlier intervention to meet Evelyn's needs.

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

7.4.1. Evelyn's family relationships were also not fully understood. There does not appear to have been exploration of why her sons appeared to be obstructive, what they feared, what they expected or even what they had to hide. Exploration, as in the case of Mr Meyers set out in sections 4.52 – 4.55 of this review, of the impact of family relationships upon Evelyn may have helped to formulate different interventions.

7.4.2. Instead, the responses of different organisations to Evelyn's sons appears somewhat contradictory. At times, their assurances were accepted, and they were considered to be protective factors, at other times they were considered to be neglecting Evelyn, at others they were preventing her needs from being met. None of these responses led to a consistent approach. There appeared to be a lack of recognition that whatever Evelyn's son's motivations were, Evelyn's wellbeing was not being promoted by them.

7.4.3. No Carer's Assessment was offered and no input from an outside specialist agency such as a Carers Centre was sought.

8. RECOMMENDATIONS

8.1. The recommendations from this Safeguarding Adult Review are considered in the following domains:

8.2. Domain 1: direct practice with individuals

8.2.1. There is a need to:

- Increase legal literacy, particularly in the ability of family members to make decisions on another member's behalf and of how to confirm and challenge Lasting Powers of Attorney. This requires management oversight and follow up with practitioners.

- Improve working with challenging relatives including how to engage them and how to identify and respond to over-zealous and coercive and controlling behaviours, whether these are intended or not. Developing partnership working relationships with local carers centres might be helpful in doing this.

- Increase the use of safeguarding processes when there are concerns about the extent to which needs are not being met.

8.3. Domains 2 & 3: Agency and interagency practice

8.3.1. There is a need to:

- Revise or create, as necessary, escalation processes and protocols so that problems of joint working, information sharing and of agreeing interventions can be resolved quickly.

8.4. Domain 4: Board level

8.4.1. Support the development of information sharing and cross-borough working in safeguarding through the Chairs Network.

8.4.2. Promote through the Chair's Network the need for a revision of guidance on carers and safeguarding to include how to respond to over-zealousness and coercion and control, whether intended or not.

8.4.3. Raise through the Pan London SAB/ national chairs network the need to improve information sharing and cross borough working including safeguarding responsibilities when someone moves frequently from borough to borough.

8.4.4. Future reviews of the London Multi-Agency Policy and Procedure should incorporate cross borough working where there are concerns that an adult at risk of abuse is being moved from borough to borough.

APPENDIX 1: Wellbeing

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2:

Mental Capacity Act and Best Interest Decisions

In practice, the first stage in assessing mental capacity is to establish if a person cannot make a decision, which involves not being able to do any one of the following (i) understand the information about the decision to be made (ii) retain that information in their mind (iii) use or weigh that information as part of the decision-making process decision and (iv) communicate their decision.

The second stage is to establish whether the person has an impairment of, or disturbance, in the functioning of their mind or brain, whether as a result of a condition, an illness, or external factors such as alcohol and drug use.

The third stage is whether or not this impairment or disturbance means that the individual is unable to make a decision when they need to.

The Mental Capacity Act also sets out a number of principles of which the most relevant to E are that “A person must be assumed to have capacity unless it is established that he lacks capacity” and that “A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests and must have regard must be least restrictive of the person's rights and freedom of action.

Lasting Power of Attorney, Deputyship and Appointeeship

Attorney: A Lasting Power of Attorney is donated by a person who has the mental capacity to do so to a representative of their choosing. This representative can then act on their behalf at a time when they lack the mental capacity to make decisions about their Property and Finances or Health and Welfare.

Deputy: A Deputy is appointed by the Court of Protection to act on the behalf of a person who does not have the mental capacity to make decisions for themselves at the time that they need to be made. Generally, a Deputy will only have powers over property and finances. Personal Welfare Deputyships are very strictly limited due to the difficult nature of appointing someone to have free reign over a person’s medical decisions, without knowing what the person’s wishes would be.

Appointee: An application can be made to the relevant benefits office to become an appointee. This is for the right to deal with the state benefits of someone who cannot manage their own affairs because they are” mentally incapable” or severely disabled.

Whilst it is the Court of Protection makes decisions on, for example, appointing a Deputy, it is the Office of the Public Guardian that handles their on-going administration and which applications should be made to search the registers, including for LPAs. There is a standard form to do this.

Appendix 3: Literature review

The literature review was conducted in November-December 2020 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources

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