Safeguarding Adults Review in respect of George

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Contents

Glossary:

Abbreviation	Definition
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
GP	General Practitioner
PLE	Practitioner Learning Event
S42	Section 42 (of The Care Act)
MCA	Mental Capacity Act
MHA	Mental Health Act
ED	Emergency Department
DNA	Did not attend
OPD	Out patients department
LPA	Lasting Power of Attorney
SACCG	Safeguarding Adults Complex Cases Group
RCA	Root Cause Analysis
ICM	Integrated Case Management
MDT	Multi Disciplinary Team
IMCA	Independent Mental Capacity Advocate

1. Foreword

1.1 Barking and Dagenham Safeguarding Adults Board is publishing this report into the care and safeguarding interventions provided to 'George' who died in hospital as a result of multi-organ failure and sepsis. There were concerns for George in the last few years of his life around his health and there was evidence he was not following his care plan or talking medication which had a major effect on his health and wellbeing. There were a number of organisations involved in this review and professionals from Social Care, Health and the Police.

1.2 The report author made a number of recommendations around multi agency working, domestic abuse, understanding complex family dynamics, Making Safeguarding Personal and application of personal curiosity for consideration across the partnership.

1.3 The Safeguarding Adults Board have acknowledged that there are areas of improvement and learning identified in this review around the planning and coordination of multi agency care. A lot of work has already been completed to address the learning points but there is still more to do and this will be implemented by the Safeguarding Adults Board.

2. Introduction

2.1. Under section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

2.2. The purpose of conducting a review is to enable members of the SAB to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

2.3. Further information on the local SAR process can be found on the Barking and Dagenham Safeguarding Adult Board (BDSAB) website.

2.4. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

2.5. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.6. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to

reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.7. The SAR referral was initially received from adult social care in 2022 and based on the information available was judged to not meet the criteria for a SAR at that time, however learning was identified and learning briefing was completed which can be seen at this link https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/safeguarding-adult

2.8. George's case was re-referred to the SAR committee in March 2023 by NELFT with additional information, and on this occasion a SAR was endorsed and commissioned.

2.9. The review process to meet these aims and objectives has followed a clear path. The methodology chosen for this review is a "Learning Together" approach. This included a panel to agree terms of reference and a focus on themes, patterns and factors together practitioner discussions and family liaison where possible. The Independent Reviewer has conducted research by analysing the information provided culminating in an overview report for the BDSAB.

2.10. The review will cover the period of 2019 to the time of George's death.

2.11. Contributing agencies:

- Barking, Havering and Redbridge University Hospitals (BHRUT)
- North East London NHS Foundation Trust (NELFT)
- London Ambulance Service (LAS)
- London Borough of Barking and Dagenham (LBBD) Adult Social Care
- London Borough of Barking and Dagenham (LBBD) Childrens Services
- The Metropolitan Police Service (MET)
- General Practitioner (GP) - Hedgemans Medical centre
- Refuge

3. Overview of the case and circumstances leading to the review

3.1. This review is about a 78-year-old man who died in hospital on 19th March 2022 as a result of multi-organ failure and sepsis, he had existing cardiac conditions and dementia. George was recorded as being White Irish, Christian and heterosexual.

3.2. George lived in a council owned property with the support of his sons. Throughout the last few years of his life there were concerns about his health, with evidence to show that he was not always following his required care plan, or taking his medication which was extremely detrimental to his health and wellbeing. Resulting from this there were concerns about neglect and coercive controlling behaviour from his sons. This review will consider these issues in the context of how agencies worked together.

3.3. There were a number of professionals involved throughout the timeframe of this review, namely the GP, Community Cardiac Team, Community Matrons, Adut Social Care, Refuge and Police.

3.4. The SAR committee acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care.

4. Key Themes identified for this review:

4.1. The SAR committee identified a number of themes for the review which were expanded by the panel members and the independent reviewer. These themes will be considered under the broader thematic areas of:

- Identification of safeguarding, and legal literacy
- Multiagency working and application of professional curiosity
- Understanding family dynamics and consideration of coercive and controlling behaviour
- Understanding the person

5. About George:

5.1. George was a 78-year-old male who lived in a council owned property. He had a number of medical conditions including heart conditions and a diagnosis of mixed dementia.

5.2. George had at least 2 sons, the youngest was still a child in the earlier part of the timeframe of this review. The living arrangements were not always clear, as George's property was a single tenant occupied home, but at different times one or another of his sons appeared to be residing with him. During these times there was a complex picture of family relationships, with his sons thought to be supporting and helping at times, whilst at other times there were concerns that they were preventing his access to required health care and acting in a coercive and controlling way. These aspects will be explored during the course of the review. For the purpose of the review the older son who was prominently visible will be referred to as "the son".

5.3. Some agencies were aware that there was a complex family background and George had to move out of the family household prior to the timeframe of thus review due to safeguarding concerns related to his son (who was a child at the time). As a result, there was significant involvement of statutory services, namely Childrens Services. This provides some context to the family functioning and relationships.

5.4. George was diagnosed with mixed dementia in 2016 and thus there were challenges with his cognitive functioning, concordance with medication and attendance at various health appointments. It can be seen that from at least 2019 he started to have significant cardiac issues, increased attendance to hospital and a requirement for care under a specialist cardiac service. As his needs increased, the presence of his sons was more visible as his main source of care and support. It is evidenced that a social care package was declined by George and his sons prior to 2019.

5.5. Throughout 2020 there was escalating concern that George was not concordant with his medication, not accessing his prescriptions and was more frequently missing essential appointments. At the same time, he was increasingly attending hospital with cardiac related presentations and thus a re-referral to memory service was facilitated. During 2021 concerns

started to emerge more about the situation at home, the perception that his son was a supportive and protective factor was being questioned thus there was concern about the degree of support that he was receiving at home and whether his son was actually obstructing his access to medication and appointments or at very least failing to support his access to them.

5.6. These concerns correlated with incidents of threatening behaviours from George's older son towards health professionals to the extent that the GP made a safeguarding referral and advised that healthcare professionals should not visit the house alone due to the threatening behaviour. A further two safeguarding referrals were made before his death, facilitating a referral to domestic abuse services and to the Complex Cases Group. Sadly, George died at the point that he was still being considered via these routes.

5.7. There is very little known about George's life, his likes, dislikes and interests or his background, and unfortunately the agencies involved in his life in the latter stage had only known him for a relatively short period of time.

6. Engagement with Family

6.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported on a daily basis and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

6.2. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[i].

6.3. Unfortunately, despite several attempts to contact family members, George's sister and his sons declined to contribute to this review and therefore there is a missing element in terms of family perspective and a deeper insight into George.

7. Parallel processes

7.1. For reference, background, and context it is helpful to consider the formal cause of death and other relevant statutory process and their conclusions.

7.2. George died in hospital on 19th March 2022 at the age of 78. The certified cause of death was:

- 1a Multi Organ Failure
- 1b Sepsis
- 1c Chest Infection
- 2 Peripheral Vascular Disease Hypertension Atrial Fibrillation Cardiac Thrombi

7.3. There is not an inquest scheduled and there are no other parallel processes taking place.

7.4. To note, a serious incident investigation was undertaken by NELFT prior to the SAR process and that report has been made available for this review.

7.5. For reference, Serious incidents that occur within the NHS are investigation in accordance with the current NHS Serious Incident Framework (2015).[ii] This will be fully replaced by Autumn 2023 with the new Patient Safety Incident Response Framework (PSIRF).

7.6. A Root Cause Analysis (RCA) is a methodology for conducting serious incident investigations and learning from incidents. The reason why an RCA was carried out was because George had died on the ITU of Queens hospital, and it was noted that he had been under the care of the NELFT community matron services due to his cardiac condition. The report also records that he had been under the NELFT memory clinic until 2016 following assessment and diagnosis of mixed dementia.

8. Key learning episodes:

8.1. To effectively consider George's journey through the timeframe of this review it is helpful to visually follow a combined chronology that evidences his contact or lack of contact with agencies, concerns identified, and actions taken.

8.2. Within the information provided for this review there is evidence of at least 100 episodes of contact with services (not exhaustive). This chronology can be seen in appendix A.

8.3. In order to simplify the safeguarding concerns/ episodes the following table of key episodes has been summarised from appendix A:

Safeguarding issue and response	Legal Framework to be considered	Local Guidance (including progress since the timeframe)
From 2019 to the time of death there were multiple missed appointments and evidence of non-concordance with medications. A care package of support for George was declined on more than one occasion by George and his son.	The Care Act (2014) The Mental Capacity Act (2005) The Serious Crime Act (2015) The Domestic Abuse Act (2021)- came into force during the timeframe of the review	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Self-neglect Policy (2023)- published post case Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
The role of the son in George's life started to emerge during a hospital admission where he was described as "*physically and verbally imposing",* on this occasion George was assessed to lack capacity. His son insisted on self-discharge against medical advice. This prompted safeguarding referral and police were contacted- no crimes were exposed or apparent.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
In 2020 there is a concern about financial exploitation reported by the bank. This was reported to the police, a safeguarding referral made and recorded in police records- George informed police that he always had his bank card on him, and only he knew his PIN. He explained that he had spent his money with his son, who was redecorating for him. The item was closed as no crimes apparent, but was referred to Adult Social Care.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
In 2020 the Community cardiac Service visited the home and noted that the door looked like it had been kicked or punched repeatedly	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
In 2021 the Older Adults Mental Health Team Doctor carried out a consultation with George's son and closed the case with no	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019)

further follow-up as son reported that the service was not required. George did not participate in this consultation. To note, George was not considered to lack capacity, nor did his son hold LPA for health matters.		Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
In 2021 the GP and practice manager visited George and observed that he was unkempt, and the house was dirty with unclean bedding, limited food and dirty cutlery present.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Self-neglect Policy (2023)- published post case Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
Late 2021 the practice nurse visited George to take bloods, offer flu vaccination and medication review and reported that the son was verbally abusive and threatening, the house was full of smoke/smelled of cannabis, he was observed to push George. It is recorded that police were contacted, and a safeguarding referral was made. There is no record of the outcome.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
January 2022- In response to the safeguarding referral a safeguarding enquiry was commenced and a visit to the house carried out. This was a joint visit with the GP, Practice Manager and Independent Mental Capacity Advocate (IMCA). The son was present and told George that they had come to murder him with the flu and shingles vaccination. George was assessed as having capacity in relation to the vaccination. The outcome was that the safeguarding enquiry was closed, and the case was referred to Refuge for Domestic Abuse advocacy services, and to the Complex Cases Group. Alongside this, he was being discussed monthly at the Integrated Care Team meeting.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case Barking and Dagenham Safeguarding Adult Board Complex Cases Group Barking and Dagenham Integrated Care Team
February 2022- George was admitted to hospital and reported he had been unwell all week and his son refused to phone for an ambulance, he was noted to be confused and said he had not been taking his medication. The hospital made a safeguarding referral, contacted the dementia team, commenced the delirium	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case

pathway and made a DoLs application. George's son insisted on taking him home from hospital and although he was by this time medically optimised, there were safeguarding concerns. Police were contacted and concluded that there was no legal framework to keep George in hospital and that the safeguarding enquiry could continue at home.		Barking and Dagenham Safeguarding Adult Board Complex Cases Group Barking and Dagenham Integrated Care Team
February 2022- safeguarding enquiry was closed as George's case has been discussed at Complex Cases Group. Refuge informed social worker that they were closing the case because there were not able to safely contact or access George, they recommended a MARAC referral due to increasing and ongoing concerns about controlling and coercive behaviour.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case
March 2022- Refuge advocacy service raised a further safeguarding referral as they had not been able to make contact with George as he has no phone and was not presenting in any community settings, the referral raised concern about risks related to the control and coercion of George by his son which was preventing him accessing healthcare that he needed- it also highlighted the risk to professionals as there had been incidents of threatening behaviour during home visits. An enquiry was initiated.	As above	London Muti-Agency Adult Safeguarding Policy and procedures (2019) Barking and Dagenham Domestic Abuse Practitioner Guidance (2022)- published post case

9. Initial appraisal of findings:

- There was an absence of professional curiosity in relation to what was happening in the house.
- There was opportunity to consider concerns far earlier which would have helped to define the presenting issues.
- Unclear risk formulation in the context of multi agency analysis
- Despite regular ways that professionals came together (Complex Cases Group and Integrated Care Group), there was an absence of a full multi-agency meeting or discussion to consider the presenting issues and risks.
- The Complex Cases Group was the default position but there was indication of a higher level of risk, this resulted in a lack of momentum about safeguarding concerns.
- Person centred care planning was not as evident as it could have been- limited evidence of the time taken to explore George's voice- he was frequently overshadowed by his son.
- The safeguarding concerns indicated further scrutiny (professional curiosity) around self-neglect and care and support needs.
- Domestic Abuse and level of risk were not always clearly understood – although recognised, the impact of coercive control and the application of a framework to address this was not evident.
- Understanding the family dynamics and the motivation behind some of the son's views and behaviours was not evident (it should be noted that much of the background family information came to light only for the purpose of this SAR and was not visible to agencies during the timeframe of this review).

10. Overarching Learning

10.1. The review has identified learning following consideration of the following areas of practice that were identified during review process, highlighted within the agency reports and discussed at panel and practitioner event.

Areas of learning:
Identification of safeguarding and legal literacy
Multi-agency approaches and professional curiosity
Understanding family dynamics and consideration of coercive control
Understanding the person

11. Analysis of findings

11.1. Identification of safeguarding and legal literacy

11.1.1. It is a helpful starting point to summarise the safeguarding concerns that agencies had about George, these included signs of self-neglect, neglect of George by his son (who was his carer) and domestic abuse, specifically coercive and controlling behaviour observed to be perpetrated by his son. Agencies did not always specifically define their concerns in those words, but they can be recognised as such.

11.1.2. The Care Act 2014 recognises self-neglect as a category of abuse and neglect. It is helpful to consider what we mean by self-neglect and how this relates to Georges circumstances. The reason why self-neglect would be an area to explore is that there were early indicators such as poor management of serious medical conditions, non-concordance with medical, repeated attendance to hospital and missed health appointments.

11.1.3. The Care Act 2014 clarified the position of self-neglect and safeguarding in its definition; *"self-neglect - this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding".* Under the Act, self-neglect now falls under the definition of causes to make safeguarding enquiries. To note, Care and Support Statutory Guidance (2016) clarified that self-neglect may not necessarily prompt an enquiry under section 42 of the Care Act (often referred to as a 'Section 42 enquiry').

11.1.4. An assessment should be made on a case-by-case basis, and a decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. However, there may come a point when they are no longer able to do this without external support. Section 42 of the Care Act states:

'Enquiry by local authority

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) – (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.'

11.1.5. The most common type of abuse identified in the National SAR analysis was self-neglect[iii].

11.1.6. Regarding the above points it is timely to consider the degree of self-neglect, neglect and domestic abuse in the context of the legal frameworks and safeguarding responses. All of these aspects and indicators were present in George's case and required a degree of unpicking, underpinned by good professional curiosity and joint approaches.

11.1.7. "*Safeguarding duties will apply where the adult has care and support needs, and they are at risk of self-neglect and they are unable to protect themselves because of their care and support needs. In most cases, the intervention should seek to minimise the risk while respecting the individual's choices.* ***it is rare that a total transformation will take place and positive change should be seen as a long-term, incremental process****."*[iv]

11.1.8. We know that George had care and support needs due to his physical illnesses and his diagnosis of dementia, without assistance he was not able to meet his own health needs and there was increasing concern about his home environment, hygiene and nutrition and overall wellbeing. A support package has been offered following a needs assessment and declined, therefore he fully relied on his son(s) to coordinate his care and support needs.

11.1.9. It should be noted that addiction can also be a significant factor when considering self-neglect and the review identifies an occasion that George was in hospital and told staff that he was

drinking two bottles of vodka per day, there was some degree of exploration with him, but this is not a theme or discussion that featured again in the agency reports or evidence. In the context of the indictors of self-neglect and the dementia diagnosis, this is an area that could have warranted further exploration, but it is difficult to ascertain the degree that this was a factor.

11.1.10. It is also difficult to ascertain to what degree the issues described in this review are "self-neglect" and to what degree the son(s) affected George's concordance with his medication and coordination of appointments and visits. For example, there are some instances where George stated that his son would not phone for an ambulance, another where he would not allow him to have a flu vaccination and others where his son insisted on a self-discharge from hospital. We also know that George could not get to appointments by himself and did not have a form of communication such as a phone. Thus, his reliance on his son was apparent, as was his isolation at times from services.

11.1.11. Another example of this point may be demonstrated in the issue of declining the carers/ care package- it is indicated in the agency records and feedback that the care package was declined by George's son, the extent to which this was explored with George and with capacity in mind is not evidenced. Likewise on the occasion when the assessment took place with the memory service, the outcome was entirely determined on a conversation with the son and did not involve George.

11.1.12. Moving on from the consideration of self-neglect, let us consider controlling and coercive behaviour. The Controlling or Coercive behaviour statutory guidance (2023) (previously 2015) [v]describes the offence as a *"pattern of repeated or continued behaviour that is controlling or coercive".* The guidance cites examples, some of which were raised at different times in George's case to include; concerns that he was being deprived of his basis needs, he was isolated from others and had limited means of communication, he was denied access to services and treatment that he needed to be well, there were witnessed occasions of "aggressive and threatening" behaviour and there was indication that his property had been damaged.

11.1.13. The controlling or coercive behaviour offence previously only captured behaviour between current intimate partners, whether or not they lived together, and ex-partners or family members who live together. This meant that abuse by an ex-partner or family member who no longer lived with the victim could not be prosecuted for controlling or coercive behaviour. It was not always clear where George's son was living, and this may have been a factor in terms of identification and response.

11.1.14. The Domestic Abuse Act 2021 amended the definition of "personally connected'' in section 76 of the 2015 Act. This removed the "living together'' requirement, which means that the offence of controlling or coercive behaviour now applies to partners, ex-partners or family members, regardless of whether the victim and perpetrator live together.[vi]

11.1.15. In terms of the right response, there were combined issues of self-neglect and domestic abuse and the multiagency approaches used in this case will be considered shortly alongside family dynamics. This will include the local processes of Complex Cases Group and Integrated Care group.

11.1.16. To support the provisions of The Care Act and The Domestic Abuse Act, Barking and Dagenham do have a multi-agency self-neglect policy and a Domestic Abuse Practitioners Guide which have been published since the time of Georges death. The application of the

legal frameworks to safeguard George are not fully evidenced in George's journey. This is likely to be due to the difficulties in accessing him at times when his son was either passively or aggressively obstructive, thus preventing services from helping or supporting him. Therefore, although services continued to have concerns, there was not a safeguarding plan in place until things escalated or when agencies made new referrals.

11.1.17. In summary so far, we know that:

- There were indicators of self-neglect, and domestic abuse (controlling and coercive behaviour)
- Self-neglect was not clearly identified or explored in George's case.
- The safeguarding investigation(s) did not gain traction in a timely way.
- Application of professional curiosity could have been improved.
- There was increasing evidence of neglect and coercive and controlling behaviours through the timeframe of the review.

11.1.18. The summary of issues has facilitated consideration of how different frameworks could be considered. We have found that there was a lack of evidence that self-neglect had been explored to a great extent however considering the findings so far, we can put this into the context of the legal powers available when there are safeguarding concerns outlined in S42 of the Care Act:

- *needs for care and support (whether or not the authority is meeting any of those needs)*
- *is experiencing, or is at risk of, abuse or neglect*
- *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

11.1.19. We know that George comes under this category by virtue of this SAR and because his health deteriorated to a large degree in the context of his care and support needs being unmet and because he was non-concordant with his required healthcare.

11.1.20. The review carefully considered the discussions of the Practitioner Learning Event with recognition that certain legal frameworks such as how The Care Act (2014), The Mental Capacity Act (2005) and the Mental Health Act (2007) and the Serious Crime Act (with reference to controlling and coercive behaviour) could be used to help people, there was a general consensus that The Care Act and the Serious Crime Act should have been better used but that the other legal powers had been applied appropriately.

11.1.21. Let us take each framework in turn and explore how George's circumstances apply to each:

- The Care Act (with the inclusion of self-neglect as a form of neglect)
- The Mental Capacity Act
- The Mental Health Act
- The Serious Crime Act

11.1.22. We have found that whilst there were several safeguarding concerns raised, they were complex and interlinked with more difficult family dynamics and a high degree of professional curiosity was needed to understand the full picture. The review notes many areas of positive practice in this case, a persistence of services in visiting, making new appointments, trying to contact George and coordinating medication, prescriptions and referrals. A high degree of

communication was also evident between services who were clearly worried and conscientious in their efforts. This is positive practice.

11.1.23. Professional curiosity is a recurring theme in SARs, Local Child Safeguarding Practice Reviews (LCSPRs - children) and Domestic Homicide Reviews (DHRs) nationally. Broadly it describes the capacity and communication skills to explore and understand what is happening with an individual or family.

11.1.24. Enhancing professional curiosity in practice encourages practitioners to challenge the assumption that people "choose" or "like" an abusive or self-neglecting lifestyle; and outlines alternative ways of thinking about these people and the reasons for the challenges they face.

11.1.25. Noted above is the point that there was not an absence of recognition of the issues, but the collective response and further exploration of the full circumstances could have been strengthened. This would have allowed the risks to be jointly considered and an approach agreed, and this will be considered in due course.

11.1.26. Let us now consider the Mental Capacity Act (2005). It is designed to protect and restore power to vulnerable people who lack capacity. The MCA states:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise.
- wherever possible, help people to make their own decisions.
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision.
- if you make a decision for someone who does not have capacity, it must be in their best interests.
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

11.1.27. The Mental Capacity Act also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

11.1.28. There is often a perception that a person cannot be vulnerable or self-neglect if they have capacity, for example they can choose their lifestyle and thus make a conscious choice to self- neglect. Under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making 'free' choices that lead to self-neglect, it is still self-neglect and action is required.

11.1.29. This means that assessing that someone has capacity does not automatically mean there is no longer a case for taking action to safeguard them, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what can be done to support them in caring for themselves. This is the relationship and application of the legal tools and provisions of the Mental Capacity Act and the Care Act.

11.1.30. The first principle of the MCA is to assume the adult has capacity unless proven otherwise. The correct application of the presumption of capacity in s.1(2) MCA[vii] is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm. In George's case we can see

that his capacity was formally assessed twice when he was unwell in hospital, and he was thought to lack capacity in relation to decisions about his health at those points of time. Mental capacity was also formally assessed by an IMCA during a joint home visit with the social worker and GP and on this occasion, he was assessed to have capacity in relation to choosing to have vaccinations.

11.1.31. It is also helpful to consider fluctuating capacity. This is when a person's ability to make a specific decision change frequently or occasionally. Such changes could be brought on by the impact of a mental illness, physical illness, the use or withdrawal of medication, the use of illicit substances or alcohol. Some people with dementia have moments in the day when they are more lucid and able to make certain decisions and, other times when they are unable to make particular decisions for themselves. To avoid hindsight bias we can only consider the assessments that were carried out and the evidence that we have, however being mindful of fluctuating capacity is a relevant point to make. To note, capacity was regularly considered and there is evidence of assessment throughout the timeframe.

11.1.32. With reference to principle 3 of the MCA, the Code of Practice[viii] highlights *"the difference between unwise decisions, which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up information about a decision, particularly if someone makes decisions that put them at risk or result in harm to them or someone else".*

11.1.33. The current Mental Capacity Act Code of Practice highlights that it is important not to judge mental capacity based solely on behaviour, appearance or "*assumptions about [someone's] condition"* (Department for Constitutional Affairs, 2007)[ix]. However, neither should it be assumed that they have capacity because of "*good social or language skills, polite behaviour or good manners*".

11.1.34. It is also important to explore both decisional and executive capacity in the context of George's case. This is a particularly relevant and helpful consideration when applying self-neglect processes, thus a person would be assessed to articulate their decision and demonstrate how they would carry it out. In this case there were occasions when George's son made decisions on his behalf and therefore it is very difficult to ascertain whether there was an unwise decision; for example, choosing not to take prescribed medications or choosing to decline a care package that meets ones assessed needs. The evidence was often weighted toward decisions being made for him and accepted without George being involved. The extent to which executive capacity was explored was less evident for that reason.

11.1.35. It is timely to mention Lasting Power of Attorney (LPA) for health matters. Identified above are examples of when George's son made decisions on his behalf, and agencies accepted those decisions without consultation. **The MCA 2005** provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions on their behalf, in which situations, and how they should do so. Through the LPA, the Act enables people to plan ahead for a time when they may lose capacity. There is no evidence to suggest that anyone held LPA for health matters, not that it was explored, but that decisions were made by George's son in the absence of it and without evidence to suggest that George lacked capacity.

11.1.36. The review finds that the MCA was utilised by professionals on occasions that it was indicated. Had George been more visible there may have been different evidence regarding fluctuating capacity, although the Community Cardiac Team who had the most prolonged

regular access to George did not think that George lacked capacity to make decisions about his health. Instead that his access was hindered by the behaviour and views of his son.

11.1.37. Moving on to the Mental Health Act, the review finds that it is unlikely that the Mental Health Act could or should have been applied as a legal framework to address the safeguarding issues that George faced. Panel members were in agreement on this matter.

11.1.38. Identified above are indicators relating to identification of self-neglect, application of The Care Act and the Mental Capacity Act. Running through all these issues was the theme of controlling and coercive behaviour and therefore consideration of how the legal powers were understood and applied is very relevant.

11.1.39. It is noted that the Domestic Abuse Act (2021) came into effect in the midst of the timeframe of this review and therefore the role and relationships with the son may not have been recognised in line with the changes in the Act definition (highlighted earlier). In terms of the domestic abuse concern in general, it is more likely than not, that controlling and coercive behaviours whilst recognised, were not explored in the fullest sense and therefore there was not enough regard given to Section 76 of the Serious Crime Act (2015) in terms of safeguarding and policing approaches on the occasions when agencies raised concerns.

11.1.40. We know there was recognition of domestic abuse because it is evidenced in the chronology, referrals and responses. We can see that a referral was made to Refuge for advocacy support however they were unable to access George safely due to the absence of a method of communication (telephone) and because his son was often present. We can also see from appendix A that there was a lack of Police involvement and this is likely because formal domestic abuse pathways had not been followed to the their fullest. Additionally, there had also been several incidents at the house when professionals had felt threatened. Prior to closing George's case, Refuge made a safeguarding referral due to their concern about all these factors. They suggested that a referral for Multi Agency Risk Assessment Conference (MARAC) may be a sensible option.

11.1.41. The various statutory frameworks have been considered when analysing the approaches that were followed to safeguard George. The review finds that The Care Act and Serious Crime Act provisions could have been utilised more effectively.

Key Finding 1: Due to the complex and interlinked issues of self-neglect indicators, neglect and domestic abuse there was some delay in applying the provisions of The Care Act despite repeated safeguarding reports and concerns. Safeguarding approaches could have been applied more coherently at an earlier stage.

Key finding 2: The review finds that the domestic abuse that George experienced was not addressed in a robust way, and as indicators became more evident, the risk response should have been differently applied. The inability for DA advocacy support to access George should have served as an escalating factor and MARAC could have been considered.

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11.2. Multi-agency approaches and professional curiosity.

11.2.1. We have considered the extent to which the safeguarding issues include self-neglect, neglect and domestic abuse were approached using the legal frameworks available. In summary that the Care Act was utilised on several occasions after professionals raised concerns and these

occasions resulted in referral to the Complex Cases Group and Refuge but did not gain enough momentum in terms of risk formulation and a coherent safeguarding plan. Another finding was that there was insufficient application of Domestic Abuse processes, and professional curiosity could have been better applied. The next step is to consider how agencies worked collectively.

11.2.2. There was definitely not an absence of action in this case, people recognised there was an issue and attempted to share information, raise safeguarding concerns and work together. The safeguarding concerns and the inconsistent ways in which George was accessing services resulted in two particular courses of action that ran along simultaneously to try and address the complex features.

i. Referral to the Complex Cases Group (as an action from safeguarding referrals and initial enquiries)
ii. Monthly case consideration at the Integrated Case Management meeting

11.2.3. Additionally, George had been referred to Refuge who were not able to safely contact or engage with George, therefore there was no direct contact with him but multiple communications between Refuge and Adult Social Care to discuss risks relating to controlling and coercive behaviour.

11.2.4. The Barking and Dagenham Safeguarding Adults Complex Cases Group (SACCG) is sub-committee of the Safeguarding Adults Board (SAB). It is a meeting where information is shared on cases presenting with the highest risk and or complexity. According to the SAB webpage, the group is made up of representatives of the Local Authority, the Police, mental health services, housing services, safeguarding officers, officers from the fire service, and other professionals as and when required.

11.2.5. The SACCG considers new cases to support the identification of high risks that is or needs to be shared across agencies, cases are also brought to monitor and review those risks. Every case represents a safeguarding concern for an adult that requires multi agency communication and approaches to addressing risk/s adequately.

11.2.6. Therefore, it was a sensible plan for George's case to be explored within this remit however this was towards the latter stage of the timeframe and may have been more effectively used at an earlier stage. Additionally, the first meeting, which took place shortly prior to George's death had a limited attendance with no health professionals present.

11.2.7. For the four months prior to George's death and running alongside the safeguarding activity and Complex Cases Group, George's case was also being discussed on a monthly basis at the Integrated Care Team meeting.

11.2.8. The integrated care team consists of Community Matrons and is part of the community Health and Social Care Services service which is provided by NELFT. The team "*ensures that patients over the age of 18 with complex health and social care needs receive the right care, in the right place and at the right time. The team works with health and social care providers to co-ordinate and offer multi-disciplinary quality care to vulnerable adults*".

11.2.9. Again, this was also a sensible approach, however there were different conversations taking place between different professionals/agencies in different muti agency remits. This resulted in a plethora of phone calls to ascertain who was doing what and there was not a clear or joined up safeguarding plan for George.

11.2.10. Additionally noted is that the prevalent and pervasive issue of domestic abuse which we know was recognised but was not fully understood or risk assessed. This was an issue that Refuge expressed concern about on several occasions about and as a result they advised Adult Social Care to consider a risk assessment and MARAC referral. They followed this up with a safeguarding referral at the point they were closing George's case due to the level of concern they had.

11.2.11. The London Borough of Barking and Dagenham define MARAC as *"a multi-agency meeting to discuss the highest risk cases of domestic abuse".* The local procedures include a MARAC risk indicator and referral form. The degree to which George's health needs were being neglected, and the behaviour that has been observed by professionals together with the lack of access to services indicated that this was an approach that could have been explored.

11.2.12. In summary, in the first half of the timeframe we can see indicators of self-neglect that would have benefited from the "Complex Cases" approach which was facilitated at a later stage. During the second half of the timeframe, we have evidence of coercive and controlling behaviour and significant concerns expressed by different professionals. At the point that Refuge Advocacy services could not access George the risk was increasing and a referral to MARAC would have been an appropriate course of action.

11.2.13. In terms of safeguarding action and multi-agency working, it is demonstrated that the safeguarding actions taken did not improve or change the situation experienced by George and it is certainly indicated that an earlier response and additional professional curiosity may have yielded a richer insight into Georges experiences.

11.2.14. The review notes that there are existing pathways for multiagency consideration, and both of these were used in George's case. The Complex Cases Group and the Integrated Care Team have different remits in their own right but they didn't complement each other in this case, it is not clear even with the benefit of hindsight what either group was seeking to achieve or how they worked together. The review suggests that in a case such as George's the Complex Cases Group would have been the better option at a far earlier stage albeit with a full multiagency contingent of professionals.

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11.2.15. In terms of practical application, it was apparent at the Practice Learning Event that there was a lack of awareness and some confusion about what pathways and processes are available and when they should be used. This is not a criticism of the services, simply an observation that if the frontline workforce do not know or understand them, then they cannot be used collectively to their full effect.

11.2.16. Identified already is that safeguarding concerns emerged during several hospital stays early in the time frame. Therefore, the earlier concerns have been formally framed under the Complex Cases Group and may have resulted in formal safeguarding activity. This would have provided a clear framework for measuring and monitoring risks over time.[x]

11.2.17. Utilising a safeguarding process also provides a formal framework for addressing carers issues in this complex case. 'Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include – a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others. Safeguarding responses to people living with dementia must be person-centred, informed by the Care Act 2014, the Mental Capacity Act 2005 and Human Rights principles.[xi]

11.2.18. Multi-agency safeguarding discussion and working, and joint risk formulation was absent in this case until later when the situation became one of crisis intervention. It is understandable to some degree that services were trying to work flexibly to engage with George and address his needs. Additionally, there was a degree of optimism in the earlier stages that the son was supporting his father and facilitating all of the care that George needed.

11.2.19. This brings us back to the issue of professional curiosity. The national analysis of SARs (April 2017 – March 2019) highlights the need for practitioners to 'exercise sufficient professional curiosity' and 'authoritative doubt'.

11.2.20. Professional curiosity could be described as a combination of looking, listening, asking, direct questions, checking out and reflecting on information received. It means not taking a single source of information and accepting it at face value. It involves testing your assumptions and triangulating information from different sources. In George's case we can see some positive examples of this such as where the Community Cardiac Service persisted in ensuring that he was receiving visits, being seen and spoken to, receiving his medications and this was all checked and discussed with other parts of the multi-disciplinary team. However, it was the collective coming together to explore agencies understanding of what was happening for George and to establish a shared understanding of risk that is not as evident as it could be.

11.2.21. In summary, whilst there are a range of legal powers available for practitioners to safeguard in situations such as George's, the justification of intervention was hampered in this case by the absence of a properly constructed multi-agency risk management strategy detailing what the perceived risks were, the likelihood of risk or neglect occurring, and the potential outcomes of both intervening and not intervening.

Key finding 3: multi-agency best practice to establish risk means working collaboratively with other agencies around the adult to gain a full picture, assess risk and plan any strategy to address it. Defensible decisions should be clearly recorded, and is especially important where situations are complex, high risk or controversial. Decisions should make reference to relevant legislation and be regularly reviewed.[xii] Although multiagency pathways were applied in this case they did not work effectively and require alignment in cases such as George's.

Key finding 4: professional curiosity is a core responsibility of all practitioners. Being more curious as professionals and 'digging deeper' into areas where there is little, or no information will help to inform assessments and empower professionals to influence key moments of decision making to reduce risks. Escalating concerns that could cause drift, delay and a shift in focus from the adults' best interests should be embraced and seen as effective care and support.

11.3. Understanding family dynamics and consideration of coercive and controlling behaviour

11.3.1. During the course of the review, it was apparent that there were some complex factors in terms of family functioning and history. There was an absence of knowledge of the living arrangements, with different accounts and understanding of whether George lived alone or if one or both of his sons were residing with him.

11.3.2. It was recorded in the NELFT records that there was a history of domestic abuse within the "family" unit and that George had moved to his own flat as long ago (at least) as 2016. The reason for this was because his youngest son, who was a child at the time was open to

statutory services. NELFT contacted Children's Services on one occasion to advise them that the youngest son was thought to be living with him.

11.3.3. Children's Services confirm that they were involved at different threshold levels from early help, child in need and child protection at different times. This involvement yields information about a complex set of family relationships, neglect concerns and parental alcohol use. George and his youngest son remained in close contact throughout this time, and his son mostly resided with him, and it is documented that this is what they both wanted.

11.3.4. It is outside of the scope of this review to explore the significant involvement of children's services however their information is helpful in considering the trajectory and impact on George. For example, we know that the family functioning was at times chaotic, there was alcohol abuse, domestic abuse and neglect present, and to alleviate some of the volatility in the family home, George moved to his own flat. Subsequently the decision was made that the most protective place for the youngest son to live was with George. However, this breached his tenancy agreement thus leading to a prolonged dispute between housing, George and children's services that took a long period of time to resolve. The reason that is relevant to this review is that George had actually been diagnosed with dementia at this time and the worry of the housing issue and the responsibility of caring for his son placed him under considerable pressure.

11.3.5. To note, aside from the information that NELFT record about a history of domestic abuse, there was little evidence or insight into the family background and therefore it is only for the purpose of this SAR that Childrens Services involvement prior to the timeframe of this review has been fully explored. Therefore, practitioners working with George within this timeframe did not have the benefit of this information. The review notes that the extent to which this information may or may not have added value, or changed how people worked with George cannot be defined without hindsight bias. However, it undoubtably does increase awareness of some of the complexities within the family, as a difficult and prolonged period of time where George may have struggled to cope with the set of circumstances that the family faced. This may have exacerbated his conditions and contributed to an overall wariness of agencies.

11.3.6. Between 2014 and early 2020 there is evidence of liaison between adult social care and children's social care on several occasions including discussions about the housing issues, clarification of Georges care package, referrals to adult social care due to concerns about poor health, and domestic abuse issues. Also to note, the older son was a constant presence during this timeframe and can be seen on many occasions trying to help, support and improve the whole situation.

11.3.7. To reiterate, it is outside the scope and timeframe of this review, but we can see evidence of a volatile family situation with two interdependent people; the younger son and George, each having an impact on each other. There were points of time where this was recognised and there are areas of good practice such as a young carers service for the son, referrals to adult social care and joint discussions about housing. However, the review finds generally, that adult services and children's services ran parallel to each other and with this particular set of circumstances, could have forged better interconnectivity to improve outcomes for both George and his son.

11.3.8. Georges older son was most visible and vocal throughout the timeframe of the review, but his youngest son was also often at the home or present at hospital too. It was evident that practitioners from different agencies had different perceptions about the relationship between George and his older son with him being seen initially as a supportive in terms of helping

George access the right medical care and treatment. However, as time went on there were several instances, incidents and reports that the relationship was difficult and there were clear indicators of coercive and controlling behaviour.

11.3.9. It should be acknowledged that the relationship between a carer and cared for person can often be difficult. Practitioners need to have a robust knowledge of safeguarding and domestic abuse and employ professional curiosity. Determining whether harm is intentional or non-intentional, needs to be understood from the perspective of its impact upon the individual who is cared-for and the potential for coercive control always needs to be considered. Practitioners need to consider safeguarding referrals in all cases of harm, irrespective of whether they consider it to be intentional or unintentional harm.

11.3.10. The reviewer is careful to avoid conjecture in the absence of family discussions. The family declined to be involved in this review processes and therefore one can only draw on the information provided through agency recorded and reflection. It is also important to avoid assumptions and work on the facts available. We are aware that George's sons experienced a difficult environment whilst growing up and this may have had a detrimental impact on the relationship their father.

11.3.11. There are many reasons for abusive relationships including family history, the prospect of financial gain and carers feeling overwhelmed and stressed by their responsibilities. Family relationships are often complex and can be complicated further by age, illness, disability and dependency. Many people experiencing abuse may choose not to challenge it, as they do not want to damage their relationship with the person they love and often most depend on. In some cases, the person carrying out the abuse may have their own problems, such as drug dependency or mental health problems. We can not validate any of this in terms of George's son(s) but we can reasonably conclude that the background and involvement of children's social care and other services may have been a factor alongside other unknown issues.

11.3.12. The issue of professional curiosity has been considered throughout the review thus far and continues to be a factor in terms of what remained unknown about family dynamics and relationships.

11.3.13. It is helpful to draw attention to a case study two in a Local Government Association (LGA) briefing on safeguarding and carers.[xiii] This is based on SAR learning completed by the Birmingham Safeguarding Adults Board, focusing on 'domestic abuse' between an older adult cared for at home by her son. They had been described as always having 'a tempestuous relationship but nevertheless as being very fond of each other'. At the learning event, professionals acknowledged the challenges of 'role reversal', which bring along increased guilt and shame on both sides, and the fear of reaching out for help.

11.3.14. In George's case there was a reluctance and perhaps a suspicion of professionals coming into the home to support him, despite an unfolding picture of George and his son increasingly struggling to meet required healthcare needs. Again, we can only base hypothesis on what we know, and we have not been able to explore further with the family, but the point above does resonate with what we know of the family history.

11.3.15. Referenced within the Childrens Services records is the involvement of a "young carers" service for the younger son, this was at a very early age (several years prior to the timeframe of this review) and because there was an emotional impact of living with, and helping to care for George who even at that time has significant health issues. This is noted as good practice.

11.3.16. Carers assessment and support was recorded to have been discussed with the older son within the timeframe of the review, but it is unclear the extent to which he recognised himself as a carer or realised the impact, particularly in the context of a difficult relationship and background. We do not know whether the older son had his own health or relationship difficulties and we also do not know the extent to which he was taking responsibility for supporting his younger brother who was transitioning from childhood to adulthood at the time of this review.

11.3.17. Another consideration is that risk of harm to the supported person may arise because of carer stress. '*Sometimes, professionals may place undue confidence in the capacity of families to care effectively and safely. This is coming to be known as 'the rule of optimism'*.[xiv]

11.3.18. Making safeguarding personal and professional curiosity should be central to practice to support safeguarding both carers and the person they care for. Timely and careful assessments should be provided for both the carer and the person they are caring for, including understanding the competing needs of each and having separate focus on each.[xv] When risk increases in relation to carers unintentionally or intentionally harming or neglecting the adult they support, often the carers are themselves vulnerable; not receiving practical or emotional support from other family members; feeling emotionally and socially isolated, or exploited by relatives or services; and have no personal or private space, or life outside the caring environment.[xvi]

11.3.19. Professionals observed occasions when George's son would present as angry and this was often in relation to specific issues such as vaccinations, new services and when George was in hospital. The GP initially raised concern about the son's behaviour, and it has been seen that his behaviour had caused concern previously. The GP raised concern not only due to George but also to protect and ensure the safety of the professionals visiting the home and was very vigilant in ensuring that this risk was shared with all relevant professionals. The review observes that social and health care professionals demonstrated resilience and persistence in managing what was an increasingly difficult situation.

11.3.20. It is interesting that the son generally declined or was resistant to any offer of support, care packages or help around medication despite the evidence that shows that the son was finding it difficult to support his father in following the required care management plan. Additionally on some occasions he was resistant to some elements of care. It may have been helpful to try and explore this and applying professional curiosity in this way may have provided opportunities for early conversations.

11.3.21. Additionally, the extent to which George and his son understood the cardiac issues and consequences of not following required care is not clear. It is evidenced that the community cardiac service spent time reinforcing the key messages, but the non- concordance continued. It is possible that the son was frightened, didn't understand or was purposely withholding and blocking access to care.

11.3.22. We can certainly see that there was a complex situation of family and inter-generational abuse, and this manifested itself in a pattern of what was perceived to be 'controlling behaviour' and at times coercive in view of what was observed by professionals. The review has already found that there could and should have been better application of joint risk formulation and domestic abuse pathways to understand and address these issues.

11.3.23. It appeared through the review that the son had very particular views about certain health related issues for example, he did not want him to be in hospital and he did not want George to be in receipt of a care package, he was obstructive in obtaining and supporting with medication and he was aggressive in his views about vaccinations. All this puts together a picture of a controlling and coercive situation, but it also raises an issue about how much was explored with George or his son. Why did his son have fixed views for example about vaccinations? Despite the concerns about control and coercion, there were not often questions raised about the decisions he made on behalf of his father and the rationale behind those decisions.

11.3.24. It is not possible to conclude on the reasons for the reluctance to work with professionals, nor whether this view was shared by George himself. This may because of a history of contact with services and bad experience leading to a general mistrust of agency involvement. The Childrens Services information demonstrates a significant degree of intervention and hostility with some services at different times.

11.3.25. It is noteworthy that there is a pattern of aggressive or threatening behaviour becoming apparent at time when vaccinations were mentioned or offered. In fact, the occasions when professionals visited the home or raised the offer of vaccinations demonstrated a particularly aggressive reaction with accusations that health professionals were trying to “murder” George.

11.3.26. The reviewer cannot find evidence that this was addressed in terms of trying to understand or explore the reasons and it should be noted that on these occasions, professionals were fearful and feeling personally threatened. A hypothesis may be that the son had some genuine fear and anxieties about vaccinations, and this created a deep-rooted anxiety about the effect on his father. This is a view that has increasingly been seen since the COVID-19 time period.

11.3.27. An article in the Lancet which was written during the timeframe of this SAR identifies a significant movement as the COVID vaccination was in its initial implementation phase. A survey commissioned by the Centre for Countering Digital Hare (CCDH) and released alongside their report found that around one in six British people were unlikely to agree to being vaccinated against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and a similar proportion had yet to make up their mind. The survey, which polled 1663 people, found that individuals who relied on social media for information on the pandemic were more hesitant about the potential vaccine. WHO has warned of an infodemic of false information about COVID-19 spreading online.[xvii]

11.3.28. It is also noted by The Lancet that although anti-vaccine activism was already increasing in the USA and internationally, the 2020 emergence of COVID-19 served as an accelerant, helping turn a niche movement into a more powerful force. Whereas earlier anti-vaccine activism focused primarily on parents and school immunisation requirements, the universal nature of the COVID-19 pandemic provided anti-vaccine activists with concerned audiences that were far larger and broader.

11.3.29. They go on to say that this started to manifest itself as threatening behaviour towards health care staff and public health professionals Reflecting broader, growing trends in anti-intellectual or anti-science populist discourse (especially in right-wing media outlets), clinicians and other health professionals who were publicly involved in pro-vaccine policy or commentary in advance of the pandemic were subject to harassment, physical threats, and violence by anti-vaccine activists.[xviii] They make interesting recommendations for a global action and approaches to combat the dynamics and response to this movement.

11.3.30. This is well outside the scope of this review, but the point is that there may have been a reason why the son felt so vehemently that he did not wish for his father to participate in the vaccination programme as this seemed to be the trigger for incidents of outwardly threatening behaviours. It may have been helpful to try and understand the reasoning and rationale for this. Also, to note- it is clearly documented on several occasions that George expressed a wish to be vaccinated and thus it was his decision to make.

11.3.31. It is important to note that there has not been the opportunity to explore this perspective with the family, however considering the evidence that was presented, these are the issues that may have warranted further exploration as part of the safeguarding response.

Key finding 5: This case highlights a complex situation over a period of years with statutory children's social care involvement running parallel to various adult services, and a high level of vulnerability and risk for both the young person and the adult. Better connectivity and correlation may have yielded a more robust package of care and support for George, and improved outcomes for George and his younger son.

Key finding 6: Professionals need to have confident and courageous conversations about the potential of abuse within a domestic setting, in relation to safeguarding concerns between the cared for person and the carer, and between generations within a family unit.

Key finding 7: Social and health care professionals should access learning and pro-actively explore methods of working with families in situations such as George's. This may include the potential of Family Group Conference (FGC) and mediation in safeguarding work with families. FGC can be used in situations where people are living with early stages of dementia, to make decisions about their future care and support needs. It can be used with older people to plan care and support if they wish to stay in their own home, and with carers, to plan support for themselves and the person they care. This may assist with the wider lens on a family, professional curiosity and there may be benefits from mediation and FGCs even where abuse has occurred, especially if intervention takes place earlier in the safeguarding process.[xix]

11.4. Understanding the person

11.4.1. It is difficult to capture a sense of George's voice from the agencies who had contact with him, however services should be commended in their persistence in trying to gain access to George to support him with the care and treatment he needed. However, for all the reasons we have explored, his voice was often non-existent or overshadowed due to the behaviours of his son.

11.4.2. In order to understand his daily experiences and get a sense of his perspective, the review has drawn on exploration of practitioner views and some of the significant factors that may have strongly contributed to vulnerability.

11.4.3. In terms of safeguarding, the focus on Making Safeguarding Personal was distracted by the complexities of this case. One practitioner reflected that they were focused on trying to get all the right things in place and perhaps George got lost in that.

11.4.4. International research shows that older adults living with dementia are at greater risk of abuse and neglect than those without a diagnosis.[xx] UK studies found that 51% of carers reported 'chronic verbal aggression'[xxi] 52% of family carers reported having engaged in some form of

abusive behaviour, the most common form being psychological abuse (33% shouting at or insulting the person) and physical abuse being much less common (4%).[xxii]

11.4.5. During an admission to hospital in February 2022 he was seen by the dementia team and a "**this is me"** proforma was completed as part of the assessment. This noted some particular views that George held to include; "*George liked to have nice pillows and blankets, loved spending time with his sons and stated they did a great job at looking after him. George enjoyed cups of tea, watching television and reading. George liked to pray to himself and had spent a lot of time travelling over the years".*

11.4.6. This provides some insight into George's personality and a sense that his sons were a very important part of his life and he valued their presence in his life. We also know that George was mobile and went out frequently without assistance. We do not have any direct reflections of his daily experiences, but we know he was described on occasion as looking "bewildered" and confused although this was during times where his son was most resistant to the input of professionals.

11.4.7. It can be seen that in general there was an overreliance on information from his son without the views or context from George, for example, the NELFT Barking and Dagenham Memory Service contacted the service user's son to carry out an assessment. This was carried on over the telephone due to the restrictions in place for COVID-19. The son advised the Doctor that his father did not need the service and George was discharged without being seen or spoken to. We are unable to ascertain what George's understanding or views were relating to this decision, or if he was even aware of it in the first instance.

11.4.8. This was a pattern seen increasingly where there was sporadic engagement and confusion over concordance with medication and it served to increase concerns that there was controlling and coercive behaviour due to a perceived level of disguised compliance by the service user's son. This is described by Reder (1993) as a process that involves carers appearing to cooperate with professionals to allay concerns and stop professional engagement. Often carers will partially engage to persuade professionals, for example, regularly missing appointments but promising to reschedule. In this case, the investigation has concluded that there was likely to be an element of disguised compliance, evidenced by the service user's son's limited engagement with the CCS and community matron team and the reports that he was compliant with his medication when in fact the evidence suggested otherwise.

11.4.9. The review identifies areas where professional curiosity could have been better applied and there was evidence of over-optimism by practitioners, specifically surrounding the circumstances that caused the damaged door in the service user's home and relating to the management of the service user's medication, by his son. Another example is also the issue of alcohol which was raised during one hospital admission. There was no further exploration of this, but one can see a significant history of alcohol use which was a factor in the prolonged involvement of children's social care in respect of his son. There was a lack of questioning and challenge, which may have identified a greater understanding of the circumstances surrounding the environment that the service user was living in, and the care being provided by his sons.

11.4.10. Practitioners need to consider how abuse and coercive control may be impacting upon a person's ability to make decisions and judgements freely, unfettered by fear, coercion, manipulation and undue influence. A judgement that a victim is free to make 'unwise

decisions' should not be made until coercive control has been considered. In this case, although it was recognised it was not fully explored.

11.4.11. Individuals experiencing domestic abuse may be isolated from other friends or family and it is important to look beyond the abuser for import social networks. Unfortunately, we do not have any more insight into George's wider network if indeed he had one.

11.4.12. To summarise in terms of the application of the Six Principles of Adult Safeguarding: empowerment, prevention, proportionality, protection, partnership and accountability. There is evidence that professionals were cognisant of these principles in terms of their persistence, the multi-agency meetings, the recognition of concerns and the safeguarding referrals that were made. What proved difficult in this case was applying those principles to a situation, where George was inaccessible, uncontactable and with some possible fluctuation in his mental capacity. Community professionals found difficult to circumvent the son who was often dominant, aggressive and obstructive thus serving as a barrier to the wider partnership understanding and response.

11.4.13. In their efforts to try and gain access to George and to ensure he was receiving all the treatment, care and medication he needed, the case did not follow a smooth safeguarding process and there was a rather "stop-start" approach with escalations being made very close to the time of his death when action could have been coordinated at an earlier stage. The result was that there was not one forum where ALL the information was considered, a muti agency risk assessment done, and a safeguarding plan produced in accordance with The Care Act and the Serious Crime Act (in response to the controlling and coercive behaviour).

Key Finding 8: The safeguarding process has been developed to ensure that the principles of making safeguarding personal are central. It is important to be clear regarding the status of a safeguarding investigation, application of alternative models such as the Complex Cases Group and a shared understanding of risk aware responses.

12. Summary of key findings

Key Finding:	Key points:
Legal Literacy	**Key Finding 1**: Due to the complex and interlinked issues of self-neglect indicators, neglect and domestic abuse there was some delay in applying the provisions of The Care Act despite repeated safeguarding reports and concerns. Safeguarding approaches could have been applied more coherently at an earlier stage.
Multi-agency coordination	**Key finding 3:** multi-agency best practice to establish risk means working collaboratively with other agencies around the adult to gain a full picture, assess risk and plan any strategy to address it. Defensible decisions should be clearly recorded, and is especially important where situations are complex, high risk or controversial. Decisions should make reference to relevant legislation and be regularly reviewed.[xxiii]. Although multiagency pathways were applied in this case they did not work effectively and require alignment in cases such as George's. **There will be a recommendation relating to this**.

	Key finding 5: This review notes that multi-agency working can also refer to intergenerational presentations where there is a need for children's social care and adult related services to work closely together to ensure the right level of care and support for all involved. **There will be a recommendation relating this this.**
Professional Curiosity	**Key finding 4:** professional curiosity is a core responsibility of all practitioners. Being more curious as professionals and 'digging deeper' into areas where there is little, or no information will help to inform assessments and empower professionals to influence key moments of decision making to reduce risks. Escalating concerns that could cause drift, delay and a shift in focus from the adults' best interests should be embraced and seen as effective care and support. Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of a person's situation[xxiv]. There was an absence of professional curiosity insomuch as the known concerns and indicators of risk were not coherently recognised and explored. In particular "controlling and coercive behaviour" was not fully considered in any multi-agency arena during the timeframe of the review. This demonstrated insufficient legal literacy meaning that practitioners may not always be prompted to or know how to apply legal powers to safeguard people. **There will be a recommendation relating to this**.
Domestic abuse	**Key finding 2**: The review finds that the domestic abuse that George experienced was not addressed in a robust way, and as indicators became more evident, the risk response should have been differently applied. The inability for DA advocacy support to access George should have served as an escalating factor and MARAC could have been considered. **There will be a recommendation relating to this.** **Key finding 6:** Professionals need to have confident and courageous conversations about the potential of abuse within a domestic setting, in relation to safeguarding concerns between the cared for person and the carer, and between generations within a family unit.
Family dynamics	**Key finding 7:** Social and health care professionals should access learning and pro-actively explore methods of working with families in situations such as George's. This may include the potential of Family Group Conference (FGC) and mediation in safeguarding work with families. FGC can be used in situations where people are living with early stages of dementia, to make decisions about their future care and support needs. It can be used with older people to plan care and support if they wish to stay in their own home, and with carers, to plan support for themselves and the person they care. This may assist with the wider lens on a family, professional curiosity and there may be benefits from mediation and FGCs even where abuse has occurred,

	especially if intervention takes place earlier in the safeguarding process.[xxv] **There will be a recommendation relating to this.**
Making Safeguarding personal	**Key Finding 8:** The safeguarding process has been developed to ensure that the principles of making safeguarding personal are central. It is important to be clear regarding the status of a safeguarding investigation, application of alternative models such as the Complex Cases Group and a shared understanding of risk aware responses.

13. Improvements made

13.1.1. The panel discussions and Practice Learning Event demonstrated areas of improvement where learning has already been taken forward and implemented. These developments are all relevant and ongoing assurance of effectiveness should be sought on a continual basic. In particular:

- Implementation of BD Self Neglect Policy (2023)
- Implementation of BD Domestic Abuse "We Believe You" Practitioner guidance (2023)

14. Conclusion

14.1. This SAR Overview Report is the Barking and Dagenham Safeguarding Adults Board's response to the death of George, to share learning that will improve the way agencies work individually and together.

14.2. George was a 78-year-old man with a serious cardiac condition, dementia and deteriorating physical health. Health professionals correctly ascertained that there was a barrier to him receiving the care and support that he needed, and this indicated some complex safeguarding features including self-neglect, neglect and controlling and coercive behaviours perpetrated by his son.

14.3. It is not possible without hindsight bias to comment on whether there could have been a different outcome for George, however it is likely that he would have experienced an improved quality of life if his overall care and support has been improved, and the safeguarding concerns responded to in a connected and multi-agency way.

14.4. There was not an absence of local multi agency frameworks, but they were not utilised to best effect in a timely way, and there were issues that were not explored as well as they could be in order to understand the family dynamics and functioning, and to put into place an effective safeguarding plan.

14.5. Good safeguarding practice must incorporate Making Safeguarding Personal as well as professional curiosity, to ensure that there is confidence to have challenging conversations with individuals and their family whilst focusing on wider wellbeing. Good safeguarding practice also requires applied knowledge of the interface between legislative frameworks covering mental capacity, mental health, safeguarding, human rights and serious crimes.

14.6. To learn the lessons from this SAR and many other similar SARs, all agencies must have a commitment to improving practice through regular communication, case discussion and reflection, shared risk assessment and risk management and shared decision making.

15. Recommendations

15.1. It is noted that progress has been made against the areas of findings. However, the recommendations made in this review should be applied as learning for the system where deeper and continual assurance is required and an action plan developed against them.

15.2. Arising from the analysis in this review the following recommendations are made to the Safeguarding Adult Board:

Recommendations:	
1. Multi-agency working	The Safeguarding Adult Board are asked to review the approaches and guidance currently available relating to multi-agency working within the workforce. The SAB is asked to develop an overarching "Complex Safeguarding Strategy" which will define a multi-agency pathway approach and take into account other multiagency pathways in the wider system. The SAB should seek assurance on: - Effectiveness of the strategy - Alignment of pathways, groups, procedures and protocols - Evidence of impact across the partnership - Oversight in managerial and professional supervision Additionally; The Safeguarding Adult Board are asked to consider together with the Safeguarding Children Partnership the interconnectedness of processes when there are complex safeguarding factors that impact on both safeguarding adult issues and safeguarding children issues.
2. Domestic Abuse	The Safeguarding Adult Board are asked to seek assurance from commissioners, providers and partner agencies on arrangements for ensuring that staff have the necessary knowledge, experience, and skills to recognise and act upon Domestic Abuse With reference to the specific findings of this review this should include: - Relevant training for all frontline staff on coercive and controlling behaviour. - Relevant training on trans-generational abuse - Relevant training and awareness raising on the use of the newly embedded Domestic Abuse Guidance for practitioners. - Ongoing assurance should be sought to ensure that good quality training happens regularly and is included in the professional development programmes of all relevant agencies.
3. Family dynamics	The SAB is asked to consider its approaches to working with families in situations such as George's. This may include the Family Group Conference (FGC) and mediation in safeguarding work with families.

4. Making Safeguarding Personal and application of professional curiosity	The Safeguarding Adult Board are asked to seek reassurance that Making Safeguarding Personal is accurately understood, and that understanding is embedded in practice across partner agencies. Additionally, the Board should continue to promote professional curiosity in practice and: - Consider its effectiveness measures to continually seek assurance that professionals are routinely applying professional curiosity in their practice and that this is proactively informing decision making. - Strengthen single and multi-agency supervision models and reflective practice opportunities. - Promote exploration of life experiences and that are contributory to family dynamics and functioning.

Appendix A - combined timeline:

DATE	EPISODE
2019/2020	
15/02/2019	London Ambulance Service (LAS) attended home address due to chest pain, noted that he was non-compliant with medication and his GTN spray was out of date
13/05/2019	LAS attended home address due to chest pain
03/06/2019	LAS attended house with reports that George was short of breath, he reported that he had fallen and had been drinking and had disagreement with son, he was noted to be non-compliant with medication- he refused to be taken to hospital
20/06/2019	DNA GP appointment
01/07/2019	Admitted to Barking, Havering and Redbridge University Hospitals Trust with chest pain. Reviewed by cardiologist, it is documented that the Doctor queried whether George has dementia as he was confused. A referral was made to Children's Services in respect of his son with concerns that he was caring for his father and not attending school.
31/07/2019	GP- Failed telephone call to George
27/07/2019	Las attended home address due to chest pain- attended ED with chest pain, discharged same day. LAS note that he was non complaint with medication and has declined carers package.
30/09/2019	LAS initial call due to collapse, call cancelled by police- no reason provided
16/10/2019	GP documented that prescription had not been picked up since March.
05/11/2019	LAS attended address due to chest pain- taken to hospital
05/11/2019 to 10/11/2019	Admitted to hospital due to cardiac ischaemia. He was noted to be "unkempt" which was tributed to dementia. It was documented that he was drinking x2 bottles of vodka per day and that he was non concordant with his medications. During this admission his adult son contacted the wad and insisted that George was to be discharged. George was noted to be agitated and lacking capacity – MCA assessment completed. George was spoke to about the alcohol use and stated his would not stop drinking as he enjoyed it. George's son attended hospital on 10/11/2019 and was documented to be "physically and verbally imposing towards staff wanting George to be discharged" and despite staff explaining about the risks of his cardiac issues, capacity and concerns about alcohol use, his son took him home. It is recorded that police were contacted and a safeguarding concern raised.
10/11/2019	Liaison between Barking, Havering and Redbridge University Hospitals Trust and NELFT regarding concerns about discharge from hospital. It is noted by NELFT that there had been a DoLS in place during the admission.
15/01/2020	LAS attended home address due to chest pain, taken to ED discharged home same day
28/01/2020	LAS attended home address due to chest pain, taken to ED discharged home same day
25/02/2020	LAS attended home address due to chest pain, taken to ED discharged home same day
26/02/2020	GP records that flu vaccine was declined – does not specify whether George declined it himself, or if a relative did this on Gerges behalf
09/03/2020	LAS attended home address due to chest pain, taken to ED discharged home same day. Noted by LAS that George is a frequent caller
13/03/2020	Attended ED with chest pain, discharged home same day

19/05/2020	LAS attended home address due to chest pain, taken to ED discharged home same day
03/06/2020	GP sent text reminder to George for a follow up blood test
24/06/2020	Did not attend (DNA) outpatients' appointment (OPD) with Cardiac Rehabilitation Service, GP informed
17/07/2020	Referral for intermediate Care OT input. Son declined input and George was discharged from service.
21/07/2020	Referred to NELFT Cardiac Community service (CCS)
24/07/2020	The Metropolitan Police Service (MET) record a concern raised by Lloyds TSB bank about financial exploitation after George told them his sons had taken his money- safeguarding referral made (this is not reflected in social care records)
31/07/2020	DNA OPD anti-coagulant clinic
04/08/2020	CCS could not contact George to arrange initial assessment
19/08/2020	Attended OPD anti-coagulant clinic, no concerns documented
03/09/2020-08/09/2020	LAS attended home due to chest pain- admitted to hospital. Liaison with one of his sons (who was a child) who said that he had only been living back with his dad for 3 weeks, but he knew that he often had chest pain. Discharge summary to GP request a referral to memory clinic. It is documented that George "absconded" from the ward during this admission and was returned by security staff.
09/09/2020	LAS attended home address due to chest pain, declined to attend hospital
12/09/2020	LAS attended home due to difficulty in swallowing
21/09/2020	OPD anti-coagulation appointment cancelled by hospital
21/09/2020	CCS attempted contact to arrange home visit
22/09/2020	CCS attempted contact to arrange home visit
23/09/2020	CCS initial assessment not attended
27/09/2020-28/09/2020	LAS attended home due to chest pain- admitted to hospital. It is documented that support was offered and discussed with son, but this was declined
29/09/2020	DNA OPD anti-coagulation appointment (likely as he was still in hospital)
01/10/2020	Cardiology OPD appointment, no problems documented
05/10/2020	DNA OPD anti-coagulant clinic
13/10/2020	GP spoke to son about required blood test, blood pressure check and flu vaccine, Geoge attended practice, and these were carried out.
21/10/2020	CCS carried out home visit for initial assessment, medication discussed
23/10/2020	Attended OPD nuclear medicine, no problems documented
23/10/2020	Cardiac Nurse home visit, Nurse noticed that there as damage to a door which looked like it had been kicked or punched. Geroge was asked about this and said he felt safe. Blood tests carried out
27/10/2020	Attended ED with chest pain, stent inserted during this admission
28/10/2020	Hospital contacted GP to ask for a referral to District Nursing team due to concern that George was not taking medication. GP made referral to district nursing requesting support
02/11/2020	District Nursing service communicated to GP that it is outside the remit of their service to offer support with oral medication.
12/11/2020	Cardiac Nurse contacted GP to say that a home visit had been carried out and George has not been taking his medication since he attended hospital, the cardiac nurse subsequently checked with pharmacy that medication had been picked up and communicated this to the GP. The cardiac nurse also checked that a referral has been made to cardiac clinic and the GP subsequently facilitated this.

13/11/2022	Discussed at Cardiac MDT due to concerns that George was increasingly non concordant with medication
16/11/2020	Failed telephone call from GP to George
20/11/2020	GP records a review of Integrated Care Plan under community cardiac team, referral to memory clinic documented and it is recorded that his "son is taking care of medication".
25/11/2020	Failed telephone call from GP to George
27/11/2020	CCS checked in with sons to enquire about medication, son said he had been taking his required meds
28/11/2020-29/11/2020	LAS attended home due to chest pain, admitted to hospital, high number of attendances to hospital was noted and this was attributed to poor compliance with medication due to memory issues. Discharged with OPD appointment and follow up with GP regarding memory. During this admission a DNACPR was discussed with George and put in place.
01/12/2020	Failed telephone call from GP to George
02/12/2020	CCS home visit, discussion with GP to chase memory clinic referral
07/12/2020	Failed telephone call from GP to George
18/12/2020	DNA OPD cardiology clinic
23/12/2020	LAS attended home due to chest pain- taken to ED and discharged same day.
26/12/2020	LAS received call due to chest pain- call cancelled, no reason provided
27/12/2020	LAS attended home due to chest pain
Brief Points: • Positive whole family practice- liaison with Children's Social Care about Goerge's son • In November 2019 there were several concerns noted whilst he was in hospital, alcohol use, poor concordance with medication and he was deemed to lack capacity and a DoLs was initiated. There are indicators of self-neglect and concerns about his son's behaviour and insistence on discharge. It is not clear what the police or social care response to this incident was. • Consideration of self-neglect was not clearly documented despite indicators (alcohol use, capacity concerns, non-concordance with required medication). There is no record of response to the safeguarding referral and therefore it is not clear what safeguarding needs had been identified. • Application of DNA CPR did not consider capacity. • Different family members making decisions, but it is but always clearly documented who they were or if they held LPA for heath matters. • The relevant of non-attendance at important follow up appointment was not explored in the context of self-neglect. • Support was declined by family members but there is no evidence that this was explored with George himself, there is an unclear picture of the home arrangements and the degree of help and support that George was receiving. • Report of financial exploitation does not yield any further follow-up or response	
2021	
21/01/2021	CCS home visit, George was ready to go out, so the full visit didn't go ahead but CCS reinforced the importance of medications
10/02/2021	Telephone assessment with Public Health and CCS regarding covid vaccination
16/02/2021	Failed telephone call from GP to George to arrange covid vaccination
09/03/2021	CCS checked in with George's son who stated that his father was well.

10/03/2021	CCS home visit- concerns that recent medication changes had not been made, contacted son who stated that George was receiving the right medication. This was not supported by the pharmacy who clarified that no changes had been made. Liaison took place between CCS, GP and pharmacy to arrange correct prescription/ dossette box.
16/03/2021	Memory clinic assessment- this consisted of a telephone call to Georges son who stated that the issues raised in the referral were no longer relevant and his Father was being supported by him. George was discharged. George did not participate in this discussion or assessment.
22/03/2021	GP documented a telephone call with the Older Adults Mental Health Team- it was recorded that the OAMHT doctor has consultation with Georges son on 16/03/2021. He was discharged from the service
21/04/2021	CCS home visit, George reported that he was well, son reported that George was taking his medication. Blood tests done
26/04/2021	CCS contacted son to say that blood tests indicated a required change to a med, prescription would be arranged
11/05/2021	Multiple calls made to George to remind him of CCS appointment- failed telephone calls
11/05/2021	Did not attend CCs appointment
02/06/2021	Telephone calls made by CCS failed
02/07/2021	GP records that the cardiology team have attempted contact several times and a further cardiology appointment has been arranged
20/07/2021	Calls made to George and sons to remind them of CCS appointment calls failed
21/07/2021	Calls made to George and sons to remind them of CCS appointment calls failed
22/07/2021	DNA CCS appointment
13/08/2021	GP carried out a home visit with Practice Manager, George was noted to be unkempt, and the house described also as unkempt with dirty bedding, unclean cutlery all over the place and limited food. George was unable to recall whether he had eaten breakfast or taken his medication, he told the GP that he doesn't have a phone and that he smokes 20 cigarettes a day.
24/08/2021	CCS contacted son successfully to remind him of appointment
26/08/2021	Did not attend CCS appointment, discharged from service. Community matron team informed
11/10/2021	Failed phone call between GP and George to discuss flu vaccine
19/11/2021	Discussed at Integrated Case Management Team- agreed that community marrons would visits to ensure George was taking meds
23/11/2021	Community Matron visited but George declined the visit as he was on his way out.
08/12/2021	Community Matron tried to contact son- no answer
10/12/2021	Son contacted to inform him that the Practice Nurse would visit to carry out blood tests
15/12/2021	Practice Nurse carried out home visit to give flu vaccine, take bloods and to do a medication review. It is documented that the son was verbally abusive and threatening towards the practice nurse. The practice nurse observed and documented that the house was full of smoke and smelled of cannabis, she observed George to look bewildered and noted that the son pushed him aside a few times and told him that the nurse was there "to kill" him. Police were contacted and safeguarding referral made.
17/12/2021	Discussed at Integrated Case Management – feedback from the recent practice nurse visit, made clear that it was not safe to do lone visits, plan to make safeguarding referral
21/12/2021	London Borough of Barking and Dagenham (local Authority) receive a referral from the GP after a home visit- the concerns raised were that George's son was preventing him from getting the right health care and treatment, had cancelled a previous package of care and had been threatening to the practice nurse. A safeguarding enquiry was undertaken, and George was deemed to have capacity, however it was

	identified that there was indication that the son's behaviour was controlling thus increasing risks such as compliance with medication- a referral was made to the domestic abuse team and Complex Cases Group and the safeguarding was closed.
Points: • **Indication that there were significant concerns about vaccination expressed by son which was at odds with what seemed to be Georges wishes to have his flu vaccination.** • **Concerns about the home environment arise, George noted to unkempt, lack of food and the house dirty, smoky and had a smell of cannabis.** • **George had reported that he didn't have a phone and therefore methods of contact and communication were persistently failing with a reliance on the son as the point of contact.** • **Increased isolation, lack of contact, missing visits and appointments.** • **Good practice for Practice Nurse to carry out fact finding and review home visit due to the number of failed appointments, this facilitated the uncovering of safeguarding issues and evidence of increased risk.** • **Police response to the Practice Nurse incident is not evidenced.** • **Good communication and persistence between health professionals and alternative methods of accessing and monitoring George put into place.** • **There is an absence of Georges voice at times because there was no method of contacting him, therefore the son represented his wishes and feelings and needs- eg memory service assessment did not include George**	
2022	
06/01/2022	Social Worker contacted GP to arrange a joint home visit
12/01/2022	Joint home visit carried out with the GP, Social Worker, Practice Manager and Independent Mental Capacity Advocate IMCA). George came to the door and told them his son was in the house but asleep. George told the team that he had not been taking his medication, he said that the house was his but that his son lived with him. A package of support was discussed with George, and he said that he did not like previous carers. George's son joined the discussion as flu and shingles vaccinations were being discussed, it is documented that George had expressed that he wanted them and the IMCA felt that he had capacity, he was invited to attend the surgery for these to be done, however the son told George that they had "come to murder him". There were shared concerns about controlling and coercive behaviour
13/01/2022	Social Worker informed the GP that a referral has been made to the Complex Cases Group and to the domestic abuse team, additionally the police had been contacted in view of the sons behaviour that the visit had observed.
14/01/2022	Referral received by Refuge advocacy service due to the concerns about sons controlling and coercive behaviour. It was noted on receipt that there was not a safe method of contacting George as he did not have a phone. This was explored several times with the social worker in terms of opportunities in community settings and it was not possible to identify a safe way of speaking to George- advocacy service therefore raised a safeguarding concern, and the case was closed on 24/01/2022
14/01/2022	Discussed at Integrated Case Management, safeguarding activity noted and plan for Complex Cases Group and domestic abuse team referral/ IMCA capacity assessment highlighted with the outcome that George was deemed to have capacity.

01/02/2022 – 02/02/2022	Admitted to hospital due to chest pain, George stated that he had been asking for an ambulance all week but his son (who lives with him) would not call for one. He said he has not been taking his medication and is documented to be confused, refusing observations and administration of medication. A safeguarding referral was made and on receipt the LA social worker advised that George should not be discharged whilst this was being investigated. The dementia team were involved and carried out an assessment and a DoLs application. The delirium pathway was commenced and "this is me" proforma utilised to capture George voice and views. On 02/02/2022 his son attended hospital and insisted that George was coming home, police were contacted and it was noted that he was medically fit for discharge and the Police view was that there was no legal framework to keep George in hospital against his will and that of his sons, the safeguarding investigation could continue with his at home, Local Authority out of hours team were informed.
01/02/2022	Referral received by LBBD from LAS- they had attended the address and George was short of breath and reported that his son lives with him, and he had been asking him for help for the last week and the son refused, it was noted that there is not a care package in place at home as the son had cancelled it. The referral included information about the property- the patient's door was damaged and looked as though it had been kicked or punched repeatedly, the house appeared to be dirty and there was a strong smell of cannabis. LBBD noted that there was increased evidence of control and coercion since the last referrals and an enquiry was initiated- during this time his son took him from hospital and police had concluded that he had capacity and there was no legal framework to keep him in hospital- safeguarding was stepped down to case management following presentation at the Complex Cases Group, this was discussed with the legal team and communicated with the GP
03/02/2022	New referral made to Refuge advocacy service following concerns raised by London Ambulance Service and hospital. It was agreed that the hospital would be a safe place to see George, but he had been discharged before they had the opportunity to see him.
04/02/2022	Refuge advocacy liaised with the GP to try and identify an opportunity to see George in the community. It did not seem that a safe method could be identified, and Refuge advised the social worker to make a MARAC referral due to increasing indication of control and coercion.
08/02/2022	IDVA discussed with practice manager at GP who confirmed that a home visit was risky due to the last incident in the house.
09/02/2022	Son contacted GP to say that George was unwell and was refusing to attend hospital
10/02/2022	Refuge advocacy service closed their input and made a safeguarding referral based on inability to visit safely due to risk in the home and no method contacting George.
10/02/2022	Discussed at Complex Cases Group and actions noted regarding fact finding and Refuge being unable to access George. There were no health professionals present
11/02/2022	Discussed at Integrated Case Management meeting, no further updates and noted that none of the professionals has seen George since before the last meeting. There were no social care professionals present
17/02/2022	DNA OPD cardiology clinic
10/03/2022	Refuge advocacy service raised a further safeguarding referral- they had not been able to make contact with George as he has no phone and was not presenting in any community settings, the referral raised concern about risks related to the control and coercion of George by his son which was preventing him accessing healthcare that he needed- it also highlighted the risk to professionals as there had been incidents of threatening behaviour during home visits. An enquiry was initiated
11/03/2022	Discussed at Integrated Case Management meeting, no further updates and noted that none of the professionals has seen George since before the last meeting

17/03/2022-19/03/2022	George was brought to hospital after collapsing at home, he was admitted to the Intensive care Unit where he was treated for sepsis, a DNA CPR was put in place on 18/03/2022 and it is documented that his next of kin was uncontactable. George died on 19/03/2022.

Points:

- **Significant increase of concerns and a distinct change in son's behaviour which was often threatening, very resistant to professionals and there was a particular challenge over the administration of vaccinations.**
- **Disengagement from Community Cardiac Service which has previously had good access to George.**
- **Recognition that there was a domestic abuse concerns and the Refuge sere were not able to safety access George.**
- **George was not seen by health professionals (except emergency and acute services) due to inability to contact him, lack of attendance at appointments.**
- **It is not clear to what extent "risk" was considered at either the Integrated Case Management meeting or the Complex Cases Group - with parallel conversations taking place in both. These groups were distinctly "health" and "social care", but it may have been helpful to have all professionals in one setting.**
- **Action from initial Complex Cases Group for health professionals to documented evident of coercive controlling behaviour- however this was already evidenced and documented.**

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[ii] serious-incidnt-framwrk-upd.pdf (england.nhs.uk)
[iii] National analysis of safeguarding adult reviews
[iv] Self-neglect: At a glance | SCIE
[v] Controlling or coercive behaviour statutory guidance (publishing.service.gov.uk)
[vi] Domestic Abuse Act 2021 (legislation.gov.uk)
[vii] MCA (2005)
[viii] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)
[ix] . Department for Constitutional Affairs (2007). Mental Capacity Act 2005 Code of Practice. The Stationery Office. https://assets.publishing. service.gov.uk/government/uploads/system/ uploads/attachment_data/file/497253/Mentalcapacity-act-code-of-practice.pdf 13. Department of Heal
[x] https://hgs.uhb.nhs.uk/wp-content/uploads/Risk-Enablement.pdf
[xi] Para 14.45, Care and Support Statutory Guidance updated 16 June 2022
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[xiii] Carers and safeguarding: a briefing for people who work with carers | Local Government Association
[xiv] *Carers and Safeguarding Adults – working together to improve outcomes*, ADASS Advice Note April 2011 https://www.adass.org.uk/adassmedia/
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[xvii] The online anti-vaccine movement in the age of COVID-19 (thelancet.com)
[xviii] Confronting the evolution and expansion of anti-vaccine activism in the USA in the COVID-19 era (thelancet.com)
[xix] https://www.researchinpractice.org.uk/adults/publications/2017/june/what-is-a-family-group-conference- for-adults-brief-guide-2017/ 24
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[xxi] International Journal of Geriatric Psychiatry: A Journal of the Psychiatry of Late Life and Allied Sciences 21(6), pp.564-571
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