QUICK REFERENCE LEARNING POINTS FROM HARROW SAFEGUARDING PARTNERSHIP'S SAFEGUARDING ADULT REVIEW – ADULT B

Learning relating to Mental Capacity, Carers and Adverse Childhood Events

Background

Adult B was a woman in her 70's who died in an emaciated state.
She had become bed bound and her living accommodation was in a very poor state; with evidence of clutter and poor levels of hygiene. Adult B often refused care.

Two of her four adult children lived with her and provided non-physical and non-intimate care for her. This complemented the work of paid carers who came 3 times a day. Her son had verbally abused her in the past and had been suspected of financial abuse. All of her children had been taken into the care when young due to neglect by her. At least one of her children was thought to have some degree of learning difficulty. Her daughter gave birth at Adult B's home and the baby was removed by the local authority because of concerns of neglect

Several local agencies had considerable involvement with her over the years leading up to her death, but records indicated that actions that could have been taken to safeguard her were not followed through.

Assessment of Carer's Needs

B's son, and her daughter to a lesser extent were often identified as being a protective factor for B. The full family history and dynamics were not adequately checked and explored. Had this have happened it is likely that a different assessment of B's children as carers would have resulted. They were never assessed for their **own needs** as carers, even though learning difficulties were suspected – and in some cases was documented as a fact, but not verified.

'Think Whole Family'

The recorded history of alleged abuse did not appear to feature in understanding the adult children's *suitability* to care for their mother.

Additionally, their own adverse childhood experiences did not appear to feature in understanding their *ability* to care for their mother.

Learning: There is a need to understand the longer-term impact of **Adverse Childhood Events** on adult functioning.

The daughter's child was taken into the care of the local authority at birth from B's home. There was no consultation with Adult Safeguarding Services about any possible transferrable risk of neglect for Adult B by the same carer.

Learning: Where there are transferrable risks across generations, there should always be consultation between children and adult services.

Mental Capacity and Self-Neglect

When service users refuse medical aid, physical assistance or other help, professionals are presented with a dilemma. Instincts to safeguard and protect those who are vulnerable are challenged by our understanding of the importance for service users of their self-determination and autonomy.

In this case, there were frequent references to B having the capacity to refuse care, but this was never subject to formal mental capacity assessment.
The Harrow Self-Neglect Policy which post-dates B's death, requires each case that proceeds to the Risk Enablement Panel to involve a current mental capacity assessment, provided that the care and medical refusal poses a significant risk to health.

Learning: Practitioners should familiarise themselves with **Harrow's Self-Neglect Policy** and establish the use of formal mental capacity assessments in cases where a service user's refusal of care or medical treatment has a significant detrimental impact on their health and wellbeing:
https://www.harrow.gov.uk/downloads/file/23878/harrow-s-safeguarding-adults-board-hsab-protocol-for-self-neglect

Impact of Covid-19

Good practice: It was apparent from the chronologies and reports supplied by the agencies that Adult B's case was affected very little by the pandemic. She received frequent face to face visits and care. Her social care service was delivered uninterrupted and she was visited frequently by district nurses, General Practice and the nurse practitioner.

Multi-agency Meetings and Leadership

The most intractable cases are often those which involve a variety of agencies. In this case, agencies were involved or held relevant histories across both adults and children's services. Practice would have benefitted from a multi-agency approach – as outlined in the new Self-Neglect Policy.
Learning: Practice should focus on multi-agency working, resilience, experienced leadership to support staff dealing with complex cases to inject purpose and positivity into cases that can have a tendency to drift and further delay.