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SAFEGUARDING ADULT REVIEW: ADULT AT AND ADULT AS

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SOUTH TYNESIDE SAFEGUARDING CHILDREN AND ADULTS PARTNERSHIP

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Section One: Introduction

1.1. Adult AT[1] was born on 29th February 1948 in the United States of America. At the time of the circumstances on which this safeguarding adult review (SAR) is focusing, she was living with her son, Adult AS, in rented property in South Tyneside. She died aged 73.

1.2. Adult AS was born on 24th January 1988. He was aged 33. His date of death, and that of his mother, has not yet been determined. However, cause of death of both Adult AS and Adult AT has been hypothesised as the result of cardiac arrest, hypothermia and emaciation. A Coroner's inquest will be held into the deaths of Adult AT and Adult AS after the SAR has been completed. This report has been compiled and signed-off by South Tyneside Safeguarding Children and Adults Partnership (STSCAP) in recognition that it will be shared with the Coroner.

1.3. Adult AT moved to the UK with her husband and son. This move might have been precipitated by the collapse of her husband's business in the USA. In 2004 her husband died. Adult AT informed a consultant psychiatrist that his cause of death was colon cancer. It appears that contact was then lost with his side of the family[2]. She consistently expressed a wish to return to the USA but said that this was not possible because of her financial position.

1.4. Records indicate that Adult AS found it difficult to adjust to life in the UK, and might have been bullied as a result of his accent. He also expressed a wish to return to the USA. Records also indicate that he was close to his father and experienced mental distress and social isolation after his father died.

1.5. A referral for consideration by STSCAP for a Safeguarding Adult Review (SAR) was submitted by Adult Social Care (ASC) on 28th February 2022. Both mother and son had been found deceased when Northumbria Police forced entry into their rented property on 20th December 2021, using their power in Section 17 Police and Criminal Evidence Act 1984. This action followed concern expressed by neighbours.

1.6. STSCAP's Practice Evaluation and Learning sub-group concluded its consideration of the SAR referral on 6th April 2022. All sub-group members agreed that the criteria for a mandatory SAR outlined in Section 44 (1) (2) (3) Care Act 2014 had been met. This recommendation was accepted by the STSCAP and Executive, and the independent reviewer was commissioned to lead the review at the beginning of July 2022.

1.7. The rationale recorded by sub-group members for the recommendation included available evidence of self-neglect and the possibility also of neglect by Adult AT of her son. Concerns were expressed about whether there had been missed opportunities for earlier intervention, information-sharing and engagement, and for multi-agency partnership working. Concerns were additionally expressed about whether coercive and controlling behaviour had been sufficiently

[1] South Tyneside Safeguarding Adults Partnership (STSCAP) agreed that this is how the SAR would refer to the individuals in this case.

[2] Adult AT informed a consultant psychiatrist that Adult AS had two half-brothers in the USA but they were out of contact. Correspondence written by her husband in 1997 and found in the family home after the deaths of Adult AT and Adult AS included a letter returned as undelivered to one of Adult AS';s half-brothers. This letter also includes references to the husband's extended family, the whereabouts of whom are not known to services involved in this review.

considered by practitioners who met Adult AT and Adult AS and who witnessed the nature of their relationship, and whether Adult AS's voice was sufficiently heard in line with the principle in statutory guidance[3] of making safeguarding personal.

1.8. **Commentary:** the SAR referral and consideration of it were timely. Minutes of the sub-group are thorough. The rationale for the recommendation to complete a SAR forms the basis of the key lines of enquiry that the review has explored.

1.9. Chronologies submitted by the services involved with Adult AT and Adult AS were combined and the sequence of contacts appears in section three. Services responded in full to the questions asked by the independent reviewer following initial analysis of the chronological accounts. A learning event was held, attended by practitioners and operational managers from all the services involved. Some of those attending had met Adult AT and/or Adult AS; some had provided supervision. Meetings were also held with staff within the local authority who had been involved in securing personal belongings that had been found in the house, and who had conducted an investigation into the involvement of a social worker prior to the deaths of Adult AT and Adult AS.

1.10. **Commentary:** all those who attended the learning event engaged with candour and with critical and appreciative reflection. Similarly, the feedback from local authority staff in meetings has been candid and has highlighted that learning has already been implemented. Responses to the questions asked by the independent reviewer have been timely and helpful. All this is to be commended and is indicative of the strength of the adult safeguarding partnership.

1.11. Adult AT's cousin, resident in the United States, has contributed information both to the independent reviewer and to a local authority operational manager. Her contribution has been embedded in the analysis that follows in section four of the report.

1.12. Neighbours and the Post Office manager have also contributed information for the review and their observations have also been embedded in the analysis.

[3] DHSC (2022) *Care and Support Statutory Guidance Issued Under the Care Act 2014*.

Section Two: Evidence-Base

2.1. There is an established evidence-base for working with cases of self-neglect. This is drawn from over 400 reviews of cases involving adults who died or experienced significant harm as a result of self-neglect[4], and from research[5]. This evidence-base will form the basis for analysis in this SAR.

2.2. The evidence-base comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with individuals and their families. The second domain then focuses on how practitioners from different agencies worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect.

2.3. What enables and what obstructs best practice might reside in one or more of several domains. Further, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.

2.4. It is recommended that direct practice includes:

2.4.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes;
2.4.2. A combination of concerned and authoritative curiosity, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills;
2.4.3. When faced with service refusal, a full exploration of what might appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage;
2.4.4. Building a picture of the person's history and developing trust through maintaining contact;
2.4.5. Comprehensive assessments of care and support needs, mental capacity, risk and mental health;
2.4.6. Consideration of involvement of wider family and social networks.

2.5. It is recommended that the work of the team around the person includes:

2.5.1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker;
2.5.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
2.5.3. Multi-agency meetings that pool information and assessments, agree a risk management plan, and consider legal options;
2.5.4. Using the duty to enquire (Section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort;

[4] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[5] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.

2.5.5. Clear and thorough recording of assessments, reviews and decision-making.

2.6. It is recommended that organisational support for team members includes:

2.6.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;
2.6.2. Support for staff working in complex and challenging situations;
2.6.3. Access to specialist safeguarding and legal advice;
2.6.4. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds, and the availability of resources and services.

2.7. It is recommended that safeguarding partnerships:

2.7.1. Develop and keep under review policies and procedures for working with self-neglect;
2.7.2. Provide multi-agency training;
2.7.3. Audit the impact and outcomes of training and of policies and procedures.

Section Three: Chronology

3.1. Separate chronologies of involvement with Adult AT and Adult AS have been combined here to give as complete a picture as possible of the contact that practitioners had.

3.2. For Adult AS chronologies have been provided by South Tyneside Council, Adult Social Care (ASC), South Tyneside Clinical Commissioning Group (now Integrated Care Board) on behalf of GPs, Cumbria, Northumbria, Tyne and Wear NHS Trust (CNTW), and North East Ambulance Service (NEAS).

3.3. For Adult AT chronologies have been provided by South Tyneside Council, Adult Social Care (ASC), South Tyneside Clinical Commissioning Group on behalf of GPs, North East Ambulance Service (NEAS), South Tyneside and Sunderland NHS Foundation Trust (STSFT), Northumbria Fire and Rescue Service and Home Group[6].

3.4. CNTW's chronology for Adult AS begins in August 2002 when he was referred by his GP into the Children and Young People's Service (CYPS). The referral letter notes the family came to the UK when he was 8 or 9 years old, that Adult AS never felt at home in the UK, always thinking of Texas as home, and never forgiving his father for bringing him to England. Adult AS's father died in September 2004. In September 2004 a GP provided Adult AT with a bereavement sick note, which was extended in March 2005. She is recorded as having declined counselling but in November 2005 as accepting medication. **Commentary:** Adult AT declining assistance is introduced as a theme. So too the degree to which her mental health was in focus. The CNTW chronology does not detail what prompted the GP referral, nor how CYPS responded. However, it is an early indication of concern about Adult AS's emotional and mental wellbeing.

3.5. In October 2005 the CYPS Consultant's assessment letter to a GP recorded that Adult AS had been seen the previous month. Adult AT is recorded as describing her husband's family as high-ranking intelligence officers who also had ship building interests. She described her husband as being a Walter Mitty character who was frequently involved in a fantasy world. She felt he had psychiatric problems, describing him as dysfunctional and unable to hold down a job for any length of time. The Consultant summarised Adult AS by saying he was an interesting young man with long standing learning and social difficulties, having been greatly upset by the recent death of his father. Hand-written notes recorded that Adult AS was feeling slightly better and was making friends at college. He was playing sports and spoke of wanting to be an actor. He denied being bullied at college and spoke of wanting to return to North America.

3.6. In January 2006 CYPS consultant hand-written notes recorded that Adult AS had left college as he was not enjoying it. His mood was recorded as "*ok*" but "*variable*." He was noted to be a "*night creature*", according to his mother "*like his father*." His speech was "*hurried as usual*" but he was "*not hearing voices at the moment*." His mother described Adult AS as happier at home although bored and with lots of energy. She felt that he worried about what would happen to her. She also wanted to return to North America and reported that she intended to access therapy. **Commentary:** the reference to hearing voices is interesting given later reports from neighbours about noise and both Adult AT and Adult AS reporting that they were being controlled from beyond the grave by their husband/father. The theme of Adult AT's mental

[6] Landlord for the property.

health also resurfaces here. The reference to Adult AS's speech here is significant in the context of a message that he left for a social worker shortly before he died, which was described as difficult to understand.

3.7. A further CYPS entry in March 2006 records that Adult AS had been seen with his mother. She felt that being at college had "*done him a world of harm*." She described him as "*like a lunatic*", imitating other young people at the college who had diagnoses of Asperger's. She said that she "*couldn't stand it*." She also described him as "*very dependent*." A CYPS consultant's letter to an adult mental health consultant noted that Adult AS did not appear to have any clear-cut psychiatric syndrome. "*His lability of mood and unusual presentation did on occasion raise the issue of possible pre-psychotic symptomology*." The plan was for referral to adult mental health services as it was felt occasional monitoring was indicated. Financial worries were also recorded. **Commentary:** it would appear that this was a family under significant strain. Adult AT's comments do not appear to have raised safeguarding concerns. There does not appear either to have been any consideration of referral to ASC regarding Adult AT's needs as a carer and Adult AS's needs as a young person transitioning to adulthood. The theme of financial issues is noted here and would become a repetitive concern for Adult AT.

3.8. In April 2006 a CYPS consultant saw Adult AS. He is recorded as sleeping "*ok*" and as playing sports. His mood was again recorded as "*ok*" but "*very variable*." He was planning to access YMCA training but had not yet applied. He said that everything at home was fine but still resented his father for having brought the family to the UK. He expressed a wish to be an actor and thought he would do better in a fantasy world. An appointment with adult mental health was awaited but Adult AT was recorded as saying that she did not think further appointments were necessary. Money was recorded as "*still an issue*." **Commentary:** here is an indication of Adult AT determining Adult AS's access to services. There are parallels between Adult AS and his father in terms of reportedly living or wanting to live in a fantasy world.

3.9. Also in April 2006 a letter was sent to Adult AS by the adult mental health service. His case would be closed as he had not responded to offers of appointments. His GP was notified. **Commentary:** case closure without outreach appears premature given what had been recorded by CYPS consultants.

3.10. In May 2006 a CYPS consultant saw Adult AS for the final time. Adult AT and Adult AS stated that they no longer required psychiatric services. The GP was informed. In July 2006 the GP re-referred Adult AS to adult mental health services at the request of Adult AT and Adult AS during an appointment. Community mental health services discharged Adult AS back to his GP in August as he did not want an appointment at that time and wanted to think about accessing services. **Commentary:** it is not clear whether Adult AS was seen on his own or whether undue influence on his decision-making was explored.

3.11. In early September 2006 the community mental health team sent a letter to Adult AS notifying him that the team had been asked by Connexions[7] to discuss any help that could be offered to him.

[7] A service providing advice and guidance for young people not in education, employment or training.

3.12. The ASC chronology records that in September 2006 Adult AS was experiencing difficulty in coming to terms with his father's death and the family's subsequent social isolation. He had apparently been offered periodic appointments with a psychiatrist although contact with a Mental Health Trust indicated that he had opted out of support. Owing to financial difficulties, Adult AT was unable to return to North America with her son. Information available at this time included that Adult AS had attended South Tyneside College but had left in December 2005 because of "*worsening personal circumstances*" that appear to have revolved around needing time to grieve. Practitioners were expressing considerable concern "*at the significant deterioration of Adult AS's emotional mental health*." Both Adult AS and his mother referred "*to the late father/husband controlling them from beyond the grave - relating to the financial difficulties which they were now in*." Every attempt to explore potential progression routes with Adult AS resulted in him bringing the conversation back to this "*unhealthy pre-occupation with his father*". **Commentary:** social isolation becomes a theme from this time. Another theme relates to uncertainty about whether or not Adult AS was on the autistic spectrum, which does not seem to have been fully explored subsequently by the practitioners who interacted with him. Further themes relate to the impact of bereavement on both Adult AS and Adult AT, and the opting out of support by them both. The focus on Adult AS's mental health is added to the concern about Adult AT's mental health. Finally, beginning here is an apparent missed opportunity since Adult AS was not in education, employment or training.

3.13. There is a detailed case note for one contact at this time from a social worker who was also an Approved Mental Health Professional and Best Interest Assessor. It reads: "*T/c to client and spoke directly with his mother who informed me her son was finding it very difficult to come to terms with his father's death. She added the bereavement was exacerbated by some longstanding problems re perceived isolation even though he has lived in the UK since he was six years old. [Adult AS's] mother is American and has permanent residency in the UK, his deceased father is British and [Adult AS] has dual nationality. … He was very close to his father and had a protracted relationship with his father's family ... Since his father's death his relationship with his father's family has completely deteriorated and there is no active contact. [They] feel they have never integrated into the South Shields community and [Adult AT] has added she sees no long-term future in South Shields although their options are severely limited by their financial situation. They have both talked about returning to the States and feel it may alleviate many of their present problems but again this is not an option at present due to financial restrictions. [Adult AT] feels her son's mood has been and is very low and he has talked of and performed some self-harm in the past although she did not want to discuss this further. She added there was a letter from the ECMHT, which arrived today, offering an appointment and she feels [her son] is ready to engage but his low mood is affecting both his and [Adult AT's] motivation re accessing assistance … It became apparent her desire to return to the US is based primarily on her fond memories of a time when she was still married with her young son living a relatively affluent lifestyle due to her late husband's business interests. The business, which he was a partner in went bankrupt in 1994 which led to the family's return to the UK. I put it to [Adult AT] that her lifestyle if she returned to the US may be very different to that which she remembers to which she agreed. I put it to her that she may want to consider applying for British citizenship before making any decision re her future as if she retained dual nationality she would also retain some significant options if she chose to return to the US. I agreed to source some information and post it to her, I also informed her I would contact the ECMHT to confirm their involvement*." **Commentary:** no records have been found that build on this conversation. It is not clear why this social worker appears not to have followed up this conversation more actively. What is also apparent is that Adult AT was speaking for Adult AS. His

voice here was not engaged with directly, a pattern that appears throughout the chronology. Finally, it does not appear that their financial situation was explored here in any detail, again a theme that reappears periodically throughout the chronology.

3.14. On 25th October 2006 records contain a letter from South Tyneside Council and NTW NHS Trust with an assessment. Adult AT and Adult AS "*appear to have a very entrenched, enmeshed relationship with some aspects of co-dependence*." Adult AS is recorded as feeling that "*he needs to protect his mother but does not feel "up to the job". He seems to feel guilty about this and exhibits some aspects of depression and anxiety and pressure of speech. He remains quiet for some time then speaks rapidly often garbling his words. Both appear to be stuck in the grief process and have not moved on. Adult AS has nothing in his life to divert his attention*." The plan was to discuss at an allocation meeting, and to consider grief counselling/cognitive behavioural therapy and employment opportunities. **Commentary:** this is the second reference to pressure of speech. It is unclear whether this plan was implemented. The mental health service chronology falls silent until July 2009 with the exception of an entry for January 2007 when it was recorded that a letter was sent by the community mental health team to personal advisers at Connexions that this was the most appropriate service for Adult AS. The GP was informed.

3.15. GP records for September 2008 observe that Adult AT was feeling low, unable to settle in the UK. **Commentary:** the chronology does not record what advice or treatment she was offered. Mental health is clearly a theme.

3.16. In July 2009 Adult AS was assessed by a community psychiatric nurse following referral from a health centre and after discussion at a community mental health team allocation meeting, it was agreed he would be offered an outpatient appointment with a consultant. That appointment took place on 6th September. Adult AS was initially seen on his own, later joined by his mother. The hand-written notes record that Adult AS remained "*negatively preoccupied*" with his move to the UK and that his mother also felt "*stuck*", had not settled and wanted to return. The consultant recorded that *"it's rather odd that a 7 year old boy did not adjust to this country and that life in the USA before age 7 has become so important that he has not been able to function in this country."* The consultant further recorded that Adult AT had said that a return to North America was not practically or financially possible. Thus, *"mother and son seem to have isolated themselves from society and their relationship has become somewhat enmeshed."* **Commentary:** clearly identified here is the importance of focusing on family dynamics and relationships.

3.17. The same record noted that grief about the husband/father's death had now become anger and blame that he had left them in this situation. Adult AS is recorded as saying that he had "*a Freudian death wish*." He was punching walls and climbing lamp posts in the apparent hope of injuring himself and dying. He stated that he had left college as a result of "*a breakdown*" and that he had no friends or social life. His self-care was described as "*ok*" but his mood was described as "*sadness, hopelessness, helplessness, cries at times.*" Adult AT expressed concern about her son's behaviour – going out at night, some obsessional habit of repeated washing, and standing in the road screaming, shouting and gesturing with his hands at nobody in particular. The record concluded that Adult AS came across "*as not a bright young man – difficulty in explaining how he feels – a bit repetitive blaming his father for all his misfortunes. Nothing clearly psychotic – no sign of self-harm.*" The plan was to refer Adult AS to psychology to explore the possibility of therapy, and to consider access to provision that would promote socialisation.

Commentary: again, there was no apparent consideration of Adult AT's needs as a carer. Adult AS clearly has a significant level of disability and mental distress.

3.18. In November 2009 the GP chronology for Adult AT observes that she had declined the offer of therapy. In December 2009 Environment Health Officers received concerns from neighbours regarding noise emanating from the property. Adult AT is recorded as alleging that the noise (banging and shouting) had been caused by her late husband and that he had told her he would do this before he died. Adult AT also told the Environment Health Officer that her son had experienced a mental break down last year and had involvement with mental health services. She is recorded as also saying that her husband choked her and she believed that her upstairs neighbours had drilled holes in their floor so they could listen to her and her son. She declined any assistance. **Commentary:** Adult AT declining assistance remains a theme. There was liaison between Environmental Health and a social worker, which was good practice. The environmental health officer was recorded as commenting that they were "*not overly concerned*." Consent for a referral to Adult Social Care had not been obtained. The judgement about the level of concern is puzzling since Adult AT's husband had died several years previously. The social worker followed up with a telephone call to Adult AT who advised that her son had an appointment for assessment in early January with a psychiatrist and that she did not need anyone making problems for them. This was perhaps a missed opportunity to conduct a home visit rather than to rely on self-assessment in a telephone call. This would have enabled an assessment of the family's circumstances and mental wellbeing. Instead, the outcome was no further action. Once again, there was no direct engagement with Adult AS.

3.19. In January 2010 a community mental health team consultant wrote to a GP to report that Adult AS had been seen and there appeared to have been a "*slight improvement*." His anti-depressant medication had been increased. In early March 2010 the consultant received a letter from Stonham tenancy support service requesting risk assessment. The consultant replied with background information, including that Adult AS might have some developmental difficulties, possibly reflective of Asperger's – repeating words and involuntary twitch in the face. Medication had been reviewed and despite chronic disability there had not been issues or thoughts of self-harm or harm to others. **Commentary:** given what was known about Adult AS and the relationship between him and Adult AT, this appears a rather limited risk assessment.

3.20. In April 2010 Adult AS was discharged by the psychology service as he had not opted in to appointments. **Commentary:** given what was known about the relationship between Adult AT and Adult AS, further thought could have been given here to whether he could opt in without external support.

3.21. In early May 2010 Adult AS was seen by a community mental health consultant. The record observes that there had been some improvement and his "*disagreeable*" behaviour in the community had stopped. Adult AT was trying to get help from the American Embassy regarding repatriation to the United States. The consultant speculated that underneath there was some sort of mild Asperger's; however the consultant did not feel sufficiently expert to make a considered diagnosis about this. Adult AS's conversation was noted as limited and he spoke in short sentences. He displayed anxious looks and displayed tics and grimacing. His anti-depressant medication was increased, with a plan to review after four months. **Commentary:** a referral for a specialist assessment could have been attempted.

3.22. On 6th June 2010 the community mental health team received information from a third party alleging that she had been harassed by Adult AS for some time; however, she did not feel that the police were dealing with her complaint appropriately. She did not wish to proceed with criminal charges as she believed Adult AS to be unwell, and she wished to speak with his care co-ordinator. She was informed that due to confidentiality the service was unable to give out any details. She was advised to contact the police.

3.23. Also in June 2010 Adult AT took on tenancy of accommodation provided by Home Group. Records observe that she was being supported by a practitioner from Stonham. In the same month Northumbria Police dealt with a concern that Adult AS was wandering at night, possibly as a result of not taking medication for depression and anxiety. The ASC chronology for Adult AS records the observation that his mother was unsympathetic about his "*condition*." The Police assessment was that she "*appeared to just ignore him and talk about him as though he was not there*." "*He seemed to be very depressed and would answer questions asked of him but his Mother would just shout over him*." Police Officers were concerned that Adult AS was not on his medication and not getting the support he needed from his mother. **Commentary:** the relationship between Adult AS and his mother resurfaces as a concern. The possibility of coercion and control does not seem to have been explored. Once again, Adult AS's own voice is not heard; his mother is speaking for him. Information-sharing by the Police with ASC was good practice.

3.24. On the same day a safeguarding manager followed up this notification from Northumbria Police with telephone calls. These calls established that Adult AS was not known to the Mental Health Trust other than for outpatient appointments with a locum consultant psychiatrist. Adult AS had last been seen in early May 2010; his next appointment was not until September. The consultant's secretary was advised of the concerns expressed by Northumbria Police. The secretary advised contact with the crisis team for support. The safeguarding manager telephoned the crisis team but was advised that a referral would not be appropriate as the concerns had arisen some time before and, therefore, did not constitute a crisis. The crisis team member agreed to ring Adult AS to see if he needed support but in a later exchange of information advised that there had been no answer on the phone or facility to leave message. There was a further exchange of information with Northumbria Police. The safeguarding manager then telephoned the GP surgery but no GP was available. A message was left asking for a GP to make contact. The safeguarding manager was told that Adult AS had just been into surgery and picked up his new prescription. The safeguarding manager recommended reallocation to be followed through by a duty officer by phone call to Adult AS and a call to the GP. **Commentary:** the safeguarding manager's information-sharing and attempts to secure support for Adult AS was good practice. Once again, however, there seems to have been a reliance on telephone contact with Adult AS.

3.25. Twelve days later a social worker telephoned the GP surgery. The GP advised that they had not seen Adult AS since November 2008. He had been seen by a locum though and had recently had his medication increased (Citalopram[8]) to 40mg. He was reported as usually visiting the surgery with his mother. The GP felt that Adult AS had anxiety, depression and possibly some mental health issues, arising from a difficult childhood because of his broad American accent and his father's death. The social worker then telephoned Adult AT, advising her that the contact was in response to the concerns expressed by Northumbria Police. She advised the social worker that they had recently moved and that her son was now taking his medication. She said that everything

[8] Treatment for depression and panic disorders.

was ok. Adult AS appears also to have confirmed that everything was ok. No further action was agreed. **Commentary:** once again reliance was placed on self-report and on telephone calls. Mental health remains a theme. Once again, Adult AT is speaking for her son. There was limited engagement directly with Adult AS.

3.26. On 28th June a senior practitioner in a Mental Health Trust received a telephone call from a learning disability practitioner. They had received an anonymous referral from a neighbour who reported raised voices, namely Adult AT shouting at her son, stating "*parents are known to kill their children and then kill themselves*". It appeared that Adult AS was not known to mental health services other than appointments with the locum consultant psychiatrist. The senior practitioner made a series of telephone calls. These established that Adult AS was being seen and supported by Stonham Support for mental health issues and that no concerns had emerged on the last visit. In fact, Adult AS was reported to be "*doing well*." The senior practitioner was led to understand that Adult AS did not have a learning disability but was experiencing anxiety and depression. Both Stonham Support[9] and Home Housing staff advised that the involvement of the police would increase the difficulties between Adult AS and his mother. **Commentary:** once again, people are speaking for Adult AS. The lack of clarity about whether or not Adult AS had a diagnosis of learning disability resurfaces here and does not appear to have been picked up and resolved. Concerns about the relationship between Adult AT and Adult AS are recorded again but no work appears to have been attempted to explore this.

3.27. The senior practitioner made a further series of telephone calls to the Adult Duty Team, the locum consultant psychiatrist, Mental Health Crisis Team and Mental Health Community Team in order to share information about the allegations and in an effort to establish case responsibility. As the situation was not seen as a crisis and as Adult AS had not consented to a referral, mental health services declined to become involved. It appears that two members of the Community Learning Disability team visited the home that day and interviewed Adult AT and Adult AS. The record states the following: "[Adult AT] *was very surprised and annoyed that concerns had been raised … and felt she is 'being spied on' as I informed her I was responding to an anonymous referral. [She] went on to state that she can no longer cope with her son's behaviour and that recently she is very frustrated with him, often shouting very loudly and making threats to harm her son. She immediately went on to say that she is devoted to her son and could never harm him but is very frustrated by his mental health concerns and how that isolated him and makes him a potential target in the community. … Support from [the locum consultant psychiatrist] and Stonham was confirmed. Adult AS did join the visit and was very quiet, still in pyjamas and stating that he is in effect now nocturnal in his habits. Adult AT agreed that her shouting and frustration was ineffective and Adult AS agreed where possible to look at the behaviours that concern his mother to try and lesson the clear stress in the family home. Both parties presented as very concerned for each other, there was no clear animosity between them and mother repeated that she loves her son dearly. The property was very well presented and both parties were keen to point out that there are no alcohol or drug issues of concern. Adult AT clearly admitted to making very threatening comments to her son and agreed that a neighbour would be concerned by the noise and comments made recently. [She] agreed to talk her concerns through with her GP and Adult AS agreed to the chance of a brought forward appointment with [the consultant psychiatrist].*" **Commentary:** there seems to have been an element of buck passing between agencies. No further action resulted from the home visit. Adult AS was not seen on his own and might have felt

[9] Part of Home Group.

constrained, therefore. This was a missed opportunity. The approach taken by practitioners appears episodic rather than connecting this concern with what was known from previous engagement.

3.28. The GP chronology for Adult AT for July 2010 observes that she was not taking medication and had been advised to restart. **Commentary:** no follow up has been recorded and the GP chronology for Adult AT falls silent until February 2013.

3.29. A tenancy visit in August 2010 by staff from Home Group did not identify any issues. In September, during a tenancy visit, Adult AT stated that she had received a new pension from America which might affect her benefits. A Citizen Advice Bureau (CAB) worker was providing advice. **Commentary:** this introduces another theme that occurs quite regularly in the chronology, namely eligibility for Housing Benefit and her apparent confusion about how much rent to pay, leading to arrears or overpayments. No connection appears to have been made at this time with earlier concerns expressed by Adult AT that their financial situation made it impossible to return to North America. It suggests that agencies were working in silos and not connecting presented issues or concerns with the history of the case.

3.30. On 7th September Adult AS was seen by the consultant psychiatrist. His mother attended "*as usual*." Adult AS remained the same and saw the solution of his life by returning to the United States. Adult AT "*as usual*" maintained that they did not have the finances. She was advised to speak to a lawyer on this. Adult AS was reportedly attending art studio and busy on his computer. He was happy with the medication. The plan was to review again in four months. Two days later the community mental health team received a letter from the American Embassy requesting information as Adult AS had applied for disability benefits[10]. This information was supplied. **Commentary:** the planned four month review does not appear to have happened. The next entry from the community mental health team comes in April 2011.

3.31. In October 2010 a social worker suggested the introduction of "*low level*" support for Adult AS. The ASC chronology records that Adult AT was irritated and agitated by the social worker's presence and declined support. Adult AS, however, accepted support from the social worker to go out. **Commentary:** Adult AT declining support reappears here. Her mental health and support needs as a carer remained out of focus since her declining support was not revisited. Listening to what Adult AS wanted was good practice but what is unclear from the chronology is whether the envisaged low level support was actually provided.

3.32. In early February 2011 Adult AT, CAB and Home Group staff were in contact with each other concerning rent payments. Further exchanges between Adult AT and Home Group staff took place in April and June 2011 on changes to Housing Benefit and on required rent payments. **Commentary:** once again, the family's financial situation becomes an issue but the focus was on resolving the immediate concern rather than, additionally, attempting to explore their financial situation more broadly.

3.33. In April 2011 a consultant psychiatrist saw Adult AS. Adult AT was present and the situation remained unchanged. The record observes that Adult AT was frustrated regarding legal issues

[10] A document was found when the contents of the home were secured following Adult AT's death. Dated 24th May 2010 this was a receipt from the US Embassy for a claim for social security widow's insurance benefits.

and the benefits she was receiving from the USA. Both Adult AT and Adult AS were described as lone figures in the town, never having managed to integrate into society and Adult AS as usual was thinking of returning to the States as he saw this as the only answer. He had stopped his anti-depressant medication and he was advised to get a prescription from the surgery. They were given "*a supportive talk*" with a plan to review again in four months. **Commentary:** what is meant by a supportive talk is unclear, as is what it was designed to achieve given the longstanding nature of the issues with which they presented.

3.34. On 17th May the community mental health team received a letter from the American Embassy requesting copies of the medical files as Adult AS had applied for disability benefit. The information was sent. Two days later Adult AS was sent an appointment for the psychology service, which followed a referral from the consultant psychiatrist in January 2011. Adult AS telephoned to cancel the appointment, saying that he no longer required the service. He was discharged. **Commentary:** the assumption clearly was that this was his own decision. However, given what was known about the relationship with his mother, it is possible that what he said was the result of her influence.

3.35. In June 2011 the ASC chronology for Adult AS records that he had not seen his GP since November 2008. It refers to depression and anxiety, for which he was recorded as now taking medication, linked to his father's death, the response by others to his North American accent, and to unspecified issues from a "*difficult childhood*." The same chronology records that a GP had indicated that Adult AS had a degree of learning disability and was reliant on his mother for his needs. She was reported to be struggling financially. Around this time an anonymous referral was received, reporting "*loud arguments*." **Commentary:** it would appear that Adult AS's repeat prescriptions had not been formally reviewed. The chronology does not detail what, if any, support Adult AS was receiving or whether a carer assessment had been offered to Adult AT. Lack of clarity about diagnosis emerges again, with Adult AS now reported to have a learning disability.

3.36. The ASC chronology for Adult AS observes that Adult AT was annoyed when a social worker visited following the anonymous referral. There is evidence of her shouting and threatening her son. **Commentary:** the nature of the relationship does not appear to have become a focus of sustained concern. Different social workers have been involved, which might have impeded the development of a relationship with Adult AT because of the lack of continuity. It is not clear how Adult AS saw the relationship with his mother.

3.37. In early August 2011 a locum consultant psychiatrist working for Northumberland, Tyne and Wear NHS Foundation Trust wrote to a team manager of the Adult Mental Health/Drug and Alcohol Service regarding Adult AS. He requested that a social worker assess Adult AS and Adult AT to explore what practical help could be offered. The letter noted that Adult AS had resided in the UK since the age of 7, had never been able to accept this, and wanted to return to North America. He is said to have blamed his father for not taking him back. The locum consultant psychiatrist observed that Adult AS had "*a degree of learning disability as well as possibly [having] an autistic spectrum type of problem*" and was "*heavily reliant on his mother*." The letter reported that Adult AT was struggling financially and had requested practical help in dealing with government agencies. She had managed to obtain benefits from both the United States and the UK. **Commentary:** this letter appears to have followed an outpatient's appointment when Adult AS was accompanied by his mother. It is not clear from available records what the response was to this letter, or whether the psychiatrist interviewed Adult AS on his own.

3.38. The community mental health team chronology at this point records that Adult AS had attended an appointment with the consultant psychiatrist with his mother. They remained unsettled in this country. Adult AS continued with his anti-depressant medication, and although not socialising, enjoyed his computer, TV and reading to keep occupied. They were given verbal support and a letter was to be sent to ASC to assess the situation and see what practical help could be offered to both, particularly for Adult AT. The GP was also informed by letter.

3.39. In October 2011 Adult AT queried the amount of rent as she had to repay pension credit. Home Group records noted that she was in contact with CAB.

3.40. In November 2011, having received no response from Adult AS regarding the offer of social support, ASC commenced case closure, effective from January 2012. **Commentary:** this appears a missed opportunity to explore reasons underpinning the lack of response. The ASC chronology for Adult AS then falls silent under August 2016.

3.41. In 2011 the Tyne and Wear Fire and Rescue Service (TWFRS) conducted a Home Safety Check (now called Safe and Well visits) and all risk questions were answered '*Prefer not to say*' or '*refused to answer*'. One smoke alarm was fitted. FRS holds no other records of engagement with Adult AT and Adult AS.

3.42. In early February 2012 Adult AS was seen by the consultant psychiatrist, the scheduled appointment for November 2011 having been rearranged because of annual leave. He attended with his mother. His condition remained much the same. Adult AT was described as "*an unhappy lady*" who was struggling with benefits in both the UK and the States. Adult AS had been sent an appointment regarding work-related issues. He was advised to attend and Adult AT had asked CAB to become involved. They were aware he might lose his benefits[11].
Adult AS looked physically well-nourished and well-groomed and stated he was quite handy with things and enjoyed his computer. The record observes that neither had integrated into society and they remained quite critical about society and the government in the UK. They were given "*a supportive talk*" with the plan to review in four months. **Commentary:** quite what the supportive talk involved and what it was meant to achieve is unclear in the context of what appears an entrenched situation. A letter was sent towards the end of May for the next review but there are no records about attendance or outcomes.

3.43. In April and August 2012 there were further Housing Benefit queries that were resolved by the Housing Benefit Team in South Tyneside Council. Adult AT had been wanting to clarify the amount of rent owed and payable.

3.44. In late February 2013 Adult AT was "*exempted*" from reviews of her hypertension as she had failed to attend appointments. **Commentary:** it does not appear that reasons for missed appointments were explored. There were further occasions subsequently when she declined treatment.

[11] When the contents of the home were secured following Adult AS's death, a letter was recovered from HM Courts and Tribunals Service dated 7th December 2011 for a pension credits appeal to be heard in February 2012. A letter was also found dated 21st February 2012 from the First Tier Tribunal Social Security. Adult AT and Adult AS's appeal had been allowed and a decision taken in November 2010 had been set aside. Pension credit of over £2000 would not be recoverable from Adult AT.

3.45. The theme of Housing Benefit and rent payments returned in March 2013 when the Home Group chronology records that Housing Benefit entitlement was split between Adult AT and her son.

3.46. In April 2013 Adult AS was reviewed by the consultant psychiatrist. He attended with his mother. The record reads: "*As usual he said very little spontaneously, stating he was 'alright', enjoying his guitar and computer and was now attending a support group arranged by the Job Centre. Adult AT remained a frustrated lady and they would both like to go back to the States; however they remain in the UK as it has certain financial advantages despite Adult AT being very vocal in never liking this society in this town and remaining rather isolated. Adult AS reported not taking any medication and did not display any signs of depression so medication was not being recommended. An assessment for possible learning difficulty and query developmental problems of either Autism or Asperger's was discussed although Adult AT does not want him to be referred for any of those assessments as she does not want him to be stigmatised. Since there was no active intervention, it was agreed he would be discharged back to GP. He could be referred again if his circumstances changed*." **Commentary:** there was no re-referral. This is the last contact that Adult AS had with mental health services. It appears that his mother was speaking and making decisions for him.

3.47. In early November 2013 Adult AT stated to a GP that she did not want to take any blood pressure medications or to consent to blood tests to be done. A high blood pressure information leaflet was given. In early February 2014 Adult AT attended a review with a practice nurse. Her blood pressure was very high but she refused medication. A week later Adult AT called the practice nurse to state she had stopped taking the ACE/I medication due to a blotch on her leg. She was advised to see her GP but there is no record that she did so. **Commentary:** the chronology does not record whether the reasons behind these refusals were explored.

3.48. The Home Group chronology records that from March 2014 there were further notes about the split of Housing Benefit between Adult AT and her son, and about fluctuating Housing Benefit.

3.49. GP records for early February 2015 note that Adult AT was exempted from hypertension review as she had failed to attend appointments. **Commentary:** GP records for Adult AT then fall silent until March 2018.

3.50. In February and March 2015 Adult AT is recorded as being very upset and frustrated because she did not know how much rent to pay and believed that different agencies were providing her with contradictory advice. She sought advice again in October about changes to her Housing Benefit, possibly linked to her receipt of a widow's surviving pension from North America that was classed as income. She was advised by Home Group staff to speak to the local authority.

3.51. Between May and July 2015, and again in October, various repairs were carried out by the housing provider. Gas servicing was also completed. Various internal and external repairs were also completed between April and November 2016. Gas servicing was also completed in June 2016. **Commentary:** no concerns appear to have been raised.

3.52. In February 2016 Adult AT again sought advice, as recorded by Home Group, about her rent and Housing Benefit. She would not speak to a female member of staff, apparently concerned that

they gave incorrect advice. There was further contact about rent and Housing Benefit in October 2016.

3.53. In August 2016 Adult AS had a face-to-face appointment with a locum GP and attended with his mother. He presented with low mood and was prescribed medication. He was also given a Talking Therapies patient information leaflet. The GP advised him to make a review appointment in 2-3 weeks, sooner if necessary. **Commentary:** there is no record that this was done, nor whether the GP spoke to Adult AS on his own. The next entry in the chronology provided by GPs and by ASC is June 2021.

3.54. With the exception of the months of October and December 2017 there was some contact between Home Group staff or contractors and Adult AT. Some contacts related to internal repairs at the property and gas servicing (April); others focused again on Adult AT's confusion about changes to her Housing Benefit, about the amount of rent she was required to pay and about rent arrears. CAB staff were occasionally involved. At times the rent account was in credit. **Commentary:** when the contents of the home were secured, letters were found addressed to Adult AT and Adult AS individually, dated 7th April 2018, advising of the outcome of their claims for housing benefit.

3.55. In September 2017 a home visit was completed by a housing manager. He spoke to Adult AT and her son about the rent account. Adult AS answered the door and invited the housing manager in. He locked the door behind the housing manager. He was asked if he could unlock the door and did this without issue. "*It appeared to be habit and no ill intention*." Adult AT "*was surprised by [the] housing manager being in the house. She was initially very angry with [the] housing manager and accused him of being there as a spy and that he had links to gangsters and terrorists*." [The] housing manager was able to explain he was only there to discuss rent and as soon as this was established, she calmed down and was "*receptive and reasonable*." The rent account was explained and Adult AT [was] "*happy that issues were resolved*." No further concerns were raised. **Commentary:** this home visit was good practice, especially as an attempt to resolve ongoing issues relating to Housing Benefit and rent payments. As recorded, the home visit provides a glimpse into the world of Adult AT and Adult AS. No onward referrals or information-sharing occurred after this visit, perhaps a missed opportunity to seek to introduce further assessment or support.

3.56. In February 2018 further internal repairs were completed. Gas safety checks were completed twice in 2018, in February and November. Only one contact has been recorded by Home Group regarding Housing Benefit and rent payments, for January 2018.

3.57. In March 2018 Adult AT attended a hypertension review with an advanced nurse practitioner. Adult AT did not want any interventions with regard to her blood pressure. She refused to have bloods taken. **Commentary:** this is a repetitive pattern. If concerned curiosity was expressed and her refusal explored, this has not been recorded.

3.58. In February 2019 Adult AT attended the GP practice for flu vaccination. Her blood pressure was also taken at the appointment and found to be high. Adult AT refused medication. There was less contact with Home Group staff and contractors during 2019. There were two contacts in March about Housing Benefit. A gas safety check was completed in September and internal repairs the following month.

3.59. In early February 2020 Adult AT attended the GP practice for blood pressure monitoring. Once again this was high and she refused medication. In October Adult AT declined vaccination for shingles and flu. **Commentary:** this is a repetitive pattern. If concerned curiosity was expressed and her refusal explored, this has not been recorded.

3.60. During 2020 contact with Home Group comprised an internal repair (February) and whether management of garden shrubs was her responsibility as tenant. A home visit to discuss management of the shrubs in July was conducted outside the accommodation and Adult AS was not seen during this visit. Her rent account was in substantial credit (August). **Commentary:** Adult AT told a practitioner in a Customer Service Centre that she was "*too sick to worry about shrubs*." The chronology does not record whether concerned curiosity was expressed about this comment.

3.61. On 18th January 2021 Home Group staff attempted to contact Adult AT about the large credit which had accrued on her rent account due to her paying over what was required in conjunction with Housing Benefit. A voicemail was left. The following day a further call was successful. Initially the staff member spoke to Adult AT's son who called for his mother to take the phone. The staff member explained to her that they had been continuing to pay a higher amount despite a change in their Housing Benefit entitlement, so they had built a large credit. A refund was issued for £3811.63 via BACS transfer. No concerns were recorded regarding Adult AS following this telephone contact.

3.62. In February 2021, following another complaint from a neighbour, there was further contact between Home Group and Adult AT regarding garden shrubs. She was advised that this was her responsibility. In March, during a follow-up telephone call, Adult AT advised that she had "*too much going on to worry about shrubs but would not elaborate on issues faced*." A voicemail message was left by Home Group staff in early April. Contact later that month with Adult AT recorded that she "*was unhappy that shrubs were still an issue but admitted that she had not done anything about it.*" She was advised about her responsibilities as a tenant. The necessary work was subsequently completed.

3.63. In February 2021 Adult AT received her first vaccination against Covid-19. In early June a GP receptionist called Adult AS to arrange for his Covid-19 vaccination, which he received on 17th July. On the same day Adult AT received her second vaccination against Covid-19. The previous day she had contacted the GP practice unhappy at having received a letter advising if she did not make contact by 21st July the practice would assume she was no longer at the address. She was advised of previously sent letters in March, May and July, and failed calls in May and July regarding bowel screening and her second Covid vaccination and she had not responded.

3.64. In May a gas safety check was completed at the property and no concerns raised. A repair to the smoke alarm was completed in September. No other concerns were raised. **Commentary:** 28th September is the last recorded contact between Home Group and Adult AT.

3.65. On 24th September North East Ambulance Service (NEAS) conveyed Adult AT to South Tyneside Hospital A&E Department. She had fallen twice that day in a shop but did not appear to have sustained a head or other injury. NEAS paramedics recorded that the Post Office manager and Adult AS had reported that she had been fallen regularly over the previous 5-6 weeks and appeared to have deteriorated. Adult AS stated that his mother's confusion had increased over the last 2 weeks. Adult AT appeared to paramedics to be unkempt. Both mother and son stated

they had not eaten for 2 weeks; however, on arrival at hospital Adult AT stated she had eaten on the previous day. Adult AT repeatedly stated that she wanted to go home and would not answer paramedic questions about history when asked. She occasionally gave some history, but most was obtained from her son and the Post Office manager.

3.66. Adult AT was unable to repeat information given to her by paramedics and unable to state the consequences of going against advice to attend hospital. She was deemed not to have capacity. She tried to walk away from the paramedics but was unable to steady herself. The crew assisted her to the ambulance for further assessment. She was confused, unable to give her past medical history or state allergies/known medications. Adult AS travelled with the crew as paramedics were concerned that he was a "*vulnerable adult*" as he had stated that Adult AT was his carer. The Post Office manager also believed this to be the case. On the vehicle Adult AS stated that he and his mother were struggling both at home and financially. The Post Office manager stated that Adult AT withdrew £600 per week. Paramedics were unable to obtain a FAST test[12] as Adult AT was non-compliant.

3.67. **Commentary:** Paramedics obtained consent from Adult AS to refer an adult safeguarding concern. This was good practice even though consent is not strictly necessary. Capacity assessment appears to have been thorough, with Adult AT having been conveyed to hospital in her best interests. Paramedics were also attentive to Adult AS, concerned that he was potentially an adult at risk. The episode clearly highlights concerns regarding self-neglect and neglect, requiring further assessment.

3.68. At South Tyneside and Sunderland NHS Foundation Trust (STSFT) Adult AT stated that she had felt light headed and thus sat down. Adult AT stated that she remembered the event and did not lose consciousness. She reported experiencing insomnia over the past few months and that this had made her drowsy during the day. Adult AT reported increased confusion over a few weeks; however, she did not feel that this was significant. She also reported that she felt her memory had been gradually worsening over the past few months. The doctor examining Adult AT detailed that he had been informed that Adult AT's son looked unkempt (faeces over himself and unkempt hair) and that arrangements had been made for respite care for Adult AT's son. The doctor documented that a safeguarding was in place.

3.69. CT Scan (Head) findings were in keeping with a subarachnoid haemorrhage. A discussion took place with neurosurgery, concluding with agreement for conservative management. There was no requirement for neurosurgical involvement. Throughout the examination, Adult AT repeatedly stated that she wanted to go home. She understood the results of the CT scan but insisted on going home. Adult AT was unable to repeat the risks of leaving hospital and the doctor felt Adult AT was not able to weigh up those risks. As such, the doctor felt that Adult AT did not have the mental capacity to make this decision. A Deprivation of Liberty application was submitted. **Commentary:** Adult AT's examination at the hospital was thorough, so too the mental capacity assessment. Self-neglect concerns are apparent.

3.70. During 24th September at the hospital, Adult AT stated that she did not know why she was there. She denied any symptoms of confusion and said that she had been "*sad*", with low mood and significant insomnia. Adult AT denied any weight loss or loss of appetite, and any suicidal thoughts.

[12] Focused assessment of facial droop, arm weakness, speech difficulty and time.

She stated that she lived with her son and was his main carer. He did not work or study, and spent time on his computer. Doctors enquired as to his health. Adult AT stated that he had no health issues and there were no concerns. She wished to leave hospital and did not seem to understand that she required medical attention. She denied appearing unkempt, confused or forgetful. The doctor documented that Adult AT did not appear to be able to retain information given to her as she had forgotten the information she had been given in regard to her CT scan. Based on Adult AT's presentation at the time, the doctor did not feel Adult AT had capacity. **Commentary:** mental capacity assessment was thorough. Also observable are mental health concerns that have emerged periodically in this chronology. Understandably the main focus was on Adult AT but her ability to be a carer for Adult AS, given his statements to paramedics and his appearance when at the hospital, should also have been a concern for all the agencies and services involved, especially given the adult safeguarding concerns referred by paramedics and STSFT staff.

3.71. Throughout 24th September Adult AT remained confused. She declined to allow full neurological observations to be carried out. However, a Malnutrition Universal Screening Tool was completed. Adult AT was found to have a BMI of 24 – Low risk. That day also STSFT staff liaised with adult safeguarding, concerned that Adult AS would be home alone. A safeguarding adult concern was completed and submitted to the local authority. **Commentary:** submission of an adult safeguarding concern was good practice.

3.72. A social worker saw Adult AS and his mother in A&E. The chronology records that "*both presented as unkempt and it seemed as though neither of them had been managing their personal care for some time. Adult AS's clothes were stained and he smelled strongly.*" Adult AT was adamant that she wanted to go home and did not want to remain in hospital. The nurse looking after her informed the social worker that a mental capacity assessment had been completed and concluded that she lacked capacity to consent to treatment and she was being taken up to a ward. Due to Covid restrictions, Adult AS was unable to go with her. **Commentary:** there is good evidence here of information-sharing and working together.

3.73. The social worker discussed with Adult AS what was going to happen when his mother went up to the ward. Adult AS presented as "*very shy and quiet but did answer questions when asked*." Adult AS said that he and his mother looked after each other but commented that they had been struggling recently. He spoke about being able to manage his own personal care needs but he could not remember the last time he showered. Adult AS said that he was scared about going home on his own and asked for someone to help him while his mother received treatment in hospital. **Commentary:** there is evidence of the social worker making safeguarding personal here.

3.74. Following advice from a manager, the social worker took Adult AS home whilst a placement was sought for him. The social worker recorded that there was only one house key. Adult AS ate a sandwich and had a drink, having said that he had not eaten all day. The social worker observed that "*the living room was in fairly good condition although the kitchen was cluttered with dishes and rubbish. The fridge was full of food but mostly seemed to be old takeaway leftovers. Adult AS's mattress was heavily stained and had no bed sheets on it. He initially said he didn't have any clean clothes but when [the social worker] entered his room, there were lots of clothes hung up on the door of his wardrobe.*" **Commentary:** good observation by the social worker. There is clear evidence of self-neglect and neglect. There is an indication here that the condition of parts of the home were different from those previously recorded.

3.75. The social worker spoke with Adult AS about living elsewhere temporarily if no-one could be found to stay with him at home. He was agreeable to this, albeit anxious. Whilst waiting for commissioners to source support, AS packed some clothes, asking the social worker to help with this, and remained in his room. The social worker confirmed with him that he was not taking any medication. Whilst in his room, the social worker overheard that he spoke to himself often and in a fairly aggressive tone. This contrasted with him being "*very calm and quiet*" when he spoke with the social worker. He regularly sought assurance about how long his mother would be away. He told the social worker that he liked to read and would like to travel and maybe live in Europe one day. He said that he was from Arizona originally and would like to go back there. He spoke about his father who had passed away; he said they had a good relationship. A residential placement was sourced and the social worker drove Adult AS there. On arrival, Adult AS again sought reassurance that it wouldn't be for long but agreed to stay there while his mother was in hospital. The social worker informed STSFT and the Out of Hours Service. **Commentary:** the social worker had clearly been able to establish a positive relationship with Adult AS. Information-sharing with other services was good practice.

3.76. On 25th September ASC received the referred adult safeguarding concern from NEAS. Following liaison between STSFT staff and the social worker, Adult AT was able to speak with her son. Adult AT continued to ask to go home. Doctors documented that Adult AT was not able to weigh up any information regarding whether to stay in hospital. Doctors felt that Adult AT could not retain information and that she was fixated on leaving hospital. Hospital staff were aware of safeguarding concerns. **Commentary:** evidence of good practice with respect to ongoing review of Adult AT's mental capacity and facilitating contact between mother and son.

3.77. On 27th September following a review by a ward doctor, Adult AT was found to be medically optimised for discharge. No formal neurosurgery follow up was required. She was very distressed and wanted to go home. She expressed concern for her son. The doctor documented that Adult AT would be able to go home once the social situation had been sorted. The following day Adult AT remained medically fit for discharge, having been reviewed by an occupational therapist, and was keen to return home with her son. STSFT staff liaised with the Let's Talk Team, a social worker advising that they would look into the safeguarding concerns and call back. Hospital staff also discussed discharge with the social worker for Adult AT's son. This resulted in arrangements for the social worker and Adult AS to be at home when Adult AT arrived on patient transport. **Commentary:** once again there is evidence of good practice in terms of practitioners working together. However, there is no documented discussion of whether Adult AT would be able to care for Adult AS. It is not clear whether her mental capacity with respect to being a carer was assessed. STSFT staff had spoken to a social worker about their concerns relating to neglect of Adult AS but there is no record of a carer assessment having been considered or completed by a social worker. The focus appears to have been on enabling her and her son to return home without concerned curiosity about the circumstances preceding her hospital admission.

3.78. The occupational therapist record highlighted that Adult AT was upset that the Post Office manager had called an ambulance for her. She was adamant that she did not fall, stating that she had sat down on the pavement as she was tired and awaiting a taxi. Adult AT confirmed that she managed with her bed, chair and toilet transfers at home. Adult AT confirmed that she was independent with indoor and outdoor mobility. She declined assistive technology and said that she could ask for help if it were required. Adult AT went on to state that she was independent with personal care, meals, domestic tasks, finance and shopping. Adult AT was keen for discharge

home. There were no concerns regarding capacity at the time of the assessment. **Commentary:** once again there is evidence of Adult AT's reluctance to accept support. Nor has the occupational therapist seen the home circumstances. Reliance has been placed on Adult AT's self-reporting. Had information about conditions within the accommodation been shared with STSFT staff by the social worker, when taking Adult AS to collect some of his clothes and belongings, this might have suggested a home assessment by an occupational therapist.

3.79. On 28th September Adult AS's social worker contacted placement staff for an update. They advised that Adult AS was doing well. He had been encouraged to shower and was eating well. However, his clothes were in an awful state. The social worker took steps to source clothes for him. The social worker also liaised with STSFT staff regarding arrangements for Adult AT's discharge. The social worker advised Adult AS that his mother was being discharged. He was keen to return home. He acknowledged that they had been struggling and was open to support, but his priority was returning home. The social worker discussed their concerns and Adult AS agreed to the social worker visiting to see how they were managing and discussing longer term support to ensure both of their needs were met. **Commentary:** evidence of good practice with respect to making safeguarding personal. However, it is not clear from the records whether what Adult AS meant by "*struggling at home*" had been explored.

3.80. The social worker drove Adult AS home and awaited his mother being brought back by hospital transport. The social worker explained to Adult AT about working with Adult AS to source some support for him. Adult AT asked if the social worker would delay a further visit until the following week but the social worker advised that due to their presentation and concern about how they would manage, they would visit this week to ensure that they were not at risk. **Commentary:** again evidence of good safeguarding practice.

3.81. STSFT sent a discharge letter with a request that the GP review Adult AT's need for amlodipine for hypertension. Neurosurgery had recommended this. Whilst Adult AT was in hospital, her blood pressure was borderline raised.

3.82. On 1st October, a referral was sent to district nurses to check Adult AT's blood pressure following her hospital discharge. The social worker visited Adult AS at home. His mother was very reluctant for Adult AS to go anywhere and repeatedly stated that she was insecure about being separated from Adult AS. Adult AS said that he would like to go for a walk so the social worker was clear with Adult AT that he should be able to leave the house and that the social worker would be with him the whole time to ensure his safety. **Commentary:** the chronology is silent on whether Adult AT's insecurity regarding her son was explored. There are glimpses once again into her mental health and into the nature of the relationship between mother and son. The social worker's insistence that Adult AS should be allowed to go out, his expressed preference, was good practice.

3.83. The social worker went for a walk with Adult AS. Adult AS disclosed that he and his mother wished to return to North America but he was unsure how likely this was. Adult AS again said that he would like some support and in particular he would like to be able to leave the house and interact with others as at present he was with his mother all the time. Adult AS liked sports such as badminton and squash and would like to be supported to get out in to the community to play these. Adult AS demonstrated that he was not aware of road safety, and had to be prompted several times to stop before crossing to avoid oncoming cars. **Commentary:** once again there is evidence of the positive relationship that the social worker had been able to establish with Adult

AS. Unfortunately, during the walk, the social worker injured her ankle. Adult AS was returned home by car, with the social worker informing Adult AT what had happened and promising to resume contact as soon as possible. This incident somewhat derailed the social worker's plans.

3.84. On 6th October a GP receptionist called Adult AS to arrange an appointment for his second Covid vaccination as this was now overdue. He advised he would contact the surgery at a later date to arrange this. On 8th October the GP received from district nurses a blood pressure reading for Adult AT. This was normal.

3.85. On 10th November the social worker visited to see Adult AS. He came to the door but did not open it. He declined to answer the door and told the social worker that he did not want to go out anywhere. He also said that he did not want to talk today and asked the social worker to leave. The social worker asked Adult AS if he still wanted some support, which he had previously spoken about. He replied that he didn't think he wanted support anymore. He did agree that the social worker could return to see him. **Commentary:** the question arises here of undue influence on his decision-making. Adult AS's change of mind should have been escalated as a concern given how Adult AS had presented when his mother had been admitted into hospital and what he had said to the social worker when not in the presence of his mother.

3.86. On 16th November the social worker discussed the case in supervision. **Commentary:** the use of supervision was good practice. However, the chronology does not record what options were discussed and what the forward plan was.

3.87. On 17th November the social worker attempted to see Adult AS but no-one answered the front door. On 30th November a practice nurse gave Adult AT community mental health forms to self-refer due to her feeling distressed over different areas of her husband's death, his treatment of her and their son whilst he was alive, and their poor circumstances today. **Commentary:** this once again highlights the theme of Adult AT's mental health and is the first real indication of her seeking help. However, signposting to services is often ineffective, especially when there is a history of declining advice and support. The social worker's inability to see Adult AS should have been escalated as a concern. Nor was the unsuccessful home visit followed up immediately.

3.88. On 4th December the social worker received a voicemail from Adult AS whilst they were not at work. When accessing the voicemail subsequently the social worker could not understand what he was saying as he was speaking quickly. Three attempts were made by phone to speak with Adult AS but there was no answer. **Commentary:** what is emerging here is the need to consider legal options (power of entry) to see Adult AS to check on his wellbeing. The social worker's absence from work after 17th November for a period of time disrupted attempts to make contact with Adult AS. The reference to Adult AS speaking quickly, making his message unintelligible, might be understandable by reference back to assessment by the consultant psychiatrist in October 2006. This assessment observed Adult AS's pressure of speech and garbled words. The social worker might not have known about this historic assessment as the information does not appear to have been shared with ASC.

3.89. The social worker made a home visit on 20th December to try to discuss any potential support that Adult AT and Adult AS might need. No one answered the door. Later that afternoon ASC received a phone call from the police advising that they had received a concern about Adult AS and his mother from neighbours who reported not to have seen or heard them for some time.

The social worker advised of their unsuccessful visit. Police advised that they might need to force entry to check on their welfare. Later in the evening the social worker received a phone call from Northumbria Police, advising that both Adult AS and his mother had been found deceased in their home. Police believed they had been deceased for some time and that Adult AT might have passed away before her son. Adult AS looked very underweight and police hypothesised he might have passed away as a result of malnourishment. Police advised they had been unable to find any documents of identification and they had very limited information on both. The social worker undertook to share what information was held by ASC. A NEAS rapid response paramedic attended. Adult AS had no respiration, no palpable pulse, no heart sounds and pupils were fixed and dilated. He was emaciated in presentation, showed signs of self-neglect, had rigor mortis and hypostasis. There was no bedding. His mattress was heavily stained. No suspicious circumstances were noted and nil cause of death obvious. Adult AT was found lying in bed in a room which was unkempt. She presented with rigor mortis and post-mortem staining. She had no respiration, no palpable pulses, no heart sounds and pupils were fixed and dilated. Her mattress was stained and there was limited bedding. No suicide notes were found or suspicious circumstances noted.

3.90. The GP was informed on 21st December by NEAS of the deaths of Adult AT and Adult AS.

Section 4: Analysis

4.1. It should be noted that much of the chronology predates implementation of the Care Act 2014 on 1st April 2015. Nonetheless, the core adult safeguarding principle, Making Safeguarding Personal, had already been developed.

4.2. Some early records, which would have proved useful in elaborating on the chronology, have been lost as a result of digitisation, the passage of time and service closures. Nonetheless, several themes consistently appear in the chronology, with important learning for practice and service improvement.

4.3. Direct Practice: Engagement and Service Refusal.

4.3.1. Consistently throughout the chronology it is clear that Adult AT did not welcome home visits from social workers and housing managers. She also routinely declined support, bereavement counselling, medication, and medical tests for herself, including after her hospital admission, and also declined assessments and support for her son. Adult AS was more prepared to accept support and help, when seen on his own, but retracted subsequently, possibly due to his mother's views. Partly as a result of what was probably her undue influence, some plans for work with Adult AS were not followed through.

4.3.2. At the learning event it was acknowledged that there was sometimes a reliance on telephone contacts and on self-reporting. There was also some reliance on signposting to services, which is often ineffective in cases of self-neglect and/or neglect. Had the repeating pattern been more evident, a different response to missed appointments and service refusals would have been indicated. Overall, those attending the learning event agreed that insufficient concerned curiosity was shown about Adult AT's decision-making both for herself and her son. It is useful, here, to draw attention to learning from safeguarding children, namely that missed appointments might helpfully be seen as "*was not brought*."

4.3.3. There were a few occasions when Adult AS was seen on his own and some occasions when social workers insisted that Adult AS had a right to express his own wishes and needs, which they would attempt to address. Adult AS also provided glimpses into their lives by acknowledging that they had been struggling. However, despite occasional evidence of persistence by social workers, by and large Adult AT was able to exercise control, for example after he returned home to live with his mother following her discharge from hospital. His refusal to open the door when a social worker visited in November 2021 was not escalated as a safeguarding concern. There was also a delay in following up the apparently incoherent message that he left for the social worker. Whilst three telephone calls were made, no home visit was conducted until 20th December. This would suggest insufficient curiosity and appreciation of risk.

4.3.4. It was observed at the learning event that Adult AT did not entirely disengage from services. There were periodic contacts with housing personnel, focusing on repairs and gas checks. There was a repetitive pattern of Adult AT seeking advice and expressing concern about payments for rent. There were occasions when both Adult AT and Adult AS were seen by GPs, pharmacists or practice nurses and receptionists. Whilst they might be described as reclusive, they were not totally out of sight. However, contacts were episodic and focused on a presenting problem or

issue. The repetitive patterns do not appear to have been recognised or to have become a focus for concern. Similarly, there does not appear to have been much concerned curiosity regarding the backstory and how they presented to the various practitioners they did interact with.

4.4. Direct Practice: Think Family and Community.

4.4.1. Adult AT consistently expressed a wish to return to North America but said that this was not possible. It does not appear that this was explored to any great degree but rather accepted at face value. It is puzzling because it is now known, from bank statements found when the belongings in the house were gathered up, that Adult AT and Adult AS did have sufficient financial resources that would have enabled a return to the United States of America. Adult AT's contact with her cousin, weekly telephone conversations and exchanges of letters, could also have facilitated a return "*home*." Her cousin has suggested that a felt stigma of having a disabled son might have been perceived as a barrier to returning. Her cousin has observed that Adult AT would not talk about his disabilities. Equally, however, her cousin has said that she did not really understand what Adult AT meant by not being able to return to North America. She also had no knowledge of the whereabouts of extended family members.

4.4.2. The chronology records occasions when concerns were noted about how Adult AT interacted with her son. There were occasions when coercive and controlling behaviour, and undue influence, could have been the focus for attempted exploration, especially when Adult AS withdrew from supports being offered and to which he had previously agreed. It does not appear that the relational dynamics between mother and son were ever explored in any depth, difficult though this might have proved. Her cousin has observed that Adult AT always kept her son close by, commenting that she would say "*he's right here*."

4.4.3. The Post Office manager noticed significant changes in both Adult AT and Adult AS. They always did a weekly shop, spending between £20 and £30. They had used the post office and shop for at least 10 years. The manager was clearly upset at the news, having assumed they had either moved or had gone into a home. The manager described Adult AT as a "*lovely lady*" who always had her makeup on up until about a year before her death when it became apparent that she was not washing and was appearing unkempt. Around this time Adult AT would often sit herself on the floor of the shop and was described as being "*not all there.*" On the occasion she fainted the manager can clearly remember Adult AT shouting that she did not want an ambulance summoned. However, the Post Office manager did call paramedics.

4.4.4. Likewise for Adult AS, up until a year before his death he was a "*big lad"* but there was then a marked weight loss. His clothes were dirty and hanging off him. The manager of the Post Office described Adult AS as "*slow"* with some type of learning difficulty but was unclear what it was. The manager noticed that Adult AT would become very impatient with him as he would repeat himself resulting in his mother shouting at him to "*shut up*."

4.4.5 The Post Office manager clearly held significant information and yet did not refer an adult safeguarding concern. Community awareness of pathways for referrals into adult safeguarding is highlighted by the manager's observations, and has been emphasised by other SARs[13].

[13] For example, East Cheshire SAB (2021) *Mervyn*.

4.4.6. The front door of their accommodation contained glass. This would have enabled anyone to observe the build-up of post. The importance of delivery drivers and postal workers thinking about adult safeguarding has been noted in other SARs[14].

4.4.5. A neighbour became sufficiently concerned to call the police. Adult AT and Adult AS were rarely seen but were always together, for example when going out to shop. No-one other than "*officials*" ever seemed to visit the house. This neighbour's observations highlight just how social isolated Adult AT and Adult AS had become.

4.5. Direct Practice: Mental Health.

4.5.1. Both Adult AT and Adult AS experienced prolonged mental distress following bereavement. Both described the husband/father as controlling them from the grave. Adult AS had prescriptions for anti-depressant medication[15] but was not always seen for reviews. At the end of November 2021 Adult AT was signposted by a practice nurse to community mental health services due to her feeling distressed over her husband's death, his treatment of her and their son whilst he was alive, and their impoverished or diminished circumstances. This highlights the importance of services responding to the impact of grief and loss, in this case both the initial bereavement and its apparent prolonged impact, and the subsequent "*little deaths*" or other losses that followed. At the learning event, based on knowledge from records and contacts with Adult AT and Adult AS, it appeared that both mother and son blamed their circumstances on the death of the husband/father, from which they never really recovered emotionally.

4.5.2. Adult AT's cousin has commented that, from their conversations, it seemed that Adult AT was "*living in the past*" and was "*obsessed with old memories*", especially of her life in the United States of America. She would report that there were many occasions when she did not feel like getting up and would stay in bed. What emerges from the chronology is that an effective response to Adult AT's mental and emotional distress proved elusive. Those attending the learning event reflected that obtaining a mental health assessment could be difficult unless it appears that detention under the Mental Health Act 1983 was a likely outcome. Mental health needs could be missed as a consequence.

4.5.3. There are mental health records dating back to 2005 that report that Adult AS found it hard to make friends, that he felt his family had been "*dumped*" in the UK, and that he wanted to be an actor and to travel. There are references to a possible diagnosis of borderline personality disorder, and to his mother describing him as a "*lunatic*" and as "*dependent*." There is also a reference to her perception that the college, which he had left, had been harming him. As noted at the learning event, this once again highlights the importance of focusing on relational/family dynamics.

4.5.4. The reference, which emerged at the learning event, that Adult AS might have had a personality disorder, connects with the uncertainty about whether he had a learning disability and/or was on the autistic spectrum. This diagnostic uncertainty was never resolved. It can be partly explained by Adult AT's apparent refusal to permit an assessment of her son with respect to possible autism. No question seemed to be asked at the time as to whether Adult AS himself would have had the capacity to take a decision about such an assessment. Equally, no consideration appears to have

[14] Cornwall and Isles of Scilly SAB (2013) *The Reliable Tradesman*. Herefordshire SAB (2020) *Samuel*.
[15] Citalopram, a treatment for depression and panic attacks.

been given as to whether his mother was or was not acting in best interests. Not only was consideration not apparently given to the requirements of the Mental Capacity Act 2005 here but once again there were missed opportunities to have made safeguarding personal. It is one further example of Adult AS not having been seen as an adult in his own right, and of how his mother's views and decision-making were accepted and privileged.

4.5.5. At the learning event, those attending observed that the requirements of the Mental Capacity Act 2005 were still not fully understood by all services, especially in relation to unwise decisions. It might also be the case that those practitioners who met Adult AS might not have fully understood the implications of autism and/or Asperger's. The Health and Care Act 2022 now requires all providers registered with the CQC to ensure their staff receive training appropriate to their role on autism and learning disabilities. Local authorities must have an adult autism strategy[16]. SARs have also highlighted the importance of practitioners understanding how best to work with people with autism[17].

4.5.6. Records in relation to Adult AS in school, and whether he was regarded as a child with special needs, have been lost as the school has long since been closed. It appears that in college he was following a course for young people with learning disabilities but no records of his time there have been found. There is a suspicion that he left college, in part, because he had been bullied. Once he left college Adult AS remained neither in education, employment or training. No-one appears to have questioned this. There does appear to have been some reviews by the Department for Work and Pensions regarding his employability, based on limited correspondence found when the contents of the accommodation were secured[18]. Those attending the learning event recognised that, as someone with disabilities, Adult AS would now be regarded as someone for whom transitional safeguarding responsibilities arose. His transition between child and adult services only appears in references to exchanges between child and adult mental health services and was not taken as an opportunity for joint working with Adult AS and his mother. Those attending the learning event questioned whether transitional safeguarding for someone like Adult AS would be better now.

4.5.7. For a time Adult AS was being seen by a consultant psychiatrist and some support was being offered to the family by a practitioner working for Stonham. It appears that these interventions came to an end because Adult AT and Adult AS saw no continuing need for them. There does not seem to have been any reflection as to whether Adult AS was making his own decision or whether it was the result of his mother's influence. Evidence from records suggests that Adult AT's and Adult AS's emotional and mental distress continued. It is questionable also what the periodic outpatient appointments with the consultant psychiatrist were designed to achieve. No change in approach is evident when it was observed that the grief reaction was prolonged and that the situation "*remained unchanged*."

4.6. <u>Direct Practice: Mental Capacity</u>.

[16] Autism Act 2009; DHSC (2015) Statutory Guidance for Local Authorities and NHS Organisations to Support the Implementation of the Adult Autism Strategy.
[17] For example, Bristol SAB (2018) *SAR Christopher* and Lewisham SAB (2020) *SAR Tyrone Goodyear*.
[18] Letters have been recovered dated October and December 2017 advising Adult AS to complete a capability to work questionnaire and to attend an assessment with a healthcare practitioner regarding his benefit claim to DWP.

4.6.1. As the chronology records, mental capacity assessments were completed by paramedics and by hospital staff regarding Adult AT's capacity to make decisions about her treatment when she collapsed at the Post Office and when she was in hospital. These assessments were appropriate and were thorough. However, once hospital staff had concluded that she was medically fit for discharge, there were missed opportunities by social care practitioners to assess her mental capacity, and in particular her executive functioning, in relation to decision-making about her caring responsibilities for Adult AS, and her ability to manage activities of daily living. Both Adult AT and Adult AS were seen by paramedics and hospital staff with evidence of self-neglect. It was assumed that Adult AT had the capacity to care for Adult AS on discharge. A coordinated meeting prior to discharge would have been helpful in ensuring that all the safeguarding concerns that had been expressed, namely self-neglect and whether Adult AS had been neglected, were not lost. Given the concerns that had been expressed by paramedics and hospital staff, and given the information held by care staff about Adult AS's needs, a social worker could have offered a carer assessment and expressed concerned curiosity about how Adult AT would manage back home.

4.6.2. Those attending the learning event recognised that there were missed opportunities to consider mental capacity at the point of hospital discharge in relation to managing activities of daily living and carer responsibilities, and questioned whether practitioners were sufficiently confident in undertaking assessments, especially given that Adult AT was adamant that she wished to return home. It was also suggested when reflecting more generally about their work experience that some practitioners shy away from assessing executive functioning and were inclined to assume decisional capacity.

4.7. Direct Practice: Safeguarding.

4.7.1. Adult safeguarding concerns were referred by paramedics and hospital staff when Adult AT was admitted to hospital, concerned about evidence of self-neglect and neglect. Adult AS was described as unkempt and covered in faeces in September 2021 when his mother was admitted to hospital. The social worker at the time was concerned about some of the conditions in the home, describing the accommodation as cluttered but not dirty. The social worker certainly witnessed the conditions in the kitchen, with a degree of clutter that prevented use of the back door. It is unclear, however, whether the social worker observed the conditions in all the rooms in the house. However, the social worker did observe conditions in Adult AS's bedroom, where there was evidence of neglect and/or self-neglect.

4.7.2. District nurses did not refer safeguarding concerns after their home visit on 8th October 2021. The sitting room where Adult AT was seen for monitoring her blood pressure was tidy. The care setting where Adult AS was accommodated when his mother was in hospital did not refer an adult safeguarding concern.

4.7.3. No adult safeguarding concerns (or prior to implementation of the Care Act 2014 referral of concerns relating to the protection of vulnerable adults) appear to have been referred earlier in the chronology, despite Adult AT's observed negative attitudes and behaviours towards her son. Contractors who undertook repairs for the social housing associations, and engineers who completed gas checks, did not report concerns. It is possible that, just as the Post Office manager reported a deterioration in how Adult AT and Adult AS presented in the last year of their lives, the condition inside the accommodation might also have deteriorated. It is also possible, as recognised at the learning event, that practitioners applied their own values to the question of

self-neglect, to the conditions in which Adult AT and Adult AS were living. This recognition highlights the value of supervision, discussed below, in exploring with practitioners what they have observed and the lens through which they are interpreting what they have seen.

4.7.4. No section 42 adult safeguarding enquiry was commenced. The concerns about self-neglect and about neglect were lost. This was because the sole focus, when Adult AT was medically fit for discharge, was on returning her and her son home. There was no safety planning. Those attending the learning event concluded that the hospital discharge process was rushed, in the sense of apparently focusing only on responding to Adult AT's wish to return home immediately with her son, and that this impeded a person-centred and a safeguarding approach with both Adult AT and Adult AS. Those at the learning event also recognised previous learning on adult safeguarding concerns that had become lost, for example when a person was in hospital and where, when medically fit for discharge, the adult safeguarding concerns had not been picked up again. Thinking safeguarding emerged at the learning event as an important reminder for practitioners and operational managers. In this case, the focus became how to get Adult AS home, not whether Adult AS should go home.

4.7.5. The admission of Adult AS into respite care, whilst his mother was in hospital, represented a window of opportunity to consider self-neglect and neglect. He had disclosed that he and his mother had been struggling but this admission does not seem to have been explored, even as the social worker took him home to collect some clothes for his respite stay. At the learning event, staff from the respite care setting were candid about what they observed. He presented as very unkempt, thin but not emaciated. They were unable to weigh him as the setting did not have functioning scales at the time. His clothes were so threadbare and dirty that they had to be replaced. He was provided with clothes and shoes. Consideration could have been given to using the Malnutrition Universal Screening Tool (MUST) in order to establish how underweight Adult AS might have been at this time.

4.7.6. Owing to the Covid pandemic, he remained in his room so staff were unable to see how he would have interacted with other residents. However, with staff he was very quiet but always happy and grateful. He could be quite forthcoming, he engaged with all staff, and settled in quickly and well. He was initially reluctant to shower but did accept help and respond to prompting. He permitted his nails to be cut and his hair and beard to be trimmed. When he returned home, he wanted to keep his new clothes and shoes.

4.7.7. Most strikingly, perhaps, was that he drank and ate really well and at all times of the day and night. As was observed at the learning event, if a child had been witnessed to eat in a placement to a degree similar to Adult AS, this would have raised concerns about child neglect. Those at the learning event recognised the importance of transferring learning from the safeguarding of children to the safeguarding of adults.

4.7.8. The social worker was right to insist with Adult AT that she would visit to check on how the family were managing after the hospital discharge, and to see Adult AS. However, when Adult AT resisted social worker visits, and when Adult AS withdrew from his previous willingness to spend time with the social worker, this was not raised within ASC as a safeguarding concern. The social worker was newly qualified and inexperienced, which might account in part for the lack of curiosity and understanding of risk.

4.8. Assessment.

4.8.1. As was observed at the learning event, there was no carer assessment for Adult AT. Nor was there a care and support assessment of either Adult AT or Adult AS. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury (Care and Support (Eligibility Criteria) Regulations 2014). Adult AT falls within this definition as a result of her subdural haematoma, the long-term effects of which can include changes in mood, concentration or memory problems, limb weakness, seizures and speech difficulties. Adult AS falls within the definition by virtue of his learning disability.

4.8.2. Even if Adult AT had refused an assessment of her care and support needs, one could have been undertaken anyway, using the provision in section 11 Care Act 2014[19]. A view was offered at the learning event that this provision might either not be widely appreciated or implemented[20]. In relation to Adult AS, if care staff had been asked, it would have become clear that Adult AS required support with activities of daily living.

4.8.3. Assessments in hospital appeared to confirm that Adult AT could manage activities of daily living once she was medically fit for discharge. This is also what Adult AT self-reported. However, given the prior evidence of neglect and self-neglect, it would have been advisable for information about the home conditions to have been shared with all the practitioners involved in order to determine whether it would have been helpful to complete assessments in Adult AT's living environment by a social worker and/or occupational therapist.

4.8.4. There does not appear to have been any social worker involvement in Adult AT's hospital discharge other than to ensure that Adult AS was at home with the one and only key to the property so that Adult AT could enter the property when patient transport took her home. The social worker had seen the poor condition of those parts of the accommodation that she had entered but this information does not appear to have been shared with hospital staff. Had a fuller picture been given, this would have added to the already existing awareness and evidence of neglect and self-neglect. Had respite care staff also been asked for their observations, this too would have added to the concerns about neglect and self-neglect. There is no record of a conversation with Adult AT about the conditions that the social worker had observed in the home.

4.8.5. At different points in the chronology Adult AS was recognised as being social isolated and there were plans to offer support in an attempt to promote his wellbeing, as required in section 1 Care Act 2014. However, plans were either not implemented or were undermined by Adult AT's influence on her son. Practitioners tended not to persist in the face of reluctance, doing the minimum professionally. It would appear that Adult AT imposed isolation on her son, for whatever reason, and that practitioners either did not have the time or the inclination to persist in challenging this and in seeing Adult AS as his own person.

4.9. Team around the Person: Working Together.

[19] The local authority must carry out an assessment of care and support needs where a person who has refused lacks capacity and assessment is in their best interests, or the adult is experiencing or is at risk of abuse or neglect (including self-neglect).

[20] Guidance on section 11 has been provided in a conversation handbook.

4.9.1. The observation above concerning information-sharing highlights the need for services to work collaboratively in adult safeguarding. Care staff could recall one telephone contact from the hospital whilst Adult AS was a resident. They had also recorded three telephone calls from Adult AT to her son.In relation to the events surrounding Adult AT's discharge from hospital, care staff were not engaged by the social worker in any conversation other than to ensure that Adult AS was ready when the social worker called to take him home. Care staff presumed that the social worker, as a representative of ASC, would take forward the earlier concerns about self-neglect and neglect.

4.9.2. Nor does it appear that anyone within the hospital followed-up with the social worker referred concerns about neglect and self-neglect during the four days that Adult AT was a patient there. Those attending the learning event reflected on the assumption that adult safeguarding was the local authority's role and responsibility. Of course, adult safeguarding, if it is to be effective, is everyone's responsibility. Equally, the focus of the social worker seems to have been solely on enabling Adult AS to be at home when his mother was discharged from hospital rather than additionally exploring with both Adult AS and Adult AT the concerns about neglect and self-neglect that had been expressed. A multi-agency risk management meeting prior to Adult AT's discharge would have been helpful in sharing all available information and in ensuring that a plan was in place for addressing the safeguarding concerns relating to neglect and self-neglect.

4.9.3. Once again, demonstrating the transfer of learning from the safeguarding of children, it was observed that, had Adult AS been a child or young person, whether or not with learning disabilities, a professionals' meeting would have been convened. No such meeting was convened around the time of Adult AT's hospital discharge or subsequently when the social worker experienced difficulties in maintaining contact with her and her son. Similarly, when compared with the safeguarding of children, it was suggested that working together across mental health and allied services was insufficiently embedded in adult safeguarding.

4.9.4. Indeed, whilst there is some evidence in the chronology of information-sharing, there were also missed opportunities. Similarly, whilst there is some evidence of liaison between practitioners and services, there were also some missed opportunities and some evidence of referral bouncing. As a result there is a strong sense throughout the chronology (2005-2021) of services and agencies working in silos.

4.10. <u>Team around the Person: Recording</u>.

4.10.1. Despite a formal management investigation, and scrutiny of available telephone records, no record of Adult AS telephoning the social worker has been found at the time it has been assumed that it was made. Moreover, the message that he left had been deleted and it is not clear why this has happened. It is hypothesised that Adult AS called the social worker when he could not raise his mother, because she had died. The social worker's response was not timely, partly because she was away from work for a time, but equally she does not appear to have appreciated the level of risk that the telephone message indicated; nor did she escalate concerns when the message that Adult AS was apparently garbled and impossible to understand, and when home visits proved fruitless.

4.10.2. It is therefore impossible to determine his mental state at the time he made the call. It is unclear why he did not telephone the police and why he did not leave the house to summon help,

unless of course he could not find the one and only front door key. It is also unclear why he did not turn the heating on; it was turned off when police entered the premises.

4.11. Organisations around the Team: Management Oversight and Staff Support.

4.11.1. Supervision is an essential component of practice, the more so in complex and challenging situations. The social worker did discuss Adult AT and Adult AS in supervision. The social worker was advised to look at options to promote Adult AS's wellbeing and to advise both mother and son of government initiatives to support families to return to their country of origin. The chronology does not record that there was a focus on self-neglect and neglect, on what paramedics, hospital staff and the social worker had seen when Adult AT was admitted to hospital and Adult AS to respite care. The chronology does not record whether the referred adult safeguarding concerns, submitted by paramedics and hospital staff, were discussed. If there was a reliance on the social worker to investigate these concerns, this did not happen as she was unable to see either Adult AT or Adult AS after the recorded supervision session. Nor does it appear that the outcome of the plan that was agreed was followed-up.

4.11.2. As full a management investigation as possible was conducted by the local authority with the social worker before the practitioner resigned. Procedural changes have also been introduced as a result, including a no-reply policy.

4.11.3. The deaths of Adult AT and Adult AS have had a considerable emotional impact on the staff and services involved. "*People have taken it hard*." Sadness about the outcome has been expressed frequently, also disappointment about missed opportunities. The importance of debriefing and supporting staff was rightly emphasised at the learning event. A determination to learn from the case has been evident to the independent reviewer.

4.12. Organisations around the Team: Workloads and Resources.

4.12.1. A theme to emerge at the learning event was the increasing volume of demand experienced by services. Those attending the learning event wanted to emphasise the need to ensure that workloads were manageable. They also highlighted the loss of experienced practitioners, with experienced staff mainly in management rather than "*on the ground*", and that resources were spread very thinly. This meant, for example, that practitioners might not have the time necessary to persist in trying to build relationships of trust. It also presented challenges for the management of complex and challenging cases when allocated workers were away from work.

4.12.2. Some of those attending the learning event felt that this reviewed case was exceptional in terms of the manner of the deaths of Adult AT and Adult AS, and the fact that two people had been involved. Others, whilst acknowledging these features, emphasised that there were similar or even riskier cases. Concerns were expressed about how, in the context of their lived experience of work, practitioners and their operational managers could build upon good practice.

4.12.3. The impact of the pandemic was highlighted at the learning event. It was suggested that all services were "*under the cosh*." There were increasing numbers of complex cases. Early intervention was required but was difficult to realise in the context of available resources and especially when people were not known and did not want to be known to statutory services.

Section Five: Concluding Discussion and Recommendations

5.1. When the police entered the property and found that both Adult AT and Adult AS had died, they encountered an environment that appeared frugal. There was evidence of clutter. Adult AS's bedroom was barren and he was severely malnourished. It appears that they had been living on take-away meals, something that Adult AT's cousin has also suggested. When local authority staff undertook further investigations, as part of securing the property and its contents, they found payments from the United States of America that had not been cashed, bills that had been paid until the final month, and accumulated funds in their individual bank accounts.

5.2. It has been suggested that Adult AT and Adult AS were reclusive. Adult AT certainly appeared to be mistrustful of practitioners. She always appears to have spoken for her son. There are other SARs that have reported similar findings and cross-case comparisons follow.

5.3. Trafford Safeguarding Adults Board (SAB) published a review in 2019[21]. This review found that the relationship between two related individuals was assumed to be supportive, which resulted in their social circumstances and the caring responsibilities that were being carried not being explored. A GP could have sent referrals to ASC for care and support assessment. In respect of Adult AT and Adult AS, there were indications that they were socially isolated and that the relationship between them was strained. There were no referrals for a care and support assessment. Although there was an occasional focus on reported concerns about the relationship between Adult AT and Adult AS, there was no sustained curiosity, especially at the time of Adult AT's admission to hospital.

5.4. The Trafford SAR found that the Mental Capacity Act 2005 was not always considered. There is no reference in the chronology of any consideration being given to Adult AS's mental capacity, for example when he expressed a strong wish to return home. There does not appear to have been a focus on whether he could protect himself from self-neglect and/or neglect. The Trafford review found that an absence of strategy meetings and ineffective inter-agency communication. A multi-agency risk management meeting could have been held prior to Adult AT's hospital discharge and Adult AS's return home to plan how to attempt to meet their care and support needs, and to address the evidence of self-neglect and neglect.

5.5. City of London and Hackney SAB completed a review in 2016[22]. This SAR involved a mother and daughters. It found a lack of clear understanding of who Mrs Y was in life, with agencies having little direct contact with her. Most communication was channelled through her daughters, and it was assumed that she had agreed to this. The SAR recommended a more personalised approach, with consent regarding communication reviewed. Engagement should be directly with the adult at risk. There were some attempts to engage directly with Adult AS but for much of the time Adult AT spoke for him. It does not appear that his consent to this arrangement was ever checked.

5.6. The City of London and Hackney SAR found a history of non-engagement. It recommended the development of a no-reply policy, which South Tyneside ASC has introduced as a result of learning from its involvement with Adult AT and Adult AS. The City of London and Hackney SAR also recommended the introduction of mechanisms to identify and escalate concerns about complex

[21] SAR *Susan and Anne.*
[22] SAR *Mrs Y.*

situations of non-engagement, and of procedures to provide a framework for practitioners to respond to cases involving self-neglect. There was no escalation of concerns subsequent to adult safeguarding referrals from paramedics and hospital staff regarding Adult AT and Adult AS.

5.7. City of Liverpool SAB published a review in 2017[23]. This SAR involved a mother and son who both displayed "*signs of vulnerability*." The mother was difficult to engage, was mistrustful of services and resisted hospital treatment for her son. The SAR concluded that Edward was invisible to most staff who accepted his mother's terms for engagement. There were missed opportunities to complete risk assessments when Edward was in hospital and there were missed opportunities to see Edward on his own, outside the family home, and to assess his wishes. The SAR concluded that there was a need to understand family relationships as part of identifying and managing risk. The review described the family as "*a closed and restrictive environment*." There are clear parallels with this review of involvement with Adult AT and Adult AS.

5.8. The Liverpool SAR found that there was an assumption that carers would make decisions on behalf of their adult children. That assumption might have been influential when services were involved with Adult AT and her son. The Liverpool SAR reported that a mental capacity assessment established that Edward could not protect himself. There is no evidence that Adult AS's mental capacity was considered.

5.9. The Liverpool SAR made recommendations with respect to advocacy, which does not appear to have been considered for Adult AS. It made recommendations with respect to care and support assessments and access to legal advice. It suggested that the practitioner responsible for a section 42 enquiry should not be the same practitioner responsible for care and support assessments. It reminded the SAB of the importance of supervision and of annual health checks for people with learning disabilities. It is not entirely clear whether Adult AS was offered annual health checks. Finally the Liverpool SAR highlighted the relevance of human rights.

5.10. A SAR published by Solihull SAB[24] (no date) also highlighted neglect of the right to advocacy and questioned how the wellbeing duty in section 1 Care Act 2014 had been implemented in this case. It too found that a GP practice did not have a procedure for engaging with patients with learning disabilities and/or who had been identified as at risk.

5.11. The Solihull SAR focused on neglect of a learning disabled son by his mother and step-father. He was always seen in the presence of his mother and usually in the family home where he might have felt constrained in terms of what he felt able to say. His mother was always present at appointments. In parallel with Adult AS, John's voice was expressed by his mother. The SAR highlighted the importance of practitioners having the skills to "*get underneath*" presenting problems and to express concerned curiosity. There were missed opportunities to intervene and to enable John to disclose his experience. Similarly with Adult AS, especially when he was in the respite care setting, the social worker missed an opportunity to engage with Adult AS, using the opening he had provided when he had stated that he and his mother had been struggling.

[23] SAR *Edward Nowell*.
[24] SAR *John*.

5.12. An unpublished review was included in the national analysis of SARs[25] that involved a mother with deep-rooted mistrust of professionals and concerns about neglect of her son and their poor living environment. Access to the son was sometimes refused and the report observed the absence of an adult safeguarding power of entry. The SAR highlighted the lack of an independent advocate who could build a meaningful understanding of the son's needs in a context where his decision-making was influenced by his mother. The SAR also highlighted the lack of joint working and the premature closure of a section 42 adult safeguarding enquiry.

5.13. There are clear parallels between the unpublished review and this SAR. That includes the finding about advocacy, which was not considered for Adult AS, and the absence of an adult safeguarding power of entry to see an adult at risk. Had the social worker escalated concerns following Adult AS's return home after his mother's hospital discharge regarding his refusal to open the front door, and had she continued to visit and been frustrated in her efforts to talk to Adult AS on his own, the absence in law of this power in England would have become more apparent.

5.14. This SAR is a human story about two individuals. Putting together pieces of the jigsaw of their lives has involved merging information held by different services. No one service had a complete picture at any point. At no point did all those involved come together to share what was known and to seek a way forward that would have addressed Adult AT's and Adult AS's needs and wellbeing. For brief periods towards the end of his life, it does appear that practitioners had a positive impact on Adult AS's wellbeing, most notably when he was accommodated in respite care whilst his mother was in hospital. However, everyone who has contributed to this review has recognised that more could have been attempted. There is a determination to learn lessons, most especially in relation to engagement, multi-agency working, information-sharing, recognition of coercive and controlling behaviour, recognition of the impact of grief and loss, and the embedding of making safeguarding personal. Some changes to procedures and practice have already been implemented.

5.15. To build on the learning from this review, South Tyneside Safeguarding Children and Adults Partnership is recommended to consider:

5.15.1. An audit of the use and outcomes of multi-agency risk management meetings.

5.15.2. An audit of mental capacity assessments with specific focus on self-neglect, executive functioning and the understanding of the five principles within the Mental Capacity Act 2005.

5.12.3. An audit of decision-making surrounding referrals of adult safeguarding concerns and of the outcomes of referrals and enquiries.

5.12.4. Seeking assurance from health and social care commissioners that there is appropriate provision for individuals experiencing longstanding, fluctuating and ongoing mental health issues.

5.12.5. Seeking assurance from health and social care operational and strategic managers that workloads are manageable and that supervision of cases involving adults at risk ensures that plans are implemented and their outcomes reviewed.

[25] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

5.12.6. Reviews published protocols, revising where this is indicated. A programme of dissemination and auditing should follow. The partnership should also consider where new protocols are needed, for example so that practitioners and managers know the procedure for escalating concerns and raising professional differences.

5.12.7. A programme to raise community awareness about socially isolated people who might be at risk of abuse and neglect (including self-neglect) and how to ensure that private and social housing landlords, along with staff working for the Post Office, utility companies and delivery services have an understanding of adult safeguarding and knowledge of referral pathways.

5.12.8. Review with the ICB the guidance given to GPs and other health care providers regarding outreach to patients at risk and/or with complex presentations when scheduled appointments and/or health check reviews are missed or consistently declined.