HARINGEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

VICTORIA

Independent reviewer and author: John Goldup

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1 Introduction

1.1 The subject of this review, Victoria, died on 25th June 2022. At the time of her death she was under the care of the Haringey Learning Disability Partnership. Following her death, the North London Integrated Care Board commissioned a review under the Learning from Lives and Deaths – People with a Learning Disability and Autistic People programme. [1]This is commonly known as a LeDeR review. A LeDeR review should be undertaken following the death of any person with a learning disability or autism over the age of four, to consider the health and social care services provided to the individual, to identify both good practice and areas for improvement which could lead to better health outcomes.

1.2 Following its consideration of the initial findings of this review, the Safeguarding Adults Review sub-group of Haringey Safeguarding Adults Board decided on 23 March 2023 that the mandatory criteria for a Safeguarding Adults Review (SAR) under S44 of the Care Act were met: that Victoria had care and support needs, that it was known or suspected that her death was the result of abuse or neglect, and that there was reasonable cause for concern about how agencies had worked together to safeguard her. To avoid duplication, it was decided that the LeDeR review should be completed before the SAR was progressed. The LeDeR review was completed and shared with the sub-group in October 2023, and terms of reference for the SAR were drawn up. An independent reviewer was commissioned in March 2024.

1.3 The purpose of a SAR is to consider the work of all the agencies and individuals involved in the case and to explore what they might have done differently, working together or individually, to prevent harm or death. "This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again."[2] It has a multi-agency focus at its core.

1.4 This sequence of events meant that work on the SAR did not begin until almost two years after Victoria's death. Such a delay potentially dilutes the impact of any learning emerging from the SAR. The LeDeR process is a non-statutory one, whereas, if the criteria set out in legislation are met, the undertaking of a Safeguarding Adults Review is a statutory duty. With hindsight, it would have been better if, rather than proceeding with the LeDeR for several more months and delaying the initiation of the SAR, the LeDeR had been closed in March 2023 in order to allow the fuller multi-agency scrutiny which is central to the purposes of a SAR to have been triggered much earlier. While the LeDeR is expected to consider both health and social care services provided, it is primarily health focused. Although it was expected that the LeDeR would provide the essential narrative for the SAR, this review has found a number of significant gaps in that narrative. In particular, the LeDeR did not consider how effectively the local authority delivered on its Care Act duties towards Victoria.

[1] https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, para.14.168

Recommendation 1: NHS England and ADASS should jointly develop guidance on the relationship between the LeDeR and SAR processes, seeking to avoid both duplication and unnecessary delays.

1.5 John Goldup was commissioned to undertake the review. He was Director of Adult Social Services in LB Tower Hamlets from 2000 to 2009, and National Director of Social Care and Deputy Chief Inspector in Ofsted from 2009 to 2013. Since 2013 he has chaired both Safeguarding Adults Boards and Safeguarding Children's Partnerships in two local authorities, and undertaken a range of independent consultancy work.

2. The review process

2.1 A SAR Panel was established to oversee the review and to support the independent reviewer. Membership was drawn from:

- LB Haringey Adult Social Care
- LB Haringey Commissioning
- Haringey Learning Disabilities Partnership
- North Central London Integrated Care Board
- North Middlesex University Hospital

The Panel was chaired by the Independent Chair of Haringey Safeguarding Adults Board. It met for the first time on 15th May 2024.

2.2 Terms of reference were agreed for the review. It was agreed that the review should focus on the period between Victoria's mother's death, in November 2018, and her own death in June 2022. A number of potential key lines of enquiry were identified:

- What learning can be identified in legal literacy around mental health and mental capacity and how did this affect the enablement of risk and choices, e.g. supporting unwise decisions?
- What learning can be identified in how agencies worked together to ensure Victoria's health and social care was appropriately managed?
- What learning can be identified in the escalation of safeguarding concerns by agencies to ensure Victoria was adequately safeguarded?
- What learning can be identified in the oversight of care workers?
- What learning can be identified in the housing assessment process in supporting Victoria to live independently?
- What learning can be identified in the impact of the COVID-19 pandemic on Victoria's health and wellbeing?
- Are there any other emerging themes to be explored through the Safeguarding Adults Review?

It was agreed that findings and learning on these issues would not necessarily provide the structure for the report, but would be interweaved as appropriate throughout.

2.3 It had been expected by the SAR subgroup that the LeDeR would provide the narrative for the report, and Individual Management Reports (IMRs) and chronologies were not requested from individual agencies. In the course of the review, however, it became clear that substantial additional information was required both to ensure an accurate narrative and to fully identify potential

learning. Agencies responded to requests for additional information and to follow up detailed requests from the reviewer. These agencies included LBH adult social care, NMUH and Homerton Hospitals, North London Mental Health Partners (formerly Barnet Enfield and Haringey Mental Health Trust), LBH housing services, and Victoria's GP Practice. All agencies cooperated fully with requests for further information, although the detailed information requested was not always available. The reviewer also had the opportunity to access Victoria's adult social care record.

2.4 One of Victoria's first cousins had been heavily involved in supporting and advocating for Victoria after her mother's death. She made a major contribution to this review as she did to the LeDeR, meeting with the reviewer at length and providing a large volume of emails documenting her interaction with services, particularly housing services. The review was sadly not able to hear Victoria's voice directly. Her cousin's involvement enabled the review to get a little closer to Victoria's lived experience.

2.5 The reviewer met with senior representatives from most of the agencies involved. He also met at length with the Community Learning Disability Nurse who had supported Victoria and her mother intensively and continuously since she was first referred to the Haringey Learning Disability Partnership (HLDP) in 2012. Most of the other interviewees, including Victoria's cousin, paid tribute to the Community Learning Disability Nurse's endless dedication to Victoria, far over and above the call of duty. Some also commented that "everything seemed to be left to [the Community Learning Disability Nurse]" and questioned whether it should have been.

2.6 At the conclusion of the majority of the fieldwork, the reviewer facilitated a multi-agency learning workshop to consider and discuss the learning beginning to emerge from the review, and additional areas that might be considered. Participants in the workshop included all the statutory agencies who had been involved with Victoria, care providers, and Victoria's cousin.

3. Victoria's story

3.1 Victoria was a British citizen, born in the UK in 1984 to Greek Cypriot parents. She is said to have had a very difficult early life. She was brought up by her mother from an early age, after allegations of child sexual abuse against her father. She attended mainstream schools, and was reported as displaying severe behavioural difficulties from the age of 8. At age 16 she was identified as having a mild learning disability. She was extremely obese, and also suffered from a number of physical health problems, including Type 2 Diabetes, first diagnosed in 2010, and heart failure and hypertension, first diagnosed in 2016. She also had liver and kidney problems, and suffered from poor eyesight. In 2016, when referred to the psychiatrist in the HLDP, she was diagnosed as suffering from Emotionally Unstable Personality Disorder (EUDP).

3.2 Her relationship with her mother is described as volatile, switching quickly between displays of affection and violent rejection. However, Victoria relied on her mother for care and for her meals. The LeDeR reported that both Victoria and her mother were very resistant to accepting services or support. It also reported that Victoria had very little social contact outside the home, although she was known In Wood Green market where she would go with her mother to

buy CDs. Home conditions and hygiene were reported to be poor. In 2016 Victoria developed severe sepsis when she was admitted to hospital with a spot on her breast.

3.3 In 2017 Victoria developed gangrene from lesions on her foot and toe and underwent a right below knee amputation after which she became increasingly bedbound. She required hoisting for all transfers, and her compliance with her rehabilitation programme was poor, failing to attend 70% of appointments.

3.4 Victoria's mother died in November 2018, leaving her entirely dependent on others for care. LBH adult social care responded quickly, commissioning an extensive care package to cover daytime care. Victoria refused nighttime care. The care was provided via spot purchase from a private care agency. The carers were expected to support her in all the activities of daily living, including the preparation of meals, self-care, emptying her commode, feeding her cat, banking, shopping and cleaning etc. They were also expected to ensure that she was taking her diabetes medication and eating regular meals. Already clinically obese, Victoria was putting on more weight, consuming mainly takeaways and also the sweets and chocolates from which for many years she had sought comfort and stimulation. The expected outcomes of the support plan included facilitating her access to the community to engage in activities of interest, although the records seen do not indicate how this was to be achieved.

3.5 At this time the local authority's housing stock was managed by Homes for Haringey (HfH), an Arms Length Management Organisation which had run the service since 2006. Responsibility for housing services returned to Haringey Council on 1st June 2022. The flat in which Victoria had lived with her mother was on the first floor with two internal levels. It was clearly not possible for Victoria to remain there. She was unable to get in or out of the flat, and as she could not climb the internal stairs she was confined to one floor. She was apparently unwilling to discuss moving initially, although the notes of a care management review which took place on 6th December 2018 state that the application to HfH for succession to mother's tenancy and rehousing had already been completed. However, Victoria was not finally rehoused in a ground floor property until March 2020. For whatever reasons, there were many months of confusion and delay, which were very stressful for both Victoria and for her cousin who took the main burden of trying to sort things out. Throughout this period Victoria was unable to leave her flat, missed crucial hospital appointments, and was at clear risk in the event of a fire or other emergency. There was an extended failure to meet Victoria's housing needs appropriately and safely within the social housing system, and this is further explored as an area of thematic analysis and potential learning in paragraphs 7.1 to 7.4 of this report. It should be noted though that the records available do not allow a full analysis of the reasons for this delay.

3.6 During this period there were escalating concerns, raised by both the Community Learning Disability Nurse and Victoria's cousin, about the quality of the care Victoria was receiving, the failure of the carers to fulfil the tasks prescribed in the support plan, and the way in which they allowed themselves to be manipulated into colluding with Victoria's self-neglect. For example, although they were supposed to encourage her to eat healthily, they would allegedly agree to buy her chocolates and accept money to also buy for

themselves. This is also further explored as an area of potential learning later in this report. The concerns continued after Victoria moved in March 2020.

3.7 As noted, Victoria moved into her new accommodation in March 2020, immediately before the outbreak of the Covid-19 pandemic and the first national lockdown. When she saw her at the end of the first lockdown, the Community Learning Disability Nurse observed what she described as a complete deterioration in her physical health. She had put on substantial further weight, her diabetes was out of control, and she was exhibiting symptoms of liver ascites with a swollen abdomen. According to some sources liver ascites is associated with a 50% mortality rate in two years from diagnosis. The Community Learning Disability Nurse consulted with the GP, but the review has not seen any evidence of medical intervention on this point. The LeDeR report suggests that the condition was not recognised until her admission to NMUH in April 2022. Victoria did attend a number of endocrinology outpatient appointments at NMUH between July 2020 and February 2021.

3.8 In February 2020 Victoria was seen in A&E at NMUH after a mixed overdose of medication. This was described as impulsive. She immediately regretted it and called an ambulance. Risk was assessed as low and she was discharged home.

3.9 In March 2020, a safeguarding concern was raised following an incident in which a carer was alleged to have stolen money from Victoria. The outcome of the safeguarding enquiry was that the allegation was not substantiated, but the care agency made a payment to Victoria of the amount that was alleged to have been stolen. The social worker working with Victoria at that point requested a change of provider. However, this request was not progressed as Victoria did not agree to a change. Concerns continued to escalate, and by August 2021, following rigorous but unsuccessful attempts to restate expectations to the provider, the Community Learning Disability Nurse again requested a change of provider. This was raised as a safeguarding concern and included concerns about:

- A support worker regularly asking Victoria for money
- “The carers frequently do not adhere to the outcomes specified in Victoria’s support plan and risk assessment’
- Not identifying and reporting health concerns
- No detailed care plan to support on day to day-to-day basis
- Gaps with inconsistent care
- Poor communication with Haringey
- Poor diabetes management
- Lack of consistent monitoring of medication
- Lack of communication with family
- No evidence of staff training, or the skills and knowledge necessary to support Victoria

The request for a change of provider was not immediately actioned. A clinical psychologist in HLDP suggested that sudden changes in Victoria's support network could be very distressing to her and could increase her risk of suicide. He also wondered whether the current care staff might be supported

with training to address deficiencies in care. A new provider was commissioned at the beginning of 2021. Victoria's cousin felt that there was an immediate improvement in the quality of care.

3.10 Victoria's mobility continued to deteriorate. She was unable to get out of the flat as her bariatric wheelchair would not get through the door. On three occasions the door had to be broken down to enable her to be taken to hospital appointments in an ambulance. Appropriate adaptations were planned, but Victoria refused consent to the work being done. From December 2021 Victoria was completely bedbound following a fall from her bariatric commode.

3.11 In the last six months of her life Victoria had five separate hospital admissions, with the recorded reasons as follows:

- 18 to 21 December 2021, Homerton Hospital, hypoglycaemia and diarrhoea
- 25 Jan to 1 Feb 2022, NMUH, fall and unsafe environment
- 18 March to 1 April, NMUH, abdominal pain, anaemia
- 17 April to 24 May, NMUH, pain in left leg, unspecified infection
- 31 May to 22 June, Homerton, discharge from abdominal wounds

The records suggest that on each admission her condition had deteriorated. On the first occasion, she discharged herself. The next day carers reported to the GP concerns about her groin area wounds which were broken, red and too painful for her to tolerate dressings. On all other occasions she was discharged home to the care of her GP, although during her penultimate admission (to NMUH in April / May) consideration was given to alternative discharge destinations. The discharge summary from the Homerton in June recommended referral to Community Palliative Care services, although her death was not expected to be imminent.

3.12 Issues arising from this pattern of repeated admission and discharge are discussed further in this report as an aspect of the thematic analysis and a potential area for learning.

3.13 Three days after her discharge from the Homerton, on 25 June 2022, Victoria suffered a sudden cardiac arrest at home. She died later that day, despite paramedic and hospital staff attempts to resuscitate her. The cause of death was recorded as sepsis of unknown aetiology. Type 2 diabetes mellitus, cardiac failure, liver cirrhosis, obesity, right below knee amputation, and learning disability were recorded as other conditions contributing to death but not related to the disease or condition causing it.

Thematic analysis and learning

4. <u>Identifying and responding to self-neglect</u>

4.1 A safeguarding concern about self-neglect was first raised with Haringey's adult safeguarding service in August 2016. In March 2017, in response to further safeguarding referrals from the London Ambulance Service and the Royal Free Hospital concerning the pressure sores and necrotic lesions that would lead a couple of weeks later to Victoria's below knee amputation, the social care record noted that "this was part of a well-established pattern of self-neglect".

Neither concern proceeded to an enquiry under S42 of the Care Act 2014.[3] No action appears to have been taken in response to the first referral. It was decided that the second referral should be responded to through the self-neglect pathway.

4.2 Similarly, the record of the review of Victoria's care held on 6th December 2018 immediately following her mother's death stated that "If Victoria continues to self-neglect, a safeguarding concern will be raised". Although the self-neglect continued and the impact became more severe, no safeguarding concern about self-neglect was raised until the Community Learning Disability Nurse formally raised one in April 2022.

4.3 Periodically, and rightly, the social care record identifies that Victoria was chronically self-neglecting. She had a whole range of serious and ultimately life-threatening health issues and a long history of poor compliance with essential medication and measures to control her diabetes and other conditions. She was morbidly obese, unable to control her eating despite feigned compliance, and was hoarding out of date food with a potential risk of food poisoning. She effectively manipulated and bribed her carers into effectively colluding with her own self-neglect. However, the complexity and seriousness of the concerns were not escalated through processes which did exist which would at the least have brought all relevant agencies together to co-ordinate their engagement, and to explore ways of responding. If the self-neglect risk assessment tool which was in place as part of the Safeguarding Adults Board Self-Neglect and Hoarding Procedure in force at the time had been completed when her health and self-care deteriorated so rapidly after lockdown, the risk would have emerged as at least moderate and probably high. This would have led to a safeguarding concern being raised: the procedure stated that "When an adult who self neglects and/or hoards and is unable to protect themselves by controlling their own behaviour comes to notice, a Safeguarding Concern must be raised and sent to the Adults Social Care service to commence an enquiry."

4.4 At that time Haringey operated a Multi-Agency High Risk Panel, "established to provide a multi-agency way of supporting work on complex and/or high-risk cases, including but not limited to hoarding, fire risk, and self-neglect and includes near miss fire risk." It does not appear that any consideration was given to taking Victoria's case to this Panel, although it was both complex and high risk. Following a review of the Panel, it was replaced in May 2021 with a Multi-Agency Solutions Panel (MASP), meeting more regularly, with more consistent senior membership, and with more robust terms of reference. This Panel was in place for the last year of Victoria's life. "Self-neglect (including personal care, medication, nutrition, and hydration" is identified in the terms of reference as one of the "areas of concern that may benefit from this multi-agency creative approach". However, her case was not referred to it.

[3] Under S42 of the Care Act, the local authority has a duty to make enquiries in order to decide if any action needs to be taken to safeguard a person who has care and support needs, who is experiencing or at risk of abuse or neglect, and who is unable to protect themselves against abuse or neglect as a result of their care and support needs. Self-neglect is identified as one form of abuse or neglect (https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, para.14.17)

4.5 Two safeguarding concerns about self-neglect were raised in the last two months of Victoria's life: one by the Community Learning Disability Nurse in April, and one by a senior nurse at NMUH in May. Both focused on the risks to Victoria caused by her self-neglect, and on the risks that her care was not being managed safely as a result of carers' non-reporting of her non-compliance with medication and other concerns. Both recommended that Victoria needed to be in a more supported environment. These concerns both proceeded to a S42 enquiry. The enquiry concluded that the risk of self-neglect and the risk from carer neglect had reduced. The position should be reviewed after six weeks if Victoria was still living at home. Sadly, Victoria's death meant this review never happened.

4.6 Victoria's GP practice had lost its contract in 2021 as a result of poor performance and was (and is) in "caretaking" – currently run by the Haringey GP Federation. In May 2022 the practice referred Victoria to the Multi-Agency Care Coordination Team. This is "a proactive and preventative care service for adults living with frailty or complex long term health care needs" run by the Haringey GP Federation and Whittington NHS Trust. This might have been a further opportunity to engage a wider professional network in seeking to safeguard Victoria and address her needs. However, the referral was not accepted as the case was already held in HLDP, itself a multi-professional service. This pattern, of referrals being made and being 'bounced back' to the HLDP, which had sometimes made the referral in the first place, was repeated on several occasions during the period covered by this review.

4.7 There appears to be a perception, in particular among health professionals in Haringey, that there is little point in raising safeguarding concerns around self-neglect, because the social care response will be that it does not meet the safeguarding threshold and that if the person has capacity to make their own decisions, however unwise, it is not a safeguarding issue. As one interviewee put it, "If the person has capacity, it's a dead end". This is of course anecdotal. However, a review of Haringey's current Multi-Agency Self Neglect and Hoarding Procedure 2022-2025[4] does show some scope for confusion. On page 10 of the document a flowchart sets out the self-neglect and hoarding pathway. It states at the beginning, "if the adult has mental capacity to make an informed decision, and there is no danger to public health, then that person has the right to make their own choices", with no further progression through the safeguarding process. However, on page 13 it says: "If an agency is satisfied that the adult has the mental capacity to make an informed decision on the issues raised, then that person has the right to make their own choices. But this should not be seen as an "all or nothing" strategy. It is in these circumstances staff needs to follow the procedures in this document." It is not clear what procedures are being referred to.

4.8 This review suggests that there is a need for further clarification of what is meant in Haringey by the "self-neglect pathway". I have been told that it is intended to mean that the response to concerns about self-neglect should not

[4] https://www.haringey.gov.uk/sites/haringeygovuk/files/haringey_multi-agency_self_neglect_and_hoarding_procedure.pdf

be to raise a safeguarding concern, if the person has the capacity to make their own decisions, but instead to undertake an assessment of their care and support needs under Section 9 of the Care Act. However, if this is the policy, the review has not seen this clearly stated in any of the policy and procedure documents reviewed. Furthermore, the review suggests that it is too absolute a formulation. A danger to public health should not be the only basis for responding to self-neglect as a safeguarding concern. The level of risk to which a person is exposing themselves must also be a consideration. This is not in any way to suggest that the use of the S42 safeguarding framework is or should be a way of imposing choices on people that they do not wish to make; but it does suggest persistent multi-agency effort should be made to explore every possible creative and often incremental way in which people might be encouraged to make different choices or to mitigate the harmful impact of some of the choices they are making. This would be an appropriate safeguarding response.

4.9 Statutory guidance on the Care Act states that a concern about self-neglect will not necessarily lead to a safeguarding enquiry under S42, and that "an assessment should be made on a case-by-case basis".[5] It may be an appropriate presumption that an adult safeguarding enquiry is not the best response to a concern about self-neglect or hoarding, and that Instead the concern should prompt an assessment of care and support needs. It should be clear though that this is an initial presumption, and the policy should set out a number of conditions which make it likely to overturn that assumption, including but not limited to the only criterion included in the statutory guidance, that there is a concern that the person is unable to protect themselves by controlling their own behaviour. The approach taken by Surrey Safeguarding Adults Board[6] might be a useful example of this approach to consider.

4.10 A Safeguarding Adults Review published by Haringey SAB in 2023 recommended that the Board should reinforce, through promotion of its Self-Neglect and Hoarding Protocol, the importance of recognising self-neglect as a safeguarding issue and considering whether it may require safeguarding action.[7] This review strongly endorses that emphasis. However, it also suggests that the Protocol itself should be revised to make clear that the fact that a person has capacity does not automatically mean that the concern should not be considered through the S42 framework.

Recommendation 2: Haringey Safeguarding Adults Board should consider revising its Self-Neglect and Hoarding Procedure to clarify that, while there is an initial presumption that concerns about self-neglect will be addressed through Care Act assessment, each case will be considered on a case-by-case basis, taking account of the level of risk to which the individual is exposing themselves.

[5] (https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, paragraph 14.17

[6] https://www.surreysab.org.uk/wp-content/uploads/2024/07/SSAB-Policy-and-Procedure-2018-FINAL-v5-26.04.2021-accessibility.pdf, page 10

[7] https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_steve_2023.pdf, paragraph 5.7

5. Mental capacity

5.1 There are references to whether or not Victoria had decision-making capacity, within the meaning of the Mental Capacity Act 2005, throughout both health and social care records. However, they are generally recorded in terms such as "she is considered to have capacity" rather than based on any recorded capacity assessment. People who knew Victoria well raised concerns about her decision-making capacity on several occasions, but these did not lead to formal assessments. One of the recorded outcomes of a social care review in July 2020 was that a mental capacity assessment should be undertaken. This does not appear to have happened. This review has seen records of only three mental capacity assessments. Two of these were undertaken at the Homerton Hospital. One related to her decision to self-discharge in December 2021, which she was deemed to have capacity to make; the other to the decision to accept the insertion of a PICC[8] line (to avoid multiple cannulations) in June 2022. On this occasion she was judged to lack capacity, and the procedure was carried out under sedation without her consent. The third was carried out at NMUH in May 2022. This is discussed in paragraph 5.2 below.

5.2 On every occasion that Victoria was admitted to hospital she was determined to return home as quickly as possible. However, staff were also concerned on each occasion about the safety of home discharge, and whether Victoria really understood the risks to which her self-neglect and poor compliance with medical and dietary advice exposed her.

- A professionals' meeting at NMUH in March 2022 considering Victoria's potential discharge agreed that ward staff should undertake a capacity assessment before a discharge decision was made. Again, this does not appear to have happened.
- During Victoria's last admission to NMUH (April / May 2022), Victoria's GP suggested a discharge planning meeting should be held as the Community Learning Disability Nurse had expressed her concern that Victoria did not understand the implications of refusing treatment and was not processing and understanding information. A multi-disciplinary team meeting was held. Prior to this meeting, an OT carried out an assessment of Victoria's capacity to make decisions about her discharge destination and plans. She reported to the meeting that she had that capacity, although she acknowledged that she did not have full information about Victoria's past behaviours. In the meeting, the Community Learning Disability Nurse outlined at length her concerns about Victoria's self-neglect, her non-compliance with medication, her manipulation of carers and professionals, and her pattern of agreeing with plans and then not complying with them once at home. The meeting suggested that Victoria should be discharged to a respite care placement while work was undertaken with her carers on how they could more proactively support her. Victoria rejected the only placement available as she would not be able to take her cat, and she was discharged home.
- Prior to discharge from the Homerton in June 2022, Victoria's social worker and ward staff agreed that a mental capacity assessment should be

[8] A peripherally inserted central catheter

undertaken before a discharge decision was made. The social worker requested that this assessment be undertaken by a doctor or an Occupational Therapist. According to information provided to the review by the Homerton, the OT advised that the assessment should be carried out by someone who knew Victoria's home situation, her personality and communication methods, and care options in the community. The social worker agreed but said that her diary was full.

5.3 One of the central principles of the Mental Capacity Act, that the starting point should always be a presumption that the individual has capacity to make their own decisions, seems to be well embedded in professional cultures in Haringey. Similarly, the principle also contained in Section 1 of the 2005 Act, that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision" seems to have had been influential in shaping practice on Victoria's case. As one interviewee put it, "To override her unwise decisions would have been a deprivation of her liberties." However, the Code of Practice on the Act is also clear that "There may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation … These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices."[9] Victoria made many decisions which could be considered as unwise during the period covered by this review: her refusal of nighttime care after her mother's death, her rejection of supported living options, decisions about compliance with rehabilitation following her amputation, with diabetes care, and other medical advice, decisions about diet, and decisions about discharge from hospital. There should have been a clearer focus on her decision-making capacity. This is not to argue that it would have been right necessarily to override any of those decisions; but it would have been right at least to have clearly assessed at key points whether she had the capacity to make them.

5.4 One interviewee commented to the reviewer, "If she said the right things, she was assumed to have capacity. But she couldn't put them into practice." This touches on the question of executive capacity. For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision.[10] The assessment of capacity cannot always be based purely on the responses given during assessment: it should also take into account how the individual has been observed to actually make decisions in a "real-world" situation. Someone may appear to be able to weigh facts in a discussion – for example, about the risks to their health of not taking medication, or of uncontrolled chocolate eating for diabetes - but if they cannot use the information in real life situations when actually making the decision they may still lack mental capacity. The capacity assessment undertaken in May 2022 (second bullet point, paragraph 5.2 above) did not consider the question of executive capacity, as it was acknowledged that the professional carrying out

[9] https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf, paragraph 2.11

[10] https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf, paragraph 4.21

the assessment did not have information about Victoria's ability to use the information provided in those real-life situations.

5.5 Locally[11] and nationally, poor understanding or application of the Mental Capacity Act is a recurring theme in Safeguarding Adults Reviews. It frequently leads to a recommendation for more training. However, while regular and updated training is of course important, it is key that training fully incorporates some of the complexities touched on in the paragraphs above: the difference between respecting a person's right to make unwise decisions and failing to recognise the accumulated harm to which repeated unwise decisions are exposing the person, and the issue of executive capacity. It is also important that professionals have ready access to clear guidance on these issues. Enfield[12] and Hillingdon[13] have both produced material which it might be useful to consider as possible examples.

Recommendation 3: Haringey Safeguarding Adults Board should review the policy, guidance and training content relating to assessment of mental capacity available to professionals within the partnership, to ensure that it fully addresses the issues raised in this and other SARs which it has published in the last five years.

6. Other safeguarding issues

6.1 At the learning workshop held as part of this review, participants from both primary and secondary health care stated that they very seldom receive feedback from adult social care in Haringey on safeguarding concerns which they raise. They said that their common experience is that they are not informed if the concern is being taken forward as a S42 enquiry, the reasoning behind that decision, or the outcome of any such enquiry. They felt that this was a disincentive to raising safeguarding concerns. They also felt that it militated against information sharing and multi-agency working, the holistic and coordinated delivery of care, and the effective translation into practice of the mantra, "Safeguarding is everybody's business". There was a recognition however that there had been some improvement in communication and dialogue recently.

6.2 These views were strongly contested by senior management in adult safeguarding in Haringey. The reviewer was assured that all safeguarding concerns receive an automated email acknowledgement with a message saying that the service will seek to consider the concern within ten working days. He was also told that the referrer will be informed of the decision following triage about whether the concern will be progressed through a S42 enquiry or an alternative route, and the reasons for that decision. The referrer will also be informed of the outcome of any enquiry. Service performance is measured

[11] https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_steve_2023.pdf, https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_ms_taylor_2019_pdf_549kb.pdf
[12] https://mylife.enfield.gov.uk/media/34489/executive-capacity-7-minute-briefing.pdf
[13] https://hillingdonsafeguardingpartnership.org.uk/wp-content/uploads/2022/04/Mental-Capacity-What-Practitioners-Need-to-Know-7.pdf

against performance indicators on whether referrers are notified of referral outcomes.

6.3 It was very striking and concerning to hear such almost diametrically opposed statements on this issue. Hopefully the acknowledged recent improvements in communication will start to bring the different perceptions closer together. It does not seem, though, that the SAB can yet be sure that this recommendation from the "Steve" SAR[14], published in July 2023, has been fully implemented:

> "Ensure that the local authority has in place an effective system for providing feedback to referrers of safeguarding concerns, with particular reference to:
> a) Whether the referral is being taken forward under S42 or not;
> b) If not taken forward, the reasons why, and what alternative might be necessary;
> c) If taken forward, the outcome once the S42 process is complete."

Recommendation 4: Haringey SAB should take steps to assure itself, and reassure partners, that recommendation 9 in the "Steve" SAR has been implemented, and to consider what more may need to be in place if implementation is not yet complete.

6.4 On 22.6.22, the day Victoria was discharged from the Homerton, the hospital raised a safeguarding concern with Haringey about alleged aggressive behaviour observed from a carer while Victoria was still in hospital. This was referred to Hackney Adult Safeguarding Service, as the Homerton is in Hackney. Although technically correct, this does strike the reviewer as a process-focused rather than a person-centred response, given that by the time the referral was considered in Haringey Victoria had returned home with care continuing to be provided by the agency whose worker was the subject of the concern.

6.5 The reviewer was told that at the time of the discussion (July 2024) there was a backlog of safeguarding concerns in adult social care waiting to be considered running into the hundreds. If this is or remains the case, it cannot be acceptable.

Recommendation 5: Haringey Adult Social Care should take urgent action to eliminate any backlog of safeguarding concerns received which are awaiting consideration and appropriate action.

7. Victoria's housing needs

7.1 After her mother's death in November 2018, as noted in paragraph 3.5 above, Victoria was living alone in a flat which she could not get in or out of, and in which she was confined to one floor of a two-floor property. She clearly had an urgent need for rehousing in more suitable and safer accommodation. She was however not able to move to a ground floor property until March 2020.

7.2 According to the records in Haringey's Lettings and Rehousing Service, Victoria's application for rehousing to ground floor accommodation was not received in Lettings from Tenancy Management until the end of June 2019. However, according to the notes of a a care management review held on 6th December 2018, the application to Homes for Haringey for succession and rehousing had already been completed by that time. The review has not been

[14] https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_steve_2023.pdf

able to establish why it did not reach Lettings until over six months later. The application for succession to mother's tenancy was processed in Tenancy Management Services in January 2019, and a medical assessment requested. This was received in March. The review has not been able to establish who the medical assessment was requested from, why it look so long, or what it said. There is no indication that it was treated as a matter of urgency. The review has been informed by the former Head of Tenancy and Community Services that "The Housing Liaison Officer then seems to get batted about between teams for a month or two whilst trying to find somewhere to refer her to for more suitable accommodation."

7.3 There may also have been some confusion about whether Victoria was applying for general housing stock or for supported accommodation, which both the Community Learning Disability Nurse and her cousin were trying to persuade her to accept. In May 2019 the Community Learning Disability Nurse and Victoria's social worker at the time made a referral for an assessment for supported housing to HfH Housing Related Support in May 2019. The feedback was that this did not appear to be the right way forward and it should be explored via the HLDP (who had made the referral) as there were accommodation services dedicated to supporting adults with learning disabilities which they would be able to explore directly that Housing Related Support could not access.

7.4 The Council has recently agreed a Vulnerable Tenants and Leaseholders Policy. This policy includes admirable commitments to a proactive response when Housing Management services become aware of a tenant's vulnerability, to assist them in maintaining their tenancy or to ensure that they are referred to appropriate agencies for support. It also commits the Council's housing services to a "vigilant" approach to adult safeguarding concerns. Such a proactive approach however was not evident in the period after Victoria's mother's death in November 2018.

7.5 The review is not able to reach a conclusion on any learning that can be identified in relation to the housing assessment process, due to the lack of detailed information. The reviewer was however advised that the service is not confident that a similar case would be more effectively managed today. There continue to be delays in the process, particularly when different teams are involved. If anything is to be learned from Victoria's experience to improve services for vulnerable tenants, a review with fuller access to available information is required.

Recommendation 6: LB Haringey Housing Services should conduct an internal review of lessons to be learned from Victoria's experience.

7.6 Once the application for rehousing reached Lettings, it was processed and agreed promptly, and Victoria was able to start bidding for properties. She was not able to manage the online bidding process herself, and her cousin undertook it with her and on her behalf. She was successful in bidding for a ground floor flat owned by a registered social landlord, and signed a tenancy agreement in early October 2019.

7.7 Victoria's cousin describes the property as in a terrible state, rat-infested, and a former drug den. She had the property cleaned, decorated and new flooring

installed at her own expense. Victoria was unable to move into the property until some adaptations had been made, in particular the provision of a ramp for access and the provision of some essential security measures. There followed many months of confusion, delay and arguments over what was the responsibility of the registered social landlord and what was the responsibility of HfH or the Council. Two OT assessments were carried out by a private company, commissioned by HfH. These assessments are described by a Council officer in an email seen by the review as not worth the paper they were written on. The review has seen voluminous correspondence between the parties. Having read that correspondence, it is not possible to dissent from statements contained in them such as "we are just going round in circles" and "the way this service user has been left in limbo is absolutely appalling".

7.8 In December 2019 Victoria's cousin raised a complaint with the local authority in which she described lack of communication, lack of process, lack of accountability and lack of action on safeguarding concerns. It was responded to by the Interim Head of Service for the Learning Disability Partnership, who referred in that response to a number of failings on the part of the registered social landlord – failure to accept their responsibilities, lack of communication, failure of senior management to respond when the social worker sought to engage them with the urgency of the situation, and lack of attendance at a professionals' meeting convened to seek a way forward. He said he would be escalating the concerns with the Council's Housing Services who held a partnership agreement with Registered Social Landlords setting out expectations. It is not known whether such escalation took place. By early 2020 Victoria's cousin's understanding was that the only thing which was essential before Victoria could move into her new flat was the provision of a portable ramp that could be bought over the counter and installed. Victoria finally moved into the property in March 2020.

7.9 The review has been assured that much work has been undertaken over the past three years to re-examine, re-set and strengthen relationships between the Council and registered social landlords at both an operational and strategic level; and that it is likely that issues of this kind would now be picked up and resolved much sooner. There are not however formal escalation processes in place to resolve issues where either party feels the other is failing to deliver on their responsibilities in a particular case. The review recommends that consideration be given to putting such processes in place.

Recommendation 7: LB Haringey Housing Services should consider agreeing with registered social landlords in the borough formal escalation processes to resolve issues where either party feels that the other is failing to deliver on their responsibilities in a particular case.

8. The management of quality of care concerns

8.1 The Community Learning Disability Nurse and Victoria's cousin were raising concerns about the care provided for Victoria by the commissioned care agency from an early stage. These concerns are described in paragraphs 3.6 and 3.9 of this report. Victoria refused to agree to a change in provider in March 2020. Given that reports suggested that, rather than supporting Victoria in addressing her own self-neglect, the care provided was compounding that self-neglect and

was in itself neglectful, this should have been questioned. The local authority was not obliged to continue funding care if it believed that care to be at best inadequate and at worst harmful. It was very important to give full consideration to the views and wishes of the person receiving that care, but they should not necessarily have overridden the local authority's duty of care to that person.

8.2 A care management review took place in July 2020. According to Victoria's cousin, who attended the review meeting and shared her concerns, the carers did not know what they were supposed to be doing, and had had no instructions or guidance. They did not know what medication Victoria should be taking, assuming that she would, and thought their role was just to give it to her. One carer did not know she was diabetic. There was some restatement of the expectations of what the carers would do in this discussion. However, the provider remained in place. A further review in May 2021 attempted to specify a much more detailed set of expectations and requirements:

- The agency was to allocate a care co-ordinator to regularly visit to ensure the carers were doing the tasks specified in the support plan, and to forward fortnightly reports to Haringey
- Carers to support with health care appointments
- To maintain a medication compliance record
- To implement "a structured and detailed care plan and risk assessment"
- To ensure checking on Victoria's blood sugar level and its recording, informing line managers of any significant change
- To ensure the floors were dry
- To do two hours shopping a week, recording the spend and the change provided

8.3 Care continued to be inadequate, and in August 2021 the Community Learning Disability Nurse raised a safeguarding concern detailing the continuing failures and again requesting a change of provider, as described in para.3.9 above. A new provider took over at the beginning of 2022. The level of concern about the quality of care reduced, although some concerns continued to surface. A safeguarding concern was raised in February 2022 by the HLDP physiotherapist that Victoria's wheelchair cushion was smeared with dried faeces. As described in paragraph 4.5 above, two safeguarding concerns raised in April and May 2022 included concerns that her care was not being managed safely as a result of carers' failing to report her non-compliance with medication and other concerns.

8.4 With hindsight, it seems clear that the care Victoria received between November 2018 and December 2021 was inadequate. It is of concern that it was allowed to continue for so long. From discussions and from the records seen, it appears that the brunt of trying to improve the situation fell heavily on the Community Learning Disability Nurse and Victori's cousin, constantly raising issues with the carers, negotiating with them, and trying to give them direction. This was not an appropriate burden to fall on a family member or on a Community Learning Disability Nurse, whose role within the multi-disciplinary team is primarily focused on promoting positive health outcomes.

8.5 The Brokerage and Quality Assurance Teams in Adult Social Care Commissioning have no record of being made aware of professional and family

concerns about the care provided by either domiciliary care agency. This is surprising, given that Brokerage received two requests for a change of provider, one in April 2020 and one in August 2021, and both raising concerns about the quality of care being provided. At least five safeguarding concerns were raised which reported in some detail serious concerns about the quality of care: in April 2020 (paragraph 3.9), in August 2021 (paragraph 3.9), in February 2022 (paragraph 8.3), and in April and May 2022 (paragraph 4.5). In addition, the Homerton Hospital raised a safeguarding concern in June 2022 about alleged aggressive behaviour by a carer towards Victoria while she was an inpatient. None of these concerns were made known to the Quality Assurance Team.

8.6 The review understands that at the time of these events there was no clear policy or procedure in place which made clear an expectation that operational staff should inform the Quality Assurance Team of any concerns about quality of care being delivered by an individual provider to a service user. However, in 2023 the Council launched a new Quality Assurance and Contract Management Framework[15] which sets out both an expectation and a process:

> "Team Managers and Service Managers who have concerns about the quality of the service being provided, must refer to the team for advice, and to discuss the possibility of a referral for the Quality Assurance Officer to work with that provider or service area. Referrals into the team should be by email into the Quality Assurance referral inbox within Liquid Logic (Organisational Safeguarding) and should include the level of concern and what priorities the Quality Assurance Officers should focus on."

This is a positive development. It appears however that this expectation of information sharing between operational practitioners and Quality Assurance is relatively new to the Haringey culture. It needs to be consistently reinforced and embedded.

8.7 The review also understands that even before the 2023 Framework was introduced there was a clear expectation that quality of care issues raised as a safeguarding concern would be shared with Quality Assurance. It is not clear why the concerns raised in April 2020, August 2021, February 2022, April 2022, and May 2022 do not appear to have been shared.

8.8 Many safeguarding concerns which are essentially about quality of care issues will not proceed to a S42 enquiry. However, such concerns should always be passed on to the Quality Assurance Team.

Recommendation 8: The Haringey Adult Safeguarding and Quality Assurance Services should work together to ensure that all concerns relating to an individual provider raised as part of a safeguarding concern, whether or not the concern progresses to a S42 enquiry, are shared with the Quality Assurance Team.

9. Learning disability and mental health

9.1 The review has found general agreement that if Victoria had a learning disability at all, it was very mild, and that today she would not be considered eligible for a specialist learning disability service. However, there are a number of service

[15] https://trixcms.trixonline.co.uk/api/assets/haringeyadults/c3d58677-a573-4488-bafc-936c0ed21843/qacm-framework-revised-01jul24.pdf

users with similar levels of learning disability who, for historic reasons, continue to be on the caseload of the HLDP. It seems likely that the main driver of her behaviour, her relationships, and her way of dealing with her life was the emotionally unstable personality disorder (also known as borderline personality disorder) with which she had been diagnosed in 2016. She demonstrated many of the characteristics generally associated with EUPD – emotional instability, disturbed patterns of thinking, impulsive behaviour, and intense but unstable relationships.[16] She was not however under the care of mainstream mental health services and did not have a care co-ordinator under the Care Programme Approach.

9.2 The multi-disciplinary team within the HLDP includes a consultant psychiatrist. The role though is slightly different from that of a consultant psychiatrist in mainstream mental health services, who clearly leads the multi-disciplinary team and holds ultimate clinical responsibility. The consultant in HLDP will see individuals referred to her other members of the team or the GP, usually for a limited number of sessions, and only maintains an ongoing relationship if the individual is on psychotropic medication. The review does not question the appropriateness of effectiveness of the role as it is currently structured. However, for individuals whose primary condition is mental ill-health rather than learning disability, a closer relationship with mainstream mental health services would be beneficial.

9.3 Victoria's GP referred her to adult mental health services, run by Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), in August 2018. He suggested a meeting between "the psychiatric team", the GP, District Nursing and the community learning disability team to discuss how to manage Victoria's deteriorating health. The case note on the BEHMHT information system reads "Forwarded to Haringey LD". The then consultant psychiatrist in the HLDP met with the GP and the Community Learning Disability Nurse. The notes of the meeting recorded that Victoria's capacity was "debatable" and that the psychiatrist would carry out a mental capacity assessment. HLDP records do not show that this assessment was in fact carried out.

9.4 The HLDP psychiatrist saw Victoria three times in 2020, following the overdose referred to in paragraph 3.8 above. By the second meeting in May, she appeared to be coping well, and was not exhibiting symptoms of anxiety, low mood, or psychosis. At the last meeting in December, she did not wish to further engage. The psychiatrist referred her to the HLDP psychology service (with whom she also did not engage), with ongoing contact and support from the Community Learning Disability Nurse.

9.5 There was a further GP referral to BEHMHT on 9th June 2021, asking for a "mental health assessment". A letter was sent saying, "Dear Dr GP, you referred this patient, but they seem to already be under the psychiatrist in the LD team. We have forwarded the referral onto the LD team." However, no record of this referral can be found in the HLDP system.

9.6 The GP contributing to this review felt that on this last occasion Victoria would have benefitted from referral to the BEHMHT Personality Disorder Team. It appears that the lack of connection with mainstream mental health services

[16] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/

means that it more difficult for service users in the HLDP to access such specialist services.

Recommendation 9; BEHMHT and the Haringey Learning Disability Partnership should jointly review the arrangements for the provision of mental health services for service users under the care of HLDP, with a view to more effective collaboration and improved access for HLDP service users to specialist mental health services.

10. Multiple hospital admissions 2021 - 2022

10.1 As outlined in paragraph 3.11, Victoria spent almost eight weeks of the last six months of her life in hospital in five separate admissions. The review has sought to explore whether there were opportunities during this period to pull primary health care, secondary health care, and community health and social care services together to try and develop a co-ordinated plan across specialisms and organisational boundaries to seek to arrest Victoria's decline and promote more positive outcomes. This did not happen.

10.2 Everybody contributing to this review agreed that there are immense difficulties in ensuring regular information sharing between agencies and professionals through a period of such changes and hospital admissions: ensuring that at any one time everyone in what should be the "team around the patient" knows what is happening and what has happened, and can contribute to the plan about what will happen next. The focus, in very pressured services, tends to be on dealing with the current presentation and the current acute issue. Existing computer systems do not make it easy to track information: it was said at the learning workshop that one hospital would not necessarily know if a patient had recently been in a different hospital (although the discharge summary from the Homerton in June 2022 did clearly indicate that information had been obtained about the admission to NMUH in April and her discharge a week before she had been admitted to the Homerton). The sharing of information can be slow: Victoria's GP did not receive the discharge summary from the Homerton, which requested an urgent referral to palliative care services, until six days after her discharge – by which time, sadly but unexpectedly, Victoria was dead. Responsibilities are sometimes unclear. That discharge summary requested the GP to make a referral to community palliative care: primary care and community-based professionals felt strongly that the palliative care should have been in place before Victoria was discharged. The Community Learning Disability Nurse recalls that on discharge Victoria's abdomen was still swollen and bloated[17] has had the unintended consequence in some cases of patients returning home with significant unmet health and social care needs even in the short term.

10.3 Victoria's case was discussed on two occasions at the weekly multi-disciplinary team teleconference coordinated by NMUH as a patient experiencing repeated admissions. This did not however seem to lead to any greater coordinated planning between primary care, hospital, and community health and social care services. It was reported to the review, however, that there are now monthly meetings between the lead consultant for learning disability at NMUH and the

[17] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

HLDP team to discuss service users of common concern, which has been welcomed as a positive development.

10.4 Both primary and secondary health care representatives in the learning workshop felt that the further roll out of the London Urgent Care Plan[18] could make a significant contribution to improved sharing of information across the healthcare system. The UCP is described as "an NHS service that enables every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital." Participants in the workshop reported that the UCP had initially been developed with a focus on end of life care, but that it could have benefits for a wider group of patients. It was suggested that greater use of the UCP will make a huge impact on highlighting complex patients, sharing information between partners and working proactively to support vulnerable people.

Recommendation 10: The Integrated Care Board should support wider roll out of the London Urgent Care Plan across the local healthcare system, working with other ICBs across London.

11. Conclusion

11.1 It must be recognised that working with Victoria, striving with her to improve her quality of life, influence her self-destructive behaviours, and keep herself safe, was immensely challenging for her family and for all the professionals involved. Many of those involved tried hard to achieve these things. Particular mention should be made of the unflagging commitment of the Community Learning Disability Nurse to supporting and trying to help Victoria over ten years, sometimes in the face of her rejecting and aggressive behaviour and always "going the extra mile". Victoria's cousin told the review that "no one person is to blame for what happened to Victoria, but there were some fundamental failings in the system". Broadly, this review concurs with that judgement.

11.2 The review has identified those failings or weaknesses in the system as including;

- There were unfortunate delays in commissioning this review
- The pattern of Victoria's behaviour should have been identified and escalated as a serious case of self-neglect much earlier. The structures in place to support multi-agency assessment of the risks to which she was exposing herself, multi-agency planning, and multi-agency ownership of those risks, were not used. The burden of managing the risk fell to too great an extent on the shoulders of the Community Learning Disability Nurse.
- Clarification is needed of what is meant by "the self-neglect pathway" in Haringey. The lack of clarity, and the perception that adult safeguarding services in the borough are resistant to referrals about self-neglect and do not feedback appropriately to referrers, is a disincentive to partners raising appropriate safeguarding concerns around self-neglect.
- In common with many other reviews, this review has highlighted weaknesses in both the understanding and the application of the Mental Capacity Act 2005.

[18] https://www.onelondon.online/urgent-care-plan/;

- There was an extended failure to meet Victoria's housing needs appropriately and safely within the social housing system.
- There were serious concerns about the quality of care Victoria received over an extended period. It is of concern that this inadequate care was allowed to remain in place for so long. Five separate safeguarding referrals raised concerns about the quality of care being provided. These concerns were not shared with the Quality Assurance Team.
- Victoria would have benefited from a closer relationship between mainstream mental health services and the HLDP
- Victoria experienced multiple hospital admissions in the last six months of her life. The system did not facilitate co-ordinated planning across specialisms and organisational boundaries to seek to arrest Victoria's decline and promote more positive outcomes.

11.3 Recommendations arising from this review are collated in the final section of this report. It must be acknowledged, however, that these are very stubborn issues, especially when all the organisations involved are under the enormous pressures experienced in 2024 by all public services – pressures of both huge demand and limited, indeed inadequate, resources. In 2019, Haringey SAB published a Safeguarding Adults Review of the case of "Ms Taylor". This reflected on practice between 2015 and 2017. This review of Victoria's case is concerned with practice between 2018 and 2022. Although the cases are very different, the similarity in some of the findings are very striking. The Ms Taylor review highlighted:

- A lack of comprehensive and holistic risk assessment
- Mental capacity was not fully assessed, despite features of Ms Taylor's situation that should have given rise to the need to undertake such an assessment.
- The seriousness of concerns was not escalated
- Unwise decisions were not construed as self-neglect

There were very similar issues in Victoria's story.

12. Recommendations

Recommendation 1: NHS England and ADASS should jointly develop guidance on the relationship between the LeDeR and SAR processes, seeking to avoid both duplication and unnecessary delays.

Recommendation 2: Haringey Safeguarding Adults Board should consider revising its Self-Neglect and Hoarding Procedure to clarify that, while there is an initial presumption that concerns about self-neglect will be addressed through Care Act assessment, each case will be considered on a case-by-case basis, taking account of the level of risk to which the individual is exposing themselves.

Recommendation 3: Haringey Safeguarding Adults Board should review the policy, guidance and training content relating to assessment of mental capacity available to professionals within the partnership, to ensure that it fully addresses the issues raised in this and other SARs which it has published in the last five years.

Recommendation 4: Haringey SAB should take steps to assure itself, and reassure partners, that recommendation 9 in the "Steve" SAR has been implemented, and to consider what more may need to be in place if implementation is not yet complete.

> "Ensure that the local authority has in place an effective system for providing feedback to referrers of safeguarding concerns, with particular reference to:
> d) Whether the referral is being taken forward under S42 or not;
> e) If not taken forward, the reasons why, and what alternative might be necessary;
> f) If taken forward, the outcome once the S42 process is complete."

Recommendation 5: Haringey Adult Social Care should take urgent action to eliminate any backlog of safeguarding concerns received which are awaiting consideration and appropriate action.

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Recommendation 7: LB Haringey Housing Services should consider agreeing with registered social landlords in the borough formal escalation processes to resolve issues where either party feels that the other is failing to deliver on their responsibilities in a particular case.

Recommendation 8: The Haringey Adult Safeguarding and Quality Assurance Services should work together to ensure that all concerns relating to an individual provider raised as part of a safeguarding concern, whether or not the concern progresses to a S42 enquiry, are shared with the Quality Assurance Team.

Recommendation 9; BEHMHT and the Haringey Learning Disability Partnership should jointly review the arrangements for the provision of mental health services for service users under the care of HLDP, with a view to more effective collaboration and improved access for HLDP service users to specialist mental health services.

Recommendation 10: The Integrated Care Board should support wider roll out of the London Urgent Care Plan across the local healthcare system, working with other ICBs across London.