A review of key lines of enquiry concerning how services worked with Paulette and with each other, with recommendations for the improvement of safeguarding practice and management of practice (September 2023)

Paulette

A Safeguarding Adult Review for Haringey Safeguarding Adults Board

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Section One: Introduction

1.1. Paulette[1] died, aged 56, in March 2022. Cause of death was multiple organ failure and sepsis (Klebsiella pneumonia). Secondary causes of death were dementia, sarcoidosis, previous Corona Virus 2019 infection, and metastatic malignancy (abdomen) of unknown origin. No inquest has been held into Paulette's death.

1.2. A Safeguarding Adult Review (SAR) referral was submitted from Adult Social Care in July 2022. This followed a letter sent to Haringey Legal Services in June 2022 by solicitors representing one of Paulette's sisters. The letter requested a SAR and proposed various key lines of enquiry. There followed an exchange of correspondence over several months between Haringey Safeguarding Adults Board (HSAB) and the solicitors on the precise terms of reference for the SAR.

1.3. The original solicitors' letter had suggested that Paulette's death resulted from abuse and neglect at the care home by multiple agencies. HSAB concluded that, on the basis of available evidence from the agencies involved, Paulette did not appear to have died as a result of abuse or neglect. However, HSAB also concluded that there was potential for multi-agency learning and therefore commissioned a discretionary SAR under the mandate in section 44(4) Care Act 2014. Nonetheless, Paulette's sisters remain of the view that her death resulted from neglect.

1.4. Following exchange of correspondence with solicitors instructed by Paulette's sister, the following key lines of enquiry were agreed for the discretionary review.

1.4.1. What learning can be identified in the approach between agencies to secure authorisation of Paulette's deprivation of liberty under the Mental Capacity Act 2005 during her residence at the care home?

1.4.2. What information did organisations have about Paulette's mental capacity and how did this influence decisions around her deprivation of liberty?

1.4.3. What learning can be identified in the approach between agencies to consider and review long-term care and accommodation options for Paulette?

1.4.3.1. How can agencies work together to ensure that the existence of the block contract for [this care home] (or any other care home) does not stop those agencies from ensuring that individualised care planning and best interests decisions are made about each service user or patient?

1.4.3.2. What learning can be identified in the approach between agencies to ensure that a person's tenancy is protected and their rent paid on temporary admission to a care home, in circumstances where their long-term care has not yet been decided?

1.4.4. What consideration was given to the suitability of Paulette's ongoing placement at the care home in meeting her cultural, social and emotional needs?

1.4.5. What learning can be identified in the approach between agencies to secure assessment and access to wheelchair and seating services, physiotherapy and tissue viability and continence services for Paulette?

1.4.5.1. Did Whittington Health policy around access to wheelchair and seating services act as an obstacle to the way in which organisations worked together to safeguard an individual care home resident such as Paulette?

[1] Paulette's given name is used with the permission of her family.

1.4.6. What learning can be identified in the approach between agencies in planning Paulette's discharge from the Homerton Hospital in February 2022, when her future residence and care were undecided within the Court of Protection case?
1.4.7. To what extent did agency responses to the Covid-19 pandemic affect Paulette's care and treatment?
1.4.8. Is there any evidence that discriminatory abuse (racist abuse, in particular, but also class bias) affected Paulette's care and treatment?

1.5. To understand how Paulette's circumstances developed, and to explore the key lines of enquiry, it was agreed that the review would look at the care and support that Paulette received from January 2019 until her death in March 2022. Any significant events which fell outside of the scope of the review would also be included. Agencies and services with any involvement in Paulette's care and support, placement and healthcare, were requested to provide both chronologies and critically reflective individual management reviews (IMRs). Contributions to the review have been received from:
1.5.1. Paulette's GP
1.5.2. Whittington Health NHS Trust
1.5.3. Haringey Revenue and Benefits Service
1.5.4. The care home
1.5.5. Metropolitan Police
1.5.6. North Middlesex University Hospital
1.5.7. Haringey Housing – Tenancy Management
1.5.8. Haringey – Housing Demand
1.5.9. Homerton Hospital
1.5.10. Haringey Adult Social Care
1.5.11. North Central London ICB
1.5.12. Barnet, Enfield and Haringey Mental Health Trust (BEHMHT)
1.5.13. Local authority Commissioners
1.5.14. Care Quality Commission (CQC)

1.6. The SAR process has been overseen by a panel comprising senior leaders representing the agencies and services involved. An independent chair was appointed for the panel. The independent reviewer also attended all panel meetings.

1.7. The independent reviewer has met virtually with both of Paulette's sisters and their contributions to the SAR have been embedded in this report. They have also commented on the report itself. The independent reviewer is grateful for their reflective and candid contributions. HSAB has also endeavoured to contact Paulette's partner and son. However, her son has not responded to invitations to engage. No contact details for her partner have been forthcoming. Paulette's sisters would like their extended family to be appraised of the review's outcomes.

1.8. A learning event was held, attended by practitioners, operational managers and senior leaders, at which the key lines of enquiry were further explored with a focus not just on what did or did not happen but also on understanding the context in which work took place and on answering the question "why?" The learning event also explored what changes individual agencies and services had made already as a result of learning from this case, and what further developments were indicated.

Section Two: Paulette

2.1. Paulette's two sisters have offered a rich insight into Paulette as a person. Paulette was the eldest of three daughters. She was a party animal, she loved life. She could be mischievous, with a smile when she was up to something. She was very outgoing and active, and did not really care for education. Her father died at quite a young age of cancer. Paulette enjoyed her life, was a happy-go-lucky character and she had fun. She socialised and loved music. She had a sweet tooth. She was outgoing and generous, and always had time for everyone. She was easy to talk to and is missed by large numbers of people. She loved to go to the market and had lots of friends there. She was also a bouncer at a friend's club at weekends; she loved meeting people. She enjoyed working for a government service for many years until she was made redundant.

2.2. Paulette originates from a large family based in Haringey; some of the elders remain there but most of the family have moved away. Paulette embraced her family's Jamaican culture; she was very much a family person and loved Jamaican food. Her love of Jamaican culture was represented at her funeral. She had wanted to visit Jamaica one more time before she died.

2.3. Paulette lived with her partner and her son. Both of Paulette's sisters have described some distance between Paulette's partner and themselves and the wider family. Paulette's loyalties were to her partner and to her son. This meant limited or lost contact for some time with her sisters. When Paulette asked for financial help, one of them bailed her out financially. This involved paying for her rent. On renewing contact, it became clear that Paulette wasn't taking her prescribed medication and her sisters were shocked by the state that she was living in. They sensed that there were things that Paulette wanted to tell them but couldn't. They noticed that adjustments such as ramps had been installed in Paulette's home and they were surprised that Paulette's living conditions had not been raised as a concern. This is the background to Paulette's sister referring an adult safeguarding concern of financial abuse and neglect to the local authority in February 2019, reinforced by the debts in Paulette's name for multiple mobile phones, arguments between her and her partner, and being covered in faeces when she was admitted into hospital.

2.4. Paulette's sisters have described how the family elders advised on how to deal with Paulette's situation and regular family updates were held about this. It was agreed that one of Paulette's sisters would act as the contact person with the services supporting Paulette; she acted on her behalf and saved all correspondence. She obtained lasting power of attorney for Paulette's finances and health and welfare.

2.5. Paulette was diagnosed with dementia by unknown cause following hospital admission after a fall in 2019 which led to her being temporarily re-housed in a care home. Her sisters noted that Paulette had also been prone to falls when she was younger (10-15 years before). Paulette had diabetes but had managed it. Paulette had always had a generous build, but she lost a lot of this weight after the fall in 2019. One of her sisters called for an ambulance following her fall at home as neither Paulette's partner nor her son had done so. Paulette had named one of her sisters as next of kin when she was admitted to Homerton Hospital.

Section Three: Outline Chronology

3.1. Prior to Paulette's hospital admission following a fall in February 2019, some agencies have provided information about contacts with her. Whittington Health Community Therapy Team provided physiotherapy input between April and July 2018, and occupational therapy input between August and October 2018. Paulette had one session with the podiatry team in September 2018 and missed an appointment with the bladder and bowel service in August 2018.

3.2. Paulette had been known to North Middlesex University Hospital since November 2009, when she attended Accident and Emergency for leg pain. She visited A&E 6 times between 2009 and 2018. These attendances were appropriate visits, she was treated and medically cleared to be discharged from Accident and Emergency. In May 2014 she attended her first outpatient appointment and she was seen multiple of times over the years. Some outpatient appointments were for ophthalmology (2014), clinical psychology (2014), endocrine (2017) colorectal (2018) and gynaecology. On 4th June 2018 she attended due to constipation and abdominal pain, something which was to become a recurring them. She was medically cleared and discharged from A&E with recommended follow up with her GP. On 13th November 2017 she attended A&E following a fall whilst out shopping. She was known to have recurrent falls, for which she was under UCLH. She sustained facial injuries but no fractures.

3.3. Paulette had some outpatient appointments at Homerton Hospital in 2006. On 28th and 29th August 2019 Paulette had a short medical admission, having presented with a 5 day history of feeling generally unwell. She had recently been treated with eradication therapy for helicobacter pylori. She was known to have type 2 diabetes but had not been taking her medication for 5 days prior to admission. She was treated with intravenous fluids and insulin infusion. She was seen by the Diabetes Specialist Nurse for education. She felt much better when her blood glucose levels came down and so was discharged home. She was prescribed a once daily insulin regime and oral hypoglycaemic with meals.

3.4. Homerton Hospital provided emergency care for Paulette after she sustained a fall at home in February 2019. "*It transpired quickly that she was presenting with an unusual presentation of cognitive decline and reduced functioning but no clear diagnosis had been established for someone at such a young age and it also appeared that family were struggling to support her with increased care needs at home. Reviews by therapists early on into admission established the need for care on discharge to manage Paulette's needs*." Investigations sought to identify the cause of Paulette's cognitive decline and piece together what investigations had already taken place, which required liaising with other hospitals and specialists. "*A diagnosis was obtained on 7th March of amyloid angiopathy - a condition in which proteins called amyloid build up on the walls of the arteries in the brain. This causes bleeding into the brain (haemorrhagic stroke) and dementia. The aim in cerebral amyloid angiopathy is to treat the symptoms, as there is no current cure. Once diagnosis was obtained referral was made to the specialist neuro therapy team and discharge planning was expedited. Although the MDT felt home with a micro environment set up and a package of care was the least restrictive option, the primary next of kin was … keen for Paulette to be [accommodated] in a specially adapted ground floor flat. They*

were also very against a care home as they thought Paulette was too young for this." The lead nurse for dementia became involved and a specialist unit in Haringey for younger adults with dementia was identified[2]. "*Other interim bed options for discharge were also being identified as it was established there would be a long wait for a bed at the specialist unit and it was by this point decided that home would not be a viable option – Paulette's sister was adamant home not suitable.*" On 9th May the specialist unit had a bed vacancy and with the agreement of the medical team and Paulette's sister, she was transferred there on 13th May.

[2] Paulette's sisters have said that they were unaware of the involvement of the lead nurse for dementia.

Section Four: Analysis of the Key Lines of Enquiry

4.1. The analysis in this section draws on the chronologies and independent management reports provided by the agencies involved in this SAR, alongside contributions from Paulette's sisters and those practitioners and managers who either attended the learning event or gave their time for interviews.

What learning can be identified in the approach between agencies to secure authorisation of Paulette's deprivation of liberty under the Mental Capacity Act 2005 during her residence at the care home?

4.2. The GP IMR states that primary care clinicians were not directly involved in this aspect of Paulette's life. The care home's chronology records that an assessment relating to deprivation of liberty was carried out virtually by a doctor on 8th April 2021 and by a best interest assessor on 12th April. The outcome of these assessments is not recorded in the care home's chronology. The care home IMR observes that application to deprive Paulette of her liberty was applied for and approved.

4.3. Homerton Hospital has observed that it has been unable to verify if Paulette was subject to a deprivation of liberty authorisation during her 2019 hospital admission. The hospital believes that she was not formally deprived of her liberty during the 2022 admission.

4.4. Whittington Health has advised that their staff responded to Paulette's specific health needs. She was known to have dementia and this was factored into consideration when assessing her ability to understand and engage with recommended care plans.

4.5. The ASC chronology for late July 2021 states that no deprivation of liberty was granted in 2019 and 2020. It describes this as "*an error*" and acknowledges that the local authority "*should have commissioned new assessments as Paulette remained in the same placement*." Assessments had been received in June 2019 but a decision had remained outstanding and in October 2020 the process had been closed as no longer appropriate.

4.6. The ASC IMR is candid about this key line of enquiry, as follows: "*There is clearly a disconnect between the work undertaken by [the care home] and Adult Social Services given that Paulette was being deprived of her liberty for two years without authorisation being in place. It appears that there were assumptions made that [deprivation of liberty] was in place given references made during the period between 2019 – 2021 on our records by other practitioners. In May 2019 the Adult Service did receive a DoLS [application] from [the care home] with an urgent authorisation dated 29th May (no extension for urgent authorisation). Form 4 completed dated 5th June. Form 3 completed dated 17th June with [a best interest assessor] recommending [approval] for 5 months. However, it appears that [the local authority] did not grant [approval] for this request and no further action was taken until 2021. It's interesting to note that this issue was not raised at the reviews which it could be argued should be something that is clarified in all such circumstances. However, given this was during the COVID lockdown period some*

mitigations as to why the right questions were being asked when things are being done remotely could be a reason as to why."

4.7. **Commentary:** there is no reference in the care home's chronology to the sequence identified by ASC regarding application for, and assessment relating to deprivation of liberty in May/June 2019. Accurate record keeping is a core requirement for best practice. Every review should clarify the legal status underpinning the work being done and the service being provided.

4.8. The ASC chronology for late July 2021 records that the Court of Protection authorised a standard authorisation until May 2022 whilst alternative placement options were pursued. Nonetheless, the ASC chronology for 25th January 2022 records a social worker suggesting that deprivation of liberty safeguards should be considered for Paulette's return from Homerton Hospital to the care setting as this was an interim placement. However, the Court of Protection had already authorised a standard authorisation until May 2022.

4.9. At the learning event views were expressed that Paulette's case was not unique but, rather, emblematic, something that practitioners had encountered "*quite frequently*." An additional complexity might have been Paulette's fluctuating capacity and her escalating cognitive decline, for example between the time when her temporary placement was agreed and when she was initially placed. At the learning event this decline became clear, with the care setting applying for Paulette to be deprived of her liberty but not hearing back from the local authority. A sense also emerged at the learning event that during the pandemic communication between clinicians in hospitals and practitioners in the local authority regarding capacity and best interest assessments, and applications to deprive a person of their liberty, had not been sufficiently robust. Some training had since been provided and processes reviewed. Nonetheless, it appeared to remain difficult sometimes to know who was coming from the local authority as part of deprivation of liberty procedures and to obtain feedback afterwards.

4.10. Doubts were also expressed about how practitioners across services and agencies understood the next steps to take when a person, with or without decisional capacity, and family members (who might or might not hold lasting power of attorney for health and welfare) objected to a proposed placement[3]. Moreover, those attending the learning event recognised that concerns about deprivation of liberty without lawful authorisation had arisen nationwide.

4.11. Paulette's sister holding the lasting power of attorney knew from care home staff that deprivation of liberty assessment was planned. She believed that an assessment had been done but then heard nothing further. She did not realise at the time the importance of deprivation of liberty safeguards and no-one explained their significance, relevance or importance. It was only when lawyers became involved that procedures for deprivation of liberty safeguards were completed. There is learning here about how services work with family members to which this report returns below.

[3] This is a concern that has featured in other SARs, for example Adult A (2017) East Sussex Safeguarding Adults Board.

4.12. **Commentary and Recommendation One:** the local authority has accepted that Paulette was unlawfully deprived of her liberty. Haringey Safeguarding Adults Board should consider whether it has sufficient assurance that deprivation of liberty procedures are now working effectively, that social workers are legally literate in this respect, and that individuals are not being unlawfully deprived of their liberty.

What information did organisations have about Paulette's mental capacity and how did this influence decisions around her deprivation of liberty?

4.13. Both the GP and Whittington Health IMRs refer to a diagnosis of dementia. The GP IMR states that Paulette was "*acutely confused*" when admitted to hospital in February 2020. This IMR references dementia reviews completed in May 2019 and February 2020. At this time Paulette was diagnosed with "*uncharacterised dementia*" and had multiple medical issues, including sepsis and hypoglycaemia. In January 2021 the IMR records that Paulette had been found to have "*marked leukoencephalopathy*."

4.14. Whittington Health has confirmed that staff did not assess whether deprivation of liberty safeguards were applicable when visiting the care home. Homerton Hospital has confirmed that Paulette's mental capacity was not assessed at the point of admission in 2019 or 2022.[4] This IMR states that mental capacity was assessed regarding discharge planning but not for care and treatment whilst Paulette was in hospital. It further states that deprivation of liberty safeguards were never considered as part of Paulette's care plan. During the 2022 hospital admission Paulette's capacity to consent to blood transfusions was assessed; as she was found to lack capacity, best interest principles were applied. The IMR also confirms that the local authority social worker had requested a mental capacity assessment in relation to decisions about accommodation post-discharge but this was not carried out as it was deemed not necessary since Paulette was returning to the care home and assessment could be completed there[5].

4.15. North Middlesex University Hospital's IMR confirms that the hospital was aware of the Court of Protection proceedings at the time of Paulette's admission, and that Paulette's sister, who held lasting power of attorney, was aware of her admission. She was updated on Paulette's health and the plan for her treatment, with which she apparently agreed. The hospital has advised that there is no evidence of capacity assessments having been done at the point of admission to establish whether or not Paulette could consent to admission and treatment. There is, however, documented evidence of care being delivered in her best interests because she could not verbalise consent.

4.16. North Middlesex University Hospital's IMR confirms that there is no evidence of discussion with Paulette's sister, who held lasting power of attorney, regarding any application to deprive Paulette of her liberty and no application was submitted whilst she was an in-patient there. There is reference to discussion with Paulette's sister regarding a "do not resuscitate notice."

[4] However, see 4.88 below where it appears that assessments were done shortly after Paulette's 2022 admission.

[5] See Section Six: Single Agency Reflections on Lessons Learned with Recommendations below.

4.17. The IMR from Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) observes that Paulette was unable to provide consent because of her cognitive impairment and that best interest decisions were therefore taken.

4.18. The care home has reported that Paulette was able to make decisions regarding her day-to-day care needs and that she was consulted daily about these decisions. It has stated that care plans were in place to support staff to assist Paulette with her care needs. Paulette's sisters, however, have stated that Paulette would only talk to one staff member in the care home, as a consequence of which decisions were discussed with Paulette's sister who held lasting power of attorney.

4.19. The local authority's housing demand service has confirmed that it had been informed in July 2021 that Paulette lacked capacity and that her sister was dealing with all matters[6]. Consequently, that service liaised with Paulette's sister and social worker rather than with Paulette directly. However, it also appears that a social worker had confirmed that Paulette was "lucid", could communicate her needs and had capacity.

4.20. **Commentary:** although Paulette had been reported to lack capacity, it would have been good practice to have spoken with her directly alongside liaising with her sister and social worker. Indeed, several evaluations of practice submitted by the agencies involved, for example by Homerton Hospital and by the police, observe that Paulette was not routinely spoken with; rather, reliance had been placed on what family members said. Making Safeguarding Personal, as a core adult safeguarding principle, should be standard practice whether or not a person has decisional and executive capacity. There also appears to have been contradictory opinions as to Paulette's decisional capacity.

4.21. The ASC IMR comments as follows: "*Paulette was diagnosed with dementia by Queens Square Hospital on 29th March during her first admission into hospital. A capacity assessment was undertaken (18th March 2019) regarding her ability to determine her discharge destination, but she was deemed to lack capacity to decide this. A new assessment of capacity was undertaken 12th July 2021 asking if she could make decisions around her long-term accommodation which she was also found to lack capacity to do. From documentation relating to interactions with Paulette and her sister, there does not appear to be anything that might suggest that her presentation improved and that she could have regained a level of cognition that may have provided a different outcome to a capacity assessment. That being said once the placement was deemed to be permanent (December 2019) then a new capacity assessment should have been undertaken to ascertain whether or not she had capacity at that point around her accommodation*." The ASC chronology for early July 2021 records that Paulette was unable to retain information.

4.22. Several contributions at the learning event recognised that, despite Paulette having been assessed at different times not to have capacity for particular decisions, she should nonetheless have been involved in decision-making. There were times when it appears that she was not involved and, consequently, her own voice was not heard.

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[6] Paulette's sister who held lasting power of attorney has stated that housing staff were aware of the situation in late 2019 and that she had received email communication to that effect.

4.23. It was suggested that some practitioners, for example police officers, have insufficient training about mental capacity and therefore a lack of understanding, for example of fluctuating capacity, and of skills. It was suggested that this affected police involvement when there were adult safeguarding concerns referred regarding financial abuse and neglect. It was a contributory factor to Paulette not being engaged with directly and her voice therefore not being heard.

4.24. It was also suggested at the learning event that practitioners, for example social workers, might be unclear about their role and responsibilities, and their duty of care, when there is someone who holds lasting power of attorney for finances and/or health and welfare. This is an issue that has arisen in other SARs[7]. Some uncertainty was expressed about how to respond when there was concern that a person holding lasting power of attorney was not acting in the person's best interest. Also evident was some reluctance to challenge the views expressed by those holding a lasting power of attorney. This too could be a contributory factor to Paulette's voice not being heard directly and to a failure to consider whether the appointment of an advocate was advisable.

4.25. One aspect of how services engaged with Paulette's sisters, and especially the sister who held lasting power of attorney, revolved around placement decision-making. It appears that there was agreement regarding the initial temporary placement in the care setting, partly because of concerns about financial abuse and neglect when Paulette had been living at home, and partly because the architecture of her home could not be adapted to allow her to live safely there. Subsequently, however, the available documentation appears to indicate that some practitioners/clinicians ruled out any form of community living whilst others continued periodically to search for community living options. Her sisters, and indeed Paulette herself, are recorded as having been very keen on moving on from the care setting into her own accommodation with a care package of care and support. There is no record of a whole system candid conversation about what was possible, what was safe, and what was really in Paulette's best interests. Ultimately, had Paulette not died beforehand, the Court of Protection might well have ruled on this question.

4.26. At the learning event it was also acknowledged that Paulette's mental capacity should have been assessed on admission to hospital. A view was also conveyed that capacity cases are becoming more complex.

4.27. **Recommendation Two:** Haringey SAB should consider providing training and a written briefing on practitioner roles, responsibilities and duty of care when a person holds lasting power of attorney.

What learning can be identified in the approach between agencies to consider and review long-term care and accommodation options for Paulette?
March-May 2019

4.28. Housing Demand's chronology records that on 1st April 2019 a social worker referred Paulette for sheltered housing as she could not manage the stairs in her tenancy and, additionally, a safeguarding concern had been raised about financial abuse and neglect. Following discussion with Paulette's sister about whether supported housing would be suitable,

[7] For example, Brent SAB (2021) SAR Leocardo.

on 13th June the social worker confirmed a step-down referral for permanent sheltered accommodation. On 28th June the social worker confirmed that a review had concluded that Paulette's needs, and attendant risks, could be managed in the community and reaffirmed the request for an assessment for supported housing. The care home provided information at this point.

4.29. **Commentary:** there were delays between April and mid-June 2019, and again between late June and 6th August when the social worker requested an update. It is possible that the delays were the result of staff shortages. An assessment was completed on 12th August, with Paulette's sister present. The assessment recommended priority one. The application was, however, not approved as Paulette's support needs were considered too high for sheltered accommodation. A referral for extra care was made.

4.30. The Commissioning Brokerage chronology begins with an entry on 19th March 2019 to the effect that no step-down flats were available, with the position unlikely to change in the medium term. This position was reiterated on 4th April. A temporary residential care enquiry was submitted to another London Borough later in April, there being no vacancies within Haringey, including at the care setting in which Paulette was eventually placed. An offer to consider offering Paulette a place was received from a care setting on 23rd April, with a request to receive support plans to facilitate an assessment. By 30th April Paulette had been in hospital for 67 days and concerns were being expressed that she was at risk of acquiring infections.

4.31. **Commentary:** it appears that there were difficulties sourcing a temporary residential placement for someone under the age of 65. This age consideration might have disqualified the aforementioned offer unless it proved the only option to meet Paulette's immediate needs. Whilst aware of the resource position of statutory services, Paulette's sisters have stressed that a duty of care was also owed to Paulette.

4.32. Further efforts were made into May 2019 to source possible providers and a panel agreed a weekly funding ceiling. On 2nd May a possible option was identified. There followed negotiation on the weekly cost and assessment of this placement offer was delayed in order to facilitate Paulette's sister to view the care setting.

4.33. **Commentary:** flexibility on the weekly ceiling for placement costs was good practice, as required by administrative law. It certainly appears that resources were limited for someone of Paulette's age. Paulette was in fact placed in the Haringey care setting on 13th May and Paulette's sister is recorded as having been happy with the placement. Paulette's sister has emphasised, however, that she was only happy for the placement to proceed on the understanding that it would be temporary whilst other, in her view, more appropriate placement options were pursued. Nor does she understand why a promising alternative option, available shortly before Paulette's admission to the temporary placement, unravelled.

4.34. Adult Social Care's submission observes that: "*there were a number of attempts to get Paulette back into a community setting during 2019. The social worker dealing with the case at that time explored a return home, sheltered accommodation and extra care. All of these options were seen as preferable to a nursing placement even if that placement was only intended to be short term. Unfortunately, each of these options was eventually ruled out by those assessing as*

not being appropriate either due to safety or level of presenting need." The ASC submission records that Paulette required assistance and support with mobilising and with personal care. She was stated to be doubly incontinent. The ASC chronology records the difficulties in sourcing a placement owing to Paulette's age, CQC rating of care/nursing homes, level of Paulette's needs and distance from Haringey.

4.35. Homerton Hospital's submission for the review observes that the multidisciplinary team "extensively considered" discharge plans in 2019, with family involvement in a meeting with healthcare practitioners and social worker. Mental capacity best interest principles and least restrictive options were applied as Paulette had been assessed as unable to retain information. Discharge planning included a home visit with Paulette, family members and clinicians, which concluded that single level living was needed. The Homerton chronology records that Paulette had fallen several times in hospital and that she needed close supervision. Paulette's sister with lasting power of attorney has told the independent reviewer that she had to resist a medical plan to discharge Paulette home with a care package when this had been deemed unsafe by other health and safeguarding practitioners.

4.36. **Commentary:** the home visit to assess Paulette's needs and attendant risks in her home environment was good practice. The Homerton chronology clearly records the options that were being weighed, including a return home with adaptations and care package, especially if Paulette lived in a micro-environment. It also records the high risk of falls in this option and Paulette's apparent lack of safety awareness. Family involvement was good practice, with Paulette's sister recorded as unhappy both about Paulette returning home, because of safeguarding concerns regarding financial and psychological abuse, and about placement in a nursing home. However, in terms of "thinking family", curiosity does not appear to have been expressed about why Paulette's partner and son were not visiting.

4.37. Options appear to have been limited because of lack of sheltered accommodation and care home vacancies, and because of Paulette's age. Shortly before Paulette was medically fit for discharge, the care setting where she was eventually placed became an option and staff there had worked previously with younger adults with dementia. Paulette's sisters have emphasised that a local authority has a legal duty to meet an individual's needs under the Care Act 2014, but also has more general duties to develop services and "*shape the market*" in an area, to make sure that there is enough provision available for the people living in their area that need it. Paulette's sisters have asked for assurance regarding how the local authority is meeting these statutory duties. This request for assurance could be addressed in the recommended summit involving commissioners.

4.38. **Commentary:** the Homerton chronology records that Paulette's sister was unhappy with the discussion of discharge options because she wanted information about diagnosis and management. Notwithstanding Paulette's diagnoses of dementia of unspecified aetiology, including primary neurodegenerative disease with rapid rate of deterioration, and leukodystrophy, a checklist for continuing healthcare was not completed and the placement referral did not indicate health needs. It has been suggested to the independent reviewer that there was a lack of clarity about the degree to which Paulette required ongoing nursing care and whether practitioners and clinicians were clear in articulating their assessment that Paulette would be at greater risk if living in a community setting.

4.39. The care setting's submission records that Paulette was identified as requiring long-term care and accommodation, and that these options were explored prior to admission between the local authority, healthcare clinicians and her family. It also observes that, other than when the care setting carried out a pre-admission assessment, it was unaware of Paulette's involvement in placement decision-making. **Commentary:** preadmission assessment was good practice. Even if the placement was a best interest decision, following Mental Capacity Act principles, making safeguarding personal still requires Paulette's involvement.

4.40. Paulette's sisters have commented that she was ineligible for sheltered housing because of her age. One extra-care housing option was found that would have taken Paulette but she lost her place as a result of having a pressure sore and having to be turned every six hours. At this time Paulette was still walking and a walking frame had been provided to help build up her strength. The sisters understand that hospital consultants had recommended that Paulette return home with carers and occupational therapy input. This option was discounted because of safeguarding concerns and the layout of her tenancy. As a temporary measure, Paulette was placed in a care setting. Paulette's sisters understood that the care setting was registered as a specialist dementia centre and became concerned when, shortly afterwards, the sign was removed.

May-December 2019

4.41. An initial six-week review of Paulette's temporary placement was held on 24th June, as required in law. Paulette had settled but her sister, who was present, felt that there was insufficient stimulation. A decision was reached to research off-site activities. A day centre was located but transport had to be funded by Paulette's family and was only accessible when care setting staff could accompany her. She was reported to be compliant with care and support, and to be independent with eating and drinking. She required assistance with personal care. The review recommended that the placement continue, temporarily, whilst a move to a sheltered flat was pursued. **Commentary:** given the level of her health and care needs, it is questionable whether sheltered accommodation was a realistic option.

4.42. Paulette's sisters had asked that she not be placed with older people, given her age. However, she was placed in a unit where the other residents were considerably older. Both sisters have expressed their regret that they were unable to find an alternative living option for Paulette.

4.43. A social worker continued to explore accommodation options. Paulette's sisters have expressed appreciation of the social worker's efforts to source alternative options. None of these options materialised because of distance from Haringey or the level of Paulette's needs, which included four hourly repositioning day and night. In mid-August sheltered accommodation appears to have been ruled out and extra-care recommended. In December the social worker completed a transfer summary that identified risks of falls, cognitive decline, skin breakdown, and deterioration of Paulette's health. Her care needs were likely to increase. The placement was to remain temporary, however, whilst Paulette awaited assessment for sheltered accommodation. **Commentary:** given that Paulette was under constant supervision in the care setting, the appropriateness of sheltered accommodation and/or extra-care might seem unlikely. Nonetheless, the option for more independent living remained the aspiration. Paulette's sisters have questioned whether, in fact, Paulette was supervised regularly. On their visits they have stated that they could see what appeared not to be happening, uneaten meals

not taken away, Paulette not being made comfortable, and a lack of social engagement and stimulation.

January-September 2020

4.44. **Commentary:** the ASC chronology falls silent from early December 2019, when a social worker completed a transfer summary, until April 2020 when a new social worker was allocated to Paulette and a placement review was deferred by agreement until Paulette's health had improved. This delay can only be partly explained by the timing of the impact of the pandemic. Placement review was further delayed because of imposed government and care setting pandemic restrictions. Tensions emerged between ASC and Paulette's sister, partly as she wished to be present for an in-person placement review. Even when the care setting agreed to facilitate an in-person review, this did not happen as lockdown restrictions were renewed. There were also delays in the care setting providing documentation required for a placement review. The social worker at the time thought that a change of practitioner was needed, and once again requested rehousing for Paulette.

October 2020-July 2021

4.45. **Commentary:** the ASC chronology falls silent here. It has been suggested to the independent reviewer that this gap might be explained by the impact of the pandemic on services. Nonetheless, no placement review had been completed.

July 2021-March 2022

4.46. A social worker was allocated to Paulette at the beginning of July. The ASC chronology records that a new housing assessment was requested at the beginning of August, with Paulette's sister informed. The Housing demand chronology records a social worker referral for supported housing on 27th July, observing that Paulette wished to move back into the community with live-in carers. There was a waiting list for allocation for an occupational therapist assessment to determine Paulette's functioning, with this allocation not being effected until 9th September. Further delay resulted from disagreement regarding whether the occupational therapist needed to see Paulette's previous accommodation. The occupational therapist visited her previous home on 8th October and assessed Paulette at the care setting on 21st October. The assessment concluded that a return home was not viable as Paulette was not ambulant and a stair lift was not feasible. The Housing Demand chronology also records the outcome of the occupational therapist assessment. However, it also records for 6th October that Paulette did not wish to live in supported housing and was requesting general needs housing for herself and her son. The social worker chased up the lack of physiotherapy that could help to facilitate Paulette's return to community living. In mid-November the social worker requested a search for alternative properties. Physiotherapy assessment found a marked deterioration in Paulette's functioning. Paulette's sisters have commented that intensive physiotherapy was first recommended in 2019 so it would not be surprising that by October 2021 a significant deterioration in Paulette's functioning had been observed.

4.47. **Commentary:** by this time assessments were being compiled for the Court of Protection, which ordered on 22nd November that a "benefits/burden" analysis be completed relating to Paulette's current placement against community living. A placement review was completed on 20th December. Paulette was able to communicate her wishes. Her sister wanted Paulette to be moved, concerned about her social isolation, deterioration of her mental wellbeing and alleged lack of adequate treatment for pressure ulcers.

4.48. On 5th January 2022 the social worker requested a meeting to discuss housing options. The Housing Demand chronology records that the social worker requested an update on housing on 7th January. This meeting was held on 2nd February. Long waiting lists for accommodation (upwards of one year) were reported. Efforts to expedite an offer were recorded as failing. Paulette's admission to Homerton Hospital prompted the social worker to request clarity regarding Paulette's potential for rehabilitation. On 16th February the social worker sent potential care setting options to Paulette's sister. The ASC chronology records that Paulette's sister was concerned that if Paulette was moved to an alternative placement, the local authority would forget her. Paulette's sister did not want discharge back to the care setting because of safeguarding concerns and sought a rehabilitation placement. However, clinician assessment concluded that Paulette did not meet the criteria for inpatient rehabilitation. The possibility of completing the continuing healthcare checklist was raised again and one alternative placement explored.

4.49. **Commentary:** several submissions to this review suggest that practitioners were uncertain about the processes to follow. Paulette also had highly complex and specialist health and care needs and there appears to have been a lack of resources to respond to her comorbidities. On reading this report, Paulette's sisters have expressed disappointment at the absence of discussions with them about the lack of resources and have again questioned how the local authority is meeting its duties regarding market sustainability and development. Health, social care and housing services did not routinely come together to share information and assessments, and to agree a plan for meeting Paulette's needs. Such meetings might have helped to clarify whether or not Paulette could safely live in the community. There were also delays in providing information or completing assessments. Finally, the ASC submission observes that case recording by social workers was good; the Housing Demand submission by contrast indicates that internal record keeping was poor.

4.50. **Commentary:** in reviewing learning regarding Paulette's 2022 discharge from Homerton Hospital, a candid reflection is offered, namely that Paulette herself was not involved enough in discharge planning. Even if by that time she did not have mental capacity with respect to the decision about where she should live, she nonetheless should have been involved as far as practicable in line with the principle of making safeguarding personal.

4.51. **Commentary:** there is some documentary evidence to suggest that Paulette's placement was seen by some departments within the local authority as permanent from late 2019. Other departments within the local authority, and services elsewhere, still thought of the placement as temporary. However, Paulette's family never abandoned hope that she could live in the community rather than in a care home. As reported in a social worker's statement for the Court of Protection in March 2022, healthcare clinicians appear to have ruled out inpatient rehabilitation but not necessarily community rehabilitation, although her prospects were at best "*unclear.*" The disagreement about what was in Paulette's best interests was appropriately referred to the Court of Protection which, in November 2021, ordered updates on housing, safeguarding, occupational therapy, physiotherapy and the care plan. By February 2022 Paulette required 24-hour care and completion of the checklist for community healthcare funding was identified as required.

4.52. As time passed Paulette's sisters believe that she became increasingly "*fearful*" and less "*bubbly and chatty*." They observed that Paulette turned from "*being compliant to scared, petrified of being there*." Eventually Paulette would only talk to her sisters.

4.53. A focus at the learning event was on decision-making between residential/nursing care and living in the community; between Paulette's and her sister's stated wish that she should live in her own accommodation, "*in my own place*", with a care and support package, where she would be happy, and placement in a care setting where, from the perspective of at least some practitioners and clinicians, she would be safe and her health and care needs fully met. Those attending the learning event saw decision-making about Paulette's placement as not unique but emblematic of other cases involving questions of risk, autonomy, and duty of care.

4.54. "*What good is it making someone safer if it merely makes them miserable*?"[8] This well-known judicial observation captures the choice facing practitioners in Paulette's case. The Court of Protection has ruled on other cases[9] where the choice has been between deprivation of liberty and safety, where health and social care needs would be met but at the expense of a person's wishes, and those of their representatives, and living with risk in the community with the maximum care package that could be provided. Several observations at the learning event reflected on practice when faced with such choices: "[we] *need to balance duty of care vs person's desires vs risk. Once the immediate risk is mitigated, it is important for practitioners to reflect on the situation and consider the person's quality of life and their happiness.*" "[there] *seems to be anxiety re risk in ASC. Need to empower staff to be an advocate without being concerned about personal comeback. Should work in a collaborative way to consider risk and decision making.*" "[We] *need to have a proportionate response to risk, rather than restricting people.*" Analysis later in this report will reflect further on the choice between institutional care and community living in terms of how services worked together and with Paulette and her sisters regarding this decision, and whether practitioners are well supported when analysing risk.

4.55. The analysis above has highlighted the shortage of available placements and of suitable accommodation in the community. One observation at the learning event is particularly pertinent here, namely: "*there is an area of learning around how practitioners respond to early onset dementia, as this is quite a rare occurrence, and younger adults will have different wishes to older adults*". **Recommendation Three:** Haringey SAB should consider hosting a summit of commissioners and providers to review where there are gaps in available resources, as exemplified in this case, and what strategic planning is possible in response.

How can agencies work together to ensure that the existence of the block contract for this care home (or any other care home) does not stop those agencies from ensuring that individualised care planning and best interests decisions are made about each service user or patient?

4.56. This is a subsidiary component of the third key line of enquiry. The local authority's IMR from commissioners observes that Paulette was placed in a general nursing bed on a spot commissioned basis, which falls outside the block contract. Commissioners expect that, for on

[8] MM (An Adult)[2007]

[9] For example, Westminster City Council v Manuela Sykes [2014] EWHC B9 (CoP); Lancashire and South Cumbria NHS Foundation Trust and Lancashire County Council and AH [2023] EWCOP 1

the spot placements, care providers will notify brokerage, social workers and safeguarding teams if there are any concerns about placement suitability.

4.57. The ICB IMR also observes that the initial admission to the care home was through its intermediate care beds to support the Paulette's recovery and with a view to plan move-on accommodation. "*These short-term beds are not part of the overall block contract for 60 beds.*"

4.58. The care home's IMR is explicit in refuting any negative impact on individualised care planning and best interest decisions for Paulette. It asserts that each resident's needs are assessed holistically regardless of contract and that care plans and risk mitigation plans are drawn up by staff to support individual residents. The IMR states that multi-disciplinary team meetings, including GPs, social workers, family members and individual residents are held as part of this process. **Commentary and Recommendation Four:** The care home's IMR might be read as "practice in theory." Haringey SAB should consider whether an audit of care home practice would be useful to seek assurance regarding assessment and planning to meet care and support needs, and to mitigate risks.

What learning can be identified in the approach between agencies to ensure that a person's tenancy is protected and their rent paid on temporary admission to a care home, in circumstances where their long-term care has not yet been decided?

4.59. This too is a subsidiary question in the third key line of enquiry. The care home IMR observes that its staff are unaware of how this process works since it is dealt with by the local authority.

4.60. The ASC chronology records that whether or not Paulette's son would have tenancy rights was first questioned in April 2019. The Housing Tenancy Management IMR observes that tenants can claim housing benefit for 52 weeks after placement in residential care. It reflects that this information could be communicated earlier to residents once the council has been informed of a placement.

4.61. The Haringey Revenues and Benefits Service IMR lists dates when Paulette assumed her tenancy and when decisions were made subsequently regarding entitlements to council tax reductions and housing benefit. It reflects that council tax decision-making was incorrect but that housing benefit decision-making was correct. It observes that liability decisions should have been timely and correct. There should have been better liaison between Revenues and Benefits, and Housing to share information and complete the picture of the household circumstances. It is candid about lessons learned, namely that processes, prioritisation and decision-making were poor, with an acceptance of delays resulting in a poor customer experience. It attributes some of the delays to an "ill-advised system replacement in 2019 that led to substantial backlogs of work."

4.62. Paulette's sisters have been critical of the lack of clarity regarding procedures surrounding financial assessment and responsibility for the placement, and the lack of responsiveness when they questioned the bills they had received. They have also questioned the time taken to establish whether or not Paulette's partner and son had tenancy rights. This delay, they felt, had impacted on the search for accommodation where Paulette could live in the community. As a

result they had submitted a formal complaint to the Local Government and Social Care Ombudsman. In their view there followed delays in implementing the Ombudsman's recommendations and further attempts to claim that Paulette owed money from her estate for rent arrears. They have concluded that "*the council's lack of joined up working around Paulette's tenancy management and rent arrears is a particular area that needs to be improved*."

4.63. **Recommendation Five:** Haringey SAB might wish to consider whether it should seek assurance about how Revenues and Benefits and Housing Tenancy share information and work collaboratively.

4.64. **Commentary:** the Haringey Revenues and Benefits Service IMR records that the aforementioned work backlog has been cleared and prioritisation streamlined. It notes that written procedures will be developed and implemented as part of the re-shaping of the service. Procedures for better liaison with Housing on accounts in arrears will also be part of the service re-shaping. It suggests a need for council tax training for relevant council staff. **Recommendation Six:** Haringey SAB should consider seeking assurance that these plans have been implemented.

What consideration was given to the suitability of Paulette's ongoing placement at the care home in meeting her cultural, social and emotional needs?

4.65. In its submission the care home has stated that Paulette's social, cultural and emotional needs were considered and met, as outlined in care plans. The local authority commissioners' IMR states that placements are made and accepted on the basis of social work assessments of an individual's support needs. It further highlights that the care home assessed Paulette prior to her admission in May 2019 and that her family was involved.

4.66. Whittington's records do not contain any indication that Paulette was unhappy at the care home. Homerton's records for 2022 similarly do not suggest that any concerns were raised with the treating team. **Commentary:** at the very least this would seem to indicate shortcomings in information-sharing and collaboration since there is evidence that Paulette was unhappy at the care home and wished to move into her own accommodation.

4.67. **Commentary:** also apparent is that each of Paulette's health, accommodation, cultural, social and emotional needs appear to have been seen and responded to in isolation. Available records, for example from her GP, describe her needs as "highly complex" and yet everyone involved or with a potential contribution to offer did not meet together to share information and to devise a care and support, accommodation and healthcare plan.

4.68. **Commentary:** the use of multi-disciplinary and multi-agency meetings might have helped to avoid a problem identified by the BEHMHT IMR, namely that the speech and language therapy service recorded problems making contact with care home staff who could assist in arranging assessments of Paulette's needs. That IMR recommends the need for better lines of communication, including a named staff member as a single point of contact. For "highly complex" patients/residents/service users, the services involved should consider how best to

coordinate their involvement and contribution. This theme is picked up later in this report under the heading “working together.”

4.69. The ASC IMR responds as follows. “*The initial placement at [the care home] had not intended it to be a long-term placement ... Reviews should look holistically at any care arrangements and always look at ways in which it can be improved. I think all conversations were around moving Paulette into a community setting as soon as would be possible and perhaps there was less of a focus on the cultural, emotional needs. It does not appear to be something specifically addressed by practitioners or the sister other than moving her back into a community option. We have more recently (April 2022) introduced a new strengths-based model which has seen us change how we approach our conversations with residents with a much greater focus on better understanding each person as an individual, not defining them by their disability, to ensure a much more person centred and holistic approach to identifying and meeting outcomes*.”

4.70. During the learning event, and in individual interviews with practitioners, culturally appropriate care has been acknowledged as essential[10]. However, challenges have been encountered in discharging individuals from hospital into culturally appropriate care. Doubts were expressed about whether culturally appropriate care was considered and concerns articulated that family members were expected to organise it. One explanation for this was a tendency to see Paulette’s needs predominantly through a physical health and medical lens, with some practitioners and clinicians recognising that such an approach was neither motivational nor empowering. A second explanation might reside in what commissioners actually commission and whether the focus is mainly on providing a safe space rather than a setting where, in addition, a person’s cultural interests and social networks are also provided for.

4.71. **Commentary:** there does not appear to have been a bespoke plan for identifying and meeting Paulette’s cultural, social and emotional needs, or indeed for promoting her wellbeing generally as required by section 1 Care Act 2014. The initial assumption that her placement would be temporary, followed by some focus on seeking alternative accommodation arrangements might provide partial explanation for this omission. There were, however, gaps when there does not appear to have been an ASC allocated worker who could give detailed consideration to how Paulette’s cultural, social and emotional needs would be met.

4.72. Paulette’s sisters have commented that the provision of social stimulation would have been helpful. Paulette would have benefited greatly from participating in activities and being taken out. They have described how the “*light was dimming in her eyes, which was painful to see*.” She became “*very subdued, lost mobility and went downhill*.” Essentially, “*she was disappearing*.” They have emphasised what they believe to have been lack of funding for dementia support and observed that they had paid for Paulette to attend a specialist centre as they had been told that no funding was available to support her with dementia specialist support. They have commented that at times no staff were available to take Paulette to a day centre. With reference to her cultural identity, they have commented that she was fed food that she did not like. What they believe to have been an absence of stimulus for Paulette links back to comments made above about the objective when placing people in residential and nursing care. The report returns to these comments in the next section of the report under commissioning.

[10] https://www.cqc.org.uk/guidance-providers/adult-social-care/examples-culturally-appropriate-care

4.73. **Recommendation Seven:** Haringey SAB should consider seeking assurance about the outcomes of the introduction of the strengths-based model.

4.74. **Recommendation Eight:** Haringey SAB should consider conducting an audit of commissioned placements and of care packages provided to people living in the community to seek assurance that social, cultural and emotional needs are recognised and provided for in age appropriate care plans, as part of a commitment to making safeguarding personal.

What learning can be identified in the approach between agencies to secure assessment and access to wheelchair and seating services, physiotherapy and tissue viability and continence services for Paulette?

4.75. The care home's IMR has stated that referrals were made on the basis of identified needs and that assessments were arranged for Paulette. The care home has suggested that services worked well together to meet her needs appropriately and promptly.

4.76. Whittington's IMR and chronology indicate that Paulette received assessments from, and had access to physiotherapy, tissue viability and continence services. It is also suggested that there was no indication that Paulette was not provided with a suitable wheelchair to mobilise around her placement setting. Homerton Hospital's IMR observes that Paulette was not discharged in 2019 in a wheelchair, having received extensive therapy during this hospital admission. Paulette was not identified as needing a therapy referral on discharge. It is also reported that there was no need for referral to a tissue viability nurse as her skin was intact. Similarly, with no change to her continence at that time, no onward referral to continence services was completed.

4.77. The ASC IMR comments in relation to physiotherapy input that there seems to have been a delay from when the referral was made to the Integrated Community Therapy Team (ICTT) by a social worker. A referral was made to ICCT in July 2021 yet records show in discussions with legal services that no feedback had been received from ICCT by October. It appears that the physiotherapy assessment was completed on 10th November 2021. **Commentary:** whether or not this type of delay is normal for the service given the demand it has and the resources at its disposal, for an individual with "*highly complex*" needs, it is regrettable.

4.78. Paulette's sisters do not believe that she received sufficient physiotherapy and that this contributed to her physical decline. They had even offered to pay for physiotherapy privately as they felt that this was crucial to Paulette's recovery. They believe that Paulette was kept in bed for too long and commented that they had walked her up and down the corridors to maintain her mobility. They have criticised the absence of a suitable wheelchair for Paulette, observing an instance when she fell out of a wheelchair on the last occasion when staff took her out. They had offered to purchase a suitable wheelchair but had been told that this was not allowed.

Did Whittington Health policy around access to wheelchair and seating services act as an obstacle to the way in which organisations worked together to safeguard an individual care home resident such as Paulette?

4.79. This is a subsidiary element to this key line of enquiry about service provision to meet Paulette's needs. The Whittington chronology for mid-November 2021 refers to a referral to the wheelchair service being rejected as there was no indication that the pool of wheelchairs in the care home did not contain a resource that was appropriate for Paulette to use outside the care home. The same chronology and IMR refers to a referral being rejected as the "*mobility and seating solution service does not provide wheelchairs to clients in care home settings. It is the responsibility of the care setting to have a pool of wheelchairs for residents' use*."

4.80. The Whittington submission also requests clarification, since it suggests that in their records there was no indication that Paulette was unable to access an appropriate wheelchair for use, or that her seating was not appropriate.

4.81. The ASC IMR observes that a social worker alerted the care home manager that "*they investigate the suitability of the wheelchair that they provided to Paulette as concern had been raised by her solicitor and by her sister also that it may not be suitable.*" The ASC IMR recommends that, "*given there are specialist services in Haringey it would benefit those services being available to everyone to access especially given the specific needs of individuals in residential/nursing placements*." The ASC IMR observes that the webpage for the Mobility and Seating Solution Centre (MSSC) states that the service is open to all clients with a Haringey GP. However, this does not appear to be accurate given the information that the service is not provided to those in a residential/nursing placement. It suggests that "*there are questions as to how a poor fitting wheelchair for Paulette could have increased the risks of pressure ulcers*."

4.82. The care home, however, has commented that it does not provide specialist wheelchairs, which should be purchased by individual residents or family members following assessment by physiotherapy and occupational health.

4.83. **Commentary:** it seems that there might have been a breakdown in communication between the care setting and Whittington with respect to Paulette's mobility and seating needs. Additionally, the mobility and seating solution service appears to have adopted a blanket policy with respect to care home residents, which does not permit the exercise of discretion in individual cases. One of the standards within administrative law cautions against the adoption of blanket policies, unless explicitly authorised by legislation, since it fetters discretion. The independent reviewer has been told that there is a discretionary element to the policy regarding wheelchair provision, in which case records must show how that discretion has been considered.

4.84. **Recommendation Nine:** Haringey SAB should consider seeking assurance that, where there is a requirement for specialist wheelchairs services and provision, this is available to care homes.

What learning can be identified in the approach between agencies in planning Paulette's discharge from the Homerton Hospital in February 2022, when Paulette's future residence and care were undecided within the Court of Protection case?

4.85. Homerton Hospital has provided a detailed chronology for Paulette's admission between 3rd January 2022 and 15th February 2022. For the purposes of this key line of enquiry the salient information offered by the Hospital follows. Paulette was admitted with abdominal pain. She had not been eating or drinking and needed time to swallow. She could feed herself but only

slowly. She had moderate acute pancreatitis with portal vein thrombosis. The Hospital's overall assessment was that Paulette had "*significant medical comorbidities*."

4.86. **Commentary:** the Hospital's chronology at the time of admission contains elements of good practice. It refers to discussions with one of Paulette's sisters and with a local authority social worker, evidence of some working together and thinking family. It refers to adapting communication with Paulette, an implicit reference to making reasonable adjustments as required by the Equality Act 2010. It records that Paulette's sister believed that she had become bed bound due to staff shortages during the pandemic and that Paulette wished to move back into the community. There are extensive references to the involvement of a range of clinical disciplines, and the identification of Paulette's clinical deterioration.

4.87. **Commentary:** however, the Hospital chronology and IMR accept that no-one verified that Paulette's sister held lasting power of attorney for health and welfare. Nor was the content of the application to the Court of Protection further explored. On admission Paulette was observed to have category three skin damage. However, no safeguarding concerns appear to have been referred to the local authority, an omission.

4.88. By 10th January the chronology records that mental capacity and best interest assessments had been completed, due to "*progressive multifocal leukoencephalopathy.*" Paulette's sister had been involved and there were discussions about the life threatening conditions that Paulette was experiencing. **Commentary:** there is evidence of thinking family, with Paulette's sister being involved in discussions about risk and benefits of treatments. Communication with Paulette was adapted to explain in simple terms the treatment that she required. She appeared able to "*nod*" her consent but unable to explain or repeat back why she needed particular treatments. It had also become clear, evidencing the principle of making safeguarding personal, that Paulette did not wish to return to the care setting and that she wanted accommodation in a flat with live-in carers. It was acknowledged that a temporary placement might be required whilst this option was explored.

4.89. By 19th January Paulette was medically fit for discharge but this was then delayed by Paulette testing positive for COVID, by hospital acquired pneumonia, and by awaiting the outcome of blood tests. She was eventually discharged back to the care setting once her period of isolation following COVID had ended. **Commentary:** Homerton Hospital's IMR and chronology record discussions with Paulette's family about discharge. It is recorded that Paulette's legal team and family were content for her to be discharged back to the care home, and that there was no court order preventing this.

4.90. The Homerton chronology for 26th January records that a social worker had requested that a mental capacity assessment be completed and an application considered for Paulette to be legally deprived of her liberty as she was disputing her placement and had previously been found to lack capacity to decide about where she should live. This request was not actioned whilst Paulette was in hospital. It appears from the chronology that there was agreement between hospital staff and the family that issues relating to where Paulette would live in future and the need for mental capacity assessments would be resolved in the community.

4.91. The ASC IMR records correspondence regarding this hospital discharge from Paulette's legal team, which confirms the position described by Homerton Hospital. It reads: "*However, I wish to point out that my client*[11] *is not seeking an interim placement for Paulette. As my client shall set out in her statement*[12]*, the conversation which she maintains she had with her sister's social worker was with regards to Paulette being discharged to a suitably adapted property in the community. However, if this cannot be achieved upon Paulette's discharge, and if the recommendation from the hospital discharge team is not for Paulette to undergo rehab in their rehabilitation centre before moving back into the community, she would support Paulette's return to [the care home]."*

4.92. The ASC IMR continues as follows: "*It is evident that any move to a housing provided property in the community was at a minimum a year away and as such discharge back to [the care home] appears to have been the only option considering this case was being considered by the Court of Protection. There was dialogue between adult services and the Homerton around the court case, capacity issues and alternative options for stepping down but ultimately the decision for her to return to [the care setting] was taken on discussion with Paulette's legal representation*."

4.93. **Commentary:** it appears that Paulette's social worker was not updated about her hospital discharge after they made an enquiry on 1st February. In a statement for the Court of Protection dated 11th March 2022, a social worker states that the local authority was not informed of Paulette's discharge and had not seen a discharge summary. This is a shortcoming relating to how services were working together. The Homerton chronology refers to the care home having agreed to readmit Paulette but there does not seem to have been consideration prior to discharge of whether care home staff could manage Paulette's multiple and complex needs.

4.94. At the learning event views were expressed regarding lack of communication between social workers and health care practitioners, with fewer social workers now coming into the health care settings. Contrasting views were offered regarding use of multi-disciplinary meetings, with some attendees commenting that they happen frequently but others suggesting that they are under-utilised for safeguarding and safe discharges. Multi-agency, multi-disciplinary meetings are crucial in ensuring that all those involved in meeting a person's health and social care needs have a complete picture of available information. Timing of such meetings prior to hospital discharge could be challenging, especially in the context of wishing to avoid the risk of a hospital acquired infection.

4.95. For Paulette it does not appear that there was a multi-agency meeting to plan her discharge, having explored options and balanced risk against expressed wishes and desired outcomes, and to coordinate an approach to addressing her health, social and accommodation needs. Possible explanations were offered, namely uncertainty about who would be responsible for setting one up, alongside the longer-term impacts of the pandemic on how services were working, and anxiety about what level of risk it was appropriate for practitioners to accept.

4.96. Some doubt was expressed as to whether there were sufficient medical investigations prior to Paulette's discharge, for example relating to why she experienced such stomach pain.

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[11] Paulette's sister who held lasting power of attorney.
[12] To the Court of Protection.

Additionally, it was recognised that care home staff need to feel involved in decision-making regarding a resident's medical care, having advocated for their health needs. Finally, views were expressed that the approach to Paulette's hospital discharge was not person-centred as she was not included in meetings.

4.97. Paulette's sisters have remarked that she appeared increasingly reluctant to return to the care setting and they have wondered whether this apparent fear was connected to care quality. They were increasingly desperate to achieve a move out of the care setting and only agreed to her return there so that she would not be forgotten and because they still understood the placement to be temporary. They do not believe that those involved understood the impact on them of events since February 2019, in a context where family and community elders had given the sisters the responsibility to achieve best outcomes for Paulette.

To what extent did agency responses to the Covid-19 pandemic affect Paulette's care and treatment?

4.98. The Whittington Hospital IMR states that there is no evidence that Paulette's care needs were not addressed. However, some assessments and interventions were delayed and/or completed by telephone as opposed to face-to-face as a result of the pandemic. The BEHMHT IMR has reported similarly. The Homerton Hospital IMR reporting on Paulette's admission in 2022 notes that she contracted COVID and was transferred to an isolation ward. Face-to-face visiting was restricted and family contact was facilitated through the use of IPaDs "what's app" video calls. Paulette's sister was permitted to visit. The Homerton chronology also contains a statement to the effect that Paulette's sister believed that she had become bed-bound in the care home due to staff shortages occasioned by the pandemic.

4.99. The Housing Demand IMR states that the pandemic did not impact on that service's approach to assessment but might potentially have caused some delays due to staff shortages. The ASC IMR observes that a planned review around June/July 2020 was delayed because Paulette's sister wanted to be physically present at a time when the care home was restricting family visits due to lockdown.

4.100. The care home's IMR states that the pandemic did not impact on Paulette's care and treatment. The care home states that it had sufficient personal protective equipment and staffing. Weekly GP rounds continued, albeit virtually, and paramedics were called when Paulette was unwell. Paulette received all her vaccinations. However, the care setting has acknowledged that the pandemic had an impact on family visits.

4.101. The ASC IMR suggests that "*most people in receipt of health and social care services during the pandemic are likely to have experienced impacted provision. This is due to the extremely high demand and pressure in the system, restrictions, lack of placement options, discharge planning and lockdown arrangements. The first lockdown occurred a few months after Paulette moved into [the placement] and this most likely did impact on the ability to actively explore community options for her. This continued until the following year when [it was] identified that Paulette was contesting her placement and the case was presented to the Court of Protection.*"

4.102. Those attending the learning event or speaking in interviews were very mindful of the ongoing impact of the pandemic. Admiration was expressed for how care home staff had responded to the challenges, complexities and tragedies of the pandemic. Whilst digital solutions might have helped, it was suggested that practitioners had become more distant from service users/patients, and also from each other in terms of peer support and multi-disciplinary/multi-agency working together. "*Not going in [to care settings] did not sit easily but the risks were too high*." The pandemic had also impacted working relationships, for example social worker attendance at hospital ward rounds. The pandemic had also affected staffing levels, when practitioners and managers became unwell, and prioritisation of cases. There remained an ongoing fear of the virus, which was impacting on any full return to in-person working: "*we are all now having to negotiate the challenge of whether the risks have abated such that we feel more comfortable going back towards in-person work*."

4.103. The following quotation from the learning event captures the discussion. "*Some of the issues resulted from the profound affect the pandemic had on staff professionally and personally. Weaknesses in the system were brought into sharp focus. People were trying to do their best in an extremely challenging time. This had an impact on management and frontline practice. There was chaos in care homes, with changing government directives regarding visitors, etc. People struggled to manage in this unprecedented and challenging context. Health and social care practice has drifted as a legacy of the pandemic and because of the huge recruitment, retention and funding pressures.*"

4.104. Paulette's sisters have also recognised the impact of the pandemic: "*it did not help*." They thought that the pandemic had been "*hard on her*" and she had become "*less responsive*." "*It was a difficult time for Paulette not seeing family and having to remain in the care home indefinitely due to Covid-19*." They have commented that communication with the local authority became email-based and contributed to their feeling that they were not heard. Restrictions on visiting the care setting also meant that the family rota of daily visiting was no longer possible to support Paulette and to monitor the care being given.

4.105. In summary, the pandemic had been experienced as an unprecedented time, as "*awful and traumatic*." At the learning event a need was expressed to "*reset expectations*" and to engage in a whole system conversation about recovery. **Recommendation Ten:** Haringey SAB should consider convening a summit to explore the ongoing impact of the pandemic, specifically what can be recovered from pre-pandemic ways of working, what should be retained from the adjustments made in response to the pandemic, and what new ways of working should be promoted.

Is there any evidence that discriminatory abuse (racist abuse, in particular) affected Paulette's care and treatment?

4.106. In the submitted IMRs the services have either stated that there is no evidence of discriminatory abuse or that there is no record of any allegations having been made or concerns raised. Paulette's sisters continue to believe that there was discrimination. **Commentary:** the Equality Act 2010 requires agencies to counteract discrimination and promote equality of opportunity, for example through reasonable adjustments, for individuals with one or more protected characteristics, such as race, gender and disability. No chronology or IMR makes

specific and explicit reference to how the provisions in the Equality Act 2010 were understood or implemented for Paulette.

4.107. Paulette is usually described in chronologies and IMRs as Black Caribbean but one submission records her ethnicity as "White British" whilst another does not distinguish between Black/African/Caribbean/British. **Commentary:** just because a service is multi-cultural in terms of staffing and individuals receiving care, support and treatment, is not necessarily a guarantee of compliance with the requirements in the Equality Act 2010. Haringey SAB's thematic review on homelessness identified insufficient attention to issues of race, culture and gender. **Recommendation Eleven:** Haringey SAB should consider seeking assurance that services are aware of, and implementing their duties as codified in the Equality Act 2010.

4.108. Those attending the learning event did focus on anti-discriminatory practice. They recognised a tendency in society to not recognise the abuse and neglect of older adults or adults with disabilities. They questioned whether sufficient focus was given in practice and in supervision of practice to ageism and racism.

4.109. Paulette's sisters would like to think that racism was not a factor in the care and support that Paulette received but accept that it might have been present in the form of "*stereotypes of a black person on benefits*" and assumptions about a "*dysfunctional black family*." They could not discount either the presence of negative perceptions of the sisters who have been advocating for Paulette and challenging the local authority's management.

Section Five: Further Analysis

5.1. The evidence-base for best adult safeguarding practice comprises the domains of direct practice, the team around the person, organisational support for practitioners and managers, governance of adult safeguarding and, finally, the national legal, policy and financial context within which adult safeguarding is situated. In addition to the components of these domains that are explicitly addressed by the agreed key lines of enquiry, there are additional elements where good practice and learning for practice and service development can be identified from the agency submissions and from contributions at the learning event and during individual interviews.

Direct practice

5.2. <u>Assessment, planning and intervention – healthcare</u>: this component explores the timeliness and thoroughness of assessments, planning and treatment in response to Paulette's ill-health. From the outset, beginning with her February 2019 admission into Homerton hospital, primary and secondary care clinicians understood that Paulette was a "*complex patient*." That complexity is illustrated by the number of hospital admissions and outpatient investigations between 2019 and 2022. It is also illustrated by the range of outpatient and inpatient investigations, including obstetrics and gynaecology, endocrinal, renal and colorectal, gastroenterology, diabetic retinopathy and ophthalmology, neurology and respiratory, urology and haematology.

5.3. **Commentary:** good practice is evident, for example in GP receipt of hospital discharge summaries, referrals to and feedback from hospital clinicians, and Paulette's GP seeking advice about medication management and treatment. In this sense primary and secondary care clinicians worked together. However, there are references in the information provided by the GP especially to Paulette not attending outpatient appointments. This does not seem to have prompted reflection on whether, in fact, these were examples of Paulette not being brought to appointments, and therefore of an adult safeguarding concern.

5.4. **Commentary:** there are also examples of repetitive patterns. For example, NMUH has recorded five hospital admissions in 2020. Sometimes high or low blood sugar levels were implicated and/or hypothermia. Such repetition might have indicated the need to review monitoring of Paulette in the care setting. Additionally, whilst there is evidence of good multi-disciplinary assessments and treatment planning when Paulette was an inpatient, in other respects her medical conditions were responded to in isolation. Outside of hospital admissions, there were no occasions when Paulette's physical health was considered in a multi-disciplinary meeting.

5.5. The same picture appears true when considering healthcare assessments and treatment planning when Paulette was resident in the care setting. The Whittington Health chronology has seven entries between July and October 2019 covering appointments with podiatry, community rehabilitation technicians (walking aids, equipment and adaptations) and physiotherapy. Recommendations were passed to care setting staff, namely exercises for Paulette to maintain her mobility. Paulette's sisters remain concerned that her needs for physiotherapy were not adequately addressed.

5.6. **Commentary:** in a clear reference to mental capacity, entries in July 2019 record that Paulette was able to consent and understood the benefits of recommended exercises. Subsequent

entries for 2019 do not reference mental capacity. From August 2019 the entries record a "*noticeable change*" in Paulette's physical condition, such that she was unable to complete exercises. Paulette's sister is recorded as having asked about physiotherapy input and, in a timely response, a community rehabilitation technician and physiotherapist visited five days later. Plans were provided for care setting staff. However, in October 2019 Paulette was discharged by the therapy team and her "*noticeable*" decline does not appear to have prompted any referral for a whole system review of her physical health (including whether application for continuing healthcare funding was then appropriate) and placement.

5.7. There are seven entries on the Whittington Health chronology for 2020. These inputs centred on nutrition and dietetics review, physiotherapy assessments, and occupational therapy assessments and reviews. By May 2020 Paulette was no longer walking and she was being transferred using a standing hoist. Her weight was monitored and she was discharged by the nutrition and dietetics practitioners when she was eating well and her weight was stable. Physiotherapy assessment recorded "*further decline*" in August 2020, by which time she required full body hoist transfers. She was able to feed herself with assistance. By November she was fully assisted with mobility and care needs and an occupational therapist concluded that Paulette had no rehabilitation needs. There was a plan, however, to provide a palm protector, deterioration (contracture) having been noticed in her right hand. Paulette was recorded as able to follow prompting, despite her dementia, and advice was given to staff.

5.8. **Commentary:** occupational therapists demonstrated good awareness of Paulette's physical and mental health. However, she was discharged from occupational therapy in December 2020 when ongoing monitoring might have been appropriate as further decline was foreseeable. Paulette's declining health does not appear to have prompted review of the funding of her placement or a whole system review. There is no explicit reference to Paulette's mental capacity.

5.9. The Whittington Health chronology for 2021 has four entries, covering district nurse continence assessment, physiotherapy assessment and team visits by tissue viability nurses. The physiotherapy assessment in October 2021 was prompted by Paulette wanting to walk again but the referral was deemed inappropriate. The chronology entry explicitly refers to Paulette's mental capacity, observing that dementia clearly affects cognitive processing ability and that Paulette was unable to follow prompts or to engage in therapy for rehabilitation. She required assistance with all activities of daily living. Concern expressed by Paulette's sisters about her skin integrity prompted involvement of tissue viability nurses, with clear instructions being given to care setting staff.

5.10. **Commentary:** explicit reference to mental capacity was good practice. Good awareness of the needs of dementia patients was shown. The Care Quality Commission was notified of concerns and a safeguarding alert referred about skin damage. However, there was no review of the funding of her placement or a whole system review of her physical and mental health needs.

5.11. The Whittington Health chronology has three entries for 2022 when tissue viability nurses visited the care setting. On one occasion they could not assess Paulette's skin integrity as care home staff had already dressed her wounds. On the second occasion she had been admitted to hospital. A physiotherapist also contacted the care setting to carry out an assessment but Paulette was in hospital. **Commentary:** in its review of the chronology, Whittington Health

observes that recommended care plans were followed by staff in the care setting so that there was no indication that Paulette's placement was inappropriate.

5.12. The BEHMHT chronology records the involvement of the speech and language team, with referrals from ASC or the care setting. A swallowing assessment was requested in April 2020 and appears to have been completed in June whilst Paulette was an inpatient. This was a best interest intervention. Food modification strategies were advised. Paulette now required assistance with eating. Communication assessments were completed in September and November 2021.

5.13. **Commentary:** referrals from the care setting and ASC were good practice but the chronology observes that some referrals from the care setting contained limited information and that there were difficulties contacting care setting staff. However, once contact was established, information-sharing was effective. SALT practitioners provided advice verbally and in writing. Clinical assessment and reporting practice appears to have been good. However, there appears to have been limited oversight as to whether the advice was being followed. In January 2022 the care setting requested a review but this had already been carried out the previous November. This might reflect poor communication within the care setting and/or increasing concern about the setting's ability to cope with Paulette's decline and to follow the advice that had been given.

5.14. **Commentary:** Paulette's physical and mental health needs were highly complex. The GP received reports and discharge summaries, and would have known that Paulette's physical health, communication and cognition were declining. The GP was the one healthcare practitioner who held information about the range of assessments, treatment plans and interventions. Medical management in primary care was supported by multi-disciplinary team meetings with a consultant in care of the elderly but these meetings did not address social issues. Otherwise, other than when Paulette was an inpatient, no whole system, multi-agency meetings were convened.

5.15. At the learning event and in individual interviews there has been a focus on coordination when a patient has multiple and complex physical health problems. One view expressed was that it is unrealistic to expect GPs to coordinate healthcare interventions because of workloads. Nonetheless, a GP did conduct weekly in-person or virtual consultations with care home residents and staff and, despite primary care being "full on and overwhelming", conversations and coordination did take place within the health centre and with nursing staff in the care setting. Another view was that it should be easier to ensure coordination when a person was an inpatient or resident in a care home. However, the involvement of different NHS Trusts for different health needs was experienced as adding to the complexity.

5.16. From a primary care perspective it was suggested that "*structures need to be looked at*" in several senses – when to involve clinical specialists, and how to identify those patients with complex needs and repetitive presentations to discuss in a multi-disciplinary forum. Discussion below returns to the theme of multi-disciplinary and multi-agency meetings.

5.17. Paulette's sisters have commented positively on the sensitivity of hospital staff, the care provided by hospital nurses and the approach of a social worker. They have, however, expressed concern about some of the care that Paulette received in the care setting. For example, they believe that some bed sores were not reported as safeguarding concerns and were the outcome

of insufficient turning. The section on commissioning, below, returns to this theme of the quality of care. However, it should be noted that a consultant in neurology and stroke medicine has suggested that Paulette's loss of mobility "*could be consistent with slow development of progressing brain injury leading to increased tone, weakness and reduced function in legs*." The same consultant observed that Paulette was at high risk of pressure sores due to "*being immobile, dependent, diabetic, over-weight and taking steroids*." This difference of opinion, including on whether or not interventions by care home staff and tissue viability nurses were adequate and working, is yet another reason indicating the importance of convening multi-agency and multi-disciplinary meetings to review all available information and to plan accordingly, with family involvement. The section on working together, below, returns to this theme.

5.18. Think family: there are numerous instances recorded in chronologies of Paulette's sister being involved in decision-making. ASC and BEHMHT, for example, record occasions when the timing of assessments and reviews was arranged to accommodate Paulette's sister. However, especially in the ASC submissions, tensions and friction were evident between the local authority and Paulette's sister, particularly during 2020 and 2021, resulting in the involvement of the Court of Protection and the Local Government and Social Care Ombudsman. During the height of the pandemic, the local authority has described being at "*loggerheads*" with Paulette's sister over her wish to have an in-person rather than virtual placement review. Periodically there was also "*friction*" regarding Paulette's sister's concerns at the lack of physiotherapy exercises being provided in the care setting. Paulette's sisters believe that her rights and entitlements were not met, including respect for their advocacy for her, and that clear explanations were not given about, for example, deprivation of liberty safeguards, the provision of physiotherapy, or how her care and support needs, and her wellbeing were being promoted.

5.19. Homerton Hospital's submission is critical of staff not seeking to clarify the terms of the lasting power of attorney held by Paulette's sister. The local authority's commissioners' chronology and commentary concludes that learning includes the "*need to ensure timely and accurate communication to clients*" and the need to ensure "*timeliness of response*." This includes whether Paulette's sisters were ever formally informed that the placement had been made permanent from 6th December 2019 as extra care was unable to meet her needs. This information is reported in the local authority's commissioning submission. The ASC submission records that Paulette's sister was not notified of Paulette's hospital discharge in February 2022.

5.20. At the learning event and in individual interviews, practitioners have questioned whether they "*did enough with Paulette's family*" and the impact of work pressures and the pandemic on the "*time heavy but important*" moments with patients/service users and their families. Recognised also were the skills needed to engage with "*embedded feelings and emotions, concerns and complexity*." Supervision in this context is discussed below. Here the focus falls on expressed concerns about whether health and social care practitioners are confident when engaging with family members who hold lasting powers of attorney, especially when there are disagreements about how to balance risk with a person's happiness when needing to act in their best interests.

5.21. Paulette's sisters have stated that they did not feel "*listened to*" and have been critical of practitioner responsiveness – "*no-one calls you back*" and "*no-one responds to emails*." This perceived lack of responsiveness is in part what prompted their complaint to the Local

Government and Social Care Ombudsman regarding Paulette's tenancy, and their application to the Court of Protection.

Team around the person

5.22. Working together and use of multi-agency (risk management) meetings: the evidence-base for adult safeguarding recommends that in complex cases a lead agency is appointed and a key worker named whose role is to coordinate information-sharing, arrange whole system meetings, and monitor implementation of plans to meet needs and mitigate risks. This did not happen for Paulette, although a social worker in February and March 2002 did suggest to her GP that a meeting be convened, in part to complete the CHC checklist, but Paulette died before this could happen. The outcome, referring back to the key line of enquiry regarding Paulette's long-term care, was that there was no whole system oversight of Paulette's placement in the context of the progressive decline in her physical and mental health.

5.23. Homerton Hospital's submission is critical that staff did not try to establish what concerns had been expressed about Paulette's placement that had resulted in proceedings before the Court of Protection. The same submission reflects that staff could have involved the lead dementia nurse earlier when treatment and discharge plans were being considered. The ASC submission records that Paulette's social worker was not notified of Paulette's hospital discharge in February 2022.

5.24. A court conference was held in mid-February 2022, as part of the proceedings before the Court of Protection. This conference appears to have focused on the reasoning behind inpatient rehabilitation having been ruled out in favour of consideration of community rehabilitation. It also focused on Paulette's discharge back to her placement despite safeguarding concerns when she was admitted into Homerton Hospital.

5.25. NMUH in its evaluation of practice has identified that a multi-agency meeting should have been convened in response to Paulette's repeat admissions into hospital, for example as a result of hypoglycaemic events.

5.26. How agencies worked together was a prominent theme at the learning event, especially focused on the use of multi-agency and multi-disciplinary meetings. The feasibility and practicality was questioned of following the pan-London procedures with respect to timeframes for convening multi-disciplinary strategy meetings when safeguarding concerns had been raised. It was noted that there was not a core team around Paulette that could have coordinated responses to her health, accommodation and social care needs. Consequently, Housing Management staff "*were unaware of much that was going on*" and public protection police colleagues were not informed of some of the adult safeguarding concerns. Also noted was that Paulette had not been routinely present in the discussions that did take place.

5.27. A multi-agency solutions panel in Haringey is an attempt to provide a space to have discussions about balancing risks/needs/happiness/safety. This panel might not be widely known and appears under-utilised. Uncertainty was expressed regarding whose responsibility it would be for convening a multi- agency risk management meeting. Concerns were voiced that multi-disciplinary and multi-agency meetings were not routinely convened to discuss safeguarding issues, urgent care plans and/or safe discharge, and that when meetings were convened, not everyone with a contribution to make attended.

5.28. The importance of multi-agency and multi-disciplinary meetings was emphasised, not least because of the volume and complexity of information to be shared in a context where different services use their own electronic recording systems. They were important also for agreeing a proportionate response to risk and for providing practitioners, managers and families with a forum where difficult decisions can be taken collaboratively. A sense emerged of needing to make the systems in place work effectively, which would include challenging any professional or disciplinary hierarchies and promoting practitioners' confidence in working collaboratively. It would include reinstating, where these had lapsed, opportunities for care home staff to attend ward meetings to listen and to understand the complexities of a person's needs and the additional support that might be required. **Recommendation Twelve:** Haringey SAB should consider with practitioners and managers across health, housing, social care and uniform services what steps to take to embed the use of multi-agency meetings in practice.

5.29. Safeguarding literacy: this component of the evidence-base explores whether adult safeguarding concerns were appropriately referred to the local authority using the three criteria in section 42(1) Care Act 2014. It then explores local authority decision-making about whether or not to undertake an enquiry, or to cause an enquiry to be conducted by another agency, under section 42(2) in order to establish what action might be necessary to safeguard the person.

5.30. Paulette's sister referred an adult safeguarding concern in February 2019. The concern related to alleged neglect and financial abuse by Paulette's partner and son. ASC has confirmed that Paulette's sister renewed her safeguarding concern at the end of March. It appears that the earlier referral had not been recorded on the system. The safeguarding referral was closed on 12th September with no further action as Paulette was in a place of safety and, therefore, any potential risk had significantly reduced. The outcome of the alleged abuse was recorded as inconclusive. Paulette's sisters have expressed some concern at the outcome, particularly regarding the concern about possible financial abuse and how her redundancy money had been used and the debts that had been accrued in her name. It should be noted here that the police were only referred the concern about financial exploitation and closed this due to a lack of evidence. Police were not referred a concern about neglect.

5.31. **Commentary:** it appears that Homerton Hospital chased ASC for the outcome of this safeguarding concern in March since Paulette's sister had referred to her concerns during discussions with clinicians about what was in Paulette's best interests. It appears that there were challenges in obtaining information from the local authority. Adult Social Care also sought an update from the police in early August regarding their investigation. The police found no evidence of a crime having been committed. However, it is questionable whether Paulette was the subject of coercion and controlling behaviour and unable to protect herself owing to her deteriorating mental and physical health.

5.32. A safeguarding referral was received on 7th July 2021 from the care setting regarding a pressure ulcer graded as a deep tissue injury. Further concerns were raised by Paulette's sister, an allegation of carers not taking Paulette out of bed and not giving her physiotherapy, not changing her incontinence pads regularly, and carers not washing Paulette regularly. A section 42 enquiry was carried out by a social worker, concluding that: *"Due to Paulette's complex needs she is at risk of pressure sores and requires ongoing continence care. Following the pressure sores she was referred to the tissue viability nurse, in which her pressure sores were identified as not*

requiring dressing and needing to be monitored. According to the tissue viability nurse report the pressure areas require monitoring; however, there was no mention of any deep tissue injury and the waterlow score was 21. Paulette also has pressure relieving equipment and ongoing continence care to minimise any risk of developing further pressure sores." The safeguarding enquiry was closed on 3rd August, recording that abuse/neglect was unsubstantiated.

5.33. **Commentary:** the conclusion does not address the concerns expressed by Paulette's sister regarding the quality of care that Paulette was receiving. Paulette's sister continued to express a wish that Paulette return to living in the community, and the Court of Protection had become involved in this decision.

5.34. A third safeguarding concern was referred on 26th November 2021, once again relating to a pressure ulcer situated on Paulette's sacrum. Once again, Paulette's sister felt that there was no adequate treatment plan for Paulette's pressure ulcers, and was concerned about the quality of care being provided. The section 42 investigation report notes previous sacrum moisture lesions in May, June, September and October, and observes that Paulette required two-hourly repositioning to encourage wound healing. There was a further concern that Paulette's mouth had become stuffed with food when being fed. A safeguarding meeting held on 23rd February 2022 concluded that staff in the care setting had not referred Paulette soon enough to tissue viability nurses and that recording of when Paulette was repositioned was insufficient. The meeting recommended retraining, which was completed by 11th April. The meeting noted that an agency carer and permanent staff members gave conflicting accounts, and that there had been previous nutritional difficulties.

5.35. **Commentary:** there were, arguably, some noticeable absences from the safeguarding meeting, namely Paulette's GP and healthcare practitioners, such as tissue viability nurses and diabetes specialist nurses. The safeguarding enquiry found abuse/neglect to be wholly substantiated. The enquiry was closed on 14th April. The meaning is unclear of the statement that the allegation of force feeding "*is held*." Records note that it is "*likely that Paulette choked on food due to the volume in her mouth*." Paulette's sister is recorded as requesting that the enquiry be broadened out to include the Care Quality Commission and the local authority's commissioning team. It does not appear that the risks to other residents were considered during this enquiry. Indeed, ASC records appear to suggest that those involved were unclear whether a provider's meeting was required, raising doubt about how the interface between section 42 enquiries and provider concerns procedures was understood. Finally, the enquiry was protracted because of delays in receiving information from the care setting.

5.36. **Commentary:** The ASC submission states that "*there appears to have been appropriate oversight of [the safeguarding enquiries] including a planning meeting with the last of the safeguarding concerns shortly before Paulette's death. The 6 principles of safeguarding appear to have been adhered to*." However, Paulette was still alive when the third safeguarding enquiry was ongoing and it is unclear what the safeguarding plan to mitigate the risks of further pressures wounds and choking was in the event that she returned to the care setting. It also appears from ASC's own chronology and records that safeguarding concerns emerged around 18th February 2022 regarding medication mismanagement or malpractice, namely diabetes medication being stopped due to advice on a hospital discharge summary. It also appears that around 8th March hospital nurses observed that Paulette was afraid when touched and that she had indicated that people had hurt her. A social worker sent an email to North Middlesex

University Hospital regarding this concern but there was no referral or enquiry into this concern before Paulette died.

5.37. The North Middlesex University Hospital chronology records several admissions where there was pressure area damage. These occurred February/March and June 2020, and again in February/March 2022. The first was recorded as category 1, the second and third as category 2, and the fourth as category 3. Those recorded as category 1 or 2 "*did not reach the criteria for a SOVA*" and were not referred therefore as adult safeguarding concerns. The hospital's evaluation of practice has concluded that there were missed opportunities to refer into adult safeguarding concerns about pressure area damage. The care setting's evaluation of practice has also concluded that staff might have raised concerns earlier about Paulette's tissue viability.

5.38. The ASC submission records a safeguarding referral from NMUH on 13th March 2022 due to pressure sores. **Commentary:** there appear to be some inaccuracies in what is recorded on this referral. It states that Paulette had no history of falls and had not had any contact with Covid-19. Neither statement is correct. It states that she was continent, which from healthcare records appears doubtful. The space for recording swallowing difficulties has been left blank. Core components of best practice are accurate recording and collation of known information.

5.39. **Commentary:** NMUH has identified learning from these episodes, namely that staff should document pressure skin damage on admission so that adult safeguarding concerns can be appropriately referred to the local authority. **Recommendation Thirteen:** Haringey SAB should consider seeking assurance about the standard of assessment and recording of pressure damage and skin integrity. It would also be appropriate to review how repetitive patterns of pressure damage are reviewed, and risks mitigated, when the category of skin breakdown is deemed insufficient to prompt referral as an adult safeguarding concern.

Organisational support and procedures

5.40. Workloads and resources: the local authority's commissioning chronology and commentary, when reflecting on financial assessment for contribution to the placement, is candid. The local authority is "*unable to explain why workflow was not actioned from 7th June 2019 to 6th November 2019*." This created delays in financial assessment and late billing. There were subsequent delays in assessment, in advising the contribution to be paid and sending instructions to revenue officers once the financial assessment had been completed. In early March this resulted in invoices being cancelled. Staff shortage might also have been influential in delays recorded in the Housing Demand chronology in responding to referrals for sheltered/supported housing.

5.41. At the learning event the workloads being carried in health and social care was acknowledged as sometimes contributing to a lack of personalisation and to services working in silos. There were also references to staffing levels impacting on how agencies worked together, namely: "*I think ideally we'd like that to happen, but I can't see how it can just because [of] staffing levels [and] also the shared demand that there is on healthcare services and also social care services*." Similarly, the pressure on hospital beds resulted in accelerated decision-making, putting pressure on collaborative ways of working.

5.42. Procedures: there appears to have been a lack of clarity, implicit in the local authority's commissioning submission, regarding housing benefit, that is payable for 52 weeks if the claimant is in residential care, even when the placement is temporary. The Housing Demand submission also recommends raising awareness of the processes involved regarding council tenants and their families when a person is admitted into residential or nursing care.

5.43. Reference has already been made in section 4 to uncertainty about the procedures to follow for convening multi-agency meetings and to the lack of use being made of the multi-agency solutions panel. A recommendation has also been offered to Haringey SAB on further embedding multi-agency risk management arrangements in practice. There has also been an earlier reference to the feasibility and practicality of the pan-London procedures regarding the timing of adult safeguarding strategy discussions. **Recommendation Fourteen:** Haringey SAB should consider sharing the findings of this SAR with the London SAB in order to contribute to its current revision of the pan-London procedures.

5.44. Supervision and management oversight: The ASC chronology and management review provide evidence of supervision discussions but not of oversight by senior managers. At the learning event concern was expressed about the availability of supervision, namely: "*I don't think reflective supervision happens as often as it should do is important when we're thinking about decision making for the people who maybe can't consent*." Supervision was recognised as essential for providing a safe space where practitioners and managers could surface their unconscious bias and the assumptions that might be influencing their practice. It was seen as an "*opportunity always to think as a team and with the person about their understanding of risk and then balancing that with the quality of life … I don't think we put the brake on always and then think as a team with that person it just time to reflect on the risk and work together*."

5.45. Individual and team supervision, and senior management oversight, alongside multi-agency meetings, offer a framework for practitioners making difficult decisions about risk that provides security for them. They provide psychological safety and have the potential to act as a counterweight to defensive practice. It was suggested that it was difficult in complex cases to judge the proportionate response to risk and that reflective supervision would help to improve decision-making since "*people are scared to do that [decide about the proportionate response to risk] sometimes because you feel quite isolated*" and fearful of the potential repercussions.

5.46. **Commentary:** it was suggested that the learning event had felt like a good reflective supervision, enabling those attending to reflect on their values and their practice. **Recommendation Fifteen:** Haringey SAB should consider undertaking an audit of supervision practice.

5.47. Commissioning: one feature of commissioning highlighted at the learning event was the impact on information-sharing across services when agencies use different electronic recording systems. Practitioners and managers were left feeling that they were compensating for inadequate systems and having to find "*work-arounds*." Another feature emerged from the discussions around the challenges of finding a proportionate response to risk and a resolution to how best to meet Paulette's health, accommodation and social care needs and preferences. The availability of a nursing care bed might have met her immediate need for care and safety but, arguably, it did not make her happy and it did not maximise her ability to recover, retain, develop and enjoy her interests.

5.48. Paulette's sisters have also highlighted a further issue for commissioners. They have referred to the care home seeming "*understaffed*" and staff appearing to be "*overworked*." They have questioned whether the care that Paulette received was in all respects good enough, highlighting for example the frequency of acquired pressure ulcers, staff responses to Paulette's physical and cognitive decline, and their approach when she appeared reluctant to eat or when she needed to use the toilet. There is at least one concern about the volume of food having been found in Paulette's mouth.

5.49. Commissioners and the Care Quality Commission have contributed to this review. They have recognised the importance of conversations with providers and with family members regarding the desired outcomes for placements, in order to seek to prevent the kind of deterioration that Paulette experienced. Whilst acknowledging that the shortage of good quality placements is a national issue, as a result of this SAR work in Haringey is well advanced to revamp commissioning strategies and to increase the staffing capacity of the quality assurance officer team. This includes strengthening the interface between commissioning, provider concerns procedures and adult safeguarding.

5.50. Work has also been undertaken, and continues, on quality assurance in the care setting in which Paulette was placed. This too, in part, has been a response to learning from this case and the concerns expressed by Paulette's sisters regarding quality of care and stimulation, and adequacy of monitoring provision. A programme of work has involved multi-agency meetings, audits, inspection and drop-in visits, and an action plan involving care setting, NHS and local authority staff. All the residents in the care setting have been formally reviewed. **Recommendation Sixteen:** Haringey SAB should consider seeking assurance at a frequency to be agreed with partners regarding quality assurance activity and outcomes with respect to this care setting.

5.51. When residential and nursing care is commissioned, is the ambition one of "*warehousing*" (just keeping them safe) or "*horticulture*" (thinking about their wider needs)[13]? There are examples of very positive activity practice with residents to maximise their quality of life[14]. There is a link here to the earlier key line of enquiry about whether the placement met Paulette's social, emotional and cultural needs. As one contributor remarked, this SAR presents an opportunity "*to re-evaluate what we do*." **Recommendation Seventeen:** Haringey SAB should consider convening a summit of commissioners and providers to consider how best to meet holistically the needs of individuals who might (otherwise) require residential or nursing care, and how to ensure that the care provided is empowering and motivational for residents and staff.

Governance of safeguarding

[13] Bland, R. and Bland, R.E. (1985) '"Contract" and admission to old people's homes.' *British Journal of Social Work*, 15(2), 133-142.

[14] Preston-Shoot, M. and Lawson, J. (2019) *Making Safeguarding Personal for Commissioners and Providers of Health and Social Care: "We can do this well".* London: Local Government Association and Association of Directors of Adult Social Services. Preston-Shoot, M. (2020) *Practical Examples of Making Safeguarding Personal from Commissioners and Providers of Health and Social Care: "We are doing this well."* London: Local Government Association and Association of Directors of Adult Social Services.

5.52. In addition to the recommendations for Haringey SAB outlined earlier, practitioners and managers drew on their lived experience of multi-agency working generally. The first related to understanding when information might be shared between services and with family members advocating for best interests. This was suggested to be a training need.

5.53. The second related to reviewing partnership working with, and support for residential and nursing care staff. It was observed that care home staff were having to manage "*higher levels of need quantitatively and qualitatively*" and did not routinely feel that they were seen as equal partners.

National context in which adult safeguarding is situated

5.54. At the learning event the policy and financial context, within which adult safeguarding is situated, was highlighted. It was observed that "*the level of funding and capacity has been massively reduced*." "*Health and social care have been decimated and annihilated*." "*I've never seen it so difficult in terms of recruitment, retention, lack of policy clarity, lack of leadership from government, lack of funding for NHS and adult social care*." "*Some of the contributions [at the learning event] about the absolute pressures on the system over the last couple of years and just how challenging all of this is, for everybody that works in this space*."

Section Six: Single Agency Reflections on Lessons Learned with Recommendations

6.1. The agencies that contributed chronologies and management evaluations identified lessons learned and suggested recommendations either for their own service and/or for multi-agency adult safeguarding partnership working. This was accompanied by reflections offered at the learning event that Paulette's case was not unique but emblematic of systemic issues that required a collaborative response to embed change. Nonetheless, these systemic issues were brought into sharp relief on account of her age which, for some practitioners at least lay outside their usual lived experience of work.

6.2. The care setting has reported that it has made "*fundamental changes*" to staffing, recruitment, supervision policy and training. It has recognised the disruption caused by staffing changes to consistency of practice. **It has recommended that there should be better follow-up of residents after admission.**

6.3. BEHMHT has reflected on the need to develop lines of communication with placement providers. **It has recommended that there should be a single point of contact in each placement.**

6.4. The Metropolitan Police submission highlights shortcomings in police officer understanding of mental capacity and of dementia, and in other services reporting concerns about pressures sores and force feeding so that assessment can be undertaken as to whether there is any evidence of criminal offences having been committed. **It has recommended education for police officers around capacity and how this may or may not affect investigations. It has also recommended multi-agency discussion between police and ASC at an early stage when there are any concerns of neglect raised.**

6.5. NMUH has acknowledged shortcomings in relation to consideration of mental capacity and deprivation of liberty safeguards, and has employed a mental capacity lead and increased the priority and roll-out of training on mental capacity assessments and deprivation of liberty procedures. It is currently reviewing its policies and processes relating to mental capacity. The hospital has reported that it is currently working closely with partner agencies to ensure that safe and appropriate discharge processes are in place for patients with care and support needs. It has also indicated that multidisciplinary working within the hospital teams is more joined up and appropriate referrals to community teams are made to ensure continuity of care in the community. **Its recommendations focus on several areas: increasing mental capacity and deprivation of liberty safeguards training and visibility in clinical areas; staff awareness and reporting of pressure ulcer concerns; discharge teams ensuring a multi-agency approach for patients with care and support needs; and establishing a frequent attenders meeting to identify the special cases that might need specialist involvement and strategy meetings setting up.**

6.6. The submission from the local authority's commissioners accepts the Ombudsman's finding of fault in the way in which the Council dealt with PH's financial assessment for her temporary care home placement. In terms of contract monitoring and quality assurance, capacity and resources necessitated a risk-based approach rather than planned regular visits to the home. Although on-

site meetings were taking place, they focussed mainly on the intermediate care beds rather than the nursing and residential provision. Reinforcing actions and changes that have occurred recently, described under commissioning in the previous section of this SAR, the submission observes that: "*Communication, effective processes and teamwork all contribute to effective social care. The recent bringing together of the social work teams, QA, commissioning, brokerage and resident services such as financial assessment under a single leadership team will enable the leadership team to further strengthen internal and external communication arrangements regarding adult social care. Processes and people resources can also be reviewed to ensure the best possible response to residents*." It further records that: "*A review of the capacity and resource requirements of an effective commissioning, contracting and quality assurance function is underway in response to a peer review of commissioning undertaken in late 2022, and is due to be completed in the first half of 2023. This work will include a review of Adult Social Services contract and quality assurance frameworks to ensure that processes and roles and responsibilities are clearly defined*."

6.7. The ICB has observed that "*operational processes and oversight could improve, for example in relation to the management of Mental Capacity Act actions or decision-making on next steps to return to the community*." It has identified a second area for improvement, namely the oversight of management of cases of patients admitted to short-term intermediate care beds to help them recover and move-on in a timely way. In response, collaborating with the local authority and NHS provider Trusts, it has advised the following:

6.7.1. "*Agreed clearer arrangements about which patients are suitable to be accommodated within intermediate care beds based on their needs, expectations of who has oversight of these patients, how they will be managed and moved-on [with] the level of support in the multi-disciplinary team to help people recover. These arrangements are captured in a brief Service Statement for the MDT and use of beds between the ICB, Council and Whittington Hospital NHS Trust."*

6.7.2. *"Agreed clearer oversight arrangements as part of agreeing this Service Statement, including re-emphasising the level of resources in the MDT (with expectations detailed in the Service Statement). This represents an increased level of resources and clarity around the role of the manager within LBH overseeing the multi-agency, multi-professional MDT and coordinating move-on of individual cases and patients."*

6.7.3. *"The MDT Manager also oversees a weekly case conference meeting with [care setting] staff, Council and Whittington Hospital NHS Trust to discuss individual cases of patients in the intermediate care beds, and which helps plan move-on. As with complex hospital discharges, ICB commissioning and system resilience colleagues also now attend some of these meetings to support more complex cases with move-on; this arrangement also provides oversight and early flagging around issues in more complex cases."*

6.7.4. *"Development of oversight and recording of information utilised by commissioners to review routinely the 'flow' of patients within [the care settings] intermediate care beds. Information is now available weekly and monthly about the number of people in [these] beds, occupancy in the 18 beds, number of discharges per month and average length of stay on discharge. This monitoring has led to a decrease in the average length of stay in 2022, as individual cases are moved on more quickly. However, all partners recognise this could improve further."*

6.7.5. *"ICB and Council investment in support to help people return to the community either directly from hospital or from community intermediate care beds, including [the care setting] beds. For example, the Council and ICB invested in a Housing Environment Coordinator in Q4 2023/24 to help people with challenging housing environments (e.g. needing deep cleans, environmental*

health input, repairs to property etc) and commissioned a Deep Clean Service, with the aim of removing environmental barriers to help people return home in a timely way."

6.8. **The ICB has recommended further embedding the improvements just outlined to better assure oversight of progress and move-on of individual cases in these short-term beds. It also recommends in the medium to longer-term, consideration of the current intermediate care commissioning arrangements in the care setting as part of a wider NCL ICB and its partners, including NCL councils, review of community intermediate care bed commissioning across North Central London.**

6.9. The Housing Demand submission reflects that delays and repetition might have been caused by the administrative process involved. Accordingly, **it has recommended the development of a briefing on frequently asked questions for colleagues about the Housing Register/transfers and supported housing assessments to raise awareness of processes involved. It has also recommended review of service standard response times for Housing Register, Transfer, Medical assessments, and Supported Housing referrals, the prioritisation approach and review of administrative processes.**

6.10. The Homerton Hospital submission observes that training focused on mental capacity assessment and deprivation of liberty safeguards has been incorporated into level 3 adult safeguarding training since January 2022 and mandated for all new registered professional joining the Trust. It monitors the numbers of staff who have completed this training. This is designed to improve the quality of person-centred care and to ensure that the Mental Capacity Act is used in clinical practice. It has also reflected that "*information sharing in a timely manner is key and requires more attention when working across different geographical areas*." Cross-border information-sharing has been highlighted in other safeguarding adult reviews[15]. **Recommendation Eighteen:** Haringey SAB should consider whether it is necessary to improve cross-border information-sharing.

6.11. The submission from Haringey Revenues and Benefits Service has acknowledged incorrect decisions and poor quality decision-making, including poor processes and prioritisation, and acceptance of delays. It attributes this in part to a system replacement in 2019 that created "*substantial*" backlogs of work. It has also acknowledged that there should have been greater exchange of information with Housing about non-payment and absence from the property. **It recommended council tax legislation training for all Council Tax staff (completed November 2022).** It notes that backlog clearance and prioritisation has been largely completed. The service will be restructured in 2023. Written procedures will be developed and implemented as part of the re-shaping of the service. Procedures for better liaison with Housing on accounts in arrears will also be part of the service re-shaping.

6.12. The ASC submission identifies several areas where improvement is required, namely:

6.12.1. "*The unauthorised deprivation of liberty is something that should not have occurred. The two year period in which the placement did not have a deprivation of liberty in place highlights issues with both local authority and care home processes*."

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[15] For example, most recently Blackpool SAB (2023) Adult V – Jessica.

6.12.2. "*There should have been a second completed mental capacity act assessment undertaken at the stage the placement became permanent. Given that the placement was essentially changed to a permanent placement this was a new decision in a new time period.*"

6.12.3. "*Council tax - The issue relating to non-payment led to incurred charges for something that Paulette should not have been liable for during her time at [the care setting]. This should have been managed at a much earlier stage and could have been avoided if the right discussions and information shared*."

6.12.4. "*Strengths-Based Practice – Ensuring that practice is as person centred and holistic as possible, we have implemented a strengths-based model or practice. This approach ensures that we define the person by their lived experiences, history and preferences allowing for a more tailored support that meets specific outcomes for that person*."

6.13. The ASC submission has offered five recommendations, namely that:

6.13.1. Practitioners must check deprivation of liberty safeguards are in place when undertaking annual reviews and report any concerns to the deprivation of liberty safeguards manager.

6.13.2. The deprivation of liberty safeguards team should review its processes to ensure they are fit for purpose and where deprivation of liberty requests are made, they are authorised in the required timeframes.

6.13.3. A process to be implemented that ensures issues around rent and council tax are addressed at an early stage between local authority departments.

6.13.4. **Mental Capacity Practitioner Manual to be reviewed and practice note shared around responsibility to ensure mental capacity assessments are time and decision specific and are actioned accordingly.**

6.13.5. **To continue with implementation of strengths-based working by moving teams into localities further strengthening the effectiveness of the model.**

6.14. Paulette's sisters hope that this review will "make it better for other people." However they have expressed scepticism about implementation of the recommendations. This scepticism is based on their experience of how the local authority in particular responded to their concerns and to the findings of the Local Government Social Care Ombudsman. Accordingly, two further recommendations are offered here. **Recommendation Nineteen:** Haringey SAB should monitor implementation of the recommendations contained in the individual agency submissions to this review. **Recommendation Twenty:** Haringey SAB should convene a learning event no later than twelve months after it has accepted this review in order to appraise with practitioners, operational managers and senior leaders the progress that has been made in implementing the recommendations. Paulette's sisters should receive an update following this learning event.

Section Seven: Final Observations

7.1. What is to be Paulette's legacy? Those attending the learning event appreciated the pen picture that was presented about Paulette, the person, as a result of information generously given by her sisters. It reminded everyone that at the heart of this SAR is a human story. Despite the examples of good practice, which the review has included, the examination of the key lines of enquiry and of the additional areas of practice and the management of practice should act as a reminder of the importance of "*human expertise*" and of respect for a person's human rights.

7.2. The evidence reinforces the centrality to best practice of a whole system approach, with all involved contributing collaboratively to maintaining a clear line of sight on how the person and their family or other advocates are experiencing service provision. The evidence also highlights the challenges involved in making safeguarding personal and achieving the best ambitions possible for individuals with health, accommodation, care and support needs. The evidence also highlights how easily compassionate and caring practitioners and managers can lose situational awareness and be undermined by system pressures in primary and secondary care, and local authority housing and social care, in which they are working. This points to Paulette's legacy needing to be dialogue and change that reaches beyond the boundaries of the Haringey Safeguarding Adults Board.

7.3. Paulette's sisters have expressed the hope that this review, for which they pushed, should make a difference for other patients and service users. The recommendations for Haringey SAB and partners, collated together here, are aimed at realising that hope.

Recommendation One: Haringey Safeguarding Adults Board should consider whether it has sufficient assurance that deprivation of liberty procedures are now working effectively, that social workers are legally literate in this respect, and that individuals are not being unlawfully deprived of their liberty.

Recommendation Two: Haringey SAB should consider providing training and a written briefing on practitioner roles, responsibilities and duty of care when a person holds lasting power of attorney.

Recommendation Three: Haringey SAB should consider hosting a summit of commissioners and providers to review where there are gaps in available resources, as exemplified in this case, and what strategic planning is possible in response.

Recommendation Four: Haringey SAB should consider whether an audit of care home practice would be useful to seek assurance regarding assessment and planning to meet care and support needs, and to mitigate risks.

Recommendation Five: Haringey SAB might wish to consider whether it should seek assurance about how Revenues and Benefits and Housing Tenancy share information and work collaboratively.

Recommendation Six: Haringey SAB should consider seeking assurance that these plans have been implemented.

Recommendation Seven: Haringey SAB should consider seeking assurance about the outcomes of the introduction of the strengths-based model.

Recommendation Eight: Haringey SAB should consider conducting an audit of commissioned placements and of care packages provided to people living in the community to seek assurance that social, cultural and emotional needs are recognised and provided for in age appropriate care plans, as part of a commitment to making safeguarding personal.

Recommendation Nine: Haringey SAB should consider seeking assurance that, where there is a requirement for specialist wheelchairs services and provision, this is available to care homes.

Recommendation Ten: Haringey SAB should consider convening a summit to explore the ongoing impact of the pandemic, specifically what can be recovered from pre-pandemic ways of working, what should be retained from the adjustments made in response to the pandemic, and what new ways of working should be promoted.

Recommendation Eleven: Haringey SAB should consider seeking assurance that services are aware of, and implementing their duties as codified in the Equality Act 2010.

Recommendation Twelve: Haringey SAB should consider with practitioners and managers across health, housing, social care and uniform services what steps to take to embed the use of multi-agency meetings in practice.

Recommendation Thirteen: Haringey SAB should consider seeking assurance about the standard of assessment and recording of pressure damage and skin integrity. It would also be appropriate to review how repetitive patterns of pressure damage are reviewed, and risks mitigated, when the category of skin breakdown is deemed insufficient to prompt referral as an adult safeguarding concern.

Recommendation Fourteen: Haringey SAB should consider sharing the findings of this SAR with the London SAB in order to contribute to its current revision of the pan-London procedures.

Recommendation Fifteen: Haringey SAB should consider undertaking an audit of supervision practice.

Recommendation Sixteen: Haringey SAB should consider seeking assurance at a frequency to be agreed with partners regarding quality assurance activity and outcomes with respect to this care setting.

Recommendation Seventeen: Haringey SAB should consider convening a summit of commissioners and providers to consider how best to meet holistically the needs of individuals who might (otherwise) require residential or nursing care, and how to ensure that the care provided is empowering and motivational for residents and staff.

Recommendation Eighteen: Haringey SAB should consider whether it is necessary to improve cross-border information-sharing.

Recommendation Nineteen: Haringey SAB should monitor implementation of the recommendations contained in the individual agency submissions to this review.

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Acknowledgement

The independent reviewer acknowledges the openness that everyone associated with this review has demonstrated. Their candid reflections and commitment to learning have provided the setting for the Safeguarding Adults Board to ensure that learning translates into service development and practice improvement.