

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Executive summary of Mr F and Mr G: A thematic safeguarding adult review in relation to adults with care and support needs and social isolation

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**Date of publication**: 17 March 2020

# 1. Executive Summary

**Introduction**

* 1. The context of this thematic safeguarding adults review (SAR) is that the SAB sub group agreed on 31 July 2018, that a themed SAR on social isolation and neglect should be carried out following two cases which met the SAR criteria. There was a Prevention of Death report issued by the Coroner 25 June 2018, on a case for which it was agreed a SAR was best to learn from the multi- agency issues that arose. It also reflects learning from the LBTH SARS and Mr. V published on 4 November 2019, and other national SARS. It draws on the review of London Safeguarding Adults Reviews by Braye and Preston- Shoot: ‘Learning from SAR’s a report for the London Safeguarding Adult Board July 2017’
	2. These reviews and reports suggest a cohort of adults whose age and social isolation in their homes can render them both vulnerable to abuse and neglect and in need of multi-agency services, which are well coordinated. The purpose of the review will be to maximize learning in relation to this cohort through IMR’s, chronologies, deep dive case analysis and practitioner learning events.
	3. Two of the cases considered in this review; that of a man referred to as Mr. F and a man referred to as Mr. G meet the criteria for a SAR, reflecting the requirements of section 44 Care Act 2014. The other cases considered are included to maximize the learning and draw out themes in order to inform the recommendations to improve practice and multi – agency partnership working.
	4. The recognition and impact of social isolation, understanding both the history and an individual’s current circumstances were identified as key themes for learning. Although, all the adults in this review were mainly without relatives to advocate for them, Mr. F did have a Care Provider and GP involved as well as his mother prior to her death, Mr. G had a neighbour, Ms. M had an independent advocate and Ms. J had both a Care Provider and GP involved. Mr. N had a Care Provider. The review considers the multi-agency involvement.
	5. 5 safeguarding referrals in the period October 2018 to June 2019 were included in this SAR. These cases were audited from the ASC database. The purpose of including the 5 cases is to provide comparative data to reflect any changes in the response to adult safeguarding referrals post the ASC department restructure.

**Summary of Findings**

This themed SAR considered the involvement of all the agencies involved in each of the cases. A recurrent theme that has been highlighted, is in some cases, limited evidence and in other cases the lack of evidence of ASC fulfilling their statutory duty to coordinate and take a lead in making decisions regarding the safeguarding concerns. With this in mind, the key learning is focused on ASC as the statutory agency responsible for ensuring Care Act 2014 Section 42 enquiries are undertaken by either ASC or partner agencies. The review has highlighted gaps in how individual agencies understand their roles and responsibilities in safeguarding enquiries. In addition, there is consideration of how multi-agencies can improve how they work together.

**Good Practice**

2.1.1 Whilst SARS identify lessons to learn by recognising gaps in practice, they can also provide an opportunity to highlight evidence of good practice. In the main 5 cases subject to this SAR, it is difficult to identify themes of good practice. There are however, isolated incidents of good practice. An example of this was the personalized response to Ms. M when she raised safeguarding concerns.

2.1.2 In the five, post restructure deep dive analysis cases, there are strong themes of good practice. These include among others; good partnerships working, good risk assessments and a personalized response to the adults.

2.1.3 There is evidence of good communication between professionals when the agency who knew them best, engaged with the adult, to ensure their privacy and dignity were respected.

* + 1. All of the professionals working with the Adults, were person centred in their approach and respected the adults’ views but also considered the presenting risks when making decisions as to how to progress. The principles of the MCA 2005 were considered when responding to an adult who lacked capacity to make decisions regarding the risk to themselves.
		2. There is evidence of good communication between professionals as to how to progress through care management. There is evidence of professionals taking responsibility for their individual roles in responding and supporting the adult. For example, in Adult 4, the immediate risk was addressed by ASC regarding lack of food and Mental Health Services made a timely intervention to address the adult’s emotional wellbeing.

**Learning Points**

**Recording**

2.2.1In the five cases subject to this SAR, the ASC written records were poor. They do not support evidence based professional decision making, multi-agency engagement and crucially they don’t contribute to holistic risk assessments recognizing both persistent and escalation of risks.

2.2.2 The ASC records do not provide evidence that the professionals working with the five adults considered the making safeguarding principles in their interventions. The records of conversations with the adults at various stages of intervention are recorded, but the records do not include the ‘voice’ of the adult.

2.2.3 The Housing records do not provide a chronology of actions. There are gaps in the evidence, of how to progress Mr. F.’s housing problems. Although, actions are recorded such as an eviction notice being considered, it is not clear when this happened. As a result, there is no overview of the ongoing risks and how the risks have escalated.

2.2.4 Records are limited in providing evidence that professionals have fulfilled their statutory duties under the Care Act 2014.

2.2.5 The lack of accurate information about the key holder for Mr. G’s held on both the Care Provider and ASC records, resulted in a delay in responding to him. The noncompliance with a failed visits procedure was highlighted as a key contributing factor to the delays in responding to Mr.’ G. However, as the Coroner’s report, 25 June 2018, states ‘It is not clear whether or not earlier intervention, following the fall, would have saved him’.

**Management Scrutiny and Oversight**

2..2.6 In all 5 cases, the quality of the management oversight and scrutiny in Adult Social Care, both operational and safeguarding was poor. This resulted in a poorly coordinated response to the concerns raised. At times, the concerns where not addressed through the safeguarding procedures.

2..2.7 The Care Act 2014 states that the Local Authority has responsibility to conduct a section 42 enquiry or to make sure others do. Research shows that a collaborative approach to safeguarding enquiries achieves the best outcomes for adults. With this in mind one can assume that if the management oversight, scrutiny and decision making was more effective in the cases subject to this review, there could have been a more successful opportunity for multi-agency partnership working under the safeguarding framework.

2..2.8 The housing officer experienced obstacle’s in progressing the safety concerns of Mr. F. but there was no evidence of the housing management involvement. This evidenced a lack of good quality supervisory oversight.

**Risk Management**

2.2.9 Safeguarding risks were consistently inadequately assessed throughout the different agency’s involvement with the adults’ subject to this review. The recorded evidence has highlighted a lack of professional skill in reflective critical thinking when assessing ongoing risk.

2.2.10 The poor and in some cases lack of risk assessment, directly impacted the multi- agencies work with the adult. The intervention was focused on one particular issue as opposed to gaining an understanding of the risks to all aspects of the adults’ life and in some cases others. This silo working by the agencies including ASC, Community Health, Care Agencies and Housing involvement working with the adult resulted in limited opportunities to mitigate the risk as the underlying causes, and the behaviours contributing to the risks are not explored adequately.

2.2.11 The safeguarding adult’s policy and procedure framework facilitates multi-agency risk assessments through all the stages. In some instances, delays and in other instances such as Ms. J’s case, the absence of the implementation of the safeguarding framework was a missed opportunity for multi-agency risk assessments.

2.2.12 The review identifies inconsistent professional’s skill in completing risk assessments. This impacted on professional judgments and actions.

**Multi-agency information sharing and communication**

2.2.13 The general duty of co -operation between the Local Authority and other agencies providing care and support, has not been applied in all the cases consistently. Agencies have raised concerns to ASC, who have failed to respond appropriately. The lack of coordination and communication, has had a domino effect resulting in lack of robust multi-agency risk assessments, responses to adults and ultimately the outcome for the adult following the referral for intervention.

2.2.14 In the cases subject to this review, there is a lack of focus on positive outcomes for the Adults. Through more multi-agency information sharing and communication, professionals from multi-agencies could have drawn on each other’s knowledge of the adults using their specific expertise to offer the most appropriate response to the adult.

2.2.15 If partners had, had a better understanding of the safeguarding policies and procedures, it is likely they could have challenged partners, including ASC when the response was not adequate rather than repeatedly referring their concerns through the same mechanisms, which were proving ineffective in addressing the risks to the adults on many occasions such as with Ms. J. and Mr. F.

2.2.16 The interface between Mental Health and ASC is inconsistent, when practitioners are referring to Mental Health Services for support and advice. There is a lack of understanding from Mental Health Services of their responsibilities in working in partnership with ASC in addressing safeguarding concerns and achieving good outcomes for the adults at risk. The partnership working in Mr. F case was an informal discussion, in Mr. G’s case there was a lack of recognition of the importance of the role of working in partnership to address Mr. G’s wellbeing.

2.2.17 Escalation to a senior level is the course of action that should be taken by professionals, where there are concerns that an adult’s safety is compromised and the current action of other agencies does not support effective safeguarding for the adult. Tower Hamlets SAB have a formal escalation policy; however, the review highlighted that professionals from all agencies did not use the pathway. In the event it was used, it is likely that a multi-agency safeguarding meeting to share information regarding the increasing risks could have been triggered at an earlier stage of involvement, in all the cases subject to this review.

**Making Safeguarding Personal**

2.2.18 A common theme through this review is the lack of evidence of personalized care from the straight forward interventions with the adult to the most complex.

2.2.19 In two of the cases, the adults were resistant to interventions but a multi-agency approach, understanding other professionals’ remits could have supported the development of contingency plans and alternative approaches to engaging with the adult.

2.2.20 There is a sense from the records that the ASC interventions are service led and that there needs to be a shift in the cultural practice of simply responding to a specific need. There is limited evidence of making safeguarding personal when responding to a safeguarding concern. Adults wishes should have been driving the interventions. With this in mind, if professionals had a better understanding of the individual, interventions may have been more person centred.

2.2.21 There is a sense from the review that the adults that were self-neglecting were seen as a ‘problem to fix’. This highlights the need for all training to include updated research and how this should impact practice, including being empathetic when working with adults and respect their dignity in empowering them to make the changes that are acceptable to them at a pace and with whom, they wish to engage.

2.2.22 Ms. M had an advocate to support her. However, in the other four cases, there is a lack of consistency in recognizing when an adult should be offered an advocate such as to Mr. G. and Ms. J.

**Legal Literacy**

2.2.23 The Mental Capacity Act 2005 was misunderstood in Mr. N’s case, when there was an attempt to make a best interest decision for him when he has capacity. While there is an absence of its use, to support safeguarding Mr. G.

2.2.24 Professionals should have recognised the need to access advice from senior management and legal department in Mr. F and Mr. G’s case, in order to exhaust all legal options of addressing the risks.

2.2.25 The review identified, lack of knowledge about the Care Act 2014 specifically, when and how to conduct a section 42 enquiry. For example, the 15 concerns raised for Ms. J and yet there were no formal enquiries through Care Act 2014 section 42.

2.2.26 The Tower Hamlet safeguarding adults at risk from abuse policy and procedures were in place during the period covered in this review. The review highlighted a lack of practice knowledge from all agencies as to how and when to raise the concern. There was evidence of inconsistent professional understanding of the safeguarding thresholds, or when to conduct a Care Act 2014 Section 42 enquiry.

2.2.27 In complex case work with high risks and a lack of engagement from the adult, when all other options of multi-agency interventions have been exhausted, professionals should seek legal advice regarding the use of High Court ‘inherent jurisdiction’. Use of inherent jurisdiction powers by the High Court may in some cases be a way of protecting an adult, with capacity, from unwise decisions regarding their health and welfare. In no cases reviewed, is there evidence that this was considered.

**Professional Attitude**

2.2.28 The themes that run through the review, reflect a professional complacency and lack of professional curiosity when working with adults with complexed needs. There is a lack of appreciation by professionals of understanding the impact of social isolation and self-neglect. Making Safeguarding personal is not underpinning decisions or actions by professionals.

2.2.29 The experience of the adults, in this review, with ASC was inconsistent, often filled with delays and ad hoc responses depending on what the concern was and who made the decision. While individual professionals attempted to resolve some of the issues, the adults were experiencing, there was no evidence of the safeguarding being progressed within the Tower Hamlets agreed multi – agency safeguarding framework.

**3. Summary of Recommendations**

Recommendations made by the thematic review are listed below. It should be noted that the period of the thematic review has taken some time to complete and so some of the practice has developed over that time. The SAB Business plan for 2019 – 2020 includes Quality Assurance and performance. The effectiveness of the recommendations should be monitored through the planned multi-agency dashboard and audit program, with a focus on improved outcomes for Adults.

**Multi- Agencies**

3.1 SAB to facilitate a Multi-Agency learning event, by March 2020, led by ASC. The aim of the learning event is to disseminate the learning from this SAR and other LBTH SARS to all multi-agency front line staff and secondly to raise awareness of new developments across the partnership. The objective being to strengthen multi-agency working across safeguarding practice. This should be supported with a 7-minute briefing to be disseminated across the partner agencies.

3.2 With a view to measuring the improvement of practice across the partnership, Agencies to develop Safeguarding Quality Assurance Frameworks which include case audits with findings reported to the SAB. Consider the use of multi-agency ‘live’ case audits to support active learning across front line operation staff.

3.3 The SAB to review their multi-agency training strategy, identifying opportunities for multi- agency training to ensure the consistent message of how and when to implement the Safeguarding Adults at risk policy and procedures and that individual’s roles and responsibilities are understood by all partners.

3.4 Raise awareness of the escalation pathway to the Multi-Agency High-Risk Panel coordinated by ASC, when obstacles prevent effective multi – agency communication and information sharing through the various forums and training across agencies.

**Adult Social Care**

3.5 Review the terms of reference for the high-risk panel to include; specific reference to a multi-agency escalation pathway for professionals to seek advice when working with adults who do not engage with services, but also where there is a vital or public interest risk to the adult and or others.

3.6 Map out pathways of forums, panels and meetings that provide support to professionals in safeguarding practice. Ensuring that they are accessible to all partners as appropriate. Information about the forums should be included on the SAB website.

3.7 ASC to further develop self-neglect and hoarding practice guidance. Agencies to embed a consistent understanding of the guidance throughout the partnership through training and multi-agency forums.

**Health**

3.8 Health Centre’s to review their procedure of monitoring and responding to failed visits, non-attendance or non-engagement of patients considered vulnerable.

3.9 High Risk Panel to include a named attendee from Mental Health Services. The Panel to give consideration as to how to involve the named GP for Safeguarding Adults when the post is recruited to. The aim being to strengthen accountability and communication between partners to work together to safeguard adults, ultimately achieving the best outcome for the adults.

3.10 Review the referral pathways for ASC to receive timely advice and support in safeguarding cases from Mental Health Services. This aims to improve joint working on complexed cases where the expertise of both Services may achieve the best outcome for the adult.