

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: A thematic safeguarding adult review in relation to adults with care and support needs and social isolation

**Author**: Belinda Oates

**Date of publication**: 17 March 2020

CONTENTS

# Heading 1

Executive Summary 2

1. Introduction
2. Summary of Findings
	1. Good practice
	2. Lessons to learn
3. Recommendations

Main Body of the Report

1. Context of Safeguarding Reviews 9
2. Terms of Reference 10
3. Scope 10
4. Methodology 13
5. The Five Adults 15
6. Social Isolation and Self-Neglect 18
7. Thematic Learning and Analysis 19
8. Five cases post restructured deep dive analysis 33
9. What has changed; Learning Points 37
10. Recommendations Tower Hamlet Safeguarding Adult Board 39
11. Glossary 42
12. References 42
13. Reviewer 43

# 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.

# 4. context of safeguarding reviews

* 1. Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SAB) must arrange a Safeguarding Adults Review (SAR) if:
1. There is reasonable cause for concern about how the SAB, member of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adults dies (s44(2)) OR’
2. If the adult is still alive and the SAB knows or suspects, that the adults has experienced serious abuse or neglect (44(3).
	1. In addition, SAB’s are free to commission a SAR in any other situations where it is thought there is valuable learning for the partnership (s44(4)).
	2. A key principle for completing a SAR, is to ensure there is a culture of continuous learning and improvement across the organisations that work together, and the approach taken to the reviews should be proportionate to the scale and the level of complexity of the issues examined.
	3. Involvement of the people who are subject of the reviews is recognised as an important aspect of the learning from the review. If the person who is the subject of the review is living, he or she will be approached to ascertain their wishes on involvement in the review and where indicated, assess capacity to consent to this.
	4. The SAB commissioned an independent author to provide the SAR report. The author is an experienced safeguarding practitioner, consultant and trainer. She holds a professional background as a social worker, working across all service areas of safeguarding adults. The author is independent of the Tower Hamlet SAB. The independent reviewer was commissioned to start the SAR in January 2019.
	5. A SAR is not designed to hold individuals or organisations to account. Other processes exist for the purpose. The SAR enables all information from partner agencies to be reviewed in one place enabling the author to identify key areas for development and learning to support SAB partners to improve ongoing safeguarding practice.
	6. The Care Act 2014 (s44(5)) states, each partner must co – operate and contribute to the review, identifying lessons to be learnt and apply the lessons to future practice.
	7. The Department of Health’s six principles for adults safeguarding should be applied across all safeguarding activity.[[1]](#footnote-1) The principles will be considered throughout the SAR as follows:

|  |  |
| --- | --- |
| Empowerment | Understanding how service users were involved in their care; involving service users or their representatives in the review |
| Prevention | The learning will be used to consider how practice can be developed to prevent future harm to others |
| Proportionality | The learning of five cases will be more effective in the learning lessons and considering the themes  |
| Protection | The learning will be used to protect others from harm |
| Partnership | Partners will co – operate with the review considering how partners are working together to safeguard adults in Tower Hamlets |
| Accountability | Agencies will be transparent in the review with the SAB holding individual agencies to account for agreed recommendations. |

* 1. Statutory guidance requires the SAB to have a quality assurance function in relation to Safeguarding Adults’ Reviews, which they commission to ensure that the review achieves an understanding of what occurred, how, and why, problematic practice occurred and any remedial action needed.

# 5. terms of reference

5.1 Two of the cases considered in this review; Mr. G and Mr. F meet the criteria for a Safeguarding Adults Review reflecting requirements of the Care Act 2014 section 44. The other cases Ms. M, Mr. N and Ms. J; are included to increase the learning and draw out themes to inform recommendations to improve practice and partnership working.

5.2 The SAR reflects learning from LBTH Safeguarding Adults Reviews and Mr. V, published 4 November 2019 and the Safeguarding Adults Review of London Safeguarding reviews by Braye and Preston-Shoot: ‘Learning from SARs a report for the London Safeguarding Adults Board 18 July 2017’, IMR’s, chronologies, deep dive case analysis and practitioner learning events.

5.3 The reviews and reports suggest a cohort of vulnerable adults, whose age and isolation in their homes can render them both vulnerable to abuse or 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 deep dive case analysis.

# 6. scope

6.1 Mr. F and Mr. G were identified by the Tower Hamlet Safeguarding Adults Board, SAR subgroup, as meeting the criteria for the Care Act 2014 Section 44 Safeguarding Adults Review on the 29.11.2018 and 7.03.2019, respectively.

6.2 The additional three cases, Ms. M, Mr. N and Ms. J were selected by the service manager who has responsibility for safeguarding in ASC. They were selected from a sample of service users aged over 65 in receipt of a domiciliary care package and were subject to a safeguarding investigation or concern over the previous three years. The service manager’s reading of the case record reflected the adults were socially isolated and that there could potentially be multi-agency learning points to address.

6.3 Four out of the five adults subject to this review are deceased. Mr. N had moved from the community to a care home. He was sent a letter from Adult Social Care Safeguarding Service Manager, inviting him to participate in the Safeguarding Adults Review. He did not respond to the invitation. His current service provider has not been included in the remit of this review. Mr. N’s lack of engagement with the SAR process was recognised as his choice and assessed as an ongoing pattern of behaviour.

6.4 All five individuals subject to this review share the following characteristics:

* They are over the age of 65
* They were or are isolated and have limited networks
* There was a significant risk of serious harm

6.5

|  |  |
| --- | --- |
| **Adult** | **Pen Picture** |
| Mr. F.  | Mr. F. was a white British, 73-year-old man who lived in a Housing Association property since 2002. He was socially isolated. He was living without electricity or gas since 2009. A safeguarding enquiry was first opened in December 2016, policies were not adhered to and there were many delays. Professionals continued to experience a reluctance from Mr. F. to engage. Police were contacted to gain entry on the 23 January 2018 due reports or Mr. F. not being seen for weeks. Mr. F. died on 23 January 2018. Cause of death was recorded as an open verdict by the Coroner, due to the decomposed state of the body.  |
| Mr. G.  | Mr. G was a 68-year-old, white British man who lived with his Mother until she died on 16 December 2016. Mr. G. was diagnosed with depression and anxiety. He lived an isolated life after the death of his Mother. He was in receipt of a care package to prevent him, self-neglecting. Mr. G. was found dead at this home on the 6 March 2018 following 4 failed visits reported by Meals on Wheels over the previous three days. The care provider did not follow the failed visits procedure, although they were also unable to gain access. When contacted, they provided ASC with conflicting information about Mr. G’s whereabouts. The Coroner issued a prevention of future deaths notice, 25 June 2018, requiring both the care provider and ASC to respond. The Coroner did not specify further actions after considering the reports from ASC and care provider. ASC confirmed a SAR would be progressed to consider the lessons to learn from Mr. G’s case.   |
| Ms. M.  | Ms. M was a 67-year-old, white British, woman. Ms. M. was known to ASC and in receipt of a direct payment enabling her to employ a personal assistance to address her care needs. She was supported throughout her interventions with ASC by an advocate from an advocacy organization. Ms. M requested support from ASC for a review to support an increase in her direct payment. Ms. M experienced ongoing delays in the response she received to her request, which resulted in her supplementing her care from her own funds. She raised a safeguarding concern alleging her care worker had stolen money, she received a personalized response but the concern did not consider the risk to the public or the ongoing risks to Ms. M such as self-neglect. Ms. M died on 19.11.2018. There were no concerns raised about the cause of her death.  |
| Ms. J. | Ms. J. was an 84-year-old woman who lived in an extra care scheme until she moved into residential care. She had limited informal social support. She was in receipt of a domiciliary care package. There were 15 safeguarding concerns raised by Ms. J’s GP, care worker, friend and Ms. J herself. None of the concerns initiated a safeguarding enquiry. There were three concerns, that her care provider neglected her, but these were not investigated under a Section 42 enquiry. Ms. J was not seen face to face by ASC between May 2015, when the allegation of serious financial abuse by a carer was raised, and July 2017 when a support worker visited Ms. J to discuss a court of protection application for financial deputy. Ms. J moved to a care home. Ms. J died at the care home on 23.11.2018. There were no concerns raised about the cause of death.  |
| Mr. N.  | Mr. N is a 93-year-old, white, British man of Jewish faith. Mr. N currently resides, in a residential care home. He was previously living in a housing association property and was in receipt of a home care package. Mr. N was isolated living in the community. There were ongoing concerns about the ‘hoarding’ in his home. He was resistant to attempts to support him. Interventions were not person centred. Although there was some multi-agency working with the housing association and care provider, his GP was a key individual with whom Mr. N had a good relationship. Safeguarding procedures were not effectively followed to support multi-agency information sharing and safeguarding planning. Since moving into the residential home, there continues to be concerns raised by the provider about his hoarding. Inclusion of this case, enables a frame of reference from someone who is still in receipt of support from social care services. |

# 7. methodology

The review included three stages.

**Stage 1**

1. Independent Management Reviews and Chronologies

All agencies involved in the adults’ cases in this review were invited to participate in contributing to the review. It is noteworthy that all that were invited for the statutory SAR of MR. F and Mr. G contributed. All agencies involved in the non-statutory cases were invited to participate but there was a limited response from agencies that were invited, but had no statutory duty to, participate in the non-statutory SARS. The table below indicates who contributed.

|  |  |  |
| --- | --- | --- |
| **Adult** | **IMR’s**  | **Other Contribution** |
| Mr. F  | * ASC
* Housing Association 1
 | * LFB – Mr. F not known
* East London NHS Foundation Trust – case records
 |
| Mr. G | * ASC
* Health Centre
* Domiciliary Care Provider 1
* Meals on Wheels
* Domiciliary Care provider 2
* East London NHS Foundation Trust
 | * Telephone conversation Service Manager Aging Well Commissioning Health and Adults and community Services
* Failed Visit Procedure August 2018
* Care provider Transfer of Care Documentation
 |
| Ms. M | * ASC
 |  |
| Mr. N | * ASC
 |  |
| Ms. J  | * ASC
* Housing Association 2
 | * GP referral letter
* Telephone conversation Service Manager Aging Well Commissioning Health and Adults and community Services
 |

1. Deep dive audit of the social care records.

The independent reviewer completed a deep dive audit into the 5 cases subject to this thematic SARS in January 2019. The purpose was to enable the reviewer to consider the most appropriate methodology to be used for the review.

1. Audit of 5 new safeguarding referrals in the period October 2018 – June 2019.

This served to provide comparative data, to enable the reviewer to analyse whether there have been any improvements in the response to safeguarding concerns since the restructuring of the ASC Department. The cases were randomly chosen by the auditor from a list of cases held by the Initial Assessment team. It is noteworthy that these cases were all from one team, whereas the cases subject to the SAR were across a number of different teams.

**Stage 2**

A separate ½ day learning workshop was planned for each case. The aim of the multi-agency workshops was for each organisation to appoint an individual, who has senior operational authority to positively reflect on the lessons learnt and take action to achieve strategic change. The workshops for Mr F. and Mr. G, the two cases that meet the statutory requirements for SARs were arranged and the following agencies were invited via email from the SAB Coordinator:

The workshop for Mr. G was postponed due to key partners not attending. The learnings from Mr F. workshop are included in the main body of this report.

Due to the poor attendance of the initial workshop it was agreed by the SAR’s subgroup that one workshop inviting all agencies involved in the 5 cases was arranged. This workshop was facilitated by the independent reviewer on the 21 November 2019. The four questions considered as part of the workshop were:

* What are the key lessons learnt by Individual Agencies?
* What changes/ initiatives have been implemented as a result of the learning from this SARS?
* How will the changes impact the outcomes for Adults and how are the effectiveness of changes measured?
* What changes can be implemented to improve multi-agency working?

The findings from the workshop are reflected in Section 12: What has changed; key learning points.

**Stage 3**

The outcome of stage 1 of this review has been analysed and collated into a written report identifying themes and learning from all 5 cases. The report has been submitted to the Tower Hamlets Safeguarding SAR panel and Executive for consideration and contribution. The learning from the workshops is included in this final SAR report. This report will be presented to the Safeguarding Adults’ Board.

# 8. The Five adults

1. **Mr. F**

Mr. F was a 73-year-old white British man who had a tenancy initially with a housing association in 2002. The housing association was subsequently transferred to another Housing association in 2005. There is little known of Mr. F as a person, as the records are all limited to information about the housing association and ASC involvement. A contributing factor to the limited personalized information, is the history of Mr. F’s declining offers of engagement with professionals. Mr. F was isolated with no recorded family or friends, other than the various concerns raised by neighbours.

Mr. F had no electricity since 2010. During the period of 2010 to 2016, housing association officers offered support to Mr. F regarding his electricity, gas and home maintenance but he was reluctant to engage with the support. There was an incident in 2010, resulting in Mr. F receiving a court notice as he was known to be storing gas cylinders in his property.

In 2016, the Housing Association referred Mr. F to ASC for support. This review focused on the period December 2016 to January 2018, when he died. Numerous concerns were raised by his neighbours, to both the housing association and ASC regarding Mr. F’s living environment and concerns of self-neglect. Mr. F was reluctant to engage with services and on most occasions, refused both housing officers and ASC access to his property or to meet with him face to face.

On 23/01/2018, neighbours raised the concern, at there being a buildup of post at Mr. F’s property and they had not seen him for up to 6 weeks. Following forced entry, Mr. F was found dead in his home. The coroner’s court ruled an open verdict. The coroner was unable to identify the cause of death due to the decomposition of the body.

1. **Mr. G**

Mr. G was a 68-year-old, white British, a retired engineer who lived with his Mother until her death on 16 December 2016. Mr. G was known to ASC, ELFT and his registered GP at Bethnal Green Health Centre. Prior to her death, Ms. G raised concerns about Mr. G’s self-neglect. Mr. G suffered from severe depression and social anxiety, over the period 2014 – 2017. Mr. G was isolated in his caring role and once his Mother died, he continued to be isolated. Very little personalized information is recorded about Mr. G. While the social worker visited Mr. G on occasion, her focus was on functional issues and making the care package work. The intervention was not strength based, to enable Mr. G to be empowered to seek outcomes and improvements in his life, an approach which could have assisted his depression and isolation.

Meals on Wheels Service reported to ASC Out of Hours, a failed delivery service to Mr. G on 3.03.2018, and again reported 4.03.2018, and to the ASC allocated worker on 5.03.2018. Mr. G had long standing issues of rejecting personal care, however, he always accepted his meals on wheels. The domiciliary care provider received no answer from him on 3.03.2018 but did not follow the failed visit policy of reporting to either the police or ASC Out of Hours service. It is not clear from the records if the carers reported to their own Management. When ASC contacted the care provider on 4.03.2018 they accepted information from the care provider that it was likely Mr. G was out. No consideration of the history or professional curiosity was applied when making the decision not to respond on the 5.03.2018. On 6.03.2018, Mr. G’s allocated worker visited with her Manager and called the police, when they could not gain access. Mr. G was found dead at his home. The police did not need to force entry as a neighbour arrived at the scene and stated that he had a key. The information about the neighbour being a key holder was not on record. During the course of the inquest, the evidence revealed matters giving rise to concern for the Coroner. The Coroner requested Coroners Regulations 28, prevention of future death reports from both ASC and the care provider as to prevent future deaths. The reports from ASC 16.08.2018, and the Care Provider, 1.10.2018 were submitted to the Coroner and the findings and actions have been considered as part of this review.

1. **Ms. M**

Ms. M was a 67-year-old, white, British woman known to ASC and in receipt of a direct payment enabling her to employ a personal assistant to meet her care needs. She was supported throughout, by an advocate from an advocacy organisation. In October 2014 Ms. M requested an increase on her direct payment to recruit a personal assistant at market rate. This was only resolved in June 2015; records do not indicate a reason for this delay.

Ms. M had difficulty recruiting a personal assistant and this impacted on her finances, as she was paying for domiciliary care while she waited for a personal assistant. Although, she was offered support by her advocate, the social work intervention was process driven with no insight into the risks the financial difficulties posed to Ms. M. Ms. M raised a safeguarding concern, regarding being financially abused by a carer. In this instance the safeguarding procedure was initially correctly applied with the immediate response to Ms. M. While the social worker’s approach to Ms. M was person centred and strength based, she failed to recognize the risk to other adults at risk. The employer of the carers response was lacking in consideration of risk and holding the carer accountable. This was not challenged by ASC social work team. Ms. M died on 19.11.2018. There are no concerns raised about the circumstances of her death.

1. **Mr. N**

Mr. N is a 93-year-old, white, British man of Jewish faith. There is little else known of him as a person as the records are focused on his hoarding behaviour with no insight into his social history.

Mr. N is known to ASC and currently lives in a residential care home. Mr. N moved from the community, where he resided in a flat managed by a registered social landlord. He was in receipt of a domiciliary care package. Mr. N was repeatedly taken to court by his housing association between the period 2014 and 2018, due to the concerns of hoarding behaviour. A care package was set up to support him with decluttering, but he would frequently be out when they attended.

1. **Ms. J**

Ms. J was an 84-year-old, white, British women known to ASC and died in Duncan Court Extra Care Scheme, having previously been in receipt of domiciliary care package in a flat managed by a registered landlord. Ms. J had eyesight problems and mobility difficulties.

Ms. J’s friend, GP, care provider and Ms. J herself raised 15 safeguarding concerns regarding financial abuse and neglect over the period 3.05.2014 to 29.09.2017. No safeguarding workflow was commenced for any of the concerns. Three of the concerns related to allegations of neglect by her domiciliary carer; none were investigated under the Care Act 2014 Section 42 enquiry or in any other process. Only one of the concerns was reported to the provider agency. On this occasion, the concern was discussed directly with the Carer by the social worker, who denied the allegation.

Ms. J’s allocated worker was a support worker from ASC. On the occasion that Ms. J raised a concern about significant financial abuse by her care worker, the support worker responded by saying ‘they would not be available to respond for 5 days’. The subsequent entries on the ASC database are minimal. There are two misleading entries which are ambiguously phrased and show no evidence that the support worker visited Ms. J about the concerns raised.

Ms. J died at Duncan Court on 23.11.2018. There were no concerns raised about the cause of death.

# 9. Social Isolation and Self Neglect

Self-neglect is a complex area of work, arising from a large range of different factors. The Care Act 2014, recognizes self-neglect as a potential safeguarding matter among those who are either in receipt of, or in need of care and support, and when their health and wellbeing or that of others is seriously compromised.

The Care Act 2014 states: ‘self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision whether a response under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.[[2]](#footnote-2)’

SARs reports frequently highlight self-neglect signs and symptoms, as a factor in, or indicators of, subsequent serious events that have resulted in life threatening consequences or even death. When seen in isolation, self-neglect and/or hoarding behaviours may not give rise to safeguarding intervention. **However, when viewed alongside other potential risks such as social isolation, such as in some of the cases subject to this review, a very different picture often emerges.**

National research and lessons learnt, highlight the challenges professionals experience when working with adults who are known to self-neglect but are resistant to working with professionals. Research indicates a collaborative and multi-agency approach to those at risk is the most effective way to achieve creative and proportionate interventions that respect the individual’s right to self-determination. The multi-agency coordinated approach is needed to determine, who is the best person to build rapport with the adult enabling them to develop a level of trust. Effective work with adults focuses on enabling the adult to develop skills and the right level of support to manage the risks presented by their individual circumstances. Naming a key worker specific is an effective way, to ensure coordination between the different agencies’ intervention by sharing information and conducting holistic risk assessments. The reviews the highlights the importance of reviewing the safety plans regularly, to address any changes in need as a result of a change in the individual circumstances.

The Mental Capacity Act 2005 provides an additional element to conducting Care Act 2014 section 42 enquiries and working with adults who self-neglect. The challenge often faced by professionals, as in the case of Mr. F, is building a relationship and rapport with an adult to enable the Mental Capacity assessment to take place.

This review has identified agencies should have worked more collaboratively to support the adults. Agencies had individual concerns but how information about the concerns and risks were managed by Adult Social Care, shared between health, housing and ASC is an area for learning. The lack of escalation by individual agencies when concerns were not addressed, highlights the need for better understanding of multi agencies duties and responsibilities under the Care Act 2014.

# 10. Thematic Learning and Analysis

**10.1 Recording**

Professionals are expected to possess the necessary skills and knowledge to demonstrate professional capability. They need to be confident, critically reflective and self-aware to analyze, review and evaluate their own skills, knowledge and professional practice. Practice must translate into records to meet statutory requirements.

10.1.1 The reviewer analysed the case recording on the ASC database, all 5 cases were poor (unclear, not including all information known, lacking in detail and inaccurate). Emails were cut and pasted on to records which add little or no value to the quality of the chronology. This was consistent with the findings highlighted in ASC IMR’s for all the 5 cases.

10.1.2 In Mr. F’s case his name was recorded incorrectly on the ELFT database, which resulted in an initial response to an IMR request as ‘Adult not known.’ Case notes shared with the independent reviewer lacked clarity of detail, including what evidence the professional considered, when a decision was made that Mr. F did not have a mental disorder. This assessment was made without seeing Mr. F. face to face.

10.1.3 The question as to whether the poor recording and subsequent delays in actions being taken, impacted the outcome for Mr. F is arguably a difficult one to answer. The records are not contemporaneous recorded. It is clear that the poor recording does not support best practice as it is ad hoc and inconsistent, preventing the reader understanding the rationale behind the delays and lack of actions taken by ASC. There is limited evidence of management oversight and scrutiny, this is discussed in more detail in section 10.2.

10.1.4 The IMR submitted from the Housing Association, highlights inconsistencies in actions being followed through. It is not clear from the housing association records, whether access was gained to Mr. F property, on the occasions an enforcement notice was given.

10.1.5 Mr. N’s and Ms. M’s case records are ambiguous and lack clarity of detail. This is especially pertinent to the complaint raised by Ms’ H and the subsequent response from ASC.

10.1.6 The ASC database recording for Ms. J is ambiguous, incomplete and inaccurate. It highlights the poor response to the 15 allegations of abuse raised by Ms. J and her support network.

10.1.7 The information provided to ASC from the Care Provider for Mr. G. in relation to the failed visits was inaccurate. Vital information regarding the identity and contact details of the only other key holder to the premises, was not recorded by Tower Hamlet ASC nor the care provider.

10.1.8 Inadequate recording is a common theme in Safeguarding Adults Reviews. This review highlighted record keeping as poor in ASC and Mental Health Services and the Care Provider. The poor recording includes absence of records, inaccurate information, unclear recording, absence of key information. The recording has an impact on the decisions made to support adults and the information sharing often preventing adults achieving good outcomes.

10.1.9 Adults and Community Services, Integrated commissioning updated the failed visit procedure in August 2018, following the Coroners Prevention of Death notice. They updated the section 8 on the provider procedures to include an updated risk assessment checklist. The urgency of reporting to the police ‘if you suspect the person, is at risk of serious harm or is critically unwell you should call 999 immediately. ‘Do not delay’ has been highlighted in red so cannot be missed or misinterpreted. This forms part of the contract with external Providers and includes guidance on a multi-agency response to failed visits, both in and out of normal working hours. Adherence to the procedure is monitored regularly through quality assurance checks. Effective implementation of the procedure, should prevent delays in multi-agency responses to failed visits, ensuring a timely response to adults at risk based on the accurate facts presented.

|  |
| --- |
| **Conclusion**10.1.10. In the five cases subject to this review the ASC written records were poor. They do not support evidence based professional decision making and crucially they don’t contribute to holistic risk assessments recognizing persistent risks and escalation of risks.10.1.11 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. 10.1.12 The IMR submitted from Housing indicate the 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. 10.1.13 Records are limited in providing evidence that professionals have fulfilled their statutory duties under the Care Act 2014. 10.1.14 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’. |

**10.2 Management Scrutiny and Oversight**

10.2.1 Over the period of review in Mr. G’s case, there were numerous managers involved in the decisions as to how to address the concerns raised. The management guidance and scrutiny was poor throughout. It included decisions not to proceed with safeguarding, poor records with no rationale to support decisions and lack of understanding of safeguarding procedures or policy.

10.2.2 The ASC records provide evidence of limited management scrutiny and guidance throughout the work with Mr. F. The quality of the records that were reviewed are poor. There is little to no evidence of management reflection and consideration in making decisions in line with safeguarding policy and procedures. There is no evidence of the social worker receiving regular supervision to support their practice in managing Mr. F’s complexed case.

10.2.3 The Housing Association were attempting to work with ASC to manage Mr. F.’s case. The housing records are detailed in terms of the work of the housing officer. It is noteworthy that the case was only escalated to senior management to discuss with ASC towards the end of Mr. F’s life. This raises questions of, at what point do housing officers escalate to their managers, for support when there are concerns about the multi-agency working. Each decision should be based on the risks to the adult, keeping in mind the making safeguarding personal principles such as proportionality, but acknowledging that if an adult is at risk of harm to self or others are at risk, professionals have a duty to raise concerns. Housing Officers, as with all professionals should receive regular supervision. When an officer has followed the agreed pathways of reporting a concern and do not succeed in receiving a response to support them to mitigate risks to the adult, the concern should be escalated to managers for support and advice and multi-agency escalation, if necessary.

10.2.4 There were three key instances in Ms. M’s case, where management clarity and scrutiny were key in addressing practice to ensure an improved outcome for Ms. M. However, all three decisions were made by different managers and at no point is there evidence that the managers considered the impact of their decision on Ms. M.

10.2.5 There is little evidence of management scrutiny in Mr. N’s case. The decision to close a safeguarding concern based on the fact that Mr. N. was no longer at risk of eviction, raises questions about the managers understanding of the complexities of working with someone who self neglects. There was no consideration of the bigger picture, i.e. the fact Mr. N continued to have a pattern of hoarding behaviour, which consequently resulted in the risks remaining.

10.2.6 15 safeguarding concerns were raised for Ms. J. None of these safeguarding concerns were progressed through the safeguarding procedures and as a result there was no safeguarding manager oversight. Operational management guidance and scrutiny was ineffective as they failed to take into consideration previous recorded information. Each operational decision was made in isolation. Key points that highlight the managers lack of understanding of multi-agency safeguarding practice are: the case being allocated to an unqualified worker and the decision to advise a worker to refer self-harm to the GP, with no further intervention from the ASC.

|  |
| --- |
| **Conclusion**10.2.7 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 co- ordinated response to the concerns raised. At times, the concerns where not addressed through the safeguarding procedures. 10.2.8. The Care Act 2014, states 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 better opportunity for multi-agency partnership working under the safeguarding framework.10.2.9. The housing officer experienced obstacle’s in progressing the safety concerns of Mr. F. but there was no evidence of the management involvement. This evidenced a lack of good quality supervisory oversight.  |

**10.3 Risk Management**

It is well established that the factors that increase an adults’ vulnerability to abuse and neglect need to be taken into account when assessing any risk to an adult.[[3]](#footnote-3) The individuals vulnerability needs to be considered, in conjunction with the individuals views and with consideration to their capacity to make a decision regarding their safety.

10.3.1 In all five cases, there was a record of some or all of the following factors that can increase an adults’ vulnerability to abuse or neglect.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Mr. F**  | **Mr. G**  | **Ms. M**  | **Mr. N** | **Ms. J** |
| Socially isolated with limited networks | **✓** | **✓** | **✓** | **✓** | **✓** |
| Refusal to accept services or refuse to engage  | **✓** | **✓****Refused personal care but accepted MOW** | ✘ | **✓** | ✘ |
| Concerns about neglecting oneself or their environment | **✓** | **✓** | ✘ | **✓** | **✓** |
| Impaired or fluctuating capacity | Never assessed | ✘ | ✘ | Never properly assessed | **✓** |
| In receipt of Domiciliary care package | ✘ | **✓** | **✓** | **✓** | **✓** |
| Allegations of abuse | ✘ | **✓** | **✓** | ✘ | **✓** |

10.3.2 Through the collation of chronologies, there is evidence that some of the factors that increase the adults’ vulnerability were recorded in the individuals’ written records. There is no evidence that the individual factors that increased vulnerability were considered, when planning how to progress with the support to the adult.

10.3.3 In the case of Mr. F, although, ASC and Housing association records, provide evidence of ongoing concerns reported by the housing association, there is a lack of any multi-agency risk assessment. Professionals fail to consider the individual risk to Mr. F’s wellbeing or the general public such as his neighbours. There is no recognition of the persistent and escalating risks reported over an extended time frame.

10.3.4 The focus was on Mr. F’s tenancy problems. There was a failure to complete a holistic risk assessment taking into account Mr. F’s history or personality. Mr. F’s neighbours regularly reported concerns, so it was assumed they ‘kept an eye on him’ but there was no attempt to seek their views in trying to understand Mr. F as a person or what level of involvement they had in Mr. F’s life. The neighbours details were not recorded as a point of contact for Mr. F.

10.3.5 Risks were consistently inadequately assessed throughout agencies involvement with Mr. G, because the staff focus was primarily on the mechanics of maintaining his acceptance of the care package, which had been identified as needed to support him living at home alone. The lack of multi-agency meetings to consider a holistic risk assessment, left Mr. G at risk of increased isolation and depression and subsequently exploitation by the carers, as he had no one to independently monitor the situation. The Health Centre failed to follow up refusal of nurse or GP intervention. If all the different agencies information had been known, it should have triggered a multi-risk assessment. Which in turn, may have enabled professionals to consider who was best to continue to try and engage with Mr. G, in relation to the ongoing concerns for his wellbeing.

10.3.6 The work with Ms. M was process driven. Ms. M requested support with an increase for her direct payment. There were delays in recruiting and this placed Ms. M under financial constraints. She subsequently had money stolen. The risk of financial difficulties was only at this point considered, but it was a very singular risk assessment. At no point was a holistic risk assessment completed.

10.3.7 Professionals focused on the ‘hoarding’ and clutter with Mr. N, without giving due consideration of his views and wishes. Although, there is mention of risk in the recordings there is no evidence of a holistic risk assessment – nor any attempt to understand who Mr. N is, as a person. All interventions are task focused with little or no attempt at gaining a better understanding of Mr. N’s history.

10.3.8 Safeguarding risks were consistently inadequately assessed throughout ASC involvement with Ms. J. The risks were apparent without further exploration and yet at no point, when the 15 different concerns were raised, did the allocated worker or their manager recognize the need to instigate a safeguarding enquiry. Through the limited recording, it becomes clear that other professionals, such as the GP had concerns for Ms. J and raised concerns for further intervention by ASC. The frequent concerns raised, should have triggered a response, in terms of a multi-agency risk assessment.

10.3.9 There is a record of a dialogue between the care provider and the ASC support worker raising concern about the frequency of calls from Ms. J. There was no professional curiosity to investigate what was causing Ms. J’s distress, but simply a response from ASC allocated worker, ‘I can’t do anything about it’. There is no evidence from the records that attempts were made to understand why Ms. J continued to call. The frequent calls continued until Ms. J moved into residential care.

10.3.10 Lack of consistent and competent risk assessments is a consistent factor in safeguarding adults’ reviews. Risk assessments involve collating and sharing information through observation, communication and investigation. It is an ongoing process that involves persistence and skill to assemble and manage relevant information in ways that is meaningful to all concerned.[[4]](#footnote-4) In the 5 cases subject to review, the lack of information sharing contributed to a lack of robust multi-agency risk assessments.

10.3.11 Agencies working with the 5 adults had different concerns at different stages of involvement. The quality of the referrals to ASC, often are as a result of an isolated incident. The quality of the risk assessment is hampered by professionals only considering a single event, such as a failed visit by GP, Housing Association or Care Provider, rather than the risk assessment being done holistically with information shared across agencies.

10.3.12 The Health Centre where Mr. G. was registered, has recognised in light of their knowledge of Mr. G’s vulnerability, that they should have followed up on Mr. G when he refused health access to the GP and nurses. The health centre has implemented a calendar system to follow up vulnerable adults to prevent vulnerable adults ‘falling through the gap’ when they are known to have health concerns and disengage or refuse health intervention.

10.3.13 Adults declining or not engaging with services such as Mr. G, Mr. N and Mr. F, or safeguarding concerns raised by individual agencies should all have individually and collectively been a prompt for a multi-agency risk assessment to identify what the actual risks are and which agency is best to support the adult.

|  |
| --- |
| **Conclusion:**10.3.14 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.10.3.15 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, behaviours contributing to the risks are not explored adequately.10.3.16 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. 10.3.17 The review identifies inconsistent professional skill in completing risk assessments. This impacted on professional curiosity, which in turn impacted on judgments and actions.  |

**10.4 Multi-agency information sharing and communication**

10.4.1 Information sharing and communication in Mr. F’s case was poor. The social worker worked with the housing association alone, without involving other key agencies such as the Police and London Fire Brigade. The partnership working with the Housing association tailed off with the social worker only sending holding emails, but not progressing matters. A professionals meeting was held after 10 months at the insistence of the Housing Association but this was only with the ASC and Housing. The minutes of the meeting were never completed. Social worker made cursory attempts to contact the Police and Fire Brigade, but this was to the public advice line and there were no further attempts to engage with the agencies.

10.4.2 The Housing Association regularly raised concerns with ASC about Mr. F but the response from the social worker was lacking and often absent. The Housing Association continued to attempt to work with Mr. F without ASC support. The lack of response from ASC was only escalated by the Housing Association towards the end of Mr. F’s life.

10.4.3 Mr. G should have been supported to access Mental Health Services. Mr. G’s GP accessed Mental Health at the turning point in Mr. G’s life, when his Mother died. There was limited partnership working between the agencies supporting Mr. G. A more holistic approach with clinical professionals, may have changed the focus of the interventions recognizing the risks around the isolation and subsequent depressions and anxiety. The social worker did communicate with the Mr. G’s GP, but this was care package focused requesting a referral for district nurse. There is no recognition in ASC work with Mr. G of the role, the other agencies could play in understanding risk and empowering Mr. G in mitigating the risks.

10.4.4 The social worker leading the safeguarding enquiry into the financial abuse of Ms. H. by her carer worked with the Provider, but failed to involve the Police and commissioning colleagues under the public interest or to consider Ms. M safety. Considering Ms. M had a serious health condition, lack of communication between ASC and the GP is a significant failure.

10.4.5 The social worker from ASC worked closely with housing association and the Care Provider but did not make an important link with Mr. N’s GP, who saw him regularly. This link is important as it could have helped professionals understand Mr. N as a person and also the importance of a referral for psychological support which the social worker did not pursue for Mr. N. A multi-agency professionals meeting with all agencies, including the GP, could have supported a more personalized approach to the support offered to Mr. N with a clearer focus on a holistic risk assessment and safeguarding planning with his views being heard and understood.

10.4.6 Mr. N was considered to demonstrate hoarding behaviour, which is well known to be a potential fire risk, but there is no record of Mr. N being offered a referral to the London Fire Brigade nor any recorded evidence that the referral was made in the public interest.

10.4.7 The ASC staff who worked with Ms. J never took a multi-agency approach. They responded to the Provider and GP electronically, but at no point was a multi-agency safeguarding or professionals meeting held to use the expertise of the agencies to understand the risks and seek an appropriate outcome for Ms. J. Despite repeated concerns about the care workers, this was never communicated with commissioning colleagues or advice sought from the Police.

10.4.8 The Housing Association were concerned about Mr. F. hoarding. They raised concerns to ASC. London Fire Brigade have no record of a referral being received for either Mr. F. himself or his address. Housing in the first instance should be reporting and chasing a referral to the Fire Brigade. The Fire Brigade could have attempted to gain access for a fire safety assessment. While Mr. F. was resistant to intervention from housing and ASC, engagement through the Fire Brigade could have been another avenue explored to risk assess, both Mr. F.’s circumstances and the neighbours.

|  |
| --- |
| **Conclusion:** 10.4.9 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. 10.4.10 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 could have drawn on each other’s knowledge of the adults using their specific expertise to offer the appropriate response to the adult.10.4.11 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.10.4.12 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 role of working in partnership to address Mr. G’s wellbeing. 10.4.13 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. |

**10.5 Making Safeguarding Personal**

10.5.1 Mr. F was reluctant to allow the agencies access to his property. He often communicated through the door or from the balcony. This makes it challenging for professionals to build rapport with an adult and understand more about them. In Mr. F’s case, neighbours frequently raised concerns about Mr. F, but the recorded conversations are focused on the state of him and his environment, without any exploration as to what the relationship is with Mr. F and what they know about him. Knowledge from other agencies, such as the medical professionals at the eye hospital and neighbours, could have given the social worker some insight into how to communicate with Mr. F rather than simply continuing unannounced visits, which were ineffective.

10.5.2 Mr. G was not listened to adequately. A key example was when the social worker changed the carer without Mr. G’s consent or wishes being sought. However, the lack of ‘hearing’ the adult’s views is a wider issue. The intervention was service led, there are limited records of understanding Mr. G as an individual. At no point in the interventions is there evidence that time was spent with Mr. G, understanding what his aspirations were and what the reasons were for him refusing support with personal care. Nor was there consideration of what alternatives he could be supported with, to empower him to address his isolation and depression.

10.5.3 The communication between the advocate and social worker was fractious. The focus should have been on Ms. M with the professionals working together to support her. Ms. M experienced long delays from ASC which led to her making a formal complaint. There were pockets of good practice in listening to Ms. M, specifically when she raised the safeguarding concern, but on a whole, the focus of all interventions were service driven rather than person centred.

10.5.4 Mr. N was visited regularly by the social worker and housing officer but never listened to. Professionals were directive with Mr. N, focusing on his hoarding behaviour, rather than building a relationship with him, where over time, Mr. N may have been able to talk about his feelings that were driving his behaviour. There was no attempt to enable Mr. N to seek outcomes or improvements in his life, an approach which could have assisted Mr. N in addressing his hoarding issues.

10.5.5 Despite Ms. J’s regular calls to different people, she was never given the opportunity to explore what the underlying concern was. She was simply labelled as ‘forgetful’. When a professional from Health reported Ms. J was experiencing feelings of self-harm and loneliness, this did not trigger a multi-agency approach to consider the best solution, the ‘problem’ was referred to her GP. At no point was a mental capacity assessment completed. Ms. J should have been offered an advocate to support her. There is no evidence that the work completed with Ms. J was strength-based practice, it was service led and inadequate.

10.5.6 Strength based approaches are not prescriptive: there is no one size fits all model. Approaches recognize that the individual is aware of their situation and the care and support they require. It also aims to ensure that the individual is always at the heart of any intervention, is supported to share their views about their family, friends and are able to contribute. In strengths-based practice the individual is empowered to have as much choice and control as possible and encouraged to propose options and solutions to enable them to have the life they want.[[5]](#footnote-5)

|  |
| --- |
| **Conclusion:** 10.5.7 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. 10.5.8 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. 10.5.9 There is evidence 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.10.5.11 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.10.5.12 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’s and Ms. J. |

**10.6 Legal Literacy**

In all cases subject to this review, the safeguarding at risk policy and procedure was adequate to be used as an effective framework to focus on positive outcomes for the adults. Professionals failed to use the procedures correctly, failed to approach the issues presented in a person centred way, failed to complete holistic risk assessments, failed to call multi-agency meetings as procedures require.

Decisions to close safeguarding enquiries because that is what the adult wishes or because the adult has capacity and does not engage, is not sufficient reason in meeting the Local Authority 2014 Section 42 enquiry statutory duty. Professionals must give due consideration to the adults wishes, the adults capacity and crucially, the risks posed to the adult and the public. Decisions to close or progress safeguarding enquiries should be done with management scrutiny and oversight.

10.6.1 Mr. F’s case records do not provide evidence of the application of the Mental Capacity Act 2005, although there are key factors which raise the reviewers doubt as to whether Mr. F had capacity to understand the risks of his living environment. Safeguarding policies and procedures require the development of a holistic risk assessment and safety planning. The multi-agency meetings support inter-agency work and offer different opportunities to understand the person and consider the best options to work with the adult to mitigate risks. In Mr. F’s case, the safeguarding policy and procedures were not adhered to.

10.6.2 At no point in the work with Mr. G was his capacity assessed, to determine if he understood the risks of refusing personal care. On eight occasions during ASC engagement with Mr. G, there was information reported which should have flagged for professionals that there were risks of abuse. It is worth noting, that some of the concerns could have been managed through care management, but they should have triggered a multi-agency risk assessment, which they did not.

10.6.3 Data Protection Act 2018 and Crime and Disorder Act 1998 specifically allows the sharing of information in the public interest. Ms. M raised a concern about being financial abused by her care worker, the ASC and Provider professionals failed to apply their legal knowledge of the duty to share information with the Police.

10.6.4 On two separate occasions the ASC professional attempted to use the Mental Capacity Act 2005 to ‘resolve’ Mr. N’s hoarding behaviour. On both occasions, the legal advice was sought via email without evidence of a discussion. The advice given, was that the presenting evidence did not support the analysis and decision by the worker that Mr. N lacked capacity to understand the risks posed by his living environment. It is questionable from the records, if professionals understood how to conduct a MCA and use the evidence how to come to a decision.

10.6.5 There were 15 safeguarding concerns raised for Ms. J. All 15 met the criteria for a concern to be logged and a decision to be made as to whether to conduct a Care Act 2014 Section 42 enquiry. None of the concerns were addressed through the safeguarding framework.

|  |
| --- |
| **Conclusion:** 10.6.6 The Mental Capacity Act 2005 was misunderstood in Mr. N’s case in an attempt to make a best interest decision for him when he had capacity. While there is an absence of its use to support safeguarding Mr. G. 10.6.7 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. 10.6.8 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. 10.6.9 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.10.6.10 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.  |

**10.7 Professionals Attitude**

The National Institute for Clinical Excellence (NICE) identifies hoarding behaviour as a psychological and behavioural issue characteristic of mature people who are often cognitively high functioning and with capacity to understand and weigh what they do, paralleling obsessive compulsive disorder and is often triggered by an episode of grief. The NICE guidelines identify that psychological therapies and anti-depressants, can both have a positive impact on the condition.

10.7.1 In Mr. F’s, Mr. G’s and Mr. N’s cases the records are written in a manner which leads the reader to assume that the adults are seen as a problem, rather than individuals with complex lives, and may need support to mitigate the presenting risks and understanding what lay behind the ‘problem’ behaviour.

10.7.2 The issues presented to professionals in Mr. G’s case were not complex. The failings relate to core social work practice. The records reflect that each intervention was seen in isolation and the focus was to resolve the ‘problem’ and move on to close his case. The interventions lack any sense of professional curiosity, to understand what is the core trigger for Mr. G’s depression and which agencies can support him with addressing it.

10.7.3 It is essential that professionals are transparent with adults and their ability to achieve their stated outcomes, but there is a fine line between discussing concerns and being discouraging and disempowering. In Mr. N’s case, the professional’s actions demonstrated a lack of faith in Mr. N’s ability to make changes. The approach was directive rather than supportive and encouraging.

10.7.4 The response to all the safeguarding concerns raised for Ms. J, was at best inadequate, at worst lacking. There is no reasonable rationale. The fact that the workers’ response to a concern is ‘they are unavailable to respond for 5 days’ and thereafter, the response is lacking, raises questions about a culture of complacency.

10.7.5 The partnership working has on occasion, been effective in sharing information, but what is lacking is a coordinated approach to supporting adults at risk of abuse. While external agencies have reported concerns, when there was an inadequate response, there was either a delayed escalation or lack of escalation to progress with the concerns.

10.7.6 These cases highlight professionals need to be more reflective and accountable for their practice. Statutory agencies including ASC, ELFT, Health and Housing should introduce ‘beyond auditing’ as a tool for ongoing quality assurance. It involves ‘active’ cases being audited by an independent auditor together with the involved manager and practitioners. The aim of ‘beyond auditing’ is to support professionals to develop their skills through having an understanding of what best practice looks like. The quality assurance framework should ensure that statutory agencies have an in-depth knowledge of the quality of practice within their agencies. This can then be provided to the SAB with some reassurance of the quality of practice. The allocated practitioners and manager are accountable for improvements, identified through the live audit

10.7.7 Relevant partner agencies need to have an internal quality assurance framework, which should include ‘dip – auditing’ to provide assurance safeguarding issues are being flagged and responded to. It allows an agency to understand where the gaps in their staffs’ skills and knowledge are when safeguarding adults.

|  |
| --- |
| **Conclusion**10.7.8 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. 10.7.9 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. 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.  |

# 11. Five cases post restructured deep dive analysis

Audit of 5 new safeguarding referrals from the period October 2018 – June 2019.

This served to provide comparative data, to enable the reviewer to analyse whether there have been any improvements in the response to safeguarding concerns since the restructuring of the ASC Department.

|  |  |
| --- | --- |
|  | Pen Picture |
| Adult 1 | Adult 1 is an 82-year-old, Bangladeshi, Asian man. Adult 1 was known to ASC since 2016. He is supported by his wife and children. Adult 1 has a diagnosis of dementia and other complexed health needs. In October 2018 following a hospital admission, Adult 1 moved to a care home. Adult 1 lacked capacity to understand his care and support needs and is subject to a DOL’s. He has presented with challenging behaviour since his admission to the care home and has been known to wander into other resident’s rooms, smear his faeces on the walls and become aggressive with staff when they try and support him. This current concern was received on 10.01.2019 from the care home. The concern was that he physically hit a staff member when the staff member was attempting to assist him to shower following an incident, when he had smeared his faeces. There was a multi-agency discussion which included a referral for a review of care needs and a medication review by the GP. The safeguarding episode was closed on the 11.01.2019 with an outcome of no enquiry needed but referral for ongoing care management. Adult 1’s care was progressed under multi – agency care management working with both him and his family.  |
| Adult 2 | Adult 2 is a 43-year-old Black, woman, from Somalia. She was not known to ASC prior to the safeguarding concern raised on 28.01.2019 by the staff at Royal London Hospital. A self-neglect concern was raised as a result of Adult 2 not attending a planned surgery for cancer. Adult 2 was contacted by telephone. She is an independent lady who lives with her husband. She has no care and support needs. She explained that she wishes to receive a second opinion regarding her medical diagnosis and it is at that point she will contact her specialist again. She did not wish to proceed with the safeguarding enquiry. The decision was made to close the enquiry on 21.01.2019 with an outcome of no enquiry needed as the adult did not have care and support needs and did not wish for any further support. The referrer was informed of the decision.  |
| Adult 3 | Adult 3 is an 82-year-old, Asian, man, originally from Bangladesh. Adult 3 speaks limited English. There is one previous recorded contact with the Adult in 2017 following a hospital admission. At this point Adult 3 declined any support. He lives with his family and they support him with domestic tasks. The current concern was opened on 6.02.2019 following a referral from Community Health who are concerned he was self-neglecting as he declined the offer of a specialist bed to manage his pressure sores. Adult 3 does not answer the phone but does have regular contact with his GP. His GP and his family were spoken to and they confirmed Adult 3 had capacity to make the decision to decline the equipment. The safeguarding concern was closed 19/03/2019 with an outcome of no enquiry needed due to the adult having capacity to decline the bed. There were no further concerns raised. The GP would continue to monitor Adult 3 medical needs.  |
| Adult 4 | Adult 4 is a 51-year-old, white, British woman. There was one previous contact with ASC in 2014 when Adult 4 requested a referral to Mental Health Services. Adult 4 spent a period in 2018 in a rehabilitation centre. During which time a family member stole a number of assets and money from her home. This was not reported or investigated through the safeguarding framework but directly with the Police. The concern was opened on 27.02.2019 following a referral from victim support regarding Adult 4 disclosing suicidal thoughts. Adult 4 was immediately contacted and the risks assessed with her via a telephone call. She was concerned about money and action was taken to provide a food voucher to address the immediate risks. Appropriate action was taken with her agreement to contact her GP and the Mental Health Community Intervention Service. These actions were taken and followed up. The safeguarding episode was closed on the 5.03.2019 with an outcome of no enquiry needed. |
| Adult 5 | Adult 5 is a 70-year-old, white, British man. Adult 5 lives alone with his dog. Adult 5 has multiple health needs including throat and skin cancer. He is previously known to ASC; a safeguarding concern raised in March 2018 when he declined access to community nurses. In September 2018 he accepted a mobile base unit and pendant alarm. Little personal history is known about Adult 5 as he declines to engage. The concern was raised on 11.03.2019 by his care navigator regarding his lack of engagement with health services and his not following advice about avoiding a solid diet and maintaining his peg feed. Numerous attempts were made to contact Adult 5 but he did not respond to calls. Adult 5 is well known to his care navigator and his GP. Information was shared with both and it was agreed that Adult 5 had capacity to decline treatment. The GP completed the mental capacity assessment. Adult 5 was offered an assessment but declined. He was offered support with walking his dog but he declined. A referral was made to the Fire Brigade but after numerous attempts at gaining access, the referral was closed. The community health i.e. the care navigator and the GP will continue to monitor the adult. The safeguarding was closed on the 27.03.2019 with an outcome of no enquiry needed due to the adult declining services and having capacity to understand the risks his choices pose to his health.  |

11.1 The reviewer audited 5 cases on the ASC database from the Initial Assessment team, that had a safeguarding concern logged between January 2019 – June 2019. It is worth noting that this is a small sample and is a narrow snapshot of practice during this time period.

11.2 In all 5 cases the concerns were closed after the conversation with the adult or an appropriate family member in the case of Adult 1. It is important to note that the initial conversations were completed by the most appropriate agency, which in two of the cases was Community Health Services.

11.3 The introduction of the initial risk assessment screening tool provided clarity of the initial presenting risks. The decisions in all 5 cases were proportionate to the risk and took in to consideration the adults or their representatives stated outcome.

11.4 Three of the adults were assumed to have capacity and did not present with a temporary or permanent impairment of the mind or brain. The principles of assessing capacity were applied in the additional two cases. The responses were timely and the management oversight was clear and in line with the safeguarding adults’ policy and procedures.

11.5 While the partnership working and information sharing between agencies is considered a gap in the 5 cases subject to the review, in these 5 post restructure cases it is considered an area of good practice. Agencies appropriately shared information and where appropriate had the initial conversation the adult.

11.6 In the SARS cases, the accessing of mental health services has been identified as a gap in practice, in the case of Adult 4 the referral and response to mental health is considered a strength. ASC confirmed that the adult had an appointment with mental health prior to closing the safeguarding concern. The response from mental health was timely.

11.7 The Initial Assessment originally called the Assessment and Intervention team, receive safeguarding referrals, risk assess, complete the ASC concern documentation and then based on risk determine the speed at which the case is transferred to the locality teams for section 42 enquiry or close cases that do not warrant a section 42 enquiry. The key change following restructure is that the initial assessment team, risk assess and hold cases for a maximum of four weeks before passing them to localities to progress the Care Act 2014 section 42 enquiry.

11.8 The 5 safeguarding concerns audited were all within the initial assessment team. The findings lead the reviewer to the opinion, that the initial assessment team is more consistent in making immediate timely decisions in line with safeguarding policy and procedure than in the 5 cases subject to this thematic SAR which, were all considered by different teams and care managed as opposed to considering them under safeguarding procedures which the Care Act 2014 requires. But this is said with the caveat, that this is a small sample of the overall numbers of concerns raised and only considered one team. A larger audit could test whether the change in operational structure has improved the outcomes for the adults when concerns are raised.

11.9 The specific areas of good practice included:

* In 2 cases, the adult was spoken to by ASC, as soon as possible on receiving the concern. In two of the cases, the adults refused to engage with ASC but would engage with Health. In both cases, information was shared appropriately between agencies to consider the risks and appropriate response to the adult. In one case the adult did not have capacity to make decisions about the safeguarding desired outcome, but his family representative was spoken to.
* The six safeguarding principles of empowerment, protection, protection, proportionality, accountability and partnership working were applied in the decisions of how to progress with the cases.
* The adults’ views or their representatives, were sought and clearly recorded in all the 5 cases.
* In two of the cases the adult refused to engage with ASC but was engaging with health. On both cases health and ASC worked in partnership to gain the adults views.
* The safeguarding risk assessment tool was used on all 5 cases to support professional decision making.
* The adults’ capacity was recorded in all 5 cases. With Adult 1 the MCA 2005 was appropriately used in making a best interest decision.
* None of the cases progressed passed the initial concern and information gathering to the planning stage of the section 42 enquiry but there is evidence of information and advice provided to the adult and other partners in the event that circumstances changed.
* All cases included a detailed record of what action has been taken and a management record with the rationale for the decision to close the section 42 enquiry after the information gathering which included the adult’s views.

# 12. What has changed key learning points

**Recommendations from Multi Agency Workshop 21 November 2019**

The multi-agency workshop involved senior managers from agencies involved in the 2 statutory SAR cases namely; Mr. G and Mr. F. The purpose of the workshop was to reflect on the learning for the agencies and agree recommendations for improved multi-agency working. The following recommendations were agreed by the agencies at the workshop on the 21 November 2019.

**Multi – Agency**

12.1 A standard safeguarding risk assessment tool to be developed to be used across all agencies. A project group to be set up to ensure the tool meets the requirements of all agencies. The project group to be led by LFB Borough Commander.

12.2 The SAB performance subgroup will be piloting the multi- agency audit template in December 2019.

12.3 In September 2019, the Safeguarding New Approach panel was launched (SNAP). It is co – chaired by the CCG Safeguarding Lead and the CEO of a domiciliary care provider. The aim of the SNAP is for providers to share best practice and raise preventative safeguarding issues. There will be support from ASC, Health and commissioning. There was be a presentation at the first meeting on supporting providers to make an effective safeguarding referral and how to escalate concerns, if needed. The use of alternative venues will aim to broaden the attendance.

**ASC**

12.4 Critical thinking workshops have been rolled out across ASC led by the Adult Safeguarding lead. The workshops are mandatory for all ASC staff. The aim is to have trained all ASC staff by April 2020.

12.5 ASC has implemented a programme of workshops led by the ASC Safeguarding lead, to all front-line practitioners focusing on improving skills in responding to adults who self-neglect and/or hoard.

12.6 Annual Deep dive audit includes a making safeguarding personal tool. The 2019 audit has reflected improvements in the quality of the case work. The findings from the deep dive audit will highlight key areas for ongoing developments.

**Housing**

12.7 Following the independent management review of Mr. F.’s case, concerns are now escalated to senior housing officers in the Housing Association as soon as there is a concern over lack of action or response. Regular internal officer meetings using the MARAC format, chaired by Head of the Community Safeguarding in the Housing Association are held to discuss safeguarding concerns in complexed cases, such as Mr. F.

12.8 A crib sheet highlighting high risk cases that need to be sent to the Housing Safeguarding lead for internal case review has been developed. This is discussed in supervision and is on the Housing internal webpage. Housing agreed to formalise the process into a written workflow.

12.9 Supervision procedure has been developed. This includes 2 weekly supervision cycle with a focus on reflective practice. This is to be written into a supervision policy.

**Health**

12.10 The recruitment process for a GP Safeguarding Lead has been started.

12.11 CCG Safeguarding Lead has initiated a program in November 2019, of level 3 training for GP’s co-facilitated with Newham GP Safeguarding Lead.

12.12 CCG Lead to review progress of developing a protocol of ‘remote registering’ adults at risk with GP surgeries when they are not registered.

**ELFT**

12.13 Hoarding clutter scales have been attached to ‘datix’ reporting system to raise awareness and improve risk assessments.

12.14 ELFT Safeguarding Conference in October 2019 included a presentation by the LFB to increase front line practitioner’s awareness of fire risk and safety.

12.15 Level 3 safeguarding training includes risks associated with self-neglect and hoarding.

12.16 December 2019 Community health newsletter for practitioners will include details of how and when, to access the SNAP panel.

**ADDITIONAL INITIATIVES Implemented**

Additional initiatives that have been implemented in the last 12 months are included to reflect the ongoing development work that is being implemented across agencies. These initiatives were not implemented as a direct learning from only this SAR but from a number of lessons learnt from SARs, national guidance and internal deep dive audits. The following initiatives have been shared by agencies with the Reviewer as actions implemented or in the progress of being implemented to improve overall safeguarding practice.

**Adult Social Care**

* 1. The Failed visit procedure was reviewed in August 2018. The implementation of this is monitored through quarterly monitoring visits from commissioning.
	2. ASC and Commissioning have strengthened their partnership working when the concerns are raised about a service provision. Commissioning will, attend a planning meeting and in most cases will be at safeguarding outcome meetings to ensure information is shared, regarding any actions or lessons that need to be addressed through the contract monitoring. ASC Commissioning facilitate Provider Forums for information sharing which may include updates in safeguarding practice.
	3. Additional initiatives include: Introduction of a High-Risk Panel to consider and support ASC, Children’s Social Care and Partner agencies to manage risk, when service users are transitioning between services or in other challenging situations.
	4. ASC have embedded a risk assessment tool for initial screening of the safeguarding concerns.
	5. ASC are developing a domestic abuse decision support tool which will be launched to aid professionals to evaluate risks in domestic abuse situations.
	6. ASC have completed a multi-stranded comprehensive review of adult Safeguarding practice. This included a practice and case file audit of over a hundred cases, a separate survey of staff, a review of the customer journey and focus groups.  All strands were researched separately before a synthesising analysis was conducted.  The cases in the audit sample dated from July 2018 to July 2019. The initial findings include; limited understanding of the escalation process which is included in the safeguarding policy and procedures. The review has also highlighted a lack of understanding and implementation of the self-neglect guidance. The report is in draft, but the recommendation from the survey will include an overall improvement plan of processes and procedures.
	7. As a result of the IMR’s of this review ASC have introduced a new forum for Safeguarding Adults Managers to attend monthly. These are led by the Managers themselves. Each team takes a turn chairing the meeting and arranging the speakers based on needs of learning identified by the group.
	8. The ASC Safeguarding Practice and Performance Quality Review Group has been set up as a result of the ASC IMR’s for this review. This is aimed at senior practitioners and team managers within ASC. The meeting considers outcome focused performance statistics and covers practice issues. The learning is shared through presentations and newly developed support materials. The aim of the group is to support ongoing management development in safeguarding adults’ decision making.

**Health Centre**

12.24 The Health Centre has implemented a calendar system to follow up vulnerable adults, with the aim of preventing vulnerable adults ‘falling through the gap’, when they are known to have health concerns and disengage or refuse health intervention.

# 13. 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 effectiveness of the recommendations should be monitored through the planned multi-agency dashboard and audit programme, with a focus on improved outcomes for Adults.

**Multi- Agencies**

13.1 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.

13.2 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.

13.3 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.

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

**Adult Social Care**

13.5 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.

13.6 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.

13.7 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**

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

13.9 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.

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

# glossary

**ASC –** ASC

**IMCA** – Independent Mental Capacity Advocate

**IMR** – Independent Management Review

**LAS** – London Ambulance Service

**MCA** – Mental Capacity Act 2005

**THSAB –** Tower Hamlet Safeguarding Adults Board

**SAB** – Safeguarding Adults Board

**OT –** Occupational Therapist

**Safeguarding Adults Section 42 Enquiry** – The Local Authority legal duty to conduct or ensure others conduct an enquiry when an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from with risk of, or experience the abuse or neglect

**SARS** – Safeguarding Adults Review

**Vital Interest** – a term used in the Data Protection Act 2018 to permit sharing of information where it is critical to prevent serious harm or distress, or in life threating situations

# References

1. Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014)

2. Department of Health & Social Care; Strengths-based approach: Practice Framework and Practice Handbook February 2019

3. London Multi – Agency Adult safeguarding policy and procedures April 2019

* 1. 4. Learning from SARs: A report for the London Safeguarding Adults Board Suzy Braye
	2. and Michael Preston – Shoot July 2017
	3. 5. SCIE: (2015) Adult Safeguarding Sharing Information
	4. 6. London Borough of Newham Self-Neglect and Hoarding Protocol
	5. 7. London Borough of Newham Self-Neglect Risk Assessment and risk levels matrix
	6. 8. London Borough of Tower Hamlets risk assessment screening tool
	7. 9. London Borough of Tower Hamlets High Risk Panel terms of reference
	8. 10. London Borough of Tower Hamlets failed visit procedure 2018

# The Reviewer

**Belinda Oates** is a qualified social worker registered with the Health and Care Professions Council. She has over 23 years’ experience of working in the field of social care. Belinda gained practice experience initially as a front-line social worker before progressing to management roles which included; multi-agency team manager and safeguarding adults operational and strategic manager.

Belinda has been working independently for the last 13 years. Her work as a consultant and trainer has focused primarily on safeguarding adults as legislated by the Care Act 2014 and Mental Capacity in line with Mental Capacity Act 2005.

1. Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014) [↑](#footnote-ref-1)
2. Care Act Statutory Guidance 2014 paragraph 14.17 [↑](#footnote-ref-2)
3. London Multi – Agency Adult safeguarding policy and procedures April 2019 [↑](#footnote-ref-3)
4. London Multi – Agency safeguarding policy and procedures April 2019 [↑](#footnote-ref-4)
5. Department of health and Social Care: Strengths Based approach: practice framework and handbook February 2019 [↑](#footnote-ref-5)