

Learning from Safeguarding Adults Reviews

The Case of Ms F

1. Purpose of the Safeguarding Adult Review

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults' Boards get the full picture of what went wrong, so that all organisations involved can improve their practice.

Organisational systems are complex. Therefore findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation.

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. Case Review findings say something more about local agencies and their usual patterns of working. They exist in the present and potentially impact in the future. **The six findings are presented in section 4 below.**

It is important that local agencies review the findings from a Safeguarding Adult Review and consider what changes can be made in local processes and practices to prevent such a case reoccurring.

2. Succinct summary of case

Ms F was a young woman who died of sepsis. With the exception of her GP, her case was not open to any service until just before her death, when she was referred to Adult Social Care by the Police. Other members of the household were well known to many services in Reading including Antisocial Behaviour and the Police, both as victims and perpetrators.

3. Appraisal of professional practice in this case – a synopsis

Various members of Ms F's household were well known separately as individuals to agencies for many years and many appropriate interventions were offered to them prior to the period under review and during it. The focus of these services was around the tenancy, in particular the state of the property and rent arrears, as well as the impact of anti-social behaviour on neighbours. **The differing drivers for services are explored further in Finding 2.**

This cycle of intervention and engagement is explored in Finding 2.

It is notable that for much of the review period, professional engagement was focused on other individuals in the family unit of which Ms F was a part, without specific interventions for her. It is also notable that the strong interdependency between members of the family went unrecognised, although this is not unexpected given that adult assessments are about individuals only. **This is explored in Finding 6.**

Prior to the period under review the case has some unique aspects. The treatment of another member of the family led to the first case that Reading Borough Council took to the Court of Protection on grounds of neglect, and one of the first Deprivation of Liberty Safeguards that was carried out on another member. Neither of these people forms part of the family unit during the period under review but the historical background is significant. **The consequences of historical knowledge is explored further in Finding 6**

Ms F had a baby removed and adopted because of concerns of neglect and the case closed by Children's Services. Following this, Ms F had no subsequent support, with the exception of her GP who had prescribed anti-depressants. This was standard practice at the time. Since then the importance of support following removal and adoption of children has been recognised, and has led to the establishment of the Future Families Project.

In February 2012, the Police were called to the household after Ms F had reportedly attempted to cut her wrists with a knife. The Police response was compassionate and well-judged: they took Ms F to A&E away from the chaotic home situation.

After this event, no further services were requested or provided to Ms F in her own right until May 2013. Between February 2012 and March 2013 professionals from a number of different agencies attended the family home, largely as part of plans to implement an eviction on the grounds of antisocial behaviour and rent arrears. Ms F was present during all of these visits, but usually as a 'background' member of the household: most interventions were targeted at her mother, as she was the tenant, and mother's partner who had a diagnosed learning disability.

The Review Team has considered carefully whether any of these professionals could have picked up at any earlier stages that Ms F, or any other members of the family were at risk, and this is discussed below. However, in general it seems that there were no reasons why visiting professionals would have singled Ms F out within the family. Ms F appeared articulate and had a reasonable level of cognition compared to other individuals living in the household. **The impact that an individual's presentation can have on assessments of vulnerability is further discussed in Finding 5.**

The Police were called to the house on numerous occasions during the review period following alleged ASB or domestic abuse and drunken behaviour.

ASB visits were made at intervals during the Review period for the clear purpose of reducing anti-social behaviour. The ASB Officers were concerned about the vulnerability of the family as a whole, and in October 2012 contacted Safeguarding Adults to check if any household members were known to ASC because of concerns about their possible vulnerability. Whilst ASB were beginning to prepare the case for eviction, the Rents Section of Housing had already gained a possession order from the Courts for substantial arrears. This had been suspended as the household had undertaken to pay back arrears. The Neighbourhood Officer did not act effectively as the conduit between the Rents Team and ASB to pull the two eviction processes (via ASB and via rent arrears) together. This was in part due to the blurring of the role of Neighbourhood Officer and ASB Officer in terms of antisocial behaviour for Council tenants at the time. Roles have been subsequently defined.

It was not until ASB formally approached the Council's Legal Team to begin the Court process in June 2012 that they became aware that the tenant was already being taken through the eviction process due to substantial rent arrears. The current reorganisation of Housing to bring the Recovery Team into the Department rather than remain in Finance should prevent this dislocation occurring.

At the same time Recovery Officers continued to try to engage the tenant using a variety of methods including phone calls and visits as well as standard letters. There is a strange effect of the Court process that Council Officers have to repeat attempts to engage and support tenants time and again because they know that the Court will refuse the eviction unless they can prove over time that the actions have not been effective by citing non-payment of arrears, state of the property, or ASB. In order to evict, the ASB Team had to establish a large body of evidence of extreme behaviour as well as the poor state of the property. They also have to prove that they have tried to provide support to vulnerable tenants. **This is explored further in Finding 2**

In December ASB Team visited the house. They noticed that Ms F looked unwell and advised her to contact her GP. This was appropriate and above expected standards.

ASB contacted Safeguarding Adults again in December 2012 to discuss their concerns about family member's vulnerability as the eviction process was continuing. They were aware that a person with a Learning Disability (the tenant's partner) was living in the house but they were concerned about the tenant and her sister. They had no concerns about Ms F. This led directly to a series of joint visits between ASB and Community Learning Disability Team (CLDT).

The decision by CLDT to assess both the tenant and her partner was above expected standards. Historical knowledge indicated that only one household member was potentially eligible for community care support but consideration was given that the tenant's needs may have changed over the time. **See Finding 4 for further exploration of this.**

CLDT and ASB joint visits and attempts to engage were tenacious and beyond what would have been expected and were made as a genuine effort to support the family. During the visit when they were given entry, Ms F was sitting on the sofa, but it was the only furniture in the room. On that occasion in February Ms F's mother volunteered that she thought Ms F was unwell and she was advised to contact the GP and ask her to visit. This was appropriate given

that both women had mobile phones, and from medication on the table it was clear that Ms F was in contact with her GP.

In February 2012, ASB took the case to the ASB Multi Agency Panel (MAP), a panel established in order to agree eviction of tenants who may have implications for other agencies. This was the only forum where there was a wider discussion of needs of the family as a group rather than individuals. The Review Team felt multi agency discussion would have been helpful much earlier. There is no structure to support this but a multi-agency strategy meeting could have been convened. MAP is not designed to take a holistic view of alternative actions, although this did in fact occur e.g. the decision to refer Ms F, her mother and aunt to the ASC Risk Enablement Panel (REP). REP is designed to examine 'stuck' cases and is used for individuals who don't necessarily reach community care criteria but who are high risk or resource intensive. In fact the referral did not take place and in any case was too late to impact on the subsequent eviction.

It is notable that the referrals to REP were INDIVIDUALS not as a family group. Ms F again does not feature as being of concern compared to others. **See Findings 1 and 2 where there is consideration of panel use, Finding 5 which explores innate bias and Finding 6 which explores the impact of assessment of individuals only.**

In May 2013 the Police were called to the house due to a neighbour dispute. During this visit, the Police Officer became concerned about Ms F because she appeared unwell. There was appropriate practice in recognition and referral of Ms F to ASC by the Police via the Protection of Vulnerable Adults Unit. It took almost 24 hours for the referral to be passed to Adult Social Care which was appropriate as the Police Officers attending had no reason to suspect the severity of Ms F's illness.

However, this meant that referral was sent late on a Friday afternoon prior to a Bank Holiday and was not picked up by the Single Point of Contact in ASC until the following Tuesday morning, below acceptable standards. The system for receipt of police referral has since been changed.

Once the referral had been triaged it was swiftly passed appropriately to CLDT as they knew the household. Because the referral was not marked as urgent, CLDT appropriately researched the household. It was appropriate to include a nurse as part of the joint visit that same afternoon given the nature of the referral. It was luck that the nurse was male and that Ms F's mother assumed he was a GP and allowed them access into the house. They chose not to insist on a physical examination due to the distress of Ms F but obtained permission to contact Ms F's GP.

The GP had Ms F flagged on the system as having LD which was incorrect but it meant she acted swiftly to make a home visit that evening, above appropriate standards. She called paramedics who took Ms F to hospital.

Safeguarding alerts made by paramedics and acute hospital staff, and the subsequent multi-agency safeguarding investigation adhered to the Berkshire Safeguarding Adults' Policy and Procedures.

Staff at RBH made every effort to understand Ms F's wishes and responded to these despite being understandably shocked at Ms F's physical condition. There was a strong multi-agency communication and joint working throughout the time period around the criminal investigation.

The efforts by Housing Needs to develop a supportive relationship and to ensure that the tenant understood the eviction process were above the expected standards particularly when the remaining family members were living in temporary accommodation.

What is notable was that the eviction process continued in parallel throughout the criminal investigation. To some extent officers were constrained by the statutory framework within which they operate but nevertheless the Review Team were surprised that the process continued. The death of her daughter coupled with the criminal investigation would have had a considerable impact on the tenant's ability to comply with the process.

Findings

FINDING 1

In Reading, the Multi-Agency Pathway for non-engagement is not consistently followed, with the consequence that multi-agency perspectives and resources are not brought to bear when previously-managed risk becomes less controllable.

SUMMARY

Reading has substantial numbers of adults who are either vulnerable or at risk, and who do not engage with services. Whilst this Safeguarding Adults Review was under way, the Safeguarding Adults' Partnership revised and re-launched an existing pathway to try and increase the likelihood of professionals, led by a senior practitioner, thinking collectively about possible new solutions in each instance of non-engaging adults where risk starts to increase. If practitioners and their managers are not familiar with the pathway, it cannot drive improvements.

Questions

- How do practitioners view the issue of non-engagement? How much of a block and a risk is it to the local safeguarding adults' system?
- What attempts have there been to tackle the safeguarding risks that can come with non-engagement?
- How can the development of the Multi-Agency Safeguarding Hub promote earlier professionals' meetings?
- How do we empower practitioners to make decisions about service users?

FINDING 2

Assessment tools cannot predict the impact of the eviction process, which results in years of preventative work being swept aside in response to a crisis.

SUMMARY

Numbers of evictions are growing nationally and there is insufficient understanding of the impact of eviction on vulnerable adults. This is particularly concerning because despite recognition that the boundaries between antisocial behaviour and safeguarding are blurred, it is hard to find any analysis of existing assessment tools and how they can predict the effects of eviction on adults with vulnerabilities.

Questions

- Do Board members know of any examples of assessment tools that can help predict the impact of eviction on vulnerable adults?
- How will the Care Act 2014 be implemented, particularly around prevention?
- What can be done to encourage multi-disciplinary assessments in line with the practice seen in the case at the centre of this Review?

FINDING 3

When agencies with different drivers are all working with a complex family, managerial panels do not always have their intended effect and vulnerabilities get lost

SUMMARY

The Review Team examined the role of the various managerial panels in Reading. For many cases these are working effectively to manage risk. However some agencies are either referring too late or not at all which means that safeguarding risks are not being anticipated and managed, and this is a heightened risk if certain panels receive the bulk of their referrals from the agency that convenes them.

Questions

- How can agencies ensure that workers refer early to panels?
- Are the criteria for referral clearly understood?
- Could referral sources to each of the panels listed above be explored, to see if the patterns mean that some cases are not being referred at all?
- How can the use of panels improve joint working between agencies?

FINDING 4

Are chaotic childless families losing out because there are fewer tools or mechanisms such as the Troubled Families initiative for professionals to use compared to when a child is present, leading to less alternatives for those adults?

SUMMARY

The risk in the safeguarding system is that when professionals in adult services are focussed on individuals (as set out in Finding 6), and in addition, lack the resources that come with programmes like Troubled Families, those professionals are more likely to struggle with services and solutions for the chaotic childless families, who according to the Case Group, are becoming an ever larger cohort within their caseloads.

Questions

- What learning from the Turnaround Families programme can be transferred across to vulnerable adults without children, whose antisocial behaviour is problematic for all agencies?
- Do agencies think a 'think family' approach is important?
- How can we reconcile the tension between focus on the service user and consideration of their wider family's needs, particularly in complex situations?

FINDING 5

Young and assertive service users are less likely to be seen as vulnerable, even in the face of known risk factors, and this has the consequence that crises are missed.

SUMMARY

The way some individuals present may preclude their being judged as vulnerable. Ms F had particular vulnerabilities due to events in her life, and for professionals working with adult service users, it is a complex task to assess what different sorts of vulnerabilities lie behind the way in which young and assertive service users present. Understanding and responding to those vulnerabilities might reduce the risk of a distressing crisis for

that young person in the future.

Questions

- When do you have to intervene?
- How can we ensure a shared understanding of what constitutes vulnerable?
- Do workers understand the impact of obesity on Mental and physical health?
- How can we skill staff up to allow them to differentiate between 'vulnerability' they perceive but cannot use to ensure support through Adult Social Care?
- Do practitioners understand the impact of situational incapacity?

FINDING 6

Assessment for adults is about individuals, without scope for focussing on co-dependent needs, which means services struggle to understand patterns of need and behaviour amongst co-dependent groups of adults.

SUMMARY

Assessment is a crucial opportunity to understand the world of an adult service user, and most families have interdependencies of some kind which it could be fruitful for assessment to explore. Doing this consistently, perhaps considering what approaches have been effective in children's services, enables professionals to understand risks that otherwise are not made transparent.

Questions

- How can we provide young people with a self-protection strategy when they live in chaotic household?
- How can staff balance being inquisitive about households and being driven by the process of individual assessment?
- Should agencies begin to map adult households with multiple needs in the same way as the troubled Families Programme has mapped households with children?