Summary Report

Safeguarding Adult Review

AA and BB 2018

Introduction

Firstly, my thoughts are with everyone affected by these tragic circumstances.

The London Borough of Hillingdon commissioned an independent Safeguarding Adult Review in 2017, and while it is very difficult and sad to read the details outlined in the report, the Safeguarding Partnership is grateful to the independent report author, Steve Chamberlain, and to everyone involved in this review for their commitment and transparency in ensuring that the recommendations were established.

The Safeguarding Partnership accepts the recommendations and as this report outlines, we have ensured that they have been used to learn lessons and underpin practice improvement across our local partnership to optimise the safety, wellbeing and quality of life of our residents.

Claire Solley

Chair, Hillingdon Safeguarding Adult Board

1. Context

In 2018 Hillingdon Safeguarding Adult Board published a Safeguarding Adult Review in respect of AA and BB. The report explored the care and support provided to two co-tenants who shared a house for seven months in 2015 and received 'floating support' from an independent provider organisation. In this period there were increasing difficulties in the relationship between AA and BB, culminating in AA stabbing BB in November 2015. BB sadly did not

survive. AA was later convicted of manslaughter on the grounds of diminished responsibility and detained under the Mental Health Act (1983).

Hillingdon Safeguarding Adult Board commissioned an independent author, Steve Chamberlain, to review the support provided to both AA and BB. This concluded with a thematic analysis and series of recommendations for safeguarding practice across local agencies. These recommendations have recently been revisited in order to evidence that the learning from this tragic case has been fully embedded into practice. The report explicitly acknowledges that there was no one single factor in isolation that influenced the outcome, but that the complex interaction with one another was significant.

The purpose of this report is to provide reassurance to the Hillingdon Safeguarding Adult Board that the recommendations of this Safeguarding Adult Review have been addressed and that there have been the necessary changes within multiagency safeguarding practice. This report will not duplicate the full circumstances as set out in the Safeguarding Adult Review, nor the detail contained within the action plan. As with any review of safeguarding practice the AA BB review noted the intersectional nature of the themes identified, consequently it is inevitable that there will be some crossover between the identified themes and recommendations.

This narrative report is based upon information and evidence provided by:

- The London Borough of Hillingdon Adult Social Care
- The London Borough of Hillingdon Housing Department
- Hestia (Service Provider for Floating Support at the time of the incident)
- Ability (Current Service Provider)
- Central and North West London NHS Foundation Trust

2. Thematic Analysis

2.1 Systems and Processes

The Safeguarding Adult Review made a number of recommendations with regard to the systems and processes that were in place in 2015 and the contribution of these to the tragic death of BB. Specific recommendations were made around the arrangements for the allocation of housing, supported accommodation and the Zoning Protocol. In revisiting the action plan it is evident that agencies have responded to the concerns identified and made the necessary changes within the existing safeguarding systems.

A key area of practice change is the development of the Hillingdon Joint Adult Complex Care Panel. This Panel is responsible both in the consideration of individual applications for funding of placements, and in the provision of a reviewing and monitoring system to ensure that treatment and care packages continue to meet assessed needs. This function enables proactive decision making around the effectiveness of care and support plans, with the early identification of any developing issues at a six week review. In 2015 BB was able to access supported housing without a Care Act Assessment and Care and Support Plan being in place. This is no longer possible; any application for supported housing is considered via the Complex Care Panel with minimum requirements in terms of formal needs assessment.

The 2015 practice of allocation of housing on the basis of vacancy, rather than with specific regard to needs assessment, is also addressed through the formation of the Complex Care Panel. The terms of reference for the Panel specifies that decisions on the appropriateness of a placement are based on the specialism and best fit for the individual, including consideration of any impact on other clients already in residence. This approach significantly reduces the likelihood of incompatible matching between individuals, and promotes the importance of consideration of any risks that one individual may pose to another. In response to the issues raised in the SAR adult social care have undertaken a coordinated review of care and support provided to all adults who receive floating support services and live in shared

accommodation. Following a Care Act Assessment alternative accommodation has been identified and residents have been moved on to more appropriate supported housing.

2.2 Knowledge and Understanding of Safeguarding

The Safeguarding Adult Review identified missed opportunities for a safeguarding adult referral in respect of AA's vulnerability to financial abuse and exploitation. Practitioners working with AA did not identify this as a safeguarding concern, nor was a safeguarding referral made in respect of the risks AA posed to BB.

In line with the Department of Health Care and Support Statutory Guidance all agencies providing support to adults have a responsibility to ensure that safeguarding practice with adults is compatible with the principles laid out within Making Safeguarding Personal. Namely that safeguarding adults:

- is person led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety

The Hillingdon Safeguarding Partnership commissions' multi-agency safeguarding training for practitioners, this is in addition to that training provided by individual agencies to employees.

Where care and support is delivered by provider services there is a Contract Management Schedule in place. This provides a framework for the identification of any developing safeguarding concerns, all providers are subject to the London Borough of Hillingdon Contract Management Schedule. Point 10.3 of the Schedule states that: *The service provider must have a Safeguarding Adult Policy and this must complement the LondonADASS Multi –agency Safeguarding Policy and Procedures*. The Contract Management Schedule further mandates a requirement for providers to ensure that all staff have training in recognising and responding to safeguarding concerns, and specifies to

providers the requirement to nominate named/designated safeguarding leads and to report safeguarding concerns. Compliance with this Schedule is monitored at quarterly meetings, enabling quality assurance of the provider response.

2.3 Needs and Risk Assessment

The importance of dynamic and thoughtful risk assessment is a central theme of the Safeguarding Adult Review. There was substantial evidence of AA's propensity for aggressive and intimidating behaviour towards his family members, and towards professionals. It was also known that AA had begun to keep a knife in his room. There is some evidence of a consideration of the potential risk that this posed to BB, however this did not result in action to reduce the risk.

Progress has been made in raising awareness of when to refer for a social care assessment through a programme of training with local authority housing staff. Central and North West London NHS Foundation Trust staff undertaken mandatory training in Clinical Risk Assessment. The Trust has a comprehensive and evidence based Clinical Risk Assessment and Safety Planning Policy in place, with clear guidance for staff around the timing, content and sharing of risk information. This policy includes a precis of the knowledge base around those factors that are likely to increase risk and guidance for staff around analysis and risk assessment.

A specific recommendation was made for CNWL around the administration of the Zoning protocols, this was addressed internally in the immediate time period following the SAR, with all staff alerted to the need to ensure clear recording of risk assessment and analysis that underpinned decisions around zoning.

The Adult Social Care Quality Assurance Process has been revised and now includes a routine audit programme for those individuals who are accessing support from the mental health team. This provides an additional level of scrutiny around the robustness of safeguarding practice in this service.

In 2015 Hestia was commissioned to provide floating support services, as an outcome of the Safeguarding Adult Review Hestia reviewed all relevant policy and procedures to ensure that learning around needs and risk assessment practice was embedded. Whilst Hestia is no longer providing floating support in the London Borough of Hillingdon they have contributed to this review and provided copies of police and procedure that clearly demonstrates developments in safeguarding practice, including specific risk assessment to consider any risk between individuals accessing support.

2.4 Communication and Information Sharing

The Safeguarding Adult Review made specific recommendations in respect of communication between, and within, agencies around risk and highlighted the challenges in achieving the appropriate balance between ensuring the individual's confidentiality with the need to share information to ensure effective risk management. These recommendations covered key areas of additional pressure; on making a placement, in handover between staff within agencies, and at the point of discharge where AA had required inpatient hospital care.

The formation of the Hillingdon Complex Care Panel provides a structure within which communication and information sharing is prioritised throughout the process of agreeing need and identifying a suitable provision. Prior to any placement being made the assessment, risk assessment and care and support plan is shared with the provider, taking into account General Data Protection Regulations. The purpose of sharing the assessment is to enable care providers to have access to comprehensive information in respect of the individual's support needs to determine the suitability of the placement. On this basis providers are provided with the information they need to inform assessment as to their capacity to meet the individual's needs in addition to consideration of the potential for conflict/risk between residents.

In reviewing the implementation of the 2018 recommendations the Safeguarding Partnership has been provided with examples of comprehensive transfer summaries that are completed as a requirement when assigned workers change within mental health services. Ability, the existing provider of floating support service use a template that is completed by staff at the end of each shift to ensure that there is effective handover of information.

The Safeguarding Adult Review found that communication between inpatient services and community teams in relation to discharge from hospital had not been effective in the planning stage, and did not follow CPA procedures. The Central and North West London Foundation Trust has a newly updated discharge and planning policy that incorporates the areas of learning identified. Hospital and community staff are provided with a clear framework around best practice for discharge.

Whilst it did not result in a specific recommendation the SAR highlighted that there had been one occasion where the police had been aware of escalating hostility in the relationship between AA and BB. BB had informed an officer than she and BB did not get along, that they had been arguing all day and she felt they should not be housed together. The current Chair of Hillingdon Safeguarding Adult Board has highlighted that this is an area not addressed within the recommendations or resultant action plan, therefore it has not been considered as part of the review of practice improvement recently undertaken. The Safeguarding Adult Board has an escalation process in place, therefore this issue can be further considered within this framework.

3. Next Steps

In 2020 Hillingdon Safeguarding Adult Board has adopted the Safeguarding Partnership model of service delivery, this reflects a strategic undertaking from the police and Clinical Commissioning Group to multi-agency safeguarding practice. The following shared priorities have been agreed:

- Working collaboratively (taking a 'whole system approach') to raise awareness and minimise the risk of abuse, neglect and self neglect; and to ensure our response is timely, proportionate, effective and in accordance with the six key principles of safeguarding adults when it does occur.

- Making Safeguarding Personal: The individual's views are central to any decision making (taking mental capacity, public interest and coercion and control into account) and any activity undertaken supports the outcome(s) the individual wants to achieve.

- To ensure the voice of the adult, their carers, their family, local data, learning from reviews, best practice guidance, emerging research and changes in legal frameworks underpin practice and service development.

- To evidence the effectiveness of single and multi-agency safeguarding arrangements and satisfy the Hillingdon Safeguarding Adult Partnership that the safety, wellbeing and quality of life of adults with care and support needs is optimised.

The Safeguarding Adult Board will continue to scrutinise the effectiveness of safeguarding practice across the multiagency partnership, providing challenge and support where required. Under the new arrangements Safeguarding Learning Events will be held to provide frontline practitioners with advice, information and guidance around key practice issues. This will includes those areas of safeguarding practice that, sadly, are often identified as areas for development in statutory and non-statutory reviews and have been highlighted above as thematic issues.

Hillingdon Safeguarding Partnership remains committed to ensuring the safety and wellbeing of adults with care and support needs, and to embedding the learning from this Safeguarding Adult Review into practice.

Hillingdon Safeguarding Partnership

August 2020