Hillingdon safeguarding adults board

SAFEGUARDING ADULT REVIEW

Carol

Contents

Introduction

The purpose of this Discretionary Safeguarding Adults Review is to identify systemwide learning in respect of Carol, following concerns about unmet care needs and delays in access to care.

Carol passed away at 77 years old. At the time of her death she was in hospital, but prior to this she had been at home, and this is where there are concerns about unmet needs, which have informed the decision to undertake this SAR pursuant to section 44 of the Care Act 2014.

The agencies who have contributed information to the review are:

- London Borough of Hillingdon Adult Social Care
- The Metropolitan Police Service
- The Hillingdon Hospital NHS Foundation Trust
- GP
- London Ambulance Service
- Central and North West London NHS Foundation Trust

Other agencies were asked for information but had no knowledge of, or history of contact with, Carol. The input and view of family members has been sought.

Methodology

- Desktop review of all available documentation.
- Interviews with family members.
- Meetings with frontline practitioners and operational managers.
- Police undertook an internal review of the criminal investigation.

Reviewers

The Safeguarding Partnership Team led the review alongside suitably independent representatives from the key statutory partners: London Borough of Hillingdon, Metropolitan Police Service, and the North West London Integrated Care Board.

Statement of Good Practice

The approach taken within this review has been proportionate to the issues arising; led by individuals who are independent of the practice and decisions made for Carol both before and after her death. Relevant professionals have been consulted without fear of blame. Family members have been invited to contribute. The review has been undertaken in line with the SAR Quality Markers as developed by the Social Care Institute of Excellence.

Criminal (and other) proceedings

There are no ongoing criminal proceedings relating to Carol.

Carol

Carol was a 77 year old and a white female. She lived with her partner of 35 years. Carol had been married previously and had a son from this previous relationship, and she was close to her grandson. In her younger years she had worked in a café and been a sociable and outgoing person. Carol had also been a carer for her mother for some years. Carol had siblings but had very infrequent contact with them. She reportedly became reluctant to have visitors in her later years and became isolated and dependent on her partner.

Carol's family have indicated that they believed she had dementia for at least a year prior to her death. However, there was no formal diagnosis. Carol's family were concerned about her ability to meet her personal care needs. During the summer of 2021, family members had noticed poor home conditions, weight loss, and that she had sustained bites from her dog.

Circumstances of Concern

Carol's partner called an ambulance when she became unresponsive. On attendance paramedics found that Carol was in a very poor condition, with her physical presentation supporting an assessment that she had been seriously unwell for some time and that her care needs had not been met. The ambulance crew transported Carol to hospital where she was admitted to intensive care. Despite the care and treatment provided, Carol did not recover.

Reflections on Professional Activity Prior to Admission to Hospital

Information about professional activity was taken both from reviewing the documentation on the social care database, an interview with Carol's family, and reflective meetings with practitioners.

There was good practice identified prior to Carol's admission to hospital. A housing officer made a home visit in June 2021 and, observing concerning indicators of neglect or self-neglect. She promptly raised a safeguarding concern through appropriate channels.

The Multi Agency Safeguarding Hub responded with appropriate standardised checks and liaised with the housing officer and Carol's partner. The concerns raised by the housing officer were appropriately identified as a care management issue and passed to the relevant locality social work team. A social

worker was allocated in July 2021. At the point of allocation, the manager reviewed the notes, directed the social worker to do the same and provided basic direction.

Alongside these examples of good practice there were opportunities for development identified through the review process:

- Proportionate assessment, including partnership working, critical thinking and challenge
- Reflective supervision
- Lived Experience, including signs and indicators of coercive control
- Application of the Mental Capacity Act 2005
- Carers assessment

Reflections On Professional Activity After Admission to Hospital

Information to inform analysis of the service responses after Carol's admission to hospital has been gathered through review of documentation and a reflective discussion with social care, police and hospital-based professionals.

There was an array of good practice apparent at the point of Carol's admission to hospital. The London Ambulance Service, Hillingdon Hospital, Adult Social Care and the police all acted swiftly and appropriately to meet Carol's immediate needs, share and collate information, and initiate both a criminal investigation and a Safeguarding Enquiry. The clinical response to Carol was swift and of good quality.

The Safeguarding Enquiry ran from October 25th 2021 until May 2022. The conclusion was that the allegation of neglect was unsubstantiated. The police Investigation ran from 23rd October to 22nd November 2021. There were no charges brought.

Several opportunities for development were also identified through the review process:

- Partnership working in the safeguarding enquiry
- Purpose of the safeguarding enquiry
- Advocacy and involvement, including family engagement
- Management oversight – the role of the Safeguarding Adults Manager
- Criminal investigations of neglect

Key Areas of System Learning

It is impossible to know whether changes in practice would have materially affected the circumstances that led to Carol's death. However, there are overarching areas of system learning that emerged through analysis of the professional practice with Carol both before and after her admission to hospital:

- Lived experience
- Supervision and management oversight
- Legal literacy
- Partnership working

Lived Experience

Effective assessment of needs and risks, and effective safeguarding, requires proactive consideration of the lived experience of adults and their families. It is important for professionals to be curious about and critically reflect on the meaning and implications of all the information available to them about the day to day lives and feelings of adults and their families. This needs to include the lived experiences of carers, as well as cared for, people.

Professionals need to have assessment skills that go beyond questions and answers. Assessments need to involve the exploration of contradictions and inconsistencies between what they are being told by different sources, including the differences between what they are being told and what they observe.

Training and supervision should promote a culture of reflecting on and attending to the lived experience of people receiving assessment, support services and safeguarding interventions.

Supervision and Management Oversight

Safeguarding partners should promote a working culture that values use of self, critical reflection and professional curiosity. Assessment of needs and risks must include critical reflection on the information received, and the use of respectful uncertainty when people appear to be making claims contrary to that which is observable. Practitioners should be supported by managers and supervisors to critique and challenge where necessary and any difficulties with doing so should be a focus of professional development and support.

Effective and skilled supervision is important to enable practitioners to critically reflect on their feelings and experiences during encounters with service users. Supervision needs to promote a culture of openness and support for practitioners, which values curiosity, sensitivity and lived experience to ensure practitioners are equipped and supported to meaningfully engage in complexity and challenge.

Legal Literacy

There is a need to improve legal literacy across all involved safeguarding partners.

Mental Capacity Act 2005

The application of the Mental Capacity Act 2005, particularly in relation to the presumption of capacity was highlighted as an issue in this review. There is an opportunity to review the quality of training and staff awareness and knowledge of best practice in this area. This could include increased use of the Safeguarding Partnership briefing on applying the Mental Capacity Act.

It may also be valuable for police to promote awareness amongst officers of offences under section 44 of the Mental Capacity Act and consider issuing training or practice guidance to increase confidence and knowledge in this area.

Care Act 2014

Even where someone declines a needs assessment under s.9 of the Care Act, their carer is still owed a duty under s.10 of the Care Act. Social workers should ensure that the duties under s.10 are discharged, and any refusal of carers assessment should be clearly documented. There is an opportunity to promote awareness of this duty. There are clear prompts within standard assessment forms used by practitioners, which reduce the risk of the duty being overlooked, but in situations where an adult refuses an assessment of need there is a higher risk of the carer's rights not being fulfilled because the standard form, with prompts, is not used. There is an opportunity to explore alternative ways to ensure compliance with section 10 in such situations.

Section 67 and 68 of the Care Act 2014 governs the duties to arrange an independent advocate, unless there is an appropriate person amongst friends and family, to support the involvement of an adult in an assessment of need and a safeguarding enquiry, respectively.

The Care and Support Statutory Guidance stipulates that a *"Local Authority must...arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry... where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them"* (paragraph 14.10); and "*It is*

the local authority's decision as to whether a family member or friend can act as an appropriate person to facilitate the individual's involvement."(paragraph 7.40)

In order to make a decision about whether an advocate is needed there needs to be active consideration of the suitability and appropriateness of friends and family members to support an adult's participation in an assessment or safeguarding enquiry. Sections 67 and 68 are relevant even when the adult has died. There is an opportunity to promote awareness and confidence amongst social workers in discharging these duties and explore barriers for practitioners in discharging these duties.

An enquiry pursuant to section 42 of the Care Act was undertaken after Carol had died. This brought uncertainty and confusion amongst practitioners about the purpose and scope of the enquiry.

An adult at risk is defined by section 42 Care Act 2014 as an adult who:

- has needs for care and support
- 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 either the risk of, or the experience of abuse or neglect.

An adult who is deceased is no longer experiencing, nor at risk of, abuse or neglect. The purpose of the enquiry, as set out in section 42 of the Care Act 2014, is to enable the Local Authority to decide whether any action should be taken in the adult's case. After Carol had passed away there was no action the Local Authority could take *in her case*.

There was, however, potential learning about how safeguarding partners had worked together to safeguard her prior to her death. There is a decision to be made locally about whether enquiries pursuant to section 42 are the most appropriate framework in which to explore potential system learning when someone has died.

It is necessary to ensure that there is clarity for practitioners about the purpose, remit and expectations of safeguarding enquiries pursuant to section 42 where there is good reason from the outset to believe that section 44 of the Care Act may apply; or, where an adult has died and there is no remaining public interest, such as concern over neglect by a care provider or risk to other people dependent on the person alleged to have caused harm.

Partnership Working

Partnership working to prevent, identify and respond to risks faced by adults with care and support needs is required by the Care and Support Statutory Guidance, and within the London Multiagency Adult Safeguarding Policy and Procedures. Cooperation of partners is required by section 7 of the Care Act 2014 which stipulates: "*Where a local authority requests the co-operation of a relevant partner, in the case of an individual with needs for care and support… the partner… must comply with the request."* This applies to both assessments and safeguarding interventions.

Partnership working requires professionals to work with each other and with adults and their families. It supports effective and timely sharing of information, builds a shared understanding of risks and responsibilities, pools professional expertise. The factors increase the professional network's ability to effectively prevent, identify and respond to potential harms. A key to effective partnership working is thorough exploration of differences of opinion and giving sufficient weight to third party sources of information, such as referrers and family members.

Within a safeguarding enquiry pursuant to section 42 of the Care Act 2014 the Local Authority has the responsibility to coordinate partnership working with all relevant parties. In this enquiry, the relevant parties were Carol's family, the police, Adult Social Care, the GP and the hospital.

There is an opportunity locally to understand and address the barriers to effective partnership working both in terms of working with family members and between organisations, with a particular focus on the barriers to partnership working between police and Adult Social Care.

Review of the working culture, attitudes, and performance monitoring around the use of multiagency planning meetings and ongoing engagement of partners in safeguarding enquiries would be beneficial.

There is an opportunity to promote the value of partnership working and encourage pro-active communication and information sharing between professionals during assessments and safeguarding enquiries.

There is an opportunity to increase awareness and use of the Safeguarding Partnership Escalation Policy amongst safeguarding professionals.