Hillingdon Safeguarding Partnership

Executive Summary Report

Safeguarding Adult Review

Ms Stitch

Independent Report Author: Allison Sandiford

Contents

1. Introduction

1.1. The subject of this Safeguarding Adult Review is Ms Stitch. Ms Stitch (who has a diagnosis of a neurodegenerative disease) suffered serious harm due to physical abuse perpetrated by two adults who were known to her. This abuse took place in a context of cuckooing and exploitation. Ms Stitch has thankfully not died, but it is believed that she could have, had a family member not found her and contacted the emergency services when they did.

1.2. At a meeting in April 2024, those present at the Safeguarding Adults Review Panel for Hillingdon Safeguarding Adults Board unanimously agreed that because Ms Stitch is an adult who has experienced serious abuse, and there is concern that partner agencies could have worked together more effectively to protect her, the criteria was met[1] for a mandatory Safeguarding Adult Review under The Care Act 2014.

1.3. The purpose of a Safeguarding Adult Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for this case should be applied to future cases to ensure continuous improvement of practice. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

1.4. This report has been authored by Allison Sandiford. Allison gained experience in safeguarding both adults and children whilst working for a police service. Allison was part of a team responsible for the force's

[1] Safeguarding Adults Reviews
(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.
(2) Condition 1 is met if—
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

contribution to delivering Early Help, preventive support and problem-solving interventions in partnership with other key local and regional agencies. She represented the force at strategy meetings and protection conferences to assess risk and negotiate actions with other agencies to instate interventions to safeguard individuals' lives. She also gained experience in chairing meetings, conferences, and partnership initiatives such as daily management risk meetings and Multi-Agency Risk Assessment Conferences. In 2019 Allison completed the SILP Lead Reviewer Course[2] and has since conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews. Allison has a positive attitude to continuing professional development and regularly attends training and seminars.

2. Confidentiality

2.1. To protect the identity of the individuals involved, the subject of this review is referred to under the pseudonym, Ms Stitch.

2.2. Once agreement for the final report has been given by the Hillingdon Safeguarding Adults Board and its partner agencies, an Executive Summary Safeguarding Adult Review report will be available on the Board's website.

2.3. Upon publication, partner agencies will be made aware, and the action plan will be shared with the agencies involved.

2.4. The review has been assured by Hillingdon Safeguarding Adults Board that the learning will be disseminated via the publication of a high-level summary, focussed on learning, and protecting anonymity, with the recommendations being progressed in the cuckooing and exploitation subgroup.

3. Methodology

3.1. Whilst completing this review, the Independent Reviewer has considered the SCIE Quality Markers and applied the principles of proportionality, learning from good practice, and engagement with families.

[2] SILP is an approach to reviewing cases in the context of Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and any other form of learning activity.

3.2. Following the receipt of agency chronologies and independent reports, an initial scoping and first panel meeting[3] was held in July 2024. This was followed by the completion of supplementary agency reports, and the panel met on two further dates to monitor the review process and contribute to the analysis and learning.

3.3. Frontline professionals[4] reflected upon their practice in a practitioner learning event which convened virtually in September 2024.

4. Terms of Reference

4.1. At the scoping meeting, the panel identified the following key lines of enquiry for the review:

- What did agencies understand of Ms Stitch's lived experience?
- What do professionals understand of exploitation/cuckooing?
- Explore any signs / indicators that Ms Stitch was experiencing financial abuse / cuckooing / sexual exploitation?
- What pathways and processes were available to professionals to manage the risk? And what did the professional response look like?
- Did services recognise and understand the effect of any co-dependency between Ms Stitch and her suspected abusers? And what was known about the perpetrators of Ms Stitch's abuse?
- What was understood by services about Ms Stitch's recognition of risk of financial abuse, exploitation and cuckooing?
- Explore the use of language in recording and assessment
- What effect did the Covid pandemic have on services and how can remote assessment affect practice?
- Identify areas of positive practice

5. Involvement of Family and Wider Community

5.1. Ms Stitch, and two of her closest relatives were notified of this review by Hillingdon Safeguarding Adults Board and invited to participate.

[3] See Appendix 1 for panel membership.
[4] See Appendix 2 for details.

5.2. The subjective experiences of support and services provided, is an important aspect of the Safeguarding Adult Review process and the Independent Reviewer would like to thank Ms Stitch for agreeing to meet with her and thank her relatives for agreeing to meet with the Head of Safeguarding Arrangements from Hillingdon Safeguarding Partnership.

5.3. Miss Stitch's and her family's invaluable contributions are woven into the body of the report.

6. Parallel Reviews

6.1. Following a criminal investigation, the perpetrators of Ms Stitch's abuse were sentenced to imprisonment.

7. Equality and Diversity

7.1. The Independent Reviewer has considered the protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation).

7.2. Ms Stitch, a white British cisgender female follows the Christian faith. There is no evidence that her religion is a relevant factor in this case.

7.3. Ms Stitch lives with a neurodegenerative disease. This an inherited[5] condition that over time, stops parts of the brain working properly. It causes progressive physical, cognitive (thinking) and psychiatric symptoms. The physical symptoms include increasing balance, coordination and mobility difficulties and speech and swallowing problems and the psychiatric symptoms include depression, anxiety, apathy and irritability. The cognitive changes include increasing difficulties with planning, organising and concentrating and people become impulsive and lack insight, making it difficult for them to understand risks and consequences of their own and others' actions. People find it increasingly harder to take on new information and make informed decisions.

7.4. There is no cure, nor is there any way to stop it from worsening. Consequently the needs of an individual living with this disease change over time; and full time nursing is needed in the later stages of the condition.

[5] Very occasionally, it's possible to develop XX disease without having a history of it in your family. But this is usually because one of your parents was never diagnosed.

7.5. People living with neurodegenerative illness may be viewed as targets for exploitation and abuse because of their care and support needs, and the impact of the disease on their ability to protect and defend themselves. Ms Stitch's increasing dependence on others for support with her healthcare needs and daily living, created opportunities for exploitation to take place which her cognitive ability and memory problems made it challenging for her to understand.

7.6. In the year ending March 2019, the Office for National Statistics Crime Survey for England and Wales 'Disability and Crime[6]', found that almost 1 in 4 (23.1%) disabled adults aged 16 years and over experienced crime, compared with 1 in 5 (20.7%) non-disabled adults.

7.7. In the three years ending March 2018, 3.7% of disabled adults aged 16 to 59 years experienced any sexual assault (including attempts), compared with 1.9% of non-disabled adults.

7.8. Ms Stitch is a survivor of mate crime, cuckooing, and financial exploitation, and has reported sexual abuse from an ex-partner.

8. Conclusions, Lessons to be Learnt and Recommendations[7].

8.1. Ms Stitch is an individual who lives with a learning difficulty and neurodegenerative disease.

8.2. Ms Stitch:

- has a supportive family,
- was (during the scoping period of this review) in receipt of a package of care, and
- often informed professionals of 'friends' who were also helping her with her care needs.

8.3. Despite this, home conditions were sometimes a concern and her finances were mismanaged. In addition, though Ms Stitch was open and engaged with professionals, she would often cancel appointments or 'miss' them. Ms Stitch was assumed to have the mental capacity to make her own decisions in relation to aspects of her care but there is no evidence of her executive functioning being considered.

[6] The latest release of published data on disability and crime in the UK and analysis of the experiences of domestic abuse and sexual assault for disabled adults aged 16 to 59 years in England and Wales. Analysis by age, sex and impairment type.
[7] By way of questions.

8.4. A lack of multi-agency working effected no single agency gaining a full overview of Ms Stitch's circumstances.

8.5. By the time the perpetrators of Ms Stitch's abuse moved into her home, the presence of 'friends' for support and 'missed' or 'cancelled' appointments had become Ms Stitch's 'norm'. This effectively stifled professional curiosity into Ms Stitch's circumstances and professionals accepted her withdrawal from their services, which granted the space for the perpetrators to conduct their horrific abuse.

8.6. The lessons learned from this Safeguarding Adult Review commissioned by Hillingdon Safeguarding Adults Board are:

1. Understanding Ms Stitch's lived experiences would have helped professionals to identify Ms Stitch's level of dependency on 'friends', and the risks of exploitation and abuse faced by Ms Stitch.

2. As a result of agencies not sharing information, or of understanding Ms Stitch, no agency ever gained a full awareness of Ms Stitch's lived experiences or barriers to accessing support.

3. It is important that safeguarding training for professionals includes a thorough understanding of how to identify cuckooing and exploitation behaviour and incorporates strategies to support victims.

4. Information known by professionals historically, did not get carried forward into later decision-making or assessments, thereby preventing effective risk management.

5. It became accepted behaviour for Ms Stitch to cancel and/or miss appointments and no agency/organisation escalated this to be a concern.

6. It is important to assess an individual's mental capacity to make financial decisions whenever there are concerns of financial exploitation.

7. Capacity guidance needs to include a prompt to consider executive impairment and because it is a complex area of work, advise how to seek further support on the subject and escalate concerns.

8. Because telephone communication made it hard to understand and recognise Ms Stitch's circumstances, robust professional curiosity was essential to aid professional assessment of risk.

9. The challenges and barriers to professional curiosity continue.

10. In the absence of a section 42 enquiry, Ms Stitch's immediate crisis was effectively addressed, but her ability to stay safe and well in the long term remained unassessed.

11. Ms Stitch's circumstances have highlighted the need to not assume that an individual who offers support and care, will be appropriate.

12. Not all professionals understand that they do not need to wait for the section 42 enquiry threshold to be reached before convening a multi-agency meeting, and that accumulating concerns such as struggles to engage and access an individual are enough.

13. An abuser will present themselves as 'caring individuals' to outsiders, but will isolate their victim using physical violence, and emotional and financial abuse, to achieve subordination and entrapment.

14. The language professionals use when recording in case notes can influence future assessment.

8.7. Panel agreed that all of the learning points are linked by common practice themes. Those being,

- the application of professional curiosity,
- the coordination of an individual's care,
- the quality assurance of assessment,
- the consideration of Executive Functioning in Mental Capacity assessment
- the choice of language in case notes / records, and
- a professional's understanding of exploitation.

8.8. In relation to the latter, this review is assured that this is being addressed through the Adult Exploitation and Cuckooing Subgroup which has been established to develop (and seek assurance about) systemwide activity to prevent, identify, and respond effectively to the exploitation and cuckooing of adults with care and support needs.

8.9. The following recommendation questions will support the improvement of practice within the other practice areas:

1. How can agencies assure Hillingdon Safeguarding Adults Board that their team leaders/managers/supervisors are trained and supported to quality assure assessments*, promote professional curiosity and recognise when (in the absence of safeguarding thresholds having been reached) to advise staff to convene a professionals meeting?

*** Assessments must**

- **incorporate historic information,**
- **have gathered and analysed appropriate information from all relevant sources, and**
- **include the subject's voice.**

2. How can Hillingdon Safeguarding Adults Board and partner agencies develop a wraparound multi-agency forum (within their existing services across all agencies) that will provide a co-ordinated professional approach to support members of the Hillingdon community who live with complex or uncommon health conditions?

3. How can agencies assure Hillingdon Safeguarding Adults Board that the Mental Capacity practice briefing has been included within their agency training packages across all aspects of their service?

4. How can agencies evidence to Hillingdon Safeguarding Adults Board that professionals across all aspects of their services are being prompted to consider Executive Functioning when considering an individual's' mental capacity?

5. How can agencies evidence to Hillingdon Safeguarding Adults Board that they are prompting and encouraging their professionals to be professionally curious, and how can Hillingdon Safeguarding Adults Board gain an improved understanding of how to support agencies with this practice?

6. What guidance can Hillingdon Safeguarding Adults Board develop to support professionals to choose best language when recording within case notes?

7.1.1. The review would ask Hillingdon Safeguarding Adults Board to deliberate these questions which identify where improvement to systems and practice is required.

7.1.2. It is the responsibility of Hillingdon Safeguarding Adults Board to use the ensuing debate to model an action improvement plan to support learning.

9. Appendix 1

The Review Panel Members

- Independent Reviewer
- Representative(s) from the:
    - Safeguarding Partnership
    - Metropolitan Police Service
    - Integrated Care Board
    - Central and North West London Mental Health Services
    - The Home Care Provider
    - Central and North West London Community Services
    - The Hillingdon Hospital
    - University College London Hospitals NHS Foundation Trust
    - London Borough of Hillingdon Housing Services
    - London Borough of Hillingdon Mental Health Services
    - XX Disease Association
    - Central and North West London Safeguarding and MCA Specialist
    - London Borough of Hillingdon Adult Social Care

10. Appendix 2

Practitioner Learning Event

A virtual learning event was held and attended by the:

- Representative(s) from the:
    - Safeguarding Partnership
    - Metropolitan Police Service
    - Central and North West London Mental Health Services
    - The Home Care Provider
    - Central and North West London Community Services
    - The Hillingdon Hospital
    - London Borough of Hillingdon Housing Services
    - XX Disease Association
    - London Borough of Hillingdon Adult Social Care
    - University College London Hospitals NHS Foundation Trust