Safeguarding Adults Review 'PETER'

Executive Summary Report
September 2022

Lead Reviewer: Fiona Bateman
Independent Safeguarding Consultant,
Safeguarding Circle

1. Introduction

1.1 Surrey Safeguarding Adults Board ['SSAB'] agreed to commission this Safeguarding Adult Review ['SAR'], following the death of an adult with care and support needs, who fell from a train platform. For the purposes of anonymity and at the request of his family he is known within this review as 'Peter'. The SSAB believed the case met the mandatory criteria under s44 Care Act 2014 for a review, given what was known about the risks of harm to Peter and believed that this case might offer important opportunities to better understand how partners could work together in the future to prevent harm to other adults at risk in similar circumstances.

1.2 Peter was a 50-year-old white, British male with a number of physical health conditions. He also had a history of alcohol abuse, which impacted on his mobility, ability to manage his self-care, remember to take medication and his behaviour. He regularly displayed aggressive and reckless behaviours when inebriated; often this resulted in a need for medical care, loss of accommodation or criminal charges. He had multiple convictions and prison sentences. He had also previously come to the attention of police, mental health and NHS emergency department staff as a consequence of having made several suicide attempts, all under the influence of alcohol. He was well known Surrey Heath Borough Council's ['SHBC'] housing and Surrey County Council's [SCC] social care departments, Police and Probation. His needs were discussed at multi-agency risk panels (CHaRMM[1] and Surrey Adults Matter[2)], he also received support from the Hope Hub charity. At his death, he had been out of prison for two days and accommodated by the SHBC's Housing team in Datchet.

1.3 He was described by staff who knew him well as a '*lovable rogue*'. When not drinking heavily, he was polite, thoughtful, proud and intensely shy. He did not find it easy to ask for, or accept, that he needed assistance. He had described his family as an important protective factor in his life. His daughter explained that he had been a capable dad, cooking for the family, house proud and taking care of his presentation. He also valued contact with his mother and gravitated to the area where his family lived in the hope of seeing them. His family and professionals spoke of Peter's stated desire to get well and of his sadness (and theirs) that he was unable to manage his addiction.

Purpose of a Safeguarding Adult Review:

1.4 The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is to:

- establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- review the effectiveness of procedures (both multi-agency and individual organisations);
- inform and improve local interagency practice by acting on learning (developing best practice); and
- prepare a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

1.5 There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Peter from harm.

[1] 'CHaRMM', which stands for Community Harm and Risk Management Meetings is the forum in Surrey for implementing powers introduced by the Anti-social behaviour, Crime and Policing Act 2014. This is a multi-agency forum, which shares information to and agree actions to reduce the negative impact that problem individuals and families have on Surrey's communities through their anti-social behaviour.

[2] Surrey Adults Matter is the name used locally for a new approach to improve lives of adults with severe multiple disadvantages, adopting the national programme (supported by a coalition of national charities including Clinks and Homeless link) 'making every adult matter'. More information is available at: http://www.meam.org.uk/the-meam-approach/ [accessed 02.07.22].

Involvement of Peter's family and frontline practitioners:

1.6 The reviewer spoke with Peter's daughter who shared information about his personality and life journey, as well as her experience (given the care she had for him) and the impact for her of his needs and the circumstances surrounding his death. His daughter wished to commend the work of staff, particularly from the Hope Hub, explained that the practical help and care they provided '*gave him extra years'*. She also raised concerns that professionals did not appear to recognise the deterioration in his cognitive functioning. The SSAB and reviewer wish to express sincere condolences to all members of Peter's family for their loss and thank them for contributing so generously to the review. We are also grateful to the professionals who worked with Peter for sharing their insight into his experiences so honestly. The efforts they and his family made to support him and try to keep him safe were apparent and it was equally clear how distressed they were at his death.

Themes: The review covers the period from November 2019, (when Peter was assessed by Surrey Council's Adult Social Care department as at risk of exploitation and in need of care and support to prevent harm arising from self-neglect) until his death in October 2021. The SSAB prioritised the following themes for illumination through the SAR:

- Given Peter's history, how well did partners understand their organisational duties; did they work together and with him to implement effective plans to reduce risks including through the Make Every Adult Matter Approach?
- How effective and well-coordinated was care planning at key points of transition such as hospital discharge and prison release, were continuity of care obligations understood and applied when he was placed out of area?
- How effective was the multi-agency response in recognising and responding to prevent an escalation of Peter's mental health and risk of self-harm/ self-neglect?

Methodology:

1.7 The SAB commissioned independent reviewers to conduct a SAR using the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time method. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies. A full list of the documents disclosed and considered as part of this review is set out within appendix A. Multi-agency learning events took place, both with front-line practitioners who worked with Peter and the leaders who oversaw the services involved in supporting them.

2. Analysis of Agencies' Actions

Given Peter's history, how well did partners understand their organisational duties; did they work together and with him to implement effective plans to reduce risks including through the Make Every Adult Matter Approach?

2.1 Practitioners and his family were aware that Peter's alcohol dependency increased the risks that his physical and mental health would deteriorate, that he would be unlikely to comply with tenancy conditions and likely to encounter criminal justice agencies, both as a perpetrator and victim of crime. Practitioners also recognised that, given the wide-reaching ramifications of his alcohol dependency, it would be beneficial for statutory services to work collectively to understand both his needs and his ability to meet those needs or protect himself from harm (including through self-neglect). He was, consequently, one of the first cohort to be accepted onto the Surrey Adult Matters programme ['SAM'] in February 2020. The SAM is a multi-agency group of professionals who regularly meet, adopting a 'Team around the Person' ['TAP'] process, to offer holistic assessment and support for individuals with complex needs. SAM also have a strategic Steering Board[3] which reviews data and emerging issues to assist

[3] The SSAB's Board manager attends SAM Steering Board

in future commissioning and service delivery at both local level and through central government. The project piloted a trauma informed outreach service for SAM clients in partnership with several homeless charities, including the Hope Hub. Professionals responsible for care pathways retain their involvement and responsibilities but work together in a more uniformed way, with the client at the heart of the process.

2.2 The SAM quickly identified the relevant agencies to be involved in his TAP, they met usually every 6 weeks to action plan together. TAP minutes evidence agencies sought to secure more suitable accommodation for Peter in the reasonable belief that once this was in place longer-term goals to improve his health and wellbeing were more achievable. The approach taken was designed as a rights-based, systems approach and consideration was given to duties owed to assess him in respect of his social care needs, provide emergency accommodation, provide support to prevent reoffending and, if he accepted support to address his alcohol dependency, ease a path so specialist addiction support would quickly be available to him. Consideration was also given by TAP members to Peter's capacity, in line with the Mental Capacity Act 2005, to understand the risks that his homelessness, offending behaviour and drinking posed.

2.3 Extensive research[4] highlights ascertaining a person's agency in complex situations can be extremely difficult, particularly where there is strong evidence of fluctuating capacity (often associated with alcohol dependency) or a divergence between how an adult 'performs' during an assessment process and how they execute decisions in real life situations. Within their practical guide for practitioners, Ward and Preston-Shoot[5] list the physical and emotional conditions most dependent drinkers display to challenge the idea that alcohol dependency is a self-determined choice. They remind practitioners that NICE guidance[6] advises assessments of capacity should consider observations of the person's ability to execute decisions in real life situations. This highlights the situational aspect of decision making. NICE advises where there is evidence (e.g. from previous case history) that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored as it could trigger further duties to ensure an adult is safe from abuse or exploitation. Practitioners reported to this review how different approaches to Peter's vulnerability and limitations to statutory legal powers (which are directly attributable to different legislative eligibility criteria that practitioners must apply) frustrated a shared understanding of Peter's ability to understand and meet his needs, causing discord when planning his care. This is a common feature in SARs involving homelessness.

System finding

- Regular attendees at the TAP recognised Peter's vulnerabilities. Their attempts to support him were frustrated by limitations on legal powers to compel Peter to comply with support offered, his ability to consistently engage with service expectations and a lack of commission services to offer accommodation-based support to compliment the support offered by the Hope Hub.
- A lack of clarity in escalation routes for multi-agency senior managers to resolve disputes between practitioners or review cases where action plans were not having any noticeable positive impact, led to conflict and services withdrawing support when Peter's needs and the risks he faced were unchanged. The organisational network supporting frontline practitioners requires strengthening, as does legal literacy with regards to the implications of a person's capacity on different statutory duties. Oversight of multi-agency risk management, particularly where significant safeguarding concerns have been raised should include regular reports on

[4] See, for example, Martineau and Manthorpe [2020] 'Safeguarding adults reviews and homelessness: making the connections' Journal of Adult Protection, 22,4, `81-197 and Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

[5] Ward and Preston-Shoot [2021] '*How to use legal powers to safeguard highly vulnerable dependent drinkers*' for Alcohol Change UK, available at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf

[6] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

emerging themes or lessons learnt to the SSAB and clear processes for disseminating changes to services/ practice back to frontline staff.

How effective and well-coordinated was care planning at key points of transition such as hospital discharges and prison release, were continuity of care obligations understood and applied when he was placed out of area?

2.4 There are specific duties within Care Act of cooperation between Local Authorities (social care and housing), NHS and Prisons so they work at strategic and operational level to promote wellbeing, prevent the escalation of needs, improve quality of care and safeguard adults with care and support needs.[7] The Care and Support guidance advises local authorities to agree and apply local protocols to ensure continuity of care if a person is leaving hospital or prison or moving to another local authority area.

2.5 Peter benefitted from good cooperation and clear processes for continuity of care on two out of the three times he was incarcerated during the review timeframe. He was assessed promptly when first detained in 2019, ensuring he was provided with necessary adaptations to assist him to manage his disability whilst in prison and that social care and probation staff were aware of his needs on release. Again, when detained in 2020, the local Prison Social Care team ensured he could access support to address his dependency both during his incarceration and on release. As a result of those interventions and the sharing of information between prison, in-reach teams and services in the community, Peter was able to engage with appropriate support on his release. This good practice was not replicated on his final prison stay, though there is evidence that he was assessed at reception, his needs were recognised to be of sufficient risk that he was admitted to the healthcare unit.[8] Unfortunately, SCC's Prison Social Care team did not receive a referral for Peter and limited information was given to Peter's probation officer shortly before his release. Prison staff did not comply with their duty to refer to SHBC's Housing Options team [s213B Housing Act] in respect of his likely homelessness on release. These were missed opportunities.

2.6 The importance of inter-departmental cooperation (and a proper understanding of the interface between Housing Act and Care Act duties to accommodate) was particularly pertinent for Peter because over-reliance on SHBC to arrange accommodation confounded SCC's responsibilities regarding continuity of his social care when placed out of borough. For much of the review period, despite acknowledging Peter was eligible for social care, SCC were unable to provide statutory support as social care providers commissioned by them would not agree to work in other areas. At the time social care providers across the UK faced significant workforce issues because of the Pandemic. SCC's social care team reported that attempts they made to negotiate with providers in other areas proved fruitless as they either did not have capacity within their workforce to take on new clients or they were unwilling to take Peter onto their caseload because of his forensic history and complex needs. To mitigate the risks of an imperfect care plan, TAP members put in place practical assistance (including travel warrants) so that he could travel frequently and access help from The Hope Hub support.

Systems finding

- Surrey partner agencies have established protocols for co-operation, including the SAM approach and there is evidence of good practice between the local authority and partner agencies, but this was not consistent or firmly embedded. In addition, the duties to ensure continuity of care for adults moving between hospital, prison and different local authority service or across geographical boundaries are not well understood and the pathways to

[7] S3, 6-7, 23-24, 76, 39-41 Care Act, accompanying regulations and Care and Support Guidance, DHSC [revised June 22], with regard to chapters 14, 17, 20-21.

[8] This service was managed by CNWL foundation trust who were commissioned to provide mental health and primary care services. Prisoners are monitored by a GP attached to the unit, nursing staff at band 7 level and health care assistants. At the time of writing this report is it understood that the health care unit has been decommissioned. HMP Highdown has changed status from a category B to Category C prison and it is understood that very few category C prisons would have a healthcare unit. Instead, this facility will be repurposed to provide support to offenders with additional needs.

secure these smooth transitions are not always easy to access, or challenge when obstacles arise.

- Currently the local multi-agency safeguarding policy includes an aspiration to reach agreement with prisons on how they can provide assurances to the SSAB[9] regarding safeguarding functions but is silent on continuity of care duties. The SSAB should consider the most appropriate forum locally that should have oversight or quality assure the those important duties. Although policy framework for prisons mirrors the statutory Care and Support guidance, the prison framework is non-statutory and therefore only advisory. There is, however, an inter-agency escalation policy and the SSAB has an active prison liaison group which focuses on pertinent safeguarding issues for prisons. All five prisons in the area have representation on that group.

- The overreliance on temporary, emergency powers to accommodate Peter under the Housing Act complicated the delivery of social care support and masked the duty to meet his eligible social care needs. This could have been overcome with a broader understanding of the legal framework for commissioning accommodation-based care under the Care Act 2014 and a broader understanding of the continuity of care obligations.

How effective was the multi-agency response in recognising and responding to prevent an escalation of Peter's mental health and risk of self-harm/ self-neglect?

2.7 Section 1 of the Care Act requires the local authority to promote an individual's wellbeing whenever it is carrying out any care and support function. Section 2 obligates local authorities to provide services or take other steps it considers will prevent or delay the development by adults in its area of needs for care and support. An early response to emerging harm can stop risks from escalating. Where an adult with care and support needs has experienced or is at risk of abuse or neglect, s.42 of the Care Act 2014 requires a local authority to make enquiries, however it is accepted a safeguarding enquiry is not a substitution for a care plan. The empowering approach adopted by SAM reflects the legal duties, but must be backed by resource and effective leadership so any disputes are swiftly resolved and creative solutions progressed with appropriate urgency.

2.8 This review is not critical of (nor do we dispute) decisions regarding Peter's capacity. However, those decisions had a practical impact on the multi-disciplinary care planning process which restricted statutory partners such that they were unable to lawfully compel Peter to accept the support offered. GP and/or specialist health involvement in Peter's TAP could have triggered medical processes to examine if his cognition was deteriorating due to physical causes. This could, in turn, have then enabled reconsideration of his mental health and/or capacity thereby unlocking possible alternative legal powers to provide restrictive care under the MHA or Deprivation of Liberty Safeguards ['DOLS']. However, given the similarities between Peter's presentations and those reported in *London Borough of Tower Hamlets v PB* [2020], the Court of Protection may not have upheld any decision to authorise a breach of his right to liberty, even if they were satisfied that he lacked capacity regarding his residence and care. As Jackson J confirmed in *Wye Valley NHS Trust v B* [2015] best interest considerations under s4 MCA are *"not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms.'* Similarly, the Mental Health Act expressly excludes compulsory detention for assessment or treatment solely on the grounds of alcohol dependency. Given the lack of powers under any legal framework to compel Peter to accept support to address his alcohol dependency, it is not

[9] 27.2 Surrey SAB Adult Safeguarding Policy and Procedures 2018.

unreasonable that the TAP relied on residual legal powers to offer support to address his care and accommodation needs.

2.9 The revised assessment which concluded Peter did not have eligible social care needs remains, objectively, difficult to reconcile with the previous assessments and reports from other members of the TAP about escalating concerns during this period. Whilst, arguably he may have not accepted support other than from the Hope Hub, (because, even if an alternative service had been commissioned by SCC's social care department, any provider would unlikely be able to quickly replicate their trusted and skilled response), the muddling of the duty to identify needs [s9 Care Act] with considerations of whether he wanted needs met [s13(3) Care Act], meant alternative proposals were not put to him to consider. In practical terms it also left a sizable gap in commissioned services for adults who, even with skilled daily input from community-based services, remain at high risk because of alcohol dependency or who, like Peter, cannot realistically access necessary daily support because they are accommodated out of borough. Practitioners reported that since Peter's death new services, including the 'Changing Futures Programme' and Housing led project will enhance wrap around support in supported housing provision.

Systems finding

- The current SAM approach encourages a system focused, rights-based approach to multi-agency assessment and care planning. During the review period this was in its infancy and faced additional, extraordinary challenges due to the Pandemic. Changes made since the review period to the SAM approach should result in greater involvement of the adult with care planning and more accountability for agencies to complete actions in a timely manner.

- Capacity assessments for adults with fluctuating capacity linked to addiction are highly complex and require those with expertise in the impacts of addiction on executive functioning. Ideally, this would be undertaken by a multi-disciplinary team enabling longitudinal consideration so that deteriorating conditions are also more easily recognised. Greater involvement of a GP and/or consultant neurologist within the TAP should have triggered a referral to the Integrated Care Team and enabled joint assessments of the extent of his cognitive impairments and any underlying causes of his inability. The essential role of health in wellbeing is reinforced by the statutory identification of ICBs both as one of the three safeguarding statutory partners within SABs, and as statutory members of the local Health and Wellbeing Board. This is similarly crucial in operational decision making and therefore, where health practitioners do not have the resources to commit to shared assessments, particularly in the context of complex co-morbidities where the underlying cause has not been established, health practitioners should provide advice for the TAP.

- There is a gap in services to support the mental health of adults, particularly those with an established addiction, who are not yet in crisis such that they pose an immediate risk to themselves or others, but may be unwilling/unable to commit to rehabilitation and abstinence. It was well understood by Peter's TAP that it was unrealistic to expect that his poor mental health could be addressed through his GP alone. Peter struggled to keep regular appointments and, as many health services moved on-line in response to threats posed by the Pandemic, he was also digitally excluded. This also made it extremely unlikely that he would have been able to make use of psychological therapies, provided through an IAPT programme.[10] The TAP, his family and staff at the Hope Hub tried hard to provide reassurance and motivation to him. When he was offered a referral for psycho-social support (in September 2021) he refused this, but those who knew him well explained that (perhaps because of pride or because he was so shy) this was often his initial response. He, and they, needed for this offer to remain open and, even if he didn't directly work with such a service, those caring about

[10] https://www.england.nhs.uk/mental-health/adults/iapt/integrating-mental-health-therapy-into-primary-care/

him would have benefitted from advice and support to assist them to monitor his mental wellbeing and alert his GP or others as soon as they had concerns regarding the danger he may pose to himself.

3. Recommendations Emerging from this Review

Recommendation 1: The SAM provide guidance for members of a TAP to include:

- guidance on the inclusion in TAP meetings of the adult, their carer or people important to them
- guidance on the inclusion of health professionals within the TAP, particularly for those where there are concerns regarding ABI or cognitive decline associated with long-term substance misuse/ alcohol dependency;
- guidance on when it would be appropriate for partner agencies to request (and share with the TAP) medical or legal expertise in respect of an adult's capacity to make decisions especially if this is regarding care, treatment or residence;
- an escalation process to the SAM Steering Board that requires the swift involvement of a multi-agency senior leaders (and budget holders) in resolving disputes or reviewing entrenched cases;
- how the SSAB and SAM Steering Board will report emerging themes or safeguarding issues to the Health and Wellbeing Board, including issues arising from lack of resource, disputes or complaints and how the SSAB and Steering Board will disseminate key learning or system improvements back to frontline staff.

Recommendation 2: The SSAB firstly seek assurance that relevant partners have delivered training or developing materials alongside relevant partners in line with the LGA's briefing on best practice for safeguarding and homelessness and Alcohol Change UK's briefing on legal powers so that misapprehensions regarding legal duties and powers are understood and applied correctly in Surrey. More importantly, SSAB should seek assurance that the impact of this has been tested, e.g. through audit activity to ensure improvements in legal literacy can be evidenced specifically in the context of addiction, how it impacts on capacity and statutory duties, including the duty to promote wellbeing [s1 Care Act], assess needs and that this is an enduring duty [s9 and 11(2) Care Act 2014] and the separate obligations that flow from eligibility [s13 Care Act].

Recommendation 3: SSAB work with partners from prison, probation and prison-based health providers to develop protocols for the sharing of information and referral pathways. This should include specific requirements to work with any members of a TAP, including third sector staff because they are working with/ on behalf of the local authority to provide support to those with complex care needs. It should also specify what information should be passed to prisons to assist in the early identification of offenders with care and support needs and facilitate early engagement with both SCC's Prison Social Care team and locality adult social care teams.

Recommendation 4: SSAB should prioritise, in collaboration with their liaison group and national leads, how best to ensure that prison and community-based services have robust information sharing and discharge processes so information about an offender's health is promptly transferred, both at the start of their detention (from community to prison) and on their release (from prison to community). Presently, because GP services for prisoners sit outside NHS primary care contract and there is no mechanism for prisoners to register for community GPs until after release, it is difficult to ensure continuity of healthcare. SSAB should consider raising this issue via the National SAB chairs' escalation processes to the Ministry of Justice and Department for Health and Social Care to resolve.

Recommendation 5: SSAB should seek assurance that partner agencies have trained their staff, including those who will be involved in any TAP, commissioning and brokerage staff on the expectations regarding continuity of care. Partner agencies should also demonstrate that training has resulted in an improvement in practice, particularly in the identification of the relevant legal framework under which the accommodation-based care is to be delivered and that TAP care plans articulate clearly who is accountable for key actions and within what timeframe.

Recommendation 6: Health, public health and social care commissioners should review data and thematic reports from the SAM to explore the gaps in mental health support available for those at high risk due to addiction. They should report to the SSAB if an early intervention model, aligned to the Make Every Adult Matter and SAM approach, could work with a TAP to provide therapy and monitoring of a person's mental health to reduce the risks associated with experiences of multiple exclusion homelessness and dependency.

Recommendation 7: The SSAB should also seek assurance from SCC and the ICB that services commissioned to provide specialist mental health and addiction support are available to provide advice to SAM and any TAP, that the role of the Health Integrated Care Team is promoted more widely across partner agencies and agencies are committed to commissioning sufficient local accommodation-based support in line with the strategic need in the area, facilitating access for those who would be eligible under health or social care legislation, including the preventative duties.