# Safeguarding Adult Review: Peter

## Applying the lessons to better support adults at risk, with co-occurring conditions

June 2023

# Case summary: Peter

Surrey Safeguarding Adults Board [‘SSAB’] commissioned a SAR into the death of ‘Peter’ who died after accidentally colliding with a train. He was known to Surrey Adult Matters and had a ‘team around the person’ working to address needs arising from physical disability, mental health issues and alcohol dependency.

- Peter had a long history of homelessness, including rough sleeping. 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. There was good multi-agency practice in the recognition of risk and practitioners quickly identified relevant agencies to involve in his TAP.
- His behaviours when intoxicated had resulted in 3 custodial sentences during the review period. 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. This good practice was not replicated on his final prison stay. He was assessed at reception and was admitted to the healthcare unit, due to high risk factors. 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.
- He died 2 days after being released from prison, having been accommodated out of area by the local authority.

# SAR Terms of Reference

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?

His family contributed to the review, commending the work of staff, particularly from The Hope Hub, as the practical help and care they provided '*gave him extra years*'. They also raised concerns that, although it seemed obvious to the family that following surgery in 2017 Peter's cognitive functioning had deteriorated significantly, this was not recognised by professionals. They questioned why he wasn't regularly assessed to ascertain whether he had developed Korsakoff Syndrome or a similar neurological condition.

**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.

Multi-agency working:

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

Planning for smooth transitions

**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 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 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.

Self-neglect: working together to de-escalate risk and care needs.

**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.
- 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 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.

# Recommendations

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

- inclusion in TAP meetings of the adult, their carer or people important to them
- 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;
- 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.

2: Relevant partners deliver training or develop materials 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. SSAB should seek assurance that the impact of training is tested, e.g. through audit activity to ensure legal literacy is 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].

**3:** SSAB work with prison, probation and prison-based health providers to develop protocols for the sharing of information and referral pathways into a SAM –TAP..

**4:** SSAB help partners to develop 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).

**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.

**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.

**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 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.

# Understanding assessments and protections planning duties for adults experiencing co-occurring conditions and homelessness

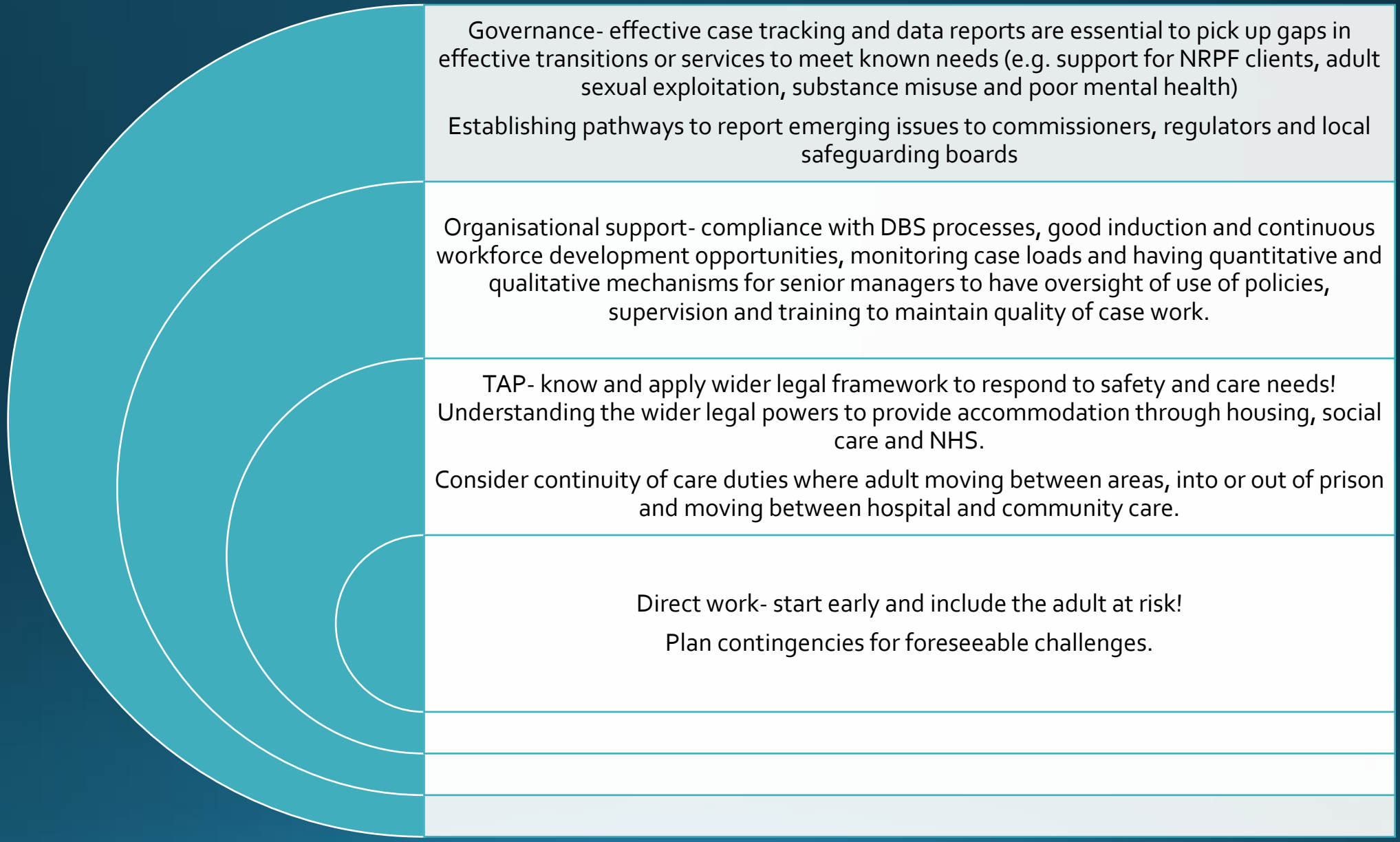
Safeguarding Circle

Common barriers to effective interventions:

Research into SAR conducted on MEH population by Kings College University identified 5 barriers:

- **Co-operation, co-ordination and leadership**: Understanding the impact of trauma, institutionalised backgrounds or complex conditions can have on a person's capacity to make decisions or protect themselves from harm requires skill and time! Also austerity has impacted on 'ownership' even though it's understood disputes shouldn't obstruct timely provision of care and support [pg 19.11 Care & Support guidance]
- **Lack of professional curiosity, normalisation of risk and disparity among practitioners**: Adults report feeling frustrated or intimidated by repeating personal history- making it difficult for one practitioner to develop the necessary rapport for a thorough multi-discipline assessment
- **Traditional access routes to assessment often do not work for this cohort**: Transient population increases complexity; statutory responsibilities are organised around concepts of 'local connection' or 'ordinary residence' and pathways for specialist provision are complex, esp if people have numerous conditions.
- **Lack of suitable provision**
- **Poor contingency planning to prevent escalation of needs**

# Learning from Safeguarding reviews- what good looks like!




Safeguarding circle, 2023

The six safeguarding principles in practice:

**Empowerment**

A human rights-based approach to safeguarding and risk assessment means moving away from paternalistic protections of those with care and support needs to supporting people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centred, strength-based perspective! Public bodies have a duty to consider vulnerability in a practical and contextual way (s149 Equality Act 2010 and *Hotak v LB Southwark* [2015]).

Munby J, *Local Authority X v MM* [2007]: *Emphasis must be on sensible risk appraisal. Seeking a proper balance and being willing to tolerate manageable or acceptable risk as the price appropriately to be paid in order to achieve some other good. What good is it making someone safer if it merely makes them miserable?"*

*DL v A local Authority* [2012] *"Between active decision makers and those certified as lacking mental capacity is a category of vulnerable adults who are open to exploitation."*

Hayden J, *LB Tower Hamlets v PB* [2020]: *'The healthy and moral human instinct to protect vulnerable people from unwise, potentially catastrophic decisions must never be permitted to eclipse their fundamental right to take their own decisions where they have the capacity to do so. Misguided paternalism has no place in the Court of Protection*.'

# The six safeguarding principles in practice:

**Prevention**

This is a pro-active duty under article 2 (right to life) and article 3 (prohibition on inhuman or degrading treatment) Human Rights Act 1998 to respond where there is a real and imminent risk. In addition, duties to prevent homelessness (s195 Housing Act 1996) and social care needs escalating (s2 Care Act 2014) require advice and assistance before service eligibility thresholds are met. This means practitioners must actively investigate with relevant partners to obtain pertinent information, consider everything reasonably be expected to know and act to meet any relevant duty of care. Be confident, if necessary, use assertive outreach as trusted assessors and your local safeguarding information sharing &/or escalation protocols:

**Protection**

Assessment and safeguarding duties are triggered on deliberately low thresholds- namely, the appearance of need and continues, despite capacitated refusal by an adult, if the local authority has concerns there is a risk of abuse or neglect (s11(2) Care Act 2014 and *South-end on Sea Council v Meyers* [2019]). Safeguarding enquiries can't be triaged on basis of the setting where care is provided, the person's mental capacity or access to services. Also note, the Homelessness Code Of Guidance [ 'HCOG' 8.44-45] includes a requirement to consider clinical vulnerability to Covid-19 for those with history of rough sleeping.

**Proportionality:** requires inquisitive enquiry, including reviewing the case history so all safeguarding issues are understood in context. The safeguarding enquiry duty (s42 Care Act 2014) is an effective mechanism to support multi-agency risk management as it is triggered whenever there is *reasonable cause to suspect* …

## An adult in the area

- Responsibility for considering any adult safeguarding concern under s42 Care Act lies with the local authority where the adult is physically present, '***whether or not the adult is ordinarily resident there***'.
- Local connection/ ordinary residence is relevant to ongoing assessment duties- interim protection plans should set out how the adult will be able to access follow up support to address longer-term needs.

## with care and support needs

- This can include conditions linked to physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. See pg6.104 Care and Support guidance.
- Consider whether 'reasonable adjustments' are necessary to access assessment and if any accommodation offered if appropriate to meet their daily needs.
- Range of useful toolkits to help identify specific conditions e.g. autism, pregnancy, brain injury. [see p25- of the toolkit]

## is experiencing or at risk of abuse/ neglect

- There is NO threshold of 'significant harm' regarding safeguarding duties to those over 18
- Guidance [pg 14.16- 14.35] and your local SAB webpages provide an '*illustrative guide to the sort of behaviour which could give rise to a safeguarding concern*'. It is important to remain up to date with research regarding types of abuse as this will inform your understanding of risk assessment and provide insight into the questions or scope of any investigation.

## unable to protect himself

- Actively consider if risk of abuse is more acute because of the adult's care and support needs. Look for patterns of neglect/ abuse.
- Duty of care isn't extinguished if the adult at risk refuses help (s42 and s11(2) Care Act).
- Making safeguarding personal and Mental Capacity Act principles- ask the adult '*do you understand why I am concerned about the level of risk to your wellbeing?*' Providing opportunity to work with the adult at risk to understand what might be preventing them from protecting themselves.

## Partnership

There are reciprocal duties to refer if a person may require social care support on discharge from hospital [discharge regs 2014] or is threatened with homelessness [s213B Housing Act] if the person is young (16-17) or a care leaver (18-24) or would leave custody without accommodation [pg23.4 HCOG]. Practitioners must also make **reasonable adjustments** so that organisational barriers (e.g. rigid operational service criteria, appointment times) don't prohibit people from securing support: *Haque v Hackney* [2017]

There are also duties to co-operate across agencies [s6-7 Care Act]. Relevant partners, including Police, DWP, health and housing providers, must co-operate when exercising their functions. Refusals only permitted if in writing and show incompatible with their own duties or would have adverse effect on their own functions.

## Accountability

The public law nature of safeguarding decisions means practitioners within 'relevant partner' agencies must satisfy their professional clinical and care governance duties. It may not be possible to persuade or compel an adult at risk to accept support, but this alone will not itself absolve practitioners of their duty of care. Careful recording of the person's capacity to understand, retain, weigh up and communicate the decision will also require evidence that practitioners have explained, in line with their professional standards and the Mental Capacity Act 2005 code of practice, any actions they are required to take to fulfil their wider core duties and the options available to the person. Public law principles of fairness are reinforced by specific legal duties for statutory bodies to provide assessment findings and reasons for decisions in writing (s203(4) Housing Act 1996 and s12.(3) Care Act 2014).

# ‘Self–neglect’

It is widely accepted that, to facilitate good outcomes, practitioners must ‘*connect **relevant legal rules** with the **professional priorities** and objectives of **ethical practice***’

**Relevant legal rules**:

- Public Health law- threshold for statutory intervention is high, but powers to enter and remove are wide (and often unconcerned with a person’s capacity) as purpose is to maintaining public safety.
- Mental Capacity law- sets out the legal rules that must be applied to assess if the adult maintain a habitable home, their personal care needs etc? If not, has someone authority (under LPA/deputy) to make decision for them? If not, what is in the person’s best interests?
- Care Act- threshold for assessment is low as based on appearance of need for the adult. There is also an enduring duty to assess and decide what support is needed to promote their wellbeing

**Practitioners' priorities**: local protocols adopt ‘*broad community approach*’ to resolve safeguarding risks associated with self-neglect that balance competing priorities to reduce risks to public health, protect property and keep adults safe whilst promoting personal dignity, control and emotional wellbeing

**Ethical practice**: All public bodies must exercise their legal powers in a way that complies with duties to the adult under the Mental Capacity Act, Human Rights Act 1998 and Equality Act 2010


# The importance of fact finding: Multiple exclusion homelessness and Safeguarding. A toolkit for practitioners

- This was designed to support fact finding, thinking, communication, and decision-making when there are safeguarding concerns about a person experiencing multiple exclusion homelessness.
- Completing the document will help set out the known facts and support recognition of concerns or likely responses. It is intended to aid communication across multi-disciplinary teams, but does not replace local risk management pathways or safeguarding policies so please make use of the resources highlighted within the guidance sections of the toolkit.
- It is designed to answer 3 key questions:
  - Have you somewhere safe to sleep tonight?
  - Do you understand why I am concerned about the level of risk to your wellbeing?
  - What help do you need to protect you?
- The toolkit is a prototype for testing- we welcome comments or suggested improvements. It is available at:

https://www.qni.org.uk/wp-content/uploads/2020/05/SafeguardingToolkitDRAFT-PDF.pdf

## Advice for Frontline staff with assessment, care and treatment or protection planning responsibilities

- Complex risk and care assessments are often split across numerous documents- ensure that the most important information (e.g. communication or engagement strategies, whether the adult can protect themselves, likely signs of increasing risks and contingency plans) are pulled through into one care plan.
- Ensure that care or treatment plan is accessible to the adult, family/advocate and staff providing day to day care. Legal requirement under s25 Care Act and absolutely crucial if placed out of area!
- Build in role for an advocate or family members, include advice on how to raise concerns and escalation routes if responses are inadequate. Family often provide longitudinal picture- vital when seeking to establish degenerative cogitative issues
- Be clear with carers about support needed to meet cultural, communication or specific therapeutic needs (e.g. SALT, manual handling, medication needs - including covert use), use (and parameters) of restraint.
- Provide routes to request reviews and escalate for specialist guidance if, more restrictions are necessary for protective care.
- When conducting reviews triangulate your views on whether care plan is sufficient with the adult, family/ advocates, local quality assurance mechanisms e.g CQC.
- Use local policy and guidance. Remember as an autonomous professional you can escalate if your concerns are not addressed satisfactorily.

# Raising a concern- possible structure

- Set out why you are writing: Are you asking for a multi-disciplinary meeting to secure assessment and/or care plans, is it for a protection plan under s42?
- Set out the facts- stating this objectively and distinguish between those that are verified, are not disputes and issues that need to be determined (e.g. John presents with behaviours such as… suggesting he may have ASD but this is yet to be assessed.)
- Set out the current risks, esp. if imminent risk of serious harm. Set out the likelihood and severity of abuse. Contextualise with relevant case history, including your objective assessment of their ability to protect themselves.
- Set out impact of needs on their ability to protect themselves and any questions regarding their capacity to understand risk, execute decisions in real life situations, any evidence of cognitive decline
- Detail available option and the adult's view of the impact that each choice may have on their wellbeing. Don't rely solely on risk tools- continuous professional judgement. Build contingency into safety plans.
- Do not ignore perpetrators responsibility for harm, stopping the abuser may assist the victim/ other family members to play a protective role. Providing the right support to carers, even those reluctant to accept professionals' involvement, may reduce the risk of unintentional harm!
- Set out how to engage, what works and what doesn't. Ask for reasonable adjustments especially if this is linked to disability, age, race etc
- Conclude with offer to collaborate to understand risk and underwrite safety- minimising harm may be most practical option, but this should be a shared risk across disciplines and with senior leaders