Safeguarding Adult Review

Executive Summary

“Laura”

August 2024

1. Introduction

This report covers a summary of the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of Surrey Safeguarding Adults Board (SSAB), relating to the care of an adult (referred to as Laura throughout this report to preserve her anonymity). The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Surrey in the future. A full report of the SAR in this case has been accepted by the SAR Panel, however it was agreed not to publish the full version of the report, due to the potential sensitivities of the case and for the welfare of Laura's family, in particular her daughter.

The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews. The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

1.1 Why Was this Case Chosen to be Reviewed?

Laura was initially referred by the office of the Surrey Police and Crime Commissioner in June 2022, following a complaint raised from her mother to her local MP. The case was discussed and accepted by the Surrey SAR Group, in September 2022. It was felt that the SAR process was appropriate, as Laura had experienced significant abuse and had several known vulnerabilities which had been identified prior to this. There were concerns about how agencies had worked together, and it was felt there could be useful learning from this case. The grounds for the SAR were discretionary, under S44.4 The Care Act 2014.

1.2 Brief Summary of the Case

On the morning of 23/09/20 Laura was discovered deceased at home by an ambulance crew, who had been called to her flat by a male associate, who left shortly afterwards, as he was there in contravention of a Court Order. It was believed by the ambulance crew that she had taken substances, as she was unresponsive when found, and this was later confirmed at a subsequent Inquest in July 2021. Her cause of death was recorded because of a mixed drug and alcohol intoxication. Laura suffered from anxiety and pain for which she took prescription and non-prescription drugs. She was found to have a level of methadone in her post-mortem blood likely to prove toxic or fatal to a person with limited tolerance of methadone and other opioid drugs. Laura had no previous record of such use.

Laura's mother (Hazel) was angry that Police informed her that no criminal charges would be brought vs the group who had exploited Laura. Hazel's view was that more action should have been taken to protect Laura from Penny's father, both during their relationship and in the months leading up to Laura's death. She felt that Laura had not been sufficiently protected from the gang who would force their way into her flat and who gave her the drugs, which she took on the night she died. She also felt that Laura's earlier experience of Domestic Abuse from Penny's father had left her so traumatised that she was effectively unable to take decisions regarding her safety and that services ought to have recognised this at the time.

Laura's ex-partner, Penny's father, was given a custodial sentence for Domestic Abuse to his subsequent partner. He was also abusive and coercively controlling towards Laura. Laura was young when she started her relationship and moved in with him. She was 21 when she had her daughter (Penny). He was much older than her and exploited Laura financially, running up significant debts in Laura's name, allegedly to fund his drug addiction.

2. Findings and Recommendations from the SAR

This section contains the priority findings from this SAR, from analysis of the work undertaken with Laura and her family. Recommended actions in response to each Finding for service improvement are set out for the Surrey Safeguarding Adults Board.

Finding 1. The relationship between domestic abuse and longer-term psychological harm to women may not give rise to eligible care and support needs, as defined in the Care Act 2014. However, it may give rise to mental health problems which can then effectively render the individual vulnerable to subsequent abuse and therefore unable to protect themselves from future harm.

Recommendation 1:
Assurance to be provided by ASC to SSAB demonstrating consideration is given to all safeguarding referrals, or SCARF reports that there is a clear eligibility criteria for assessments where there is an appearance of Care and Support needs, in line with the duties under The Care Act 2014. This should include guidelines on when such assessments should be initiated even if preliminary information suggests potential risks or vulnerabilities.

Finding 2. While police, Housing and Children's Services do act with an awareness of the consequences of trauma at the time the domestic abuse becomes known, the subsequent impact of this trauma, and how if unaddressed, can affect the adult's vulnerability to future harm, is not always recognised in subsequent contacts with Adult Social Care services.

Recommendation 2:
That all agencies working with an adult who is known to have experienced previous domestic abuse review their practice, regarding assessments, safeguarding enquiries, and service delivery, to assess whether this is consistent with a trauma-informed perspective, which recognises the impact of past trauma on how an adult presents, especially when they are at risk of further harm from abuse.

Recommendation 3:
That Local Authority review decision making processes in place where a Lead Enquiry Officer (LEO) recommends an action following a referral to the MASH team, which is subsequently over-ruled by the Safeguarding Adults Decision Maker (SAD). That a full justification and where relevant, an experienced second person should agree that this does not go forward for a further exploration of the adult's appearance of care and support needs, based on comprehensive information aligned with best practices and legal guidelines.

Finding 3. When information is shared between the police and ASC/Children's Services about risks to an adult and/or a child via a SCARF form, if this is closed without adequate further information gathering to contextualise the risks outlined in this document, those risks may be underestimated and not appropriately managed.

Recommendation 4:
Adult and Children's Service to assure the SSAB that relevant Information sharing systems will be checked and followed up for further information held about the adult/child where SCARF forms are received about domestic abuse and cuckooing, prior to decisions about a response to the SCARFs and the outcomes of SCARF referrals are shared with police who raised the SCARF.

Recommendation 5:
Adult Social Care develop protocols requiring consultation with relevant stakeholders (police, children's services, healthcare providers) in complex cases, especially those involving multiple vulnerabilities such as substance misuse and domestic abuse.

Finding 4. Protecting an adult from ASB and cuckooing requires persistence, good communication and a strategy to effectively monitor and enforce a Partial Closure Order (PCO), if this is the approach chosen. A PCO is unlikely to be successful without this and especially if opposed by the adult, in the context of coercion or control by the people it is intended to prevent gaining access to the adult.

Recommendation 6:
Where there is a plan to apply for a PCO, there is also a multi-agency plan (including all agencies detailing their own responsibilities) which is agreed at the CHaRMM as to how to monitor and review the effectiveness of this on deterring people from entering the adult's property and suitable action is taken where it is being breached. That there is a lead agency to report back on the outcome of the PCO and where necessary other legal means of addressing the situation are considered.

Finding 5. Cuckooing poses unique challenges and a need to bring together two systems, (health and well-being, along with community safety) due to the heightened risks both to the adult and often with ASB to other people from that adult. Where that adult has additional vulnerabilities and parental responsibility for a child the situation is complex and needs coordination between these systems to ensure appropriate measures are taken.

Recommendation 7:
A review of current multi-agency policy and practice guidance regarding cuckooing, to ensure coordinated systems are in place for "vulnerability assessments" alongside, or in the absence of S9 or S11 (The Care Act 2014) assessments of needs for care and support, and that these are included in plans around risk, in line with the best practice as set out in the Community Safety Agreement.

Recommendation 8:
That the assessment of an adults vulnerability to cuckooing, including all the circumstances and not just their care and support needs is considered when safeguarding concerns are raised and assessed for the need to undertake an enquiry.

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