Safeguarding Adults Review - 'Noah'

What is a Safeguarding Adults Review? A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

(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 (see below)*

(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*

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

About this briefing – A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of Noah. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners. Please take time to reflect on the findings and consider how you can learn, develop and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

Care Act 2014

Care and support needs are identified in the Care Act 2014 as the following -

What are the identified care and support needs as identified in the Care Act 2014?
(a)the adult's needs arise from or are related to a ***physical or mental impairment or illness***; and
(b)as a result of the adult's needs the adult is ***unable to achieve two or more*** of the outcomes specified in paragraph (below) and
(c)as a consequence ***there is, or is likely to be, a significant impact on the adult's well-being***.

- ☐ Do these needs mean the adult is unable to achieve two or more of the following listed outcomes? -
- ☐ Managing and maintaining nutrition
- ☐ Maintaining personal hygiene
- ☐ Managing toilet needs
- ☐ Being appropriately clothed
- ☐ Being able to make use of the adults home safely
- ☐ Maintaining a habitable home environment
- ☐ Developing and maintaining family or other personal relationship
- ☐ Accessing and engaging in work, training, education, or volunteering
- ☐ Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- ☐ Carrying out any caring responsibilities the adult has for a child

Noah was a Black/Caribbean 22 year-old man at the time of his death who was loved dearly by his immediate and extended family members.

Noah had diagnosed Severe Learning Disability and Attention Deficit Hyperactivity Disorder (ADHD).

In September 2021, he was presented to Queen Elizabeth Hospital, Greenwich (QEH) Emergency Department (ED) with shortness of breath. He was treated for aspiration pneumonia and put on a non-invasive ventilation (high flow oxygen), clinically improved, maintained oxygen saturation with a nasal cannula.

His last hospital admission to hospital was following a burn on his arm. Although burn reportedly healed in hospital, he was kept for longer for other medical complications raised whilst on admission.

Noah's health and social care needs were very high and complex. A number of agencies have been involved in his care and support. There were two open safeguarding enquiries open at the time of death; but there had been numerous safeguarding enquiries since coming to live in Bexley.

This is the learning brief on what learning was found and how you can make a difference to protecting other young adults like Noah from experiencing abuse or harm.

About the review process – Noah came to the attention of the Bexley SAB in May 2022 and went to Bexley SAB SAR Subgroup in May 2022 to make recommendations to then Independent Chair, Eleanor Brazil, had agreed the criteria had been met, but also needed to escalate to Merton SAB / partners some concerns that have been raised regarding safeguarding enquiries, placement and reviews and existing provider concerns with remaining service users at the site. Bexley SAB commissioned an Independent Reviewer to Chair and lead the SAR. Subsequently, Merton SAB coordinated the engagement of Merton services and to provide representation at the review panel. The time period for analysis through the Review was from January 2017 to March 2022. This period was chosen as starting from the point at which Children's Social Care stopped their involvement with Noah, until the time of his death.

Summary of Noah's Learning Themes –

Theme 1: Transition from childhood to adulthood - Noah had been accommodated when he was 8 years old when his behaviour at home was considered to put his young sister at risk, and he was placed at a residential school. In 2016, Noah moved school after an unexplained change in his attitude to attending school. His mother described the family being very satisfied with the schools Noah attended and with the support provided by Merton's Children and Families Service. ***From the family's perspective, the quality of support declined once Noah entered the Transition Procedures between Children and Adult Services.*** Noah had complex health and social care needs; it was therefore important that they were assessed jointly in order to facilitate the development of an appropriate care and support package to meet them. In addition, he also has specific educational needs, identified in his EHCP, that need to be addressed in his care and support plan.

Noah's health needs were well-known; they were long-standing and chronic rather than acute. Noah's social care and support needs however were changing as he grew up and developed into a young man from a particular ethnic and cultural background. These changing social care and support needs would impact, not on his health care and support needs as such, but on how they might be most appropriately met. ***Noah's health and social care and support needs therefore required to be assessed in a way that identified his ethnic and cultural background, which they were not, whether by Merton's Children and Families Services, Transition Services or Adult Social Care.***

When Noah was referred into the Transition Procedures, consideration should have been given to his possible return to live at home; while this may well not have been possible or practical, it should have been considered and his family offered assessments under s10 of the Care Act 2014 of their eligibility for services in order for an informed decision to be made about such a return home. Noah was referred to the Merton Transitions Procedures when he was 17 years old; by this time, the nature and degree of his complex health and social care needs had been known to Children and Families Services for almost 10 years. Good practice would have been for Noah to have been referred to the Transition Procedures during the academic year of his 14th birthday to provide sufficient time to assess his needs effectively, to identify potential placements, facilitate his moving to a new placement if necessary and to enable Adult Social Care to make budget for what would be a potentially major drain on the resources.

Theme 2: Continuing Health Care Funding Decisions during the transition phase - Given the nature, degree, and complexity of Noah's health needs, it is likely that he would have been eligible for Continuing Health care funding as a child. This was not identified in his assessments by Children and Families Services when he was referred into the Transition procedures or when he was assessed by Adult Social Care. When he was referred, it was to the incorrect Health Commissioner.

Theme 3: Health Pathways for those with complex needs - Given Noah's complex health and social care and support needs, it was predictable that he would require attendance and admission to hospital in emergency situations. Despite, this, there was no Hospital Passport or information pack developed and regularly updated to accompany him to hospital prior to or throughout the Review Period.

Theme 4: Continuing Health Care as an adult - While Merton Adult Social Care completed an assessment of Noah's care and support needs under s9 of the Care Act 2014, this was not subsequently routinely reviewed; Adult Social Care were aware that Noah had assessed as eligible for Continuing Health Care Funding but did not offer to review this s9 assessment or to contribute to any review of his placement nor was their involvement sought by the Health Commissioner. The same is true of Merton's Transitions Service; while Noah's EHCP was reviewed regularly until March 2020, these reviews were not coordinated with or referenced in the reviews held by CHS of his Continuing Health Care funded placement. Throughout and since the Review Period, responsibility for CHC funded services had been delegated from the statutory Health Commissioner to CHS; while this is perfectly legitimate, it does require a further level of quality assurance or contract compliance to be established. The SAR requested details of the quality assurance processes developed and implemented by the Health Commissioner of CHS and of those developed by CHS of the providers they commissioned services from. No details were provided.

Theme 5: Effective Management of out of Borough Placements - Noah's residential placements were all outside of the London Borough of Merton; such placements made by Merton Adult Social Care come under Guidance issued by the Association of Directors of Adult Social Services which stated that the placing authority should first of all check the potential host authority the quality of any possible placement and inform the actual host authority when any placement is made. As Noah's placement with PSS was commissioned by the Health Commissioner, this Guidance did not apply and was not followed. ***This resulted in the placement going ahead without the commissioner being aware of the concerns BQAT had about the provider and without Bexley Adult Social Care being aware the placement had happened.***

While the Health Commissioner actually commissioned Noah's placement with PSS, Merton Adult Social Care were party to the process and should have ensured that the ADASS Guidance was followed. Noah's health needs could not be effectively addressed in isolation from his social care and educational needs and vice versa. ***While aspects of Noah's care and support plan were reviewed, albeit not always regularly, no agency took responsibility for the coordination of the whole.*** Had the reviews of Noah's care and support plan be multi-agency, involving the commissioner, Adult Social Care, community health services and Leaving Care Services, this coordination could have been achieved with a resulting improvement in the overall quality of Noah's life.

Theme 6: Primary Care compliance with safeguarding policies and procedures - There were several examples of inaccurate or incomplete recording in the GP Practice records available to the SAR, in particular, reference to child protection procedures and information sharing.

Theme 7: PSS Policies and Procedures - The SAR identified issues with PSS' Policies, Procedures and Processes for establishing a new service as well as with their Admissions Procedures and Processes. The result was that they opened before the property and staff – both managers and care and support staff – were fully prepared to provide a safe and stimulating service. ***Noah was also placed without PSS being provided with all the necessary information to develop an effective care and support package for him. His placement was not then reviewed to confirm its appropriateness.*** The SAR also identified some areas of service provision that were not covered by the service specification of the service commissioned for Noah. ***While primary responsibility for this must lie with the commissioner, the provider also has a responsibility to its tenants/service users to ensure any service it provides is a safe and high quality one.***

Theme 8: Safeguarding Policy and Procedures - The planning around Noah's discharge from hospital reflected a number of the issues raised around the assessing of his care and support needs and the commissioning, identification and reviewing of how these would be met in the community. These include the lack of input from Adult Social Care or the Leaving Care Service, an agreed care and support package being in place before he was discharged or any review within 8 weeks of the appropriateness of the placement and/or his care and support package. The Bexley Safeguarding Procedures were not triaged in the case of the safeguarding concerns re Noah in a way to ensure their effective receipt and management. It is likely that, as a result, new safeguarding concerns were added to existing S42 Enquiries, it was not recognised that the safeguarding concerns raised about Noah could have been offences under s44 of the Mental Capacity Act 2005 and PSS were inappropriately tasked with an internal investigation into at least of the safeguarding concerns. ***There were several examples where operational staff and their managers failed to raise safeguarding concerns despite identifying issues with the care and support Noah was receiving.***

Theme 9: Local Authority Quality Assurance of Care Providers - The Bexley Quality Assurance Team (BQAT) visited and reported back to PSS concerns they had about the premises and the service provided but didn't feedback their concerns to the commissioners of those services. ***Not only did this prevent the commissioners from effectively reviewing their placements, but also prevented them from contributing to the development and monitoring of the Service Development Plan that BQAT agreed with PSS.***

BQAT were first aware of PSS before any placements were made there; they did not advise PSS of the need for the local authority to be advised of any placements made by a different commissioner. PSS consistently failed to satisfactorily respond to the Service Development Plan; the lack of any escalation process meant this didn't result in any sanctions being imposed on them. ***BQAT's internal management and supervisory structure did not pick this up.***

Theme 10: Criminal Offences against individuals who do not have capacity to safeguard themselves - Noah clearly lacked the capacity to safeguard himself or take basic decisions about his health and welfare or his finances. Despite this, no consideration was given by the Police as to the potential for the assaults, verbal and physical, to be treated as offences under s44 of the Mental Capacity Act 2005. ***Equally no consideration was given by the Criminal Prosecution Service (CPS) to the use of witness summons to support the prosecution of the alleged perpetrators of the assaults. The above prevented Noah having the access to the Criminal Justice System he was entitled to.***

Theme 11: NHS Safeguarding Systems relating to individuals in independent care provision - Noah failed to attend at least 1 appointment with the Oxleas NHSFT Community Learning Disability Nursing Service; this was not chased up, though an alternative appointment was made, nor was the reason for the failure to attend recorded. While community staff monitored Noah in his placement, they did not consistently provide guidance to non-health professionals on how best to support Noah. ***While Trust staff did visit Noah while he was an in-patient in Queen Elizabeth Hospital and University Hospital Lewisham, they were not involved, nor sought to be involved in the Discharge Planning Procedures from Epsom Hospital despite being the agency who would support him in the community on his discharge***.

While Noah was an in-patient in Queen Elizabeth Hospital and University Hospital, Lewisham, PSS staff often failed to attend to support Noah on the ward. This was not routinely fed back to PSS; as ***there was a lack of clarity as to who was responsible for commissioning this support, it was not fed back to the commissioner either. A safeguarding concern was raised promptly on Noah's admission to University Hospital in February 2022, but information about the safeguarding concerns relating to his care and support in the community before his admission was not communicated to the Hospital's internal Safeguarding Team. There was also some confusion as to the implementation of the Hospital Discharge Procedures by which Noah was deemed medically fit for discharge without his pressure ulcer being reviewed by the Tissue Viability Nurse.***

Theme 12: Legal Literacy - ***The importance of "legal literacy" for operational staff and managers across health and social care services for both children and adults cannot be overstated; an awareness of the legal powers and duties that apply is essential for the effective and safe exercise of professional practice.*** This is not to suggest that staff and managers need to be legal experts, but they do need to be cognisant of the statutory underpinning of their practice so that they know when to seek specialist legal advice.

Noah clearly lacked the capacity to make informed decisions about his health and welfare and his financial affairs. This had been known since he was a child, but no advice was given to his family by any of the professionals or agencies who supported them as to the implications of the Mental Capacity Act 2005 for decision-making in the above areas. ***This was not identified in professional supervision or in the Procedures and Processes that were implemented by Merton's Children and Families, Transitions, Leaving Care or Adult Social Care Services, the Health Commissioner or CHS or Bexley Adult Social Care.*** As a result, Noah's family were unaware of the measures contained within the Mental Capacity Act 2005 to safeguard his best interests and to provide consistent decision-making with a legal underpinning. ***The fact that this was not identified even when services were being commissioned that required formal agreement – ie the signing of a tenancy agreement – would suggest that specialist legal advice was either not sought by or wasn't available to operational staff and managers.***

At different times, a degree of knowledge of the Mental Capacity Act 2005 and its implications for the assessment and meeting of Noah's care and support needs was demonstrated, such as when a DoLS was applied for, or a Best Interest Decision meeting convened. However, these were the exceptions rather than the rule and Noah was assessed, treated and his personal information shared without any legal basis for doing so.

1: *That the SAB seek assurance that Adult Social Care has reviewed and revised as necessary its Assessment and Review Procedures and Processes under the Care Act 2014.*

2: *That the SAB seek assurance from the Safeguarding Children Board that Children and Families, Leaving Care and Transition Services have reviewed and revised as necessary their* Assessment and Review Procedures and Processes.

3: *That the SAB seek assurance from Adult Social Care that they reviewed and revised their involvement in the Transitions Procedures and Processes.*

4: *That the SAB seek assurance from the Safeguarding Children Board that Children and Families, Leaving Care and Transition Services have reviewed and revised as necessary their Transition Procedures and Processes.*

5*: That the SAB seek assurance from their local Health Commissioner that they publish and promote the Continuing Health Care Criteria and the process for making applications to Adult Social Care.*

6*: That the SAB seek assurance from the Safeguarding Children Board that their local Health Commissioner publish and promote the Continuing Health Care Criteria and the process for making applications to Children and Families, Leaving Care and Transition Services.*

7: *That the SAB seek assurance from Adult Social Care that all adults with a cognitive disability, including those with a learning disability, will be supported by a Hospital Passport or similar, informed by annual health and medication checks.*

***8**: That the SAB seek assurance from the Safeguarding Children Partnership that all children/young people with a cognitive disability, including those with a learning disability, will be supported by a Hospital Passport or similar, informed by annual health and medication checks.*

***9**: That the SAB seek assurance that Adult Social Care are offering assessments under s9 of the Care Act 2014 to all referred for Continuing Health Care funded services and subsequent reviews as appropriate.*

***10**: That the SAB seek assurance that the local Health Commissioner has reviewed and revised its Procedures and Processes for applications for Continuing Health Care Funding.*

***11:** That the SAB seek assurance from their local Health Commissioner that they reviewed and revised as appropriate their Procedures and Processes for identifying, commissioning and quality assurance of all Continuing Health Care funded services.*

***12:** That the SAB seek assurance from the Health Commissioner that they have developed, implemented, and monitor the effectiveness of robust quality assurance processes for their contracts either direct with health service providers or with those agencies who commission services on their behalf.*

***13:** That the SAB seek assurance from Adult Social Care that all out-of-borough placements it is party to, whether they commission them or not, will be commissioned in accordance with the ADASS Guidance.*

***14:** That the SAB seek assurance from the Health Commissioner that all out-of-borough placements it commissions will be commissioned in accordance with the ADASS Guidance.*

***15:** That the SAB seek assurance from the Health Commissioner that they have reviewed and revised as appropriate their Procedures and Processes for reviewing Continuing Health Care funded care and support packages.*

***16:** That the SAR seek assurance from the Health Commissioner that they have reviewed and revised as appropriate their Contract Compliance Procedures and Processes for recording and sharing personal information with contracted services.*

***17:** That the SAB seek assurance that PSS has reviewed and revised as necessary its internal Policies, Procedures and Processes.*

***18:** That the SAB seek assurance from Adult Social Care and the local Health Commissioner that they have reviewed and revised as appropriate the Hospital Discharge Planning Policies, Procedures and Processes.*

***19:** That the SAB review and revise as appropriate the multi-agency Safeguarding Adults Procedures and Processes.*

***20:** That the SAB seek assurance from its member agencies that their staff, and those in services they commission, are appropriately trained in the recognition of abuse and neglect and how to report it*

***21:** That the SAB seek assurance that BQAT has reviewed and revised as appropriate its Procedures and Processes for the inspection and monitoring of services and its management and supervisory structures.*

***22:** That the SAB seek assurance from the Police that they have reviewed their Procedures and Processes for managing criminal incidents against adults who lack capacity or are unable to give evidence.*

***23:** That the SAB seek assurance from ONHSFT that it has reviewed and revised as appropriate its internal Procedures and Processes.*

***24:** That the SAB seek assurance from the Lewisham and Greenwich NHS Trust that it has reviewed and revised as appropriate its internal Procedures and Processes*

***25:** That the SAB seek assurance from partner agencies that they have reviewed and revised as appropriate their Mental Capacity Act 2005 Policies and Procedures in response to the issues to be addressed identified in the Analysis.*

***26:** That the SAB seek assurance from Adult Social Care and their local Health Commissioner that they have ensured that the Mental Capacity Act 2005 Policies and Procedures of the services they commission have been reviewed and revised as appropriate in response to the issues to be addressed identified in the Analysis.*

27: *That the SAB seek assurance from partner agencies that their operational staff and managers and those in services they commission are "legally literate" with regard to the Mental Capacity Act 2005 and managers have easy access to specialist legal advice.*

28: *That the SAB seek assurance from partner members that they have reviewed and revised their Policies, Procedures and Processes relating to the assessment and treatment of adults to ensure they are compatible with the Mental Capacity Act 2005 and its supporting Code of Practice.*

29: *That the SAB seek assurance from Adult Social Care and their local Health Commissioner that they have reviewed all those adults who lack capacity to assess whether an application should be made to the Court of Protection to seek the appointment of a Deputy.*

30: *That the SAB seek assurance from Adult Social Care and the Safeguarding Children Board that the Transitions Procedures have been reviewed and revised as appropriate to ensure appropriate applications are made to the Court of Protection for Deputies to be appointed for young people who lack capacity.*

Questions for you to consider -

1. How well / confident are you with applying the Mental Capacity Act?
2. Did you know that there are over 20 safeguarding pieces of legislation between adults and children's services?
3. Did you know Bexley has a 'Joint Think Family Protocol'?
4. How accessible are your services for someone to speak with staff about their care and support needs especially when struggling with psychosis?
5. What risk management procedures are in place to support in ensuring risk assessments are of a sufficiently high standard and include feedback from key agencies and significant others in the person's life?

SAR Noah Executive Summary / Report

- Bexley Safeguarding Adults Board website – http://www.safeguardingadultsinbexley.com
  - The website holds an annual SAR Themed Learning & Development Programme
  - Tools and Resources for all Bexley Organisations
    - Other SAR published reports
    - 7-Minute Briefings
    - Other Resources and Links
- Email Bexley SAB at bsab@bexley.gov.uk for any support on embedding this learning.