Safeguarding Adults Review - 'Rachel'

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

Rachel has both physical and mental illness - Rachel has Fibromyalgia which is a long-term condition that causes pain all over the body, resulting in Rachel having difficulty sitting or going out into public for long periods of time. In addition to this Rachel also has a diagnosis of Emotionally Unstable Personality Disorder (EUPD), Post-Traumatic Stress Disorder (PTSD), and had complex trauma and mood instability. Rachel disagreed with the earlier EUPD diagnosis and had spent some time trying to have that amended to PTSD which stemmed from traumatic experiences of abuse as a child and domestic abuse as an adult. The difficulties Rachel experienced as a result of the impact of these conditions, impacted on his ability to cope with daily life. At the time of his incident Rachel was known by several agencies. Rachel holds a different view to agencies trying to work with her.

And **Rachel has 5 care and support identified needs: -**

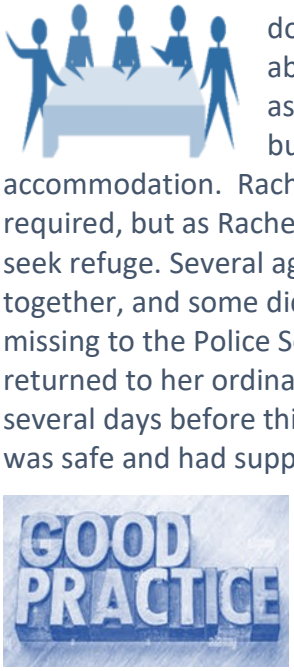
1. *Rachel is a victim of Domestic Abuse and has issues linked to her ordinary residence and is unable to make use of her home safely including inability to live in a refuge with others.*
2. *Rachel has a history of inability maintaining family and personal relationships.*
3. *Rachel has a history of not being able to access or engage in work as evidence by long standing unemployment.*
4. *Rachel does not make use of necessary facilities or services in the local community including health appointments.*
5. *Rachel is not able to carry out any caring responsibilities the adult has for a child as evidenced by her children being removed into care.*

And Rachel cannot protect herself from abuse and harm.

About the review process –

BSAB is resolved to consider how reviews can be more effective in terms of balancing the time that agencies are involved in such reviews, timeliness of reviews and learning. outcomes that can improve the service provided as partners. The methodology used was therefore based on a proportionate Serious Incident learning review model (NHS template) that would produce a concise report focused on key learning and recommendations**.**

Summary of Rachel's Serious Incident – Rachel was 38 years old when a series of events that lead to Rachel to continue to self-neglect as well as go missing whilst seeking support as a domestic abuse victim. Rachel was evicted from a Domestic Abuse Refuge as not being able to get along or live with others as well as requiring more support than initial assessed. Rachel reported to the Local Authority seeking temporary accommodation, but because she had a property allocated to her already, she was not granted the accommodation. Rachel was referred for a Care Act Assessment to determine what level of support she required, but as Rachel is a victim of Domestic Abuse and had fled to London for medical treatment and to seek refuge. Several agencies were working to support Rachel, some of whom communicated well together, and some did not. But, during this time, Rachel went missing. Rachel was eventually reported missing to the Police Service and once contact had been made, agencies learned Rachel had already returned to her ordinary residence, and she was hiding in fear from her abuser. She had not been seen for several days before this. The SAR focuses on what happened leading up to this event and ensuring Rachel was safe and had support back in her ordinary area of residence.



Rachel advised the Independent Chairs that the support services she received as being a victim of domestic abuse (DA) had been responsive to her needs, and she was pleased with the support she was given during their interactions. Rachel specifically recognised the efforts made in securing safe accommodation for her. These interactions appear to have had the effect of making Rachel feel empowered and protected. DA Support Services demonstrated preventative partnership working, by escalating the Refuge's request for the risk assessment to her manager when the consent policy & process created an obstacle to sharing information relevant to supporting Rachel. Rachel advised the Independent Chairs she was made to feel welcome by the Refuge, saying, ***"…everybody was very nice when I first got there.",*** indicating Rachel felt protected on arrival.

The Local Authority requested a Care Act Assessment indicating they were concerned Rachel was a vulnerable adult in need of protection and harm prevention. Subsequently, they ***immediately commenced*** undertaking enquiries with other organisations to determine their statutory duties to provide support and protect Rachel. And they recognised the eviction, and difficulties to provide temporary accommodation, as a potentially serious safeguarding issues. ***Escalating their concerns*** for senior managers to determine if Rachel was a vulnerable adult in need of protection and harm prevention, evidencing proactive safeguarding and partnership working. On being notified by the Refuge of Rachel's impending eviction the Local Authority requested advice from management in relation to the possibility of providing temporary accommodation as part of their Homelessness Prevention and Relief duties.

A Housing Agency went ***above and beyond expectations,*** working through various challenging situations, to ensure they maintained contact with Rachel throughout the SAR review period. During the SAR period Rachel interacted with several different organisations across a wide geographic and administrative area. A Housing Agency recognised the critical role they played in supporting Rachel and appropriately shared relevant information with other organisations working with Rachel. Throughout the SAR a Housing Agency remained actively engaged with other organisations, the Independent Chairs, and supported Rachel to help inform the SAR. A Housing Agency has a good working relationship with Rachel, as well as an

understanding of her needs, therefore they played a key role in enhancing the SAR Panel's understanding of Rachel's situation.

Once Rachel's eviction came to the Local Authority, they moved swiftly to contact the various organisations previously interacting with her, to locate and determine her safety.

Areas for Improvement including Immediate Actions Taken to Resolve the Improvement

Rachel was with a DA Support Service who reported not all relevant available information, including a risk assessment, was shared with Refuge. Despite otherwise good partnership working and communications between the two agencies, the SAR Panel found that the Refuge did not challenge the support services strongly enough on the details of the referral, such as the missing risk assessment. ***Immediate Action Taken*** - The obstacle to sharing this information was a policy requiring written consent from a victim/survivor, which was acknowledged and confirmed that verbal consent reported by the Refuge, coupled with relevant legal exceptions/exemptions, should have been sufficient, and this situation demonstrated the importance of proportionality and improving partnership working.

DA Support Service risk assessment ***was not*** shared with MARAC. It appears this was due to a simple administrative oversight and would be addressed by strengthening their accountability processes. ***Immediate Action Taken*** – Review of the process and training for staff regarding this took place before the review completed.

The Refuge report their policy is to conduct their own risk assessment during the reception process. This assessment includes questions such as; the location of the alleged perpetrator and family members, drug and alcohol use, smoking, mental and physical health, medication use, suicidal thoughts, and history of violence/offences. However, the SAR Panel was not satisfied this policy adequately filters out individuals who are beyond their support capabilities (ie. complex cases) to protect survivor/victims and prevent harm. On realising Rachel's support needs were beyond their capabilities, the Refuge ***did not engage quickly*** enough with other partnership organisations who were available to assist them with the challenges they identified supporting Rachel.

After Rachel's eviction from the Refuge, she contacted the DA Support Service several times. They acknowledged that this was a missed opportunity to prevent harm and protect Rachel when she was experiencing a ***"point of crisis***", her case should have been re-opened to provide her with advocacy.

Also, the Refuge acknowledged they could have recognised that, ***despite not using the term "eviction",*** the process of ***"moving on" or "transitioning"*** a safe accommodation resident against their will is effectively an eviction and should have acted more swiftly to identify this to the Local Authority. The first notification was made the day before the eviction. There is provision within the Housing Act 1996 (HA1996)18 for the Local Authority to be notified that a person is "***threatened with homelessness"*** up to 56 days before it occurs. It is important that any organisation referring a homeless, or potentially homeless, person to the Local Authority in order to provide as much warning as possible (up to the designated 56 days) to enhance partnership working and subsequently improve prevention of harm and protection of vulnerable adults.

There was no evidence submitted to show the Local Authority made reasonable adjustments in relation to Rachel's disability and their decisions, in relation to their Homelessness Prevention, Relief, and Main Housing duty, wasn't able to provide up-to-date evidence that they considered Rachel's 'Priority Need' status. Reports by the Local Authority and a Housing Agency indicate that Rachel was inconsistent in her

responses when asked about where she wanted to live. The SAR Panel believed that Rachel's inability to be consistent caused difficulty determining what support to provide her. However, the plans shared by Rachel during this time must also be considered along with her actions, such as daily communication with the Local Authority to proceed her Homelessness Assessment more locally, and her various other high and complex needs. Rachel's behaviour should have been recognised as an indication of her high and complex needs and triggered ***additional prevention and protection actions by agencies working in partnership to support Rachel especially as the Refuge had evicted on this rationale.***

There was Information submitted for the Review as well as discussions with Rachel herself, that indicate her intention to return 'home' was not absolute and ***agencies could have done more to gather what Rachel wanted and been proportionate in their support response to her.***

The Local Authority indicated they were aware of the possibility Rachel may have physical and mental health needs *and a*s part of their response, they had a duty of care towards Rachel to address her housing needs. However, ***no statutory safeguarding intervention actions followed (no s.42 Enquiry).***

MARAC hold letters on file on behalf of victim/survivors of domestic abuse. Both the Refuge and the Local Authority were present at the meeting where Rachel's case was discussed, and information was shared about Rachel. ***Both organisations acknowledged they could have engaged better as members of this partnership before undertaking any decisions relating to Rachel.*** The Local Authority acknowledged they could have consulted local partnerships as soon as they became aware that Rachel was a victim/survivor of domestic abuse, and their enquiries were predominantly with non-Bexley organisations which represented missed opportunities to determine Rachel's most recent status and identify the risks associated with sending her back to her 'home.'

Rachel was legally homeless under the new Domestic Abuse Bill from the moment she left her ordinary residence. This was acknowledged by the SAR Panel throughout the review, however, the Panel also felt that agencies did not understand the new duties as more could have been done to safeguard Rachel at the time.

Rachel's experiences show what impact a high and complex needs individual can have on their support workers. It was found that some workers recorded becoming ***frustrated and sometimes unsympathetic*** with Rachel's needs. The Panel want all organisations to ensure they have measures in place to monitor and review the work of staff engaged in supporting high and complex needs individuals, which also requires recognising the ***impact that supporting such individuals can have on staff and the subsequent effect this can have to safeguarding.***

There was ***no evidence*** was found to show Metropolitan Police Services attempted to conduct any further enquiries when the missing person report for a victim/survivor of domestic abuse was lodged by the Refuge. An enquiry to MARAC could have revealed that Rachel was considered a high-risk victim of domestic abuse as well as the twelve identified risks (including:- suicide ideation, mental health, and physical health). The telephone call by the Refuge when lodging the missing person report with MPS had the effect of downplaying the significance of the event being reported; ***including the language and tone used*** by the Refuge as well as the lack of clear details provided had failed to convey a sufficient sense of urgency.

The MARAC-to-MARAC referral across 2 London Boroughs ***was not updated with new information – only copied information*** from a previous MARAC-to-MARAC referral, which was from another London Borough. It appears the ***data provided was neither verified nor its validity tested***, by any MARAC, when a referral was received and then disseminated as part of the next referral.

Whilst a Housing Agency took an active role in engaging with Rachel as part of the interagency team, at times this involvement was acknowledged as crossing boundaries. Although the Housing Agency were engaged with the organisations working with Rachel, it would have been more appropriate to raise specific concerns with those organisations or to have made a Safeguarding Adults referral in respect of Rachel's unmet support, or where organisations appear to be failing their duties. There are numerous SARs, Domestic Homicide Reviews, and other similar fatality reviews which indicate the dangers of stepping too far into other specialists. It is therefore imperative that organisations ensure they stay within accepted professional boundaries.

The SAR Panel felt that all organisations (including non-commissioned services) would benefit from additional support/learning in relation to the processes surrounding safeguarding. ***This need is particularly acute in services with a high staff turnover***. BSAB currently provides a full complement of Safeguarding training for the whole partnership, the SAR Panel felt that although this is good practice, new staff and appropriate refresher training; possibly a skills audit could be done to ensure all staff are fully informed on these topics.

During the period when Rachel was missing, some information indicated they were ***"concerned"*** Rachel's case had been escalated to the level it had. Additionally, a report stated, ***"it was a surprising escalation"*** **and** ***"…if a client does not respond to a phone call or email, we would not normally report as missing. Also, that we are not responsible to be aware of the clients location every night."***

The SAR Panel agreed that as per the Care Act 2014, '***Safeguarding is everyone's business',*** and agencies would benefit from a skills audit focused on safeguarding and associated topics (e.g.: disability, domestic abuse etc) followed by a formal program of training.

Questions for you to consider -

1. How much do you know about the categories of Priority Need? How Housing assess and the Safeguarding Adult process? New Domestic Abuse Bill 2021 duties?
2. How accessible are your services for someone to speak with staff about their care and support needs?
3. 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?
4. How does your agency engage with MARAC and other high-risk panels?
5. Anything else to ensure you and your organisation understand Safeguarding is 'everyone's responsibility'.

- Bexley Safeguarding Adults Board website – 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 Briefing
  - Other Resources and Links
- Email Bexley SAB at bsab@bexley.gov.uk for any support on embedding this learning