Isle of Wight Safeguarding Adults Board

Learning Review – Miss T

Independent Lead Reviewer: Alison Ridley

Report submitted : September 2016

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1. Introduction

1.1 Summary of the case

Miss T was born in 1985. She was taken into the care of the Local Authority, became a looked-after child and was adopted. She began to experience flashbacks to the traumatic incidents and as a young adult she was diagnosed as having post-traumatic stress disorder and a personality disorder. She began to use drugs as a way of escaping the flashbacks. She began using heroin in 2004 (age 19). She had some limited contact with substance misuse services in 2005. It is understood that she began to be sexually abused and exploited as an adult in 2010. She became emotionally involved with X who was a drug user and a drug dealer, and they became a couple. Her partner would use drugs (both injecting her and withholding drugs from her) to control her. He also had control of her bank account and food supply, and was one of a number of men who were alleged to have physically abused, emotionally abused and sexually exploited her. Miss T sadly died in August 2015 following a cardiac arrest associated with drug taking.

1.2 Why this case was chosen for review

Following the death of Miss T, the Isle of Wight Safeguarding Adults Board (SAB) considered the case against the Care Act 2014 statutory criteria for Safeguarding Adults Reviews (SARs). They agreed that the criteria under section 44 were not met for a SAR to be required, but that there was sufficient reason to think that valuable learning could be gained for a case review to be undertaken. Given the intense, demanding and emotive nature of the case and active involvement of the front line practitioners and officers, it was felt that a Learning Event (which took place on 21st June 2016) should be held to enable maximum participation of those directly involved.

1.3 Nature of the review and methodology

The Learning Event was informed by a close analysis (undertaken prior to the event by the Lead Reviewer) of the extensive multi-agency case record chronology and available agency reports requested after Miss T's death. The Learning Event focused on analysing the 'key practice episodes' of the case in order to highlight elements of good practice and also points where less sound decisions appeared to have been made. The Event supported the group to further analyse these episodes in order to draw out the 'contributory factors', to gain an understanding of what influenced and led to decisions at the time.

The methodology for the Learning Event and subsequent development of Findings in this report draws heavily on the first two stages of the three stage process that is used in SCIE 'Learning Together' reviews[1]. The first stage is to develop a 'view in the tunnel' of how the case unfolded based on the accounts of front line staff, and the second phase is to develop an analysis of the contributory factors that explain how and why practice decisions were made.

Valuable learning was gained from that Event and subsequently the Lead Reviewer was able to gain input from several key practitioners and managers who had been unable to attend. The final report also reflects the subsequent work undertaken by the Lead Reviewer gained from case records, and from the application of relevant policy, legal knowledge and research.

1.4 Lead Reviewer and those involved in the process

[1] SCIE "Learning Together" case review methodology

Alison Ridley is an Independent Safeguarding Consultant who is accredited as a Lead Reviewer by SCIE and by SILP. Alison facilitated the learning event with her colleague Kathy Kelly who is also an accredited SCIE Lead Reviewer. Representatives of all the key agencies who had worked with Miss T were present at the Learning Event including many but not all of those who had been directly involved.

Constraints within the process

Unfortunately there were several key parties who were unable to attend the event including Miss T's keyworker, the Consultant Psychiatrist and the LA solicitor. The Lead Reviewer was subsequently able to gather input from the solicitor and the Consultant Psychiatrist following the event. Contributions were also sought from the relevant Local Authority senior manager and the Service Manager of the IRIS service, but unfortunately neither of these people were able to attend the Learning Event or contribute directly to the report by the time that the report was finalised. Where this may have an impact on what conclusions could reasonably be drawn, that has been highlighted within the report.

2. Appraisal of Practice

2.1 Introduction to Appraisal

The 'Appraisal of Practice' section provides a narrative account of how the case unfolded. Although the narrative does tell the story of the service user, it's primary function is to explore and appraise the responses of the professionals and agencies involved, to evaluate the effectiveness of joint working and draw out the learning.

The account incorporates appraisals of practice and management responses, both good practice and decisions or responses which either exceeded or did not meet standards which would usually and reasonably be expected. The appraisal of practice is informed by case records and the views of those professionals who worked directly on the case, many of whom were able to attend the multi-agency Learning Event on 21st June 2016. Where possible the views of key professionals who were unable to attend the Learning Event have also been incorporated. In addition the appraisals of the Independent Lead Reviewers who facilitated the event have also been incorporated into this section.

In this case the practitioners faced a combination of particularly difficult and complex challenges, which generated ethical and legal dilemmas and considerable emotional demands. The Lead Reviewer was struck by the high level of commitment demonstrated by all the practitioners involved in working on this case, and their determination to achieve the best outcome possible for Miss T.

2.2 Appraisal of practice

October 2014 – Response to initial disclosures of sexual abuse and exploitation

In October 2014 Miss T was admitted for a week to the general hospital with drug related physical conditions. She was found injecting heroin on the ward and was referred to IRIS drug and alcohol service. The following day she was discharged home and IRIS practitioners undertook a home assessment visit. The speed of response by IRIS is noted as excellent practice. Miss T told the IRIS worker that she wished to address her drug misuse. She also disclosed that her partner (X) controlled how much heroin she used and sometimes injected her, so she was not always aware of

the type or quantity of drugs she took. She was injecting into her neck and groin. IRIS commenced Miss T on methadone.

Several days later Miss T disclosed to the IRIS worker (D) that she was being sexually exploited by her partner to pay off the drug debt they had incurred. Miss T said that the exploitation was occurring on the Island and that she was also taken to the mainland where she was sexually abused by other men. The level of trust that was established with Miss T by the IRIS worker was notable, particularly in such short space of time, enabling Miss T to make significant disclosures of sexual abuse and exploitation.

The worker immediately offered Miss T the opportunity to enter emergency residential detox programme as a way of removing her from the risk of further abuse, which she refused. This response by the IRIS worker was excellent practice, providing a meaningful and practical offer that would have significantly reduced the immediate risks to Miss T if she had felt able to accept it. The IRIS worker contacted the Local Authority (LA) safeguarding team for advice but a worker was not immediately available to discuss the case. There is no record of the IRIS worker making further attempts to contact the safeguarding team or of the safeguarding team ringing back at that point.

Miss T requested that her disclosures were not shared with other agencies, which presented the IRIS team with a dilemma. While wanting to follow usual process in safeguarding to share information, they had to weigh that against the high risk of Miss T withdrawing from the service altogether at this early stage. The thoughtful considerations were indicative of a team which had experience of managing high risk situations and was able to make well balanced judgements about managing risk. Miss T was also offered the option of moving into a refuge, which she refused. On 20 October (two working days after the first disclosure) the IRIS worker raised an 'adult at risk' concern to the LA safeguarding team in line with usual practice and it was agreed that a strategy meeting would be held, which occurred on 12 November (three and a half weeks after the concern was raised). Given the serious and obviously criminal nature of the concern it is surprising that the LA safeguarding team did not contact the police at this early stage and that a strategy meeting was not given a higher priority in terms of scheduling, however it is understood that the safeguarding social worker who picked up the referral worked part time.

In early November 2014 Miss T was assessed by the mental health team and admitted briefly to the psychiatric hospital following self-harm (cutting) and an overdose. While on the ward her partner (X) brought heroin in, which was reported to the police. The ward were unaware that X might pose potential risks to Miss T, as at that point there was no safeguarding protection plan in place. Within this same period Miss T was also admitted to the general hospital in response to her concerns that she was miscarrying. Whilst in hospital in-reach contact was made by the Sexual Health Team which was good practice and very responsive, however it is noted that an opportunity for a medical examination in relation to her allegations was missed.

Following her discharge home Miss T disclosed that she had been subjected to further significant incidents of sexual abuse and exploitation. The IRIS worker again offered Miss T a residential rehab placement as a way of offering a period of safety, however she refused. Miss T alleged that some of the men perpetrating the abuse were IOW based police officers. This unusual development led to an understandable degree of uncertainty by IRIS and the LA safeguarding team in relation to how and when to involve police colleagues appropriately in the safeguarding process.

<u>November 2014 – Initial Safeguarding Strategy Meeting is held</u>

The initial safeguarding strategy meeting was held on 13 November. The meeting was chaired by (F) the LA safeguarding team Independent Chair. It was well chaired, covering information sharing and risks. A clear action plan was agreed that evidenced an early and well informed grasp of the legal options available in the circumstances. The Local Authority Safeguarding Team and IRIS were well represented and a member of the LA Legal Team was present to advise, which is also excellent practice at this early stage in the investigation. The police had not been invited due to the fact that criminal allegations against local service police officers had been made, and there was understandable concern that care needed to be taken in the handling of the allegations, given the potential risk to Miss T. The minutes confirm that a task was agreed to inform the mainland based police once Miss T was in a place of safety. This decision which is explored in **Finding 1** was understandable given the unusual circumstances of the case however it raises concerns about information sharing between agencies when a crime has been alleged, and suggests that guidance may be needed to support front line staff and managers who find themselves in this position.

It was agreed that a placement would be sourced for Miss T and funding had already been agreed by IWC's Public Health Department. The IRIS worker and service had been able to access funding in a very responsive way when an emergency situation presented itself. Due to the lack of clarity about whether Miss T had the mental capacity to make decisions to protect herself, the meeting considered use of the Mental Health Act 1983, DOLs (the Mental Capacity Act 2005) and the Inherent Jurisdiction of the High Court[2], which can be sought when an individual maintains capacity but is under duress.

Inherent Jurisdiction

Since its inception in 2007 the Court of Protection has authority to make key decisions (under the Mental Capacity Act 2005) on behalf of people who are deemed to lack mental capacity to make those decisions, but it has no legal powers to make decisions on behalf of people who retain mental capacity to make them. 'Inherent Jurisdiction' is a term used to describe powers of the High Court (found in common law not in legislation) to intervene in relation to 'vulnerable adults' when there is no specific legislation to rely on. Because the remit of inherent jurisdiction is not set out in legislation, it is still being tested out by case law, and for that reason the nature of this authority and the way it can be used is not set in stone and is not entirely predictable. Nevertheless a growing body of case law is providing an increasing understanding of how it might be applied and when it would be appropriate to apply to the High Court for them to considering using those powers.

The involvement of Miss T in the safeguarding process

Miss T was not invited to the initial strategy meeting or subsequent safeguarding meeting and during the course of the case she attended remarkably few safeguarding meetings. This was in part influenced by her variable physical and mental state, and she was also initially wary of meetings involving the police as her disclosures had included allegations against some police officers and so had not generally been keen to attend meetings. Miss T's views and wishes were actively sought and considered throughout the safeguarding process by the staff working directly with her. The efforts of professionals to support her in practical ways and to find a safe way forward for her are clearly evidenced, but it would have been positive if her voice (or that of an advocate) could have been heard more within the key decision making meetings. Consideration was not given to the allocation of an advocate to speak on her behalf, which is explored in **Finding 2**. The Care Act 2014 was not actually implemented until April 2015. The statutory guidance that supported the Act had only just

[2] Further detail about Inherent Jurisdiction can be found at Appendix 1

been issued (in October 2014) so it would be unreasonable to expect that the Local Authority safeguarding team were already familiar with 'Making Safeguarding Personal' or advocacy requirements of the Care Act 2014. However the ethos of 'Making Safeguarding Personal' was not new, and good practice would have been to have ensured the meaningful involvement of Miss T or her advocate.

November 14th 2014 – Assessment under the Mental Health Act 1983

Miss T had remained in hospital as an informal patient however on 14 November she tried to leave the unit and in line with the protection plan she was detained under a holding power of the Mental Health Act (MHA) 1983, section 5(4). A full mental health act assessment was arranged which confirmed that at that time Miss T did not meet the criteria for detention under the MHA 1983. The assessment process was thorough, with the practitioners involved giving careful consideration to the legal criteria and the principles of the Act. While Miss T did have a mental disorder, it was not felt to be of a nature or degree that warranted detention under the MHA 1983. The professionals agreed that the criminal concerns needed to be investigated by the police, and D (IRIS worker) subsequently contacted the police. This was a sound judgement to have made as the police clearly needed to be involved.

In line with the safeguarding protection plan the professionals then considered the use of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) as possible legal frameworks that could support the detention of Miss T at the unit. Judgements about Miss T's mental capacity were difficult to make. On balance it was felt by the professionals who assessed her at this time that she did have the mental capacity to make decisions about her welfare. The use of DOLS to detain Miss T would only be possible if she was found on the balance of probabilities to lack the mental capacity to make specific decisions about her welfare. There were also some concerns amongst the professionals that even if Miss T was found to lack capacity, it would not be appropriate to apply for her detention under DOLs in her 'best interests' within a psychiatric unit when she was not in need of psychiatric treatment, as that would fly in the face of the key legal principles of MCA and the guidance in the Code of Practice. It is good practice that these ethical dilemmas were explored, showing the proper consideration of Miss T's human rights alongside the risks she faced, which is recognised in **Finding 7.**

Using Inherent Jurisdiction to support the protection plan

The professionals were conscious that Miss T's decision making appeared to be constrained and her mental capacity was difficult to assess. This raised the opportunity to explore the use of inherent jurisdiction, however at this point the local professionals (including legal colleagues) were not familiar with this power, which is rarely used. It was clear that further work was required in order to establish whether an application was appropriate and what it could achieve. A further aspect associated with such an application, the implications of which were not fully appreciated by the professionals at this point, was that if the High Court were to be asked to authorise an enforced placement, the local team would need to find a suitable placement willing to take Miss T under those conditions and legal powers. Without a placement, the powers would serve no purpose. While initial work had begun to consider placement options, there had not been time to pursue this yet. The criteria for the use of inherent jurisdiction requires that an individual has mental capacity but their decision making or ability to express genuine consent is being affected by constraints they are under such as coercion or undue pressure. The High Court can apply their inherent jurisdiction to support a plan where the proposed intervention is felt to be necessary and proportionate. In this case the safeguarding protection plan was to locate an appropriate placement for Miss T that would

afford her a degree of safety and time away from the men who were seeking to control, abuse and exploit her, so that she could begin to make her own decisions about her life.

At this point in the development of the case, the safeguarding protection plan was appropriate and Miss T appeared likely to meet the criteria for the use of inherent jurisdiction, however no placement had been located that might accept her, which meant that an application to the High Court was not immediately viable. Finding an appropriate placement proved to be a particularly complex task because Miss T was ambivalent about moving off the Island and also ambivalent about whether she was ready to pursue a detox and rehab placement. The challenging search for the 'right' placement would become a recurring theme.

With all available legal options having been considered the professionals found there were no immediate legal options available to detain Miss T and so on 17 November Miss T left hospital. However over the following days she told the IRIS worker that she had experienced further serious sexual abuse, exploitation and physical assaults by multiple perpetrators, both on and off the island. She self-harmed and was taken to A&E, where her mental health was assessed and her case was subsequently allocated to a CPN. There does not appear to have been involvement of the Sexual Health Service at this point and a further opportunity for an internal medical examination was not taken.

26th November 2014 – Second Safeguarding meeting

The police had been made aware of the initial allegations on 17th November and made the necessary referrals to progress the relevant internal police processes. They attended the safeguarding meeting held on 26th November. The meeting was again chaired by F (IWC Safeguarding Team) and was well attended by staff from IWC, IRIS, Mental Health and the Local Authority Legal Team. Detailed information was shared and an agreed set of actions noted. A further Mental Health Act assessment was proposed and the group rightly recognised that specialist expertise was required. Liaison with the Human Trafficking Team and Sexual Violence Advisor was agreed for advice about placements. Further actions to progress the application to the High Court were agreed for the Chair and the Local Authority Legal Representative. The safeguarding meeting once more actively explored the possible legal options. The Local Authority (LA) solicitor had taken advice from the local regional barrister (Head of Chambers at Southampton) who had knowledge in that area of law, who highlighted some of the difficulties that would be involved. The view was adopted by the LA solicitor that an application to the High Court was not impossible, but that it was unlikely to be deemed appropriate and also unlikely to be successful.

November 2014 - The strategic response by the Police

The nature of the serious allegations made by Miss T against police officers required a strategic response in addition to the operational safeguarding response. The strategic response from within the police was achieved through setting up a Gold Strategic Group in which senior managers who are briefed about the case make strategic command decisions for implementation by Silver Tactical Managers and Bronze Operational Managers. The police investigation was led by officers from the Anti-Corruption Unit of the Professional Standards Department in collaboration with specialist trained officers from Operation Amberstone[3]. A 'sterile corridor' was set up between the different streams of work involved to ensure that the separate focus of the safeguarding officers would not be

[3] Operation Amberstone is a specialist interview team within Hampshire Constabulary that supports all victims of serious sexual assaults and anyone identified as a victim of human trafficking or modern slavery.

influenced by any information that surfaced from the work of the Anti-Corruption Unit or the Amberstone officers. The police response was highly professional and followed good practice.

On November 26th (the same day as the safeguarding meeting) Miss T disclosed to Operation Amberstone officers that an imminent trafficking event was planned for that evening. Despite the risk, she was adamant that she wished to return home. In response to this the police arranged for a series of immediate arrests that evening including Miss T and X (her partner). The police actions were timely and effective in terms of the protection they offered to Miss T, however they did not have not time to communicate with their safeguarding partners as the crisis was imminent. The sequence of events caused some concern amongst safeguarding partners, who at first interpreted the police actions as heavy handed towards to Miss T.

This was one of the points in the case where effective inter-agency communication proved challenging and misunderstandings developed. This case generated particular challenges for interagency working due to (a) the allegations having been made against serving IOW police officers and (b) the close nature of professional relationships on a small island community. Trust between professionals and across agencies is essential for effective working, and in this case the usual relationships of trust were inevitably put under immense pressure. This aspect is explored in **Finding 3.**

Miss T was arrested and seen by the Forensic Medical Examiner (FME). She was subsequently assessed and detained under Section 2 (Mental Health Act 1983) on 27th November, which authorised up to 28 days detention in hospital for assessment. It was felt that she met the diagnostic criteria in terms of mental disorders which were impacting on her ability to make informed decisions, that treatment or assessment in the community was not viable and the circumstances met the risk threshold required to justify detention for assessment. The professionals involved made sound judgements with a well-documented rationale.

During her hospital admission a clear and well communicated safeguarding plan was in place to prevent her partner having access to her. However despite the best efforts of hospital staff, it was later discovered that one of the other visitors to the ward included an alleged perpetrator. This situation further illustrated the additional difficulties for safeguarding agencies in a small island community such as this, where the nature of the informal networks means that confidentiality is difficult.

<u>December 2014 – Safeguarding meetings while Miss T is in hospital</u>

On 1 December a 'Professionals Meeting' was held on the ward and was chaired by the police. The police and Local Authority had agreed that due to the primary nature of the investigation at this point being a criminal one, it was appropriate for the police to lead on the investigation. There is some confusion about whether or not the Local Authority (LA) safeguarding team were invited to the meeting or not. The LA safeguarding Team Manager was not aware of the meeting and did not receive minutes, however those that attended have confirmed that there was no intention to exclude the LA team. This was the first of a number of meetings which were not co-ordinated by the Local Authority during December while Miss T was in hospital. Some were titled as 'safeguarding' meetings and others were titled as 'professionals' meetings, however they were in effect all safeguarding meetings because the case was open to the safeguarding process and they were actively focussed on progressing the established safeguarding plan.

At the meeting D (IRIS worker) was asked to progress a referral through the National Referral Mechanism (NRM) to the Human Trafficking Agency[4] as a vehicle for sourcing an appropriate and safe placement for Miss T. However NRM referrals require the informed consent of the service user if they have capacity to decide. The position was complicated by two factors; firstly Miss T was ambivalent about the prospect of leaving the Island and secondly Miss T's mental capacity was variable depending upon her circumstances. The meeting agreed that the NRM referral should be the main objective of their actions, but that if either Miss T's capacity was found to be lacking or she had capacity but refused to give consent to the referral, then an application should be made for the inherent jurisdiction of the High Court to authorise a placement on the mainland. While this plan was sound and showed a good grasp of the complexities of the legal position generated by Miss T's variable mental capacity to make decisions about her safety, the reliance on the intention to secure a rehab or residential placement that would accept Miss T under the authority of inherent jurisdiction remained an on-going challenge and fundamental flaw in the protection plan.

December 2014 – emerging lack of clarity with agency roles

The police were leading the criminal investigation however the broader safeguarding plan required multi-agency support. In addition the nature of this case was unusually complex with a combination of high risk for the service user and high risks for the agencies in terms of political and media sensitivity. Multiple agency involvement and the requirement for the legal expertise of the Local Authority legal team would suggest that the Local Authority should maintain a clear co-ordinating role in relation to all the other streams of work. The Care Act 2014 (and "No Secrets" before it) confirm that the Local Authority is required to co-ordinate the safeguarding enquiry, and that where the nature of the allegations require a criminal investigation, the police lead on that.

In complex cases such as this case, where there are active broader wellbeing issues, these two aspects of safeguarding should both continue in parallel, with the Local Authority having a duty to co-ordinate and ensure the wellbeing needs of the adult are being met (No Secrets and Care Act Statutory guidance 14.85). Responsibilities for co-ordinating safeguarding processes are explored in **Finding 4.**

Agency decisions about roles of workers needed to support Miss T

a) Allocation of a safeguarding social worker

The Local Authority chaired and provided representation from their safeguarding team at the first two safeguarding meetings. The Care Act statutory guidance states " It is likely that many enquiries will require input and supervision from a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want…other aspects of enquiries may best be undertaken by others with more appropriate skills and knowledge" (14.68-69). The Care Act 2014 and the multi-agency safeguarding policy do not specifically require that a social worker is allocated in each case as there is a recognition that safeguarding is everybody's business and in terms of providing support, the person who knows the service user the best will generally be well placed to undertake key aspects of direct work with the adult (whoever they are employed by).

Where an enquiry into allegations is in registered settings or family settings it is generally appropriate and necessary to allocate a social worker in the short term to make those enquiries. However in this case there was not an investigative role for the Local Authority because the police were leading on the criminal investigation, and the IRIS team were providing the on-going case

[4] See appendix 2

support and speciality expertise, so there was no immediate need for the allocation of a social worker. That approach is in line with "No Secrets" and the Care Act, however the Local Authority does need to retain overall co-ordination of the enquiry.

b) Allocation of a 'longer term' social worker

Where Local Authorities have specialist safeguarding teams that hold cases under investigation (as they do in the Isle of Wight), clear protocols are needed to govern when and how work is transferred between the investigating safeguarding team and other longer term social care teams. This should ensure clear transition and ownership of cases that require on-going social care support. In this case the Local Authority appeared to show a lack of clarity about what kind of on-going social care involvement was needed (i.e. via either the allocation of a community social worker and/or a social care package of support), which generated frustration amongst partner agencies. This is explored in **Finding 5.**

Given the particular nature of this case by December 2014 some consideration should have been given to the on-going responsibilities that were being expected of D (IRIS worker) and whether the level of support and supervision were sufficient. Unfortunately it has not been possible to gather information directly from these parties, so it is not possible to draw any precise conclusions about what level of support was offered. It might have been appropriate for two workers to jointly work this particularly intense case. The Trust could have allocated two workers or the Local Authority and the NHS Trust together could have allocated two professionals even if it was outside usual practice. Instead what appears to have happened is that the police stepped into the role of providing hands on social care support alongside IRIS. The more general issue of support for staff undertaking such intensely demanding work is explored in **Finding 6.**

A death threat was made at this time against the Mental Health Social Worker (AMHP) who had been involved in the detention of Miss T, and emotional pressure was also applied to the IRIS worker (D) by X who attended the IRIS office to discuss the situation. A referral was made by the inpatient team for an IMHA (Independent Mental Health Advocate) for Miss T as a detained patient in line with usual good practice. Meanwhile the Local Authority went to Magistrate's Court and achieved the displacement of X as Miss T's 'nearest relative' (under the MHA 1983), thus ensuring he would not be able to end her detention prematurely. During this period the community mental health team provided in-reach, in line with good practice, visiting Miss T on the ward to assess and support her mental health.

December 2014 – pressures on inter-agency communication

The police issued a press release about the arrests that had occurred, a decision made by the Police Gold Command Group. The decision was single agency and was not discussed with Miss T or with the other safeguarding partners, causing frustration and concern. The police felt they were not in control of timings as the fast pace of the developing case was a factor. This media release was felt to have presented some potential risks to the ward staff and to Miss T.

Ward staff also expressed a level of confusion about the roles of the various different police officers and police teams involved in the investigation, and communication difficulties were also illustrated between the police and ward team in relation to the issue of whether it was legally possible to withhold Miss T's letters from her. Once it was clarified that there was no power to do, the police were required to share a letter from her partner with Miss T. The ward staff felt unhappy that they were not advised when the letter was going to be shared. Unfortunately Miss T subsequently refused to give her consent to the referral to the NRM.

December 2014 – Further assessments of mental capacity

A further 'professionals meeting' was held on 12 December. At this time Miss T had been assessed as still lacking capacity in relation to her welfare. The existing options and plans were discussed again (NRM, Inherent Jurisdiction, or use of MHA or DOLs). At this stage efforts were being made to encourage Miss T to proceed with an NRM referral for a placement on the mainland, which seemed to be the most promising and empowering way of working in partnership with Miss T. The multi-agency safeguarding partners were weighing up complex ethical and legal considerations, and needing to make finely balanced judgements about what would be the most constructive way forward. This task is made even more difficult when the adult has variable or fluctuating mental capacity, and is explored in **Finding 7.**

Miss T presented in a number of different states at different times. Outside hospital, she was almost invariably under the influence of recently taken (or administered) drugs, either alone or in combination. The influence of these drugs on her mental state made it difficult to hold a meaningful dialogue about her management, the dangers of her drug use and situation and any options for the future. Once she had been in the relatively protected environment of the ward for a few weeks, the impact of drug taking was much reduced and it was possible to have more meaningful conversations. The clinical team were able to determine that she did not have any other mental disorder on top of poly-drug misuse. It was the view of the Consultant Psychiatrist that her emotional and psychological development had been adversely impacted by early and long standing trauma, which created a situation where she felt a marked dependence and need for relationships and security, even if they were putting her at risk. His view was that Miss T understood the damaging effect of continued drug use and the potential value of detoxification and rehabilitation over a longer period, but she could not make the decision to give up her accommodation or her relationship. His view was that Miss T's freedom of action was constrained by her past history of trauma and a lack of ability to make truly autonomous decisions, and for this reason, he regarded her as possibly coming under the Inherent Jurisdiction of the High Court with regard to some decision making.

By 17th December (only 5 days after she had been assessed as lacking capacity) the gradual improvement in Miss T's mental and physical health led to her being assessed as having regained her mental capacity. Significantly the Consultant Psychiatrist noted that she had capacity but that it was constrained by coercion and abuse, that she was in 'survival mode'. This assessment was significant because it suggested that Miss T's fragile psychological state needed to be understood in a different way from most other people who have drug addictions.

December 2014 – Difficulty assessing capacity and Miss T returns home

As the period of detention under Section 2 neared its end, the professionals found that Miss T was increasingly determined to return home, and she thought that she would be able to protect herself. The safeguarding meeting held on 22 December reflected the on-going difficulty of ascertaining Miss T's capacity. The notes from the meeting suggest that once again there were questions about whether she had capacity to make decisions about her safety as she (and the professionals) contemplated her willingness to return to what was highly likely to be an abusive setting. Based on the view that she might once again lack capacity, the professionals considered an urgent DOLS application, and those present at the meeting appeared to be under the impression that if Miss T was found to retain capacity then an application to the High Court would be able to provide Miss T with a place of safety, not appreciating that the outcome of any application would not be achieved quickly and that even if the High Court provided the legal authority to move and detain Miss T, it

would not provide a placement. It seems likely that if the group had fully understood the implications of inherent jurisdiction then increased efforts may have been put towards the search for a suitable residential placement on the mainland at this point.

The on-going difficulty of the safeguarding partners to gain a sufficient understanding of the nature of inherent jurisdiction is understandable, it not widely used and by its nature is difficult to grasp because it is not referred to in legislation and rarely mentioned in guidance. Even the Local Authority solicitor had no direct experience of applications to the High Court for Inherent Jurisdiction as they are prepared and taken to the High Court by a specialist barrister. During this period the solicitor had been in regular contact by phone with the Head of Chambers in Southampton, who had noted the difficulties involved in taking an application forward when Miss T's mental capacity was so changeable. The view of the LA solicitor was that an application to the High Court would be the 'last resort' option to be tried only after the more usual legal frameworks of the Mental Health Act and the Mental Capacity had been exhausted. Given the scarcity of case law covering cases of this nature, it is not possible to know how the High Court might have responded to an application. It would have been something of a test case. Safeguarding minutes also suggested that there was some confusion amongst professionals, many of them thinking that the process of applying to the High Court was actually in progress, which highlights the importance of clear communication between all safeguarding partners to inform planning.

The following day (23 December) Miss T's capacity was assessed again and she was found to have regained capacity. She wanted to return home and the ward staff had no legal framework to keep her in hospital. Her detention ran out on 24th December, however the police were not advised that the situation had changed until they rang the ward by chance that morning. This was a significant and surprising communication breakdown by the other safeguarding partners. It was Christmas Eve and key staff were on holiday including police officers and the LA Legal Advisor. At short notice the police put together a contingency plan to provide Miss T with a level of monitoring and support to complement input from other agencies. Miss T was choosing to return to a dangerous setting against police advice so they issued her with a 'threat to life notice' to formally confirm their grave concerns for her safety. Miss T remained at a high risk at home with her partner and due to the nature of her drug use. IRIS workers continued to try to persuade Miss T to consent to the NRM referral as a way of supporting her move to a place of safety, however she remained ambivalent about leaving her partner who was supplying her drugs.

<u>January 2015 – Further safeguarding in response to escalating risk</u>

A safeguarding meeting held on 6th January 2015 again considered the legal options. The LA Legal Representative again shared his perspective informed by the informal advice he had been given by the Head of Chambers. The assessment of capacity in a situation like this is for the clinicians to undertake not the lawyers, however the process of decision-making about whether an application is made to court is less clear. The health and social care staff appear to have deferred to the Legal Team. This highlights the need for clear guidance for all professionals involved in safeguarding cases about how decisions to take court action are made, particularly when there are considerable financial costs associated with such a course of action. An application to the High Court is likely to cost upwards of £5,000. There is a need for transparency about how such requests can be escalated and who are the decision makers. This is explored in **Finding 8.**

Early in the new year Miss T was interviewed by the police and made further serious disclosures of physical and sexual abuse and exploitation. She remained at high risk at home while the police continued their investigations into the allegations she had made against known local criminals,

councillors and police officers. Miss T made further significant disclosures to the police, she was very fearful and distressed, but felt too frightened to support police prosecution. In a bid to protect Miss T the police liaised with safeguarding partners to consider what options were available to protect her. As a last resort the police safeguarding team advised that Miss T should be arrested under Section 136 of the Mental Health Act 1983 by the officers who had been providing her with regular support, as it was felt impossibly dangerous and unethical to return her home. The technical legality of that action was debated and subsequently reviewed by the IPCC. While the letter of the law was not followed exactly, it is clear that the officers were working to the spirit of the law and seeking to 'protect life and limb' as the situation was understood at the time.

Miss T was relieved to be taken to the hospital and was initially open to the possibility of treatment in a drug rehab on the mainland. A mental health act assessment was undertaken but Miss T was found not to meet criteria for detention under Section 3 of the Act. An emergency DOLS authorisation was then arranged (up to 7 days) on the basis that Miss T lacked capacity. Miss T decided she wanted to return home and felt increasingly that she was being punished by being kept in hospital against her will. She changed her mind about starting a rehab placement on the mainland.

A safeguarding meeting was held on 9 January and it was agreed to apply for a standard DOLS to continue to detain Miss T in hospital. The decision to authorise only 6 weeks was made in recognition of the fact that Miss T was not in need of hospital based psychiatric treatment and that it was difficult to justify a prolonged detention in a setting that was not really appropriate. The 6 weeks was intended to allow further searches to be undertaken for a more appropriate residential placement for her on the mainland. This was good practice and showed understanding and appropriate use of the principles of the Mental Capacity Act (2005). Attempts to find a rehab placement proved unsuccessful and were made more difficult by Miss T's ambivalence about going to rehab.

One placement refused to accept Miss T as they felt that her ambivalent motivation and the combination of needs she presented with was too complex a picture for them to manage. Miss T wanted to return home but she was beginning to recognise her decisions were not wise ones, suggesting that she was regaining her mental capacity. There continued to be a continuing level of confusion amongst the professionals about whether or not an application to the High Court was being progressed (with references in minutes of meetings suggesting that the 'COP' papers were still being completed). The professionals started to actively reconsider the NRM placement option (given that Miss T was now not currently wanting to undertake rehab) however now that she had capacity again this could only be progressed with her consent. The DOLS authority ended on 26 January once it was confirmed that Miss T's capacity was regained and she returned home with advice and support from IRIS in place. She was distressed to find that her partner, who was living in her flat, had a new girlfriend.

<u>February 2015 – Efforts to provide support to Miss T in the community</u>

Miss T was referred by IRIS to Adults Social Care for an assessment of her social care needs with a view to services or a placement following rehab if it could be achieved. The police put in place a Notice of Domestic Violence Protection Order (DVPO) which was served on her partner lasting 28 days. This was very good practice, using a very new legal option to try to afford what protection was possible. When her partner almost immediately breached the order by contacting Miss T, he was arrested and bailed.

Further attempts were made to find a placement, and Miss T was assessed by one provider. She continued to allege that she had been threatened by local men who were already under suspicion of harming her. In response she was moved to at least four different places of safety during this period while a more permanent and safer housing solution was sought. Miss T was now once more willing to undergo rehab, and three possible options were considered; rehabs in Plymouth (her preferred option) or in Portsmouth and a residential placement in Bournemouth via the NRM (which Miss T was less keen on).

The police made 7 further arrests in response to the allegations made by Miss T. During this period Miss T seemed to have worsening physical and emotional health. Her drug use remained chaotic and she had no clothes or money. At one point in late February the police had to give her a food parcel. Staff from IRIS and the police were providing a huge amount of day to day practical support to Miss T, who had refused to have a social care assessment, so had no specific social care package or social worker involvement.

<u>February 2015 – Frustration over roles and responsibilities</u>

Concern was escalated by the police to their senior managers and subsequently to senior managers within the Isle of Wight Council about the relatively limited engagement of Adult Social Care in the on-going management of the case. A senior case review meeting was held on 26th February to gain a joint understanding about roles and responsibilities across the agencies and to explore why the chairing of the case had been passed to the police, why Miss T had not been allocated a social worker to assess her social care needs and whether Miss T had been kept sufficiently central to the process. The meeting allowed an airing of frustrations by the front line staff and managers; the Local Authority safeguarding Team Manager felt that there had not been good communication and asked why no decision had been made about who was the key agency. D (IRIS worker) said that she felt the case was currently not being held by anyone. These comments suggest a lack of formally understood agreed roles by all involved and perhaps a sense of how demanding the case had become.

It is impressive that these issues were escalated, showing genuine commitment by the police to the service user and the integrity of the safeguarding processes. The meeting was chaired by the Local Authority, though there was no other senior Local Authority manager present. Outcomes included an agreement by the LA safeguarding Team Manager to allocate a safeguarding social worker (SS) in the short term to pick up several tasks, and to discuss with her Service Manager whether a community team social worker could be allocated. It was also agreed that an inter-agency communication policy should be developed.

Following the meeting agreement was given by the Local Authority for an independent social worker from the main land to be employed however this proved difficult to achieve. The rationale for the decision was that there would be more expertise in this area of work held by staff on the mainland and that the nature of the case may lead to threats being made to a local social worker. In the absence of a worker from the mainland, a local social worker was subsequently tasked to pick up several specific actions. This appears to illustrate the inter-agency pressures that can develop when such a complex and high risk case is being jointly held across three agencies. Open communication at all levels between agencies is needed, and in this case there were clearly times when communication (both in terms of openly highlighting problems and in terms of listening and responding) were not as effective as they could have been. Where there are resource or other issues within agencies that appear to be impacting on how well safeguarding work can be undertaken, these issues must be escalated to the SAB. That occurred in this case and is explored in **Finding 3.**

March 2015 - Ongoing placement and accommodation issues

In early February Miss T spent several days at a rehab placement in Portsmouth but unfortunately she felt that she was not ready to continue with treatment and asked to go back to the Island. She did not want to return to her flat or to a residential placement, so a short term B&B place was found by the Local Authority. Attempts to find safe appropriate accommodation proved difficult because of the limited options on the Island. The DVPO order was still in place which provided a level of protection for Miss T from having contact with her partner. A Social Worker provided some practical support with food and journeys and completed a homelessness application form.

Miss T had decided that she did not wish to pursue the NRM referral to access a safe placement on the mainland, as she did not want to leave her friends on the Island. She was felt to have full capacity to make that decision. A high level of practical support was still also being provided by D (IRIS) and by a police officer who took forward work on house viewing, packing, storage and benefits. The support to Miss T from front line staff of all agencies was clearly demonstrated, however a particularly effective and supportive working relationship developed between the police and IRIS direct workers. The police worker in particular showed flexibility in working outside her usual remit. Miss T's drug use remained a significant concern and her physical health was suffering.

Miss T had viewed a number of flats but had not been keen on them. This period generated particular pressures and challenges for the professionals, as the level of risk and intensity of the case which had continued for over five months inevitably led to some feelings of fatigue and desensitisation. As a part of the safeguarding work a risk assessment was developed with Miss T with expectations placed upon her which were intended to provide constructive boundaries and agreements. However some of these were overly optimistic, setting high expectations which in the circumstances, it was very unlikely that Miss T would be able to achieve. During this period Miss T's capacity was generally felt to be 'good' and the focus of the professionals rightly moved to working in partnership with her to find a flat on the Island which was her preferred option, rather than seeking to impose direction on her.

The case remained open to safeguarding but on 25 March the Safeguarding Team Manager confirmed that the short term tasks for the safeguarding Social Worker role had been completed and her role would end. This was not an unreasonable decision, given the specialist role of LA safeguarding team, which is not intended or resourced to provide long term support. The LA Service Manager advised that she would progress a referral for a social care support worker to support with the on-going housing and benefits issues. Partner agencies had hoped that a qualified social worker would be allocated, so this decision was not a welcome one. It is disappointing that the Local Authority had not planned ahead (from the case review meeting held a month earlier) to ensure a support worker was ready to pick up this work, given the clear messages from partner agencies that additional support was needed. Unfortunately it has not been possible to gain the direct involvement of the senior manager within this review process, so it is not possible to draw any precise conclusions about the Local Authority perspective. However it is known that the situation led partners agencies to believe that the allocation of LA resources had not been adequately followed through, and this generated some continuing frustration.

April 2015 – significant legal decisions made and legal advice gained

During April Miss T was increasingly ambivalent about maintaining the charges against her ex-partner who was still supplying her with heroin. The safe management of her chaotic drug use remained very difficult and she was admitted to A&E following an overdose. A flat in Newport was

located but the LA still had not allocated a support worker so the Service Manager undertook to liaise with housing colleagues who subsequently agreed to assist with sorting out the rent.

A safeguarding meeting was held on 17 April. Miss T was invited but did not attend. The Crown Prosecution Service (CPS) had decided they were unable to proceed with charges in relation to any of the allegations that Miss T had made and an officer met with Miss T to update her on that decision. Miss T was disappointed and she was offered an opportunity to ask any questions, which she declined. Her right of appeal was explained to her. This was following extensive work undertaken to gather and cross reference potential evidence. The detailed criminal investigation was very thorough and also sensitive to Miss T's particular needs and presenting issues. Psychological advice was taken to ensure all possible options were pursued. Despite these efforts it proved to be impossible to find any clear evidence to support the allegations. There was some local coverage in the press about the outcome of the case.

A month earlier the LA Legal Team had commissioned formal written advice from the Head of Chambers in Southampton (the barrister who had been providing on going informal advice to the LA Legal Team). In April they received the advice which confirmed that it would be reasonable to apply to the High Court's inherent jurisdiction if the proposed plan was "necessary and proportionate" and all other legal options had been tried. The LA solicitor's view was that on balance an application to the High Court would not be appropriate. The safeguarding partners, having heard the advice of the LA Legal Team representative, did not escalate the matter, and it seems to have been accepted that an application to the High Court was not viable.

At this time there was a notable deteriorating in Miss T's condition, she disclosed further serious abuse and said that she knew further abuse was planned which she felt unable to protect herself from. Her physical and psychological state were deteriorating. Her hands were dirty, her hair was unkempt and she was not eating properly. She was at a high risk of overdose and was offered an in-patient detox or hospital admission by IRIS, which she refused. IRIS communicated directly with the police to update them on developments. The IRIS Consultant and worker continued to provide Miss T with active support, working to keep her engaged with the service. Input was provided by the MH team aimed at trying to encourage Miss T to undertake therapeutic work initially on self-esteem. D (IRIS worker) was still very closely involved. Threats were made against her and her parents during this period. Her expertise and commitment to Miss T had been remarkable, but it seems likely that more consideration should have been given to the level of support needed by the front line practitioners who were undertaking the direct work on such an emotionally challenging case.

<u>May 2015 – closure of the multi-agency safeguarding case</u>

On 14 May a safeguarding meeting was chaired by the Local Authority with one police officer present. Miss T and IRIS were not present. A decision was made to close the case to safeguarding unless there were any concerns raised by other agencies. The rationale for the decision was that a protection plan was in place which had been agreed by Miss T, she had now moved into a flat and the criminal charges relating to the earlier allegations of abuse were not being progressed by CPS. The LA safeguarding Team Manager thought that there was little more that safeguarding could offer to progress the situation. Given the closure of the police criminal investigation and the on-going difficulty that had been experienced by the safeguarding partners in trying to bring together the necessary and ever shifting components required to secure a legal and safe placement for Miss T off the Island, it was right to question whether it was still appropriate and proportionate to continue using a safeguarding framework as opposed to using on-going multi-agency case management to support and protect Miss T. However when the case was closed to safeguarding on 19th May there

had been no discussion with the IRIS team or with Miss T, which was a significant and concerning gap in practice.

In terms of closing safeguarding cases the Care Act focusses on whether or not the outcomes that were initially set (in partnership with the adult or their advocate) have been achieved or not and whether the risk of abuse has been eliminated "if ….the adult remains at risk of abuse or neglect (real or suspected) then the Local Authority's enquiry duty under section 42 continues until it decides what action is necessary to protect the adult and by whom and ensures itself that this action has been taken" (Care Act statutory guidance p. 250). The Local Authority duty to take steps to protect Miss T therefore continued during this period. The on-going risk of abuse continued to be faced by Miss T and the option of inherent jurisdiction, though problematic, had not been tried.

June 2015 – Attempts to seek the re-opening of the case to safeguarding

Miss T made further serious allegations to her IRIS worker relating to being physically assaulted, trafficked and raped over a 4 day period, being injected with GHB and rohypnol and being held against her will for several days in a flat. IRIS again liaised directly with the police, which was understandable given the close and effective working relationships that had built up. It is not clear whether at this point IRIS had been made aware of the closure of case to safeguarding. Any fresh safeguarding concerns should have been raised to the Local Authority Safeguarding Team by IRIS or by the police officers that were contacted, which would have alerted Adult Services to the fresh concerns and provoked a fresh look at whether the situation met the section 42 safeguarding criteria and should be re-opened.

Miss T was interviewed by the police and agreed to a police medical. She was reluctant to press charges and subsequently withdrew from the interview process as she was too unwell. The MH worker continued to provide regular therapeutic sessions, however the chaotic nature of Miss T's drug use continued with associated high risk. Her physical health was deteriorating and she appeared increasingly unkempt. Miss T had not paid her rent, her flat was broken into and she had threats made against her. The IRIS manager became increasingly concerned and contacted the LA Service Manager to request that the case be re-opened to safeguarding. As far as we are able to tell this did not happen, although the review process was unable to glean any further information about this aspect of the case.

Miss T made further allegations to her IRIS worker on 15 June, saying that she had been kept without food for two days. IRIS informed the police but did not make a safeguarding referral to the Local Authority, which is perhaps understandable given they had already made a direct approach to the Local Authority to ask that the case be re-opened. The Police arranged for Miss T to meet with the Independent Sexual Violence Advisor (ISVA) to talk about undertaking a video interview for use in court. Miss T did begin the video interview but felt unable to complete it. The police showed a continued and impressively high level of commitment to supporting Miss T, trying to protect her and promoting her engagement with the criminal justice process.

Miss T was given 4 weeks' notice to leave her flat, and had started to self-harm on her legs. At this point her key worker D (IRIS) was off sick and Miss T dropped out of treatment. The police were attempting to re-schedule their interview, but Miss T remained ambivalent and decided to withdraw her allegations. She was offered a placement on the mainland but remained reluctant to take up the

option of detox as she did not want to leave her ex-partner. There was limited contact by the services with Miss T during July and in early August she was sadly taken to hospital and died unexpectedly following a cardiac arrest on 5 August 2015.

3. Findings and Recommendations

The Lead Reviewer has developed the findings drawing on the work undertaken by all safeguarding partners who attended the Learning Event, and with valuable input from the co-facilitator of the Learning Event. The Lead Reviewer has developed recommendations and posed 'questions to consider' for the SAR subgroup, in order to support their generation of an action plan. The action plan will be developed and owned by the SAB.

The remit of this review has been focussed on one specific case, although it is likely that some of the learning that has emerged in this case may have a broader relevance and application. Where a broader issue is identified, some further scoping work by safeguarding partners may assist in gaining a clear sense of the size of the issues, to aid development and prioritisation of actions. Where the SAB identifies that a finding and recommendation has a broader more generic application, action planning is likely to be more challenging because the learning involves more complex and underpinning issues. Where shifts in culture or resources are indicated it may be necessary to consider additional mechanisms that the SAB can employ to support improvement to the functioning of the safeguarding system.

3.1 Chart of Findings

1	The initial lack of certainty amongst health and social care partners about how to involve the police in the safeguarding process suggest a gap in guidance that poses a risk to effective safeguarding practice.
2	There was not sufficient active involvement of the adult at risk or consideration of an advocate in decision making at safeguarding meetings.
3	In this case key issues that caused inter-agency frustration were appropriately escalated to a review meeting, but responses agreed by the Local Authority raised expectations which were not subsequently followed through or communicated well to partners.
4	The Local Authority role to co-ordinate the multi-agency focus on protection and wellbeing even during a criminal investigation should have been more robust in the early stages of the safeguarding investigation.
5	The Local Authority guidance in relation to holding and transferring safeguarding cases to

	other social work teams is not sufficiently clear.
6	In this case the complex and emotionally demanding impact on staff was not given sufficient consideration.
7	The practitioners and clinicians were committed to engaging meaningfully with the complex ethical issues involved in the assessment and support of a case of an adult at risk with fluctuating and variable mental capacity.
8	Clear transparent guidance is needed on how roles and responsibilities in relation to decision making about court applications.

- **Finding 1 - The initial lack of certainty amongst health and social care partners about how to involve the police in the safeguarding process suggest a gap in guidance that poses a risk to effective safeguarding practice.**

The Care Act 2014 statutory guidance confirms that where criminal activity is suspected, the police should be involved at an early stage (14.70). "Immediate referral or consultation with the police will enable the police to establish whether a criminal act has been committed and this will give an opportunity of determining if, and at what stage, the police need to become involved further and undertake a criminal investigation"(14.71). However the statutory guidance and the Hampshire safeguarding policy does not specifically cover the eventuality of criminal allegations being made by the adult against employees of the lead statutory agencies (e.g. police officers or elected councillors) who are leading or co-ordinating the investigation.

The agencies dealing at an early stage with the allegations (the Local Authority and Health Trust) discussed the issue of police involvement at the first safeguarding meeting and decided not to contact the police until Miss T had been found a safe placement, even though a crime had been disclosed. They were then intending to contact police colleagues based on the mainland as opposed to their local police officers. However events overtook that plan and as the severity of Miss T's situation escalated the front line professionals involved determined that the police should be contacted.

The initial judgement not to contact the police was unwise, however it is understandable in the circumstances. A lack of procedural guidance did not help, but perhaps even more significant in this case was the inevitable influence for all concerned who were working and living on a small island. The nature of working relationships and partnerships on a small island is different from authorities who operate on the mainland. There are enhanced risks that working relationships could be influenced over time in ways that could potentially become unhealthy. In the same way that large enclosed institutions are prone to become settings where abusive cultures and activities can develop unseen, there are risks for professionals operating in any small community if there is a degree of isolation.

Recommendation – The SAB to consider whether staff should be supported by guidance to assist them in managing safeguarding enquiries where allegations have been made against employees of statutory agencies. Such guidance might also usefully consider the particular impact for agencies and professionals who work on the island as opposed to the mainland, with the associated vulnerability to isolation that this inevitably involves.

- **Finding 2 - There was not sufficient active involvement of the adult at risk or consideration of an advocate in decision making at safeguarding meetings.**

The Care Act 2014 and the Pan Hampshire 'SHIP' Safeguarding policy provides clear guidance about the need for the adult's wishes to be taken into account within a safeguarding investigation "as stated by them or by their representative or advocate"[5]. The guidance states that "if the adult has substantial difficulty in being involved, and where there is no-one to support them, the Local Authority must arrange for an independent advocate to represent them"[6]. Miss T was not actively involved in the initial safeguarding meetings. This may have been because at that point (October - November 2014) the new Care Act statutory guidance has only recently been published and the safeguarding procedures had not yet been updated. However there were many times through the process when a huge amount of consideration was given to Miss T, her views and wishes. There were other times when she was clearly unable to meaningfully engage with the safeguarding process and the involvement of an advocate should have occurred. Miss T had an IMHA appointed while she remained subject to the Mental Health Act 1983 however this was a relatively brief period.

Recommendation: The SAB to consider whether this finding was case specific. If an under-use of advocacy is a broader issue then the SAB would need to consider action required to address this.

- **Finding 3 - In this case key issues that caused inter-agency frustration were appropriately escalated to a review meeting, but responses agreed by the Local Authority raised expectations which were not subsequently followed through or communicated well to partners.**

The ability of key statutory agencies to work effectively together at all levels is essential in safeguarding cases. In this case misunderstandings were generated partly by the fact that the case was relatively unusual, intense and high risk, with the added dynamic of criminal allegations having been made against serving police officers and councillors. Staff found themselves dealing with situations, dynamics and legal questions they had not encountered before.

Particular issues that created tensions across the safeguarding partnership included the role of the Local Authority in co-ordinating the safeguarding investigation, which was not sufficiently clear in the early months of the investigation. The issue of whether a community social worker should be allocated emerged, and also proved to be quite divisive. Additionally planning of the police investigation was undertaken by the Police Gold Group which was a single agency group, but that planning and communication would have been better supported as a multi-agency forum.

Working relationships between partner agencies can naturally be particularly tested when there are high risks to the service user involved and in this case there were also potentially high risks to agencies in terms of the allegations and media interest. Misunderstandings about the roles and responsibilities of the different agencies are not unusual in such a fast changing public sector, and in this case changes generated by new legislation (e.g. Care Act 2014), resource pressures and changes to organisational structures are also likely to have had an impact on how working relationships faired.

[5] Statutory guidance 14.66
[6] Statutory guidance 14.67

It is positive that despite these considerable pressures, the concerns that were generating frustration were effectively escalated to more senior managers, and with the involvement of the SAB. The case review meeting held 26th February 2015 made some headway with the issues and ensured at least that the issues were openly discussed. However outcomes requested by the police and IRIS in relation to the allocation of a social worker following the meeting were only partially followed through by the Local Authority and a clear decision and rationale for the LA response to the concerns was not then communicated by the senior Local Authority manager to safeguarding partners.

Recommendation: The SAB to consider whether the circumstances in this case which generated the frustrations and tensions between agencies (even after the issues were escalated) have been resolved or may re-occur in other cases. If they could re-occur it would be useful for the SAB to look at whether a more active role for the SAB is indicated in actively resolving differences and holding agencies to account, and how that SAB role could be developed and supported.

- **Finding 4 – The Local Authority role to co-ordinate the multi-agency focus on protection and wellbeing even during a criminal investigation should have been more robust in the early stages of the safeguarding investigation.**

The Care Act 2014 confirms that the Local Authority has the "lead role in making enquiries" (14.70) however "a criminal investigation by the police takes priority over all other enquiries" (14.75). Where there is a need for criminal and other enquires, the police investigation should also be co-ordinated with any health and social care enquiries that are also underway (14.71). The statutory guidance also confirms that in cases where a criminal investigation is underway "a multi-agency approach should be agreed to ensure that the interests and personal wishes of the adult will be considered throughout, even if they do not wish to provide any evidence or support a prosecution. The welfare of the adult is paramount and requires continued risk assessment to ensure the outcome is in their interest and enhances their wellbeing" (14.75)

The Care Act 2014 confirms that while investigation of criminal allegations remains a core aspect of safeguarding enquiries, a broader focus on the wellbeing of adults at risk and the ethos of 'making safeguarding personal' are also requirements. This remains the case where allegations have been found to be true or not (Care Act 2014 statutory guidance 14.90).

In many safeguarding cases where a criminal investigation is underway, the adult's protection and wellbeing needs may already be met through the safeguarding protection plan, however in this case, more active on-going support planning was required to ensure Miss T's protection and wellbeing. The complexity, high risk to the adult, high political risk, potential for media interest and the need for active LA legal team involvement, suggests that the Local Authority should have maintained the active co-ordination of the case throughout.

Recommendation: When the police are undertaking a criminal investigation, clarity about the roles and responsibilities of all agencies should be clarified and recorded as a part of the protection plan process.

- **Finding 5 - The Local Authority guidance in relation to holding and transferring safeguarding cases to other social work teams is not sufficiently clear.**

It is now quite unusual for community social workers to actively hold cases open for long. Following assessment of needs, a care package of support is usually put in place and the social worker or care manager will review on an annual basis.

In this case the IRIS worker was highly skilled and had already built a very effective working relationship with Miss T. D's expertise within the substance mis-use field meant that she was best placed to continue as the lead worker and proceed with the task of seeking a placement.

Adults (such as Miss T) who were not receiving a Local Authority funded package prior to the safeguarding enquiry, and are in addition ambivalent about engaging with services, may be particularly vulnerable to missing out on receiving on-going social care support due to the combination of their not having a set of needs that had previously been recognised and their ambivalence about wanting on-going support. Miss T certainly met the criteria for social care services. The national "Fair Access to Care" (FACs) eligibility framework[7], which was in place at the time (prior to the Care Act implementation) was used to assess whether an individual had 'eligible' social care needs. If 'serious abuse has occurred or will occur'[8] then the individual would be regarded as having 'critical' needs and would automatically be eligible for social care services. Miss T clearly had care and support needs which were being responded to be IRIS. She would have been eligible for social care support if she had wanted it. In this case there appeared to be a level of confusion about a) whether Miss T was eligible for social care services and b) which social care team should provide input (i.e. a social care assessment and package of care if appropriate).

Recommendation: Guidance is needed to confirm how and when allocation of cases are passed from the LA safeguarding team to longer term case workers (in cases where this is required).

- **Finding 6 - In this case the complex and emotionally demanding impact on staff was not given sufficient consideration.**

The combination of factors that were impacting on front line staff and managers included management of a very high level of risk to the service user, an adult with variable mental capacity and variable willingness or ability to engage with services, media focus, high sensitivity in relation to the criminal allegations made against serving police officers and councillors, personal threats being made to staff and their family and legal options being explored that nobody had an previous experience of using. In addition to that the nature of the allegations of extreme abuse being made were disturbing and numerous and continued over a long period. The impact of trying to provide or manage practical, consistent support to Miss T and at the same time to protect her from harm, placed staff in an almost impossible position. The level of commitment and resilience exhibited by key staff from all agencies was outstanding. However more thought should have been given to support for staff.

Recommendation: Safeguarding processes in complex cases should include proactive consideration of how staff are being supported and whether additional support or resources are required. The SAR

[7] Fair Access to Care Services (FACS), introduced in 2002, is the national eligibility framework in England for prioritising the use of adult social care resources fairly, transparently and consistently.
[8] FACS criteria (2003)

subgroup should consider how this might be achieved, for example with an addition to the standing safeguarding meeting agenda as a prompt.

- **Finding 7 - The practitioners and clinicians were committed to engaging meaningfully with the complex ethical issues involved in the assessment and support of a case of an adult at risk with fluctuating and variable mental capacity.**

While the statutory guidance around the assessment of mental capacity is clear, it is important to recognise the peculiar difficulty of this case. The Mental Capacity Act Code of Practice is limited in the guidance it offers in relation to the assessment of fluctuating or variable capacity. There are different kinds of situations when capacity may be variable or fluctuating, and some of these are easier to respond to. An individual with a condition that is progressively deteriorating may be easier to assess because the trajectory of their condition and corresponding mental capacity is understood. An individual with a condition who has improved capacity at certain times of day are also more predictable, allowing specific 'windows' when assessment of capacity can be undertaken. However if an individual's condition and/or capacity is not predictable, practitioners are in a far more difficult position in terms of assessment and planning.

The Care Act guidance confirms that "the potential for 'undue influence' will need to be considered if relevant. "If the adult is thought to be refusing intervention on the grounds of duress then action must be taken" (14.92). While that is clear and sounds straightforward, there is no guidance to support the challenge of combining a directive approach with the principles and ethos of partnership working in 'Making Safeguarding Personal'.

It is understandable that practitioners struggled with the complex path of trying to maximise an adult's independence and self-esteem when such high risks and variable capacity was involved. It is very positive that practitioners raised and seriously considered the significant ethical issues involved. The reality of progressing an application to the High Court would have meant (assuming the Court agreed to authorise the plan) the loss of significant civil rights for Miss T, and her being forcibly moved to and detained in a residential establishment on the mainland.

Recommendation: Good practice guidance is needed to support practitioners with the challenges of risk management in cases where an adult at risk has variable and/or fluctuating mental capacity.

- **Finding 8 - Clear transparent guidance is needed on how roles and responsibilities in relation to decision making about court applications.**

The Pan Hampshire 'SHIP' Safeguarding policy does not include detail about the decision making frameworks that need to be engaged to progress applications to court. In this case (which was unusual) the option of an application to the jurisdiction of High Court was discussed many times within safeguarding meetings. The regular involvement of the LA Legal Team representative at meetings was positive, however there was a lack of understanding amongst safeguarding partners about the roles and responsibilities each held in relation to contributing towards a decision or recommendation that a court application should be made.

The role of the Legal Team is to provide advice on legal options available however the final decision about whether to proceed to court is the responsibility of senior managers. In this case an application to the High Court was clearly possible once the other legal options had been exhausted and if a suitable placement had been found. The clinicians and practitioners were responsible for

making a practice recommendation about whether they thought legal action should be progressed. The decision about whether to make an application to court rests with the senior managers of the agency which is going to make the application (in this case the Local Authority). Ideally there would also with input into that decision from other safeguarding partner senior managers.

Recommendation: Guidance should be devised to provide clarity to all partners on their roles and responsibilities in relation to making decisions and actions when court applications are considered, including guidance on urgent escalation for decisions in safeguarding situations that require it.

3.2 Summary Chart of Recommendations

1.	The SAB to consider whether staff should be supported by guidance to assist them in managing safeguarding enquiries where allegations have been made against police officers or county council employees. Such guidance might also usefully consider the particular impact for agencies and professionals who work on the island as opposed to the mainland, with the associated vulnerability to isolation that this inevitably involves.
2.	The SAB to consider whether this finding was case specific. If an under-use of advocacy is a broader issue then the SAB would need to consider action required to address this.
3.	The SAB to consider whether the circumstances in this case which generated the frustrations and tensions between agencies (even after the issues were escalated) have been resolved or may re-occur in other cases. If they could re-occur it would be useful for the SAB to look at whether a more active role for the SAB is indicated in actively resolving differences and holding agencies to account, and how that SAB role could be developed and supported.
4.	When the police are undertaking a criminal investigation, clarity about the roles and responsibilities of all agencies should be clarified and recorded as a part of the protection plan process.
5.	Guidance is needed to confirm how and when allocation of cases are passed from the LA safeguarding team to longer term LA teams (in cases where this is required).
6.	Safeguarding processes in complex cases should include proactive consideration of how staff are being supported and whether additional support or resources are required. The SAR subgroup should consider how this might be achieved, for example with an addition to the standing agenda as a prompt.
7.	Good practice guidance is needed to support practitioners with the challenges of risk management in cases where an adult at risk has variable and/or fluctuating mental capacity.
8.	Guidance should be devised to provide clarity to all partners on their roles and responsibilities in relation to making decisions when court applications are considered, including guidance on urgent escalation for decisions in safeguarding situations that require it.

4. Appendices

4.1 Appendix 1 – Inherent Jurisdiction

The term refers to the court's own power, aside from legislation, to make and apply legal rules, which when used enables them to intervene in relation to adults at risk, even when there is no legislation to sanction it.

Since the implementation of the Mental Capacity Act 2005 in 2007 the Court of Protection has had jurisdiction to make key decision in relation to people who lack mental capacity in relation to those decisions. There is no legislation to make decisions on behalf of adults who do have capacity. However the High Court has retained its inherent jurisdiction (under common law)(to make some key decisions when an adult has capacity but is believed to be either:

- Under constraint or
- Subject to coercion or undue influence or
- For some other reason deprived of the capacity or free choice to make a relevant decision or express genuine consent.

The test for engaging the inherent jurisdiction of the High Court is whether the proposed intervention is necessary and proportionate. The High Court will in the first instance seek to exercise the inherent jurisdiction in a facilitative way to support the adult to make an unencumbered decision, rather than by taking the decision for or on behalf of the adult. The Court's jurisdiction is not about imposing decisions on a person. For example the High Court can seek to enable the adult to have a temporary 'safe space' within which to make a decision free from any alleged source of undue influence, this is generally exercised though injunctions against third parties, rather than by directing the vulnerable adult to live in a different setting, though that may also be possible.

The remit of the High Court's inherent jurisdiction is still being tested out by case law.

4.2 Appendix 2 – National Referral Mechanism

Information about the National Referral Mechanism can be found at :

http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism