Safeguarding Adults Review- Summary report

Rose

Date: 30th April 2024

Colleagues,

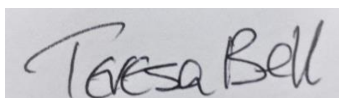
The Surrey Safeguarding Adults Board (SSAB) has today published a summary report in relation to 'Rose' following an independent Safeguarding Adults Review (SAR) being commissioned.

Firstly, the SSAB would like to acknowledge the family involvement in the review process, during an understandably distressing time for them. The SSAB would also like to acknowledge the work and time given by practitioners and frontline managers from all agencies who were actively involved in the review process In order to share the key findings from this review we have taken the decision to not publish the full review and instead publish this summary report with the recommendations taken from the review and including a few questions we wish agencies to ask when reviewing the learning.

We feel that the learning around the complexities of mental health, capacity and adverse childhood experiences should be shared with all agencies to ensure that the learning and recommendations can immediately be embedded into practice.

Please take time to review the recommendation, ask the questions and see how these can be incorporated into everyday practice,

Kind regards



Teresa Bell

SSAB Independent Chair

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What is a Safeguarding Adults Review? (SAR)

A Safeguarding Adult Board, as part of its s.44 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.'

Rose had significant complex needs including, mental ill health, struggled with poly substance misuse, self-harm, self-neglect, and suicidal ideation.

Rose had been known to services in Surrey for most of her life, she had experienced significant adverse childhood experiences, including offending behaviour which led to incarceration and homelessness.

Rose was described by her parents that as a child she was active, popular, and exceptionally talented at sport and as an adult did have periods of positive employment.

Rose had been referred to the substance misuse service 5 times , including 3 self-referrals. Each time being closed for non-engagement.

About the Review Process

The purpose of the Safeguarding Adults Review is to identify the lessons to be learned from analysing the way in which practitioners and agencies worked, together and separately, to safeguard Rose, whose needs were very complex and whose response to professionals involved with her care and support was often very challenging. It will seek to identify good practice on the part of those professionals. Where there were weaknesses, the review will seek to identify the systemic, cultural or organisational issues that contributed to those weaknesses, to what extent subsequent changes have addressed those issues, and what more needs to be done.

Why a Summary Report?

A Safeguarding Adults Review (SAR) has been undertaken by the Surrey Safeguarding Adults Board (SSAB) in respect of an adult known as ‘Rose’.

A summary report has been produced to summarise the key learning taken from the review, this is to support the facilitation of the learning, including good practice examples being shared with all professionals working across the Surrey footprint. These include members of the Safeguarding Adults Board, partner agencies and frontline practitioners.

Please take time to review the findings, reflect on practice and encourage ways to learn, develop and work together. Summary reports are there to help identify clear learning points to improve outcomes, to prevent harm occurring and to support Adults that have a need for care and support.

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Rose's Story

Rose's family would like to remember the *"beautiful, vibrant and colourful person"* she was before she became ill.

At the time of her death Rose had experienced over 10 years of accessing multiple services to support with her complex emotional and mental health needs. As a young child Rose had initially lived with her parents and sister, however in her early teens this broke down and Rose became 'looked after' by the local authority. Rose's story showed that she had experienced significant adverse childhood experiences, which resulted in further negative consequences for Rose, including a deterioration in her mental health, a history of self-harm, dual substance misuse and offending behavior. All of which left Rose vulnerable, homeless, and eventually led to her untimely death.

Rose died on 24th August 2019 by suicide. She was 26 years old. The coroner's conclusion was that whilst under the influence of recreational and prescription drugs at the time of her death as well as in extreme distress and anxiety, Rose had deliberately ended her own life with intention to do so. The coroner concluded that a lack of coordination of services, multi-agency meetings, care planning and care contributed to her death.

Overview of the Case

Rose's story highlighted her lived experiences of trauma, her longstanding involvement with services trying to address and offer support for her complex needs. Rose had adverse childhood experiences which continued to affect her transition into adulthood.

Rose was often reported to be living a chaotic lifestyle, influenced by drug and alcohol misuse, and deteriorating mental health, which made it difficult to offer her meaningful support. Rose made significant disclosures about being the victim of crime which were investigated by police to the extent they were able but resulted in the cases being closed without a prosecution, and this compounded the decline in her mental health and Rose's engagement with services was often sporadic. Rose was reported as posing a risk to herself and others, however there is no clear evidence that further support was offered after a full assessment of her care and support needs was undertaken back in 2017. Under S9 of the Care Act 2014, the local authority must carry out, or at least offer, an assessment of a person's care and support needs if they "appear" to have such needs. If a more trauma aware focus was demonstrated this may have of improved such assessments and outcomes.

At the time of Rose's death, she had been accessing mental health support from the acute mental health trust.

Learning Themes

- **The Impact of Adverse Childhood Experiences and Transition to Adulthood-**

Rose had several moves between the family home and residential placements, including a stay within a secure unit. Rose had a series of traumatic experiences as an adolescent in residential care, including moving into 'independent living' when clearly not prepared. Her constant absconding meant she had no opportunity to develop attachments or relationships with caring adults. Her behaviour led to further rejection into adulthood. It appears that adult mental health services had limited knowledge of the trauma Rose experienced and the leaving care support that should have been available during this transition period was limited.

- **Multi-Agency Working, Co-ordination, and Information Sharing-**
  Agencies working with Rose noted "Communication between the agencies involved with Rose was significantly suboptimal and not of the standard required to support Rose's complex needs. The roles and responsibilities of each agency were not clearly identified. The complex nature of Rose's needs and high level of vulnerability and risk warranted a multi-agency approach. A multi- agency meeting was not arranged, and this should have happened." A more coordinated approach should have been taken, with appropriate information sharing with agencies working together to coordinate the support Rose needed.
- **Making a Reality of the Triangle of Care.**
  The Triangle of Care is a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain mental wellbeing by including and supporting carers. For Rose this was often difficult as she would sometimes refuse to give permission for her care to be discussed with family.
- **Working with Adults with a Dual Diagnosis of Mental Ill-Health and Substance Abuse.**
  In the SABP Dual Diagnosis Mental Health and Substance Use Policy and Procedure, "The use of diagnostic labels and allocation of 'primary' problem should be avoided unless adequate assessment has taken place and a formal diagnosis has been made, particularly in new clients and in those with whom there has been limited continuous contact." With Rose it appears that often her symptoms were seen to be as a result of her substance misuse, rather than an underlying mental health condition.
- **Engagement and Disengagement.**
  Throughout Rose's story, there are repeated references to her failure to engage with or to her disengagement from services. Five referrals to i-Access ended with her being discharged from the service on these grounds after failing to keep a number of appointments. There appears to be missed opportunities to engage Rose or the opportunity to have multi agency discussions in relation to the decisions around engagement.
- **The Interaction Between Health and Social Care Needs and Responsibilities in Mental Health Services.**
  The Community Mental Health Recovery Service throughout the period covered by this review was an integrated health and social care service, managed by SABP but responsible for fulfilling all the duties of the local authority under the Care Act 2014 and other relevant legislation under a partnership agreement made under S75 of the National Health Service Act 2006 between the Trust and Surrey County Council. The

local authority Under S9 of the Care Act 2014, must carry out, or at least offer, an assessment of a person's care and support needs if they "appear" to have such needs.
An assessment was undertaken, and Rose was deemed to meet the eligibility criteria under S13 . however, there was no record of any plan as to how those needs might be met. The local authority's responsibilities were almost entirely lost sight of under these arrangements. The County Council's decision was at least in part due to a lack of confidence that the Trust was effectively delivering on the local authority's Care Act duties In November 2019 the S75 agreement for integrated health and social care services between SABP and Surrey County Council was terminated. Social care services for adults with mental health problems are now directly provided and managed by Surrey County Council.

- **Self-Neglect and Safeguarding.**
  Statutory guidance on the Care Act[1] states that a concern about self-neglect will not necessarily lead to a safeguarding enquiry under S42, and that "an assessment should be made on a case-by-case basis" It is agreed that the guidance is vague on the criteria for an assessment, Surrey Safeguarding Adult Board (SSAB) Policy and Procedures[2] state that in Surrey, the starting point will be an assumption that an adult safeguarding enquiry is not the best response to a concern about self-neglect or hoarding. Instead, the concern should prompt an assessment of care and support needs under S9 of the Care Act. It should be clear though that this is an initial assumption, and the policy sets out a number of conditions which make it more likely to overturn that assumption.
- **The Assessment of Mental Capacity**.
  Although there appears to be reference to capacity assessments being undertaken with Rose, on each occasion she was judged to have capacity. However, there are some decision-making points where greater consideration should have been given to the issue of 'fluctuating capacity'.
  Whether there was a lack of understanding among those working with Rose of the concept of fluctuating capacity it is unclear and needs to be considered.

Good Practice

Examples of good practice is present throughout the review. However, it does appear staff were hampered by the framework of the expectations of their agency, their understanding of their role, and of course the resources available to them. A Professional was persistent in maintaining contact with Rose, flexible in their approach to establishing a level of dialogue with her and trying to identify housing options for her

Two voluntary sector accommodation and support providers made exceptional efforts to hold on to Rose and prevent her becoming homeless, until a point was reached when it was no longer possible for them to provide that care and support. In both cases

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[2] https://www.surreysab.org.uk/wp-content/uploads/2021/04/SSAB-Policy-and-Procedure-2018-FINAL-v5-26.04.2021-accessibility.pdf

they managed to provide supportive accommodation for a year, in spite of the challenges her distress and her behaviour presented. Her support workers and key workers were persistent in working to develop a positive relationship with Rose, to encourage her to engage with services, and to advocate for her. This review pays tribute to their persistence and resilience.

Recommendations for Agencies to Consider.

Surrey Safeguarding Adults Board should:

Recommendation 1:

Consider whether a potential need for clearer national guidance for private health care providers and practitioners on sharing information in a timely manner should be raised via the National Escalation Protocol for Issues from Safeguarding Adults Reviews from Safeguarding Adults Boards.

Recommendation 2:

Seek assurance that the termination of the S75 agreement in November 2019 and the consequent arrangements put in place have ensured that the local authority's duties under the Care Act 2014 are now effectively met, while delivering a holistic and person-centred response to both health and social care needs

Recommendation 3:

Seek assurance that training on the assessment of fluctuating capacity is available and taken up by practitioners in all agencies whose role may require them to make such assessments and evaluate evidence of its impact.

Recommendation 4:

Review protocols on the conduct and purpose of Section 42 safeguarding enquiries and Safeguarding Adults Reviews, to avoid any unnecessary delay and duplication.

Surrey Safeguarding Children's Partnership should:

Recommendation 5:

Recognising that the practice described in this review is historic, seek assurance on the effectiveness with which the needs of young people with the most complex and challenging needs are now met in the care system and care leaver services in Surrey.

Surrey and Borders Partnership NHS Foundation Trust should:

Recommendation 6:

Audit compliance across its services with the recommendations of its Serious Incident Report, that:

> Clinicians conducting initial assessments should meet the requirement to identify carers at the point of assessment and make referrals for carers assessment. An

assurance system needs to be developed in order to ensure the learning from this incident; and

When vulnerable people with multiple agencies involved are open to the CMHRS, a multi- agency meeting should be considered to ensure that all opportunities for support are fully explored.

to ensure that they have been effectively implemented, and report to the Surrey Safeguarding Adults Board on the outcomes of this audit within six months of the publication of this review. The audit should include input from partner agencies.

Recommendation 7:

Review its definition and expectations of the care co-ordinator role, to promote the proactive co-ordination of care on a multi-agency basis, across both the statutory and voluntary sectors.

Recommendation 8:

Ensure that all medical and other clinical practitioners within its service receive training on the Trust's commitment to the Triangle of Care approach and its effective delivery within twelve months of the publication of this review.

Recommendation 9:

Review its Dual Diagnosis policy to ensure compliance with NICE Guidance on regular multi-disciplinary and multi-agency review meetings and multi-agency decision-making on discharge from services.

Recommendation 10:

Review operational policies and arrangements within and between i-Access and community mental health services to promote effective co-ordination, joint working, and shared ownership.

Recommendation 11:

Explore options for developing a more flexible and person-centred approach to service delivery within community mental health and substance misuse services, with less reliance on office-based appointments.

Surrey County Council adult social care should:

Recommendation 12:

Ensure that the conditions / factors set out in SSAB Adult Safeguarding Policy and Procedures, which may overturn the assumption that a Care Act assessment should be the first response to a safeguarding concern about self-neglect, are fully reflected in the associated Levels of Need Framework.

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Questions for Agencies to Consider.

1) How do you support adults that have experienced adverse childhood experiences?
2) When completing a mental health assessment of risk, are all factors considered?
3) Do you consider the level of drug and alcohol use explored in relation to suicidal ideation?
4) How do you consider care leaver status when assessing vulnerabilities?
5) Why was the offending behaviour and information sharing across agencies not triangulated.
6) Do you consider the views of family members when determining capacity?
7) Is there a need for further training and information to explore complex capacity assessments and how to support families to be supported to provide their views.
8) How can you support managing transitions from Children to Adult services.
9) How can you support a young person with multiple complex disadvantages?
10) How do you take a holistic approach looking at substance misuse dual diagnosis along with the mental ill health.
11) Do you consider sharing information and risk assessments with agencies when there is a risk of homelessness-
12) What support can your agency offer to help re-integration back into the community following prison release?
13) How can practitioners be more aware of the signs, implications, and risks of significant disclosures?

Links & Resources

The mental capacity act 2005 codes of practice –

https://www.gov.uk/government/publications/mental-capacity-act/

Nice guidelines-decision making and mental capacity.

https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917 , 1.4.19

Transitional Safeguarding from adolescence to adulthood-Research in Practice

https://www.researchinpractice.org.uk/all/news-views/2018/august/transitional-safeguarding-from-adolescence-to-adulthood/

trauma informed practice

[1] (https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice)

1 (https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Developing-and-leading-trauma-informed-practice.pdf)

Adult safeguarding and homelessness: a briefing on positive practice

https://www.local.gov.uk/sites/default/files/documents/25.158%20Briefing%20on%20Adult%20Safeguarding%20and%20Homelessness_03_1.pdf , and references

[1] See, e.g., https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

[1] https://www.healthysurrey.org.uk/community-health/making-every-adult-matter

[1] https://www.healthysurrey.org.uk/community-health/making-every-adult-matter/changing-futures

Triangle of care

[1] https://carers.org/resources/all-resources/53-the-triangle-of-care-carers-included-a-guide-to-best-practice-in-mental-health-care-in-england

Dual Diagnosis Mental Health and Substance Use Policy and Procedure

Dual Diagnosis Mental Health and Substance Use Policy and Procedure : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Coexisting severe mental illness and substance misuse- NICE Quality Standard

https://www.nice.org.uk/guidance/qs188

This power, under S8 of the Care Act, is expertly discussed in the Safeguarding Adults Review on Peter, which has recently been published by the Surrey Safeguarding Adults Board.

https://www.surreysab.org.uk/wp-content/uploads/2023/03/SSAB-SAR-Peter-Overview-Report-Sept-2022-FINAL.pdf

Victim support - is an independent charity who offer independent support and information to victims of crime.

https://www.victimsupport.org.uk

Citizen's advice bureau offers guidance to find advocacy services –

Citizens Advice

Surrey Safeguarding Adult Board

1 https://www.local.gov.uk/national-escalation-protocol-issues-safeguarding-adults-reviews-safeguarding-adult-boards

https://www.surreysab.org.uk/wp-content/uploads/2021/04/SSAB-Policy-and-Procedure-2018-FINAL-v5-26.04.2021-accessibility.pdf

https://www.surreysab.org.uk/wp-content/uploads/2022/08/Adult-Social-Care-Levels-of-Need-V5-August-2022-.pdf

Please visit the Surrey Safeguarding Board for more resources-Homepage - Surrey Safeguarding Adults Board (surreysab.org.uk)