Learning from Safeguarding Adults Reviews

The Case of Ms F

# Purpose of the Safeguarding AdultReview

Safeguarding AdultReviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults’ Boards get the full picture of what went wrong, so that all organisations involved can improve their practice.

Organisational systems are complex. Therefore findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation.

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. Case Review findings say something more about local agencies and their usual patterns of working. They exist in the present and potentially impact in the future.

It is important that local agencies review the findings from a Safeguarding AdultReview and consider what changes can be made in local processes and practices to prevent such a case reoccurring.

# Succinct summary of case

Ms F was a young woman who died of sepsis. With the exception of her GP, her case was not open to any service until just before her death, when she was referred to Adult Social Care by the Police. Other members of the household were well known to many services in Reading including Antisocial Behaviour and the Police, both as victims and perpetrators.

Findings

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| FINDING 1 **In Reading, the Multi-Agency Pathway for non-engagement is not consistently followed, with the consequence that multi-agency perspectives and resources are not brought to bear when previously-managed risk becomes less controllable.** | |
| **SUMMARY**  Reading has substantial numbers of adults who are either vulnerable or at risk, and who do not engage with services. Whilst this Safeguarding Adults Review was under way, the Safeguarding Adults’ Partnership revised and re-launched an existing pathway to try and increase the likelihood of professionals, led by a senior practitioner, thinking collectively about possible new solutions in each instance of non-engaging adults where risk starts to increase. If practitioners and their managers are not familiar with the pathway, it cannot drive improvements.  **Questions**   * How do practitioners view the issue of non-engagement? How much of a block and a risk is it to the local safeguarding adults’ system? * What attempts have there been to tackle the safeguarding risks that can come with non-engagement? * How can the development of the Multi-Agency Safeguarding Hub promote earlier professionals’ meetings? * How do we empower practitioners to make decisions about service users?  |  | | --- | | FINDING 2 **Assessment tools cannot predict the impact of the eviction process, which results in years of preventative work being swept aside in response to a crisis.** | | **SUMMARY**  Numbers of evictions are growing nationally and there is insufficient understanding of the impact of eviction on vulnerable adults. This is particularly concerning because despite recognition that the boundaries between antisocial behaviour and safeguarding are blurred, it is hard to find any analysis of existing assessment tools and how they can predict the effects of eviction on adults with vulnerabilities.  **Questions**   * Do Board members know of any examples of assessment tools that can help predict the impact of eviction on vulnerable adults? * How will the Care Act 2014 be implemented, particularly around prevention? * What can be done to encourage multi-disciplinary assessments in line with the practice seen in the case at the centre of this Review? | | FINDING 3 **When agencies with different drivers are all working with a complex family, managerial panels do not always have their intended effect and vulnerabilities get lost** | | **SUMMARY**  The Review Team examined the role of the various managerial panels in Reading. For many cases these are working effectively to manage risk. However some agencies are either referring too late or not at all which means that safeguarding risks are not being anticipated and managed, and this is a heightened risk if certain panels receive the bulk of their referrals from the agency that convenes them.  **Questions**   * How can agencies ensure that workers refer early to panels? * Are the criteria for referral clearly understood? * Could referral sources to each of the panels listed above be explored, to see if the patterns mean that some cases are not being referred at all? * How can the use of panels improve joint working between agencies? | | |
| FINDING 4 **Are chaotic childless families losing out because there are fewer tools or mechanisms such as the Troubled Families initiative for professionals to use compared to when a child is present, leading to less alternatives for those adults?** |
| **SUMMARY**  The risk in the safeguarding system is that when professionals in adult services are focussed on individuals (as set out in Finding 6), and in addition, lack the resources that come with programmes like Troubled Families, those professionals are more likely to struggle with services and solutions for the chaotic childless families, who according to the Case Group, are becoming an ever larger cohort within their caseloads.  **Questions**   * What learning from the Turnaround Families programme can be transferred across to vulnerable adults without children, whose antisocial behaviour is problematic for all agencies? * Do agencies think a ‘think family’ approach is important? * How can we reconcile the tension between focus on the service user and consideration of their wider family’s needs, particularly in complex situations? |
| FINDING 5 **Young and assertive service users are less likely to be seen as vulnerable, even in the face of known risk factors, and this has the consequence that crises are missed.** |
| **SUMMARY**  The way some individuals present may preclude their being judged as vulnerable. Ms F had particular vulnerabilities due to events in her life, and for professionals working with adult service users, it is a complex task to assess what different sorts of vulnerabilities lie behind the way in which young and assertive service users present. Understanding and responding to those vulnerabilities might reduce the risk of a distressing crisis for that young person in the future.  **Questions**   * When do you have to intervene? * How can we ensure a shared understanding of what constitutes vulnerable? * Do workers understand the impact of obesity on Mental and physical health? * How can we skill staff up to allow them to differentiate between ‘vulnerability’ they perceive but cannot use to ensure support through Adult Social Care? * Do practitioners understand the impact of situational incapacity? |
| FINDING 6 **Assessment for adults is about individuals, without scope for focussing on co-dependent needs, which means services struggle to understand patterns of need and behaviour amongst co-dependent groups of adults.** |
| **SUMMARY**  Assessment is a crucial opportunity to understand the world of an adult service user, and most families have interdependencies of some kind which it could be fruitful for assessment to explore. Doing this consistently, perhaps considering what approaches have been effective in children’s services, enables professionals to understand risks that otherwise are not made transparent.  **Questions**   * How can we provide young people with a self-protection strategy when they live in chaotic household? * How can staff balance being inquisitive about households and being driven by the process of individual assessment? * Should agencies begin to map adult households with multiple needs in the same way as the troubled Families Programme has mapped households with children? |