Liverpool Safeguarding Adult Board

Safeguarding Adult Review

‘Joseph’

‘Brief Summary’

Contents

1. SUMMARY

1.1 This Safeguarding Adult Review (SAR) concerns the care and treatment of a 72-year-old man who will be referred to in this report as 'Joseph' (not his real name). Joseph suffered from mental ill health as well as substance misuse. He lived in supported accommodation when he was found in December 2019 in poor condition. Thankfully Joseph has made a good recovery and no longer resides at the Supported Accommodation highlighted in this report.

1.2 Liverpool Safeguarding Adult Board, Independent Chair, Duncan Dooley-Robinson has agreed on behalf of Liverpool Safeguarding Adult Board to publish this review focusing on the learning and the recommendations identified through the Independent Review Authors and panel members scrutiny of this case. The omission of specific details has been withdrawn to protect the identity of the Individual.

1.3 Specific detailed findings from this review will be disseminated locally to practitioners and professionals to inform learning and practice improvement.

2. PURPOSE OF A SAFEGUARDING ADULT REVIEW (SAR)

2.1 A Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

- an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect,
- **or an adult is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect, and**
- **there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.**

A Safeguarding Adults Board may also arrange for a SAR of any other case involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs).

2.2 The purpose of a SAR, as described very clearly in the Statutory Guidance[2], is to ensure *"lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account".*

2.3 There is no single prescribed method to conduct a SAR. The Statutory Guidance[3] places emphasis on local decisions with a focus on *"what needs to happen to achieve understanding, remedial action and very often, answers for families and friends of adults who have died or been seriously abused or neglected"*

[1] Care Act 2014 (legislation.gov.uk) Sections 44(1)-(4)
[2] Care and support statutory guidance - GOV.UK (www.gov.uk)
[3] Chapter 14.170 Care and support statutory guidance - GOV.UK (www.gov.uk)

2.4 On 6 August 2020, the Safeguarding Adults Review sub-group of the then Merseyside Safeguarding Adults Board considered the circumstances of the case and decided that the criteria for a Safeguarding Adults Review were met. Delays were then experienced due to the dissolution of the Merseyside Safeguarding Adults Board. The need to commission a Safeguarding Adults Review was passed to the newly established Liverpool Safeguarding Adults Board.

2.5 On 30 September 2021, Ged McManus was appointed as the Independent Chair and Author of the review. He is an independent practitioner who has experience as a Safeguarding Adults Board chair. He has written and chaired a number of reviews, including Safeguarding Adults Reviews, Domestic Homicide Reviews and MAPPA[4] reviews. He has never worked for any agency involved in the review and was judged to have the appropriate skills and experience for the role.

2.6 Carol Ellwood-Clarke supported the Chair of the review. She retired from public service (British policing, not Merseyside) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison.

2.7 Between them, they have undertaken over sixty reviews including the following: Child Serious Case Reviews; Safeguarding Adult Reviews, multi-agency public protection arrangements (MAPPA) serious case reviews; and Domestic Homicide Reviews.

2.8 The first meeting of the review panel took place on 24 November 2021. Meetings were held by Microsoft Teams video conferencing due to restrictions in place as a result of Covid-19. The panel met six times, with the final meeting being on 13 July 2022.

3. Agencies Contributing Information to the Review

3.1 A Panel of senior staff from across the partnership were drawn together to guide the SAR and take responsibility on behalf of Liverpool Safeguarding Adults Board; to ensure proper process was followed and to support the preparation of the report and the agreed recommendations.

3.2 The following agencies were represented on the SAR panel:

Liverpool Adult Social Care

Mersey Care NHS Foundation Trust

Liverpool CCG

Care Agency

Housing

Merseyside Police

3.3 Agencies were asked to provide an Individual Management Report (IMR) – a detailed written report from agencies on their involvement with Joseph. As well as the IMRs, each agency provided a chronology of interaction with Joseph, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR), whether internal procedures had been followed, and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to identify learning and make recommendations where appropriate. Each IMR author had no previous knowledge of Joseph, nor had any involvement in the provision of services to him.

3.4 The IMR should include a comprehensive chronology that charts the involvement of the agency with the subject of the review over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Joseph; and any other action taken.

3.5 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

3.6 IMRs were received from Mersey Care NHS Foundation Trust, Liverpool Adult Social Care, Care Agency, Housing, and Liverpool University Hospitals NHS Foundation Trust. A chronology of involvement was received from Joseph's GP, which was supplemented by an abbreviated IMR. Brief information was received from others, for example, Merseyside Police.

4. Practitioner Events

4.1 The SAR panel considered whether to hold a practitioner event. Due to a significant number of staffing changes in the services involved since the events under review, it was considered that a practitioner event would be impracticable.

5. Joseph's Involvement in the Review

5.1 Joseph was visited at his new home by a member of the SAR panel who is experienced in dealing with people who have mental health problems. The panel member informed him that the review was taking place. Joseph could remember his time at supported accommodation and recalled his time in hospital after becoming unwell at supported accommodation. Joseph indicated that he understood about the review and the report it would produce. He declined to answer any questions about the past. Due to the manner in which Joseph answered questions, the panel member was satisfied that Joseph had an appropriate level of understanding, the ability to retain and weigh up information relating to involvement with the report and had the ability to communicate. However, Joseph did not want to participate in the process and declined the offer of receiving a copy of the completed report, and/or the panel member going through the report with him.

6. Family Involvement in the Review

6.1 Joseph's family met with the Independent Reviewers and contributed to this review.

6.2 Josephs family raised a number of concerns in December 2019 with Care Agency staff, in relation to the state of his room and his health. They also sent a letter Following Joseph's admission to hospital on 18 December 2019, to Adult Social Care setting out a number of concerns.

6.3 An advanced draft of the overview report was shared with Joseph's family and their views are reflected in the final report which will be shared with practitioners in Liverpool.

7. Terms of Reference

7.1 The purpose of a Safeguarding Adults Review is neither to investigate nor to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- Review the effectiveness of procedures of both multi-agency and individual organisations;
- Inform and improve local inter-agency practice;
- Improve practice by acting on learning and developing best practice.

8. Specific Terms of Reference

1. What services did your agency provide to Joseph?
2. Did professionals have any concerns regarding the welfare, including abuse or neglect, and care or support needs of Joseph? Did professionals know what to do with those concerns?
3. What safeguarding concerns did your agency raise? Were there any other opportunities to raise a safeguarding concern or hold a planning meeting in accordance with local multi-agency safeguarding adult policy and procedures?
4. What risk assessments were completed for Joseph, and what risk assessment tools were used? Were the outcomes of these assessments appropriately shared with partner agencies?
5. What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around Joseph?

6. Did colleagues consider Joseph's 'lived experience'? In particular, his economic and social circumstances, access to the support of family and friends, and the impact of racial, cultural, linguistic, faith, disability or other diversity issues on his circumstances, and their capacity to access support?

7. Was the legal basis for family members to act on Joseph's behalf properly considered, evidenced, and applied? Did services listen to and act on the views, wishes, and concerns of Joseph and his family? How was this done?

8. Was information shared appropriately between agencies? Were escalation policies followed if there were any differences in approach between agencies?

9. Did your agency follow its policies and procedures, including the multi-agency safeguarding policy and procedures? Were the policies and procedures fit for purpose?

10. Did any organisational change, during the period under review, have an impact on the quality of service delivered?

11. Has your agency identified any outstanding or innovative practice in this case?

9. Summary of Learning Identified by the Panel

Narrative
Joseph suffered from hypothermia despite being in his own room, which should have been warm.

Learning
There are additional risks to people with mental health issues from the BME community – BME citizens are more susceptible to cold injury/hypothermia than the general population.

Narrative
The reliance on the existing Contract Monitoring Framework to monitor the service provision of a long-term contract, which is not subject to any other regulatory oversight, may be insufficient to build the confidence of service users, relatives, and the wider public in the service provided.

Learning
Site visits can play an important role in monitoring service provision.

Narrative
Both Mersey Care NHS Foundation Trust and Adult Social Care operated independently of each other in Joseph's case.

Learning
Support to service users is enhanced when agencies collaborate effectively to provide services to them.

Narrative
Adult Social Care (Careline) did not recognise that the circumstances leading to Joseph's hospitalisation in December 2019, provided sufficient justification for a safeguarding alert.

Learning
Although there was no further harm in this case (due to Joseph's hospitalisation), delays in accurate decision-making can lead to people being exposed to further harm.

Narrative
Although Care Agency, Mersey Care, and Adult Social Care all completed their own risk assessments, which broadly covered the same risks, there is no evidence that the assessments were shared.

Learning
Sharing the assessments between the three agencies may enable a more comprehensive risk management plan – eliminating potential gaps in an individual agency risk assessment.

Narrative
Joseph's family are frustrated by apparent inconsistencies in the ability or willingness of agencies to share information with them.

Learning
Motivated family members can be significant assets in supporting people with complex needs. The ability of agencies to share information, needs to be clearly understood by agency staff and relatives.

10. SUMMARY OF RECOMMENDATIONS

1. Prior to the onset of winter 2022, an individual risk assessment should be completed for each resident at Supported Accommodation – taking into account, the learning from this review. This is in relation to the additional susceptibility of people with mental health issues and the BME community to cold injury/hypothermia. Effective action must be taken to ensure that risks identified are effectively managed or eliminated.

2. Adult Social Care should review their contract monitoring framework, prioritising those sites where there is no other regulatory oversight. This should include a framework to enable partners to easily report and discuss quality issues. The result of that review should be reported to Liverpool Safeguarding Adults Board by December 2022.

3. Adult Social Care and Mersey Care NHS Foundation Trust should provide evidence and assurance to Liverpool Safeguarding Adults Board that they collaborate effectively together in cases where there is a right to after care under Section 117 of the Mental Health Act (For example, by a joint case audit).

4. Adult Social Care (Careline) should provide evidence and assurance to Liverpool Safeguarding Adults Board that decision makers have appropriate training and supervision.

5. Liverpool Safeguarding Adults Board should consider the creation of a policy framework to enable its constituent members and third-sector providers to share risk assessments – in the interests of service users.

6. Liverpool Safeguarding Adults Board's constituent agencies and service providers should provide assurance to the Board that their staff have guidance and support on how to appropriately share information with relatives. The Board should produce an appropriate overview, for example, 'a seven-minute briefing' on when and how information can be shared with relatives.

7. Agencies that have identified individual learning within this review, should provide evidence to Liverpool Safeguarding Adults Board that their recommendations have been implemented and embedded into practice.

8. Liverpool Safeguarding Adults Board's constituent agencies and service providers should provide evidence to the Board that the learning from this review has been disseminated within their agency.

11. Conclusion

The panel identified a number of learning points and recommendations that they feel can contribute to improving services and reducing risks for other people in the future. The progress against the recommendations identified will be reported in future Liverpool Safeguarding Adult Boards Annual Report.