

## **Bedford Borough and Central Bedfordshire Adults Safeguarding Board**

### **Safeguarding Adult Review regarding Ms A: Executive Summary**

#### **Introduction**

- 1.1** This paper provides an executive summary of the process and outcomes of a safeguarding adult review (SAR) regarding Ms A, an adult at risk, which was undertaken due to 'concern that partner agencies could have worked more effectively to protect the adult'. There were concerns that Ms A had been at risk of neglect and modern slavery when she was an in-patient on a Mental Health Ward. There had been a prolonged multi-agency investigation process, which endeavoured to safeguard Ms A. The decision to arrange a SAR was taken, under section 44 of the Care Act 2014, by the Bedford Borough and Central Bedfordshire Adults Board at its meeting on 15th August 2015.
- 1.2** The Safeguarding Adult Review was requested following a recommendation from the closing Adult Protection Case Conference held on 5th June 2015, due to 'the complexity of the case, communication difficulties between agencies and the outcome of the case for the individual'. At this Case Conference it had been concluded that neglect within a situation amounting to modern slavery had been substantiated.
- 1.3** The Safeguarding Adult Review Report regarding Ms A was presented to the Bedford Borough and Central Bedfordshire Adults Safeguarding Board on 8th November 2016, and the recommendations agreed.
- 1.4** The Safeguarding Adults Board, in accepting the report, concluded that, whilst Ms A's circumstances had been far from ideal, and the outcome of her leaving the UK suddenly left agencies with a sense of unease, there was no evidence that any agency had failed Ms A and she had been safeguarded as far as had been possible throughout the period.

#### **2 Recommendations**

- 2.1** The SAR recommended that:
  - 2.1.1** The final report is offered to be shared with the family in a meeting with relevant representatives as agreed by the SAB Sub Group on behalf of BBCBASB
  - 2.1.2** Joint multiagency training in legal literacy principles is considered – covering the Mental Capacity Act, Mental Health Act, Care Act and Human Rights Act, to assist in improving a shared understanding and approach. Further areas of training to be considered: on the application of the Mental Capacity Act when people have fluctuating mental capacity and mental ill health; specific training for staff on understanding and identifying instances of domestic servitude/modern slavery and safeguarding practice; targeted training for 'champions' who can support their colleagues in developing their practice; targeted training for AMPHs on safeguarding; training for managers and supervisors to be able to support and professionally challenge staff in this area of practice
  - 2.1.3** Options are explored for developing or applying from elsewhere a 'Toolkit on modern slavery' for professionals
  - 2.1.4** Chairing of safeguarding conferences should be consistent and ensure that ownership and implementation of actions is consistently monitored and effected

- 2.1.5 In complex cases, continuity of safeguarding coordination between hospital and community, and continuity of safeguarding risk oversight, prevention of casework 'drift' and appropriate protection planning are ensured through lead safeguarding practitioner co-ordination or escalation for senior management oversight of case progression
- 2.1.6 Develop a multi-agency escalation protocol to support effective communication and decision making within and between agencies and professionals
- 2.1.7 Protection plans are monitored or audited to ensure that they are proportionate and appropriate, specifically when professionals fear that 'unwise decisions' are being made by a the subject of the safeguarding enquiry
- 2.1.8 Support staff to develop confidence and competence through promoting relationship based and outcome focused approaches to working with people in keeping with the Care Act and Making Safeguarding Personal (when working with people who may not want safeguarding enquiries to be pursued, may lack capacity in this area, who don't want to or who can't engage in safeguarding processes)
- 2.1.9 Guidance for staff from all agencies is developed on working with informal carers who are alleged abusers to support them in undertaking safeguarding enquiries and protection planning
- 2.1.10 Relevant policies, procedures and systems are reviewed as appropriate to ensure that the learning from this SAR is supported and reinforced.

### **3 Safeguarding Adult Review Purpose and Process**

- 3.1 The purpose of this SAR was 'to ensure there is a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying what works and to promote good practice'. The aims of this SAR were defined as, not to allocate blame or responsibility, but to identify ways of improving how agencies work together to help and protect adults with care and support needs, who are at risk of harm and abuse and are unable to protect themselves, as described in Chapter 14 of the Care Act 2014 Guidance. The review is not a re-investigation of the case, but a review of what happened to elicit learning for the partnership.
- 3.2 The SAR about Ms A was undertaken in line with the Bedford Borough Council and Central Bedfordshire Council Multi Agency Safeguarding Policy and Procedures and the six safeguarding principles described in the Care Act 2014 guidance: empowerment, prevention, proportionality, protection, partnership and accountability.
- 3.3 The review model used was: to appoint a SAR panel with an independent chair, including senior representatives from core agencies involved in supporting Ms A; construct an integrated chronology with information from relevant agencies; appoint an independent reviewer to work with the panel and produce a summary report containing analysis and issues; hold a learning event to discuss the findings and develop recommendations and actions to take forward the learning; formally report to the Safeguarding Adults Board Sub Group for discussion, agreement, implementation and monitoring. The SAR panel met three times and the learning event workshop was held on July 11<sup>th</sup> 2016. The Chair of Panel was Glenda Tizard, Community Manager, POhWER and the lead reviewer and overview report writer

was Dr Adi Cooper OBE, independent consultant. Panel members were from Bedford Borough Council, Beddoc, East London Foundation Trust, Bedfordshire Clinical Commissioning Group and Bedfordshire Police.

- 3.4** There was some delay in starting the review process due to unavoidable circumstances in a key agency and the decision to interview a number of staff from key agencies by the Chair and lead reviewer. This meant that the SAR was completed by July 23<sup>rd</sup> 2016, and not within the envisaged six month time frame.

#### **4 Ms A and Case Chronology Summary**

- 4.1** Ms A's parents died when she was young and family members supported her through her education. She came to the U.K. on a student visa and attended College. When she completed her studies she continued to live with her family members, doing housework, cooking, cleaning and ironing, looking after their 3 children and receiving regular 'pocket money'. Her student visa had expired and during her hospital stay her immigration status was clarified as an illegal over-stayer and due for administrative deportation.

- 4.2** An integrated chronology of contact with key agencies was compiled from contributions from: Bedfordshire Police; East London Foundation Trust (mental health services); Bedford Borough Council adult safeguarding services; Bedford Borough Council Children's services; Bedford Borough Council Legal services; BEDOC; Bedford Clinical Commissioning Group.

- 4.3** Ms A was admitted to a psychiatric Ward under section 2 of the Mental Health Act in September 2014. She presented as 'mute', 'catatonic', 'very malnourished and dehydrated'. A few days after admission she started talking and she made disclosures to staff that concerned them. In October 2014 a safeguarding alert was raised by a nurse on the Ward regarding concerns of neglect, emotional and psychological, financial and material, and institutional abuse, as well as 'concerns that she maybe being used as a modern day slave'. A protection plan was developed. Ms A was diagnosed with schizophrenia and treated.

- 4.4** A prolonged safeguarding investigation was undertaken between October 2014 and June 2015 according to current policy and procedures, with numerous case conferences and other meetings.

- 4.5** The safeguarding investigation included the following range of areas: Ms A's physical and mental health history, college attendance, immigration history and status; Mental Capacity Act assessments and advocacy; evidence of neglect or indications, such as behaviours, of modern slavery and referral to the National Referral Mechanism; interviews with family members and actions to displace her family members as the 'Nearest Relative' due to the safeguarding concerns; protection planning, use of Section 17 leave and alternative options to returning to live with her family members.

- 4.6** In her first months in hospital Ms A was reported as behaving inappropriately 'hugging randomly staff and kneeling in front of them'. She would not sit down and eat with other patients but behaved 'as a servant', wanting to serve others. It was reported that the Ward staff themselves were divided in their opinions about her behaviours: 'some feel (the behaviour and practice indicate that the situation) is cultural, some feel it is neglect/slavery'. On several occasions Ms A did not engage with professionals undertaking processes or was reported to avoid engagement. She was reported as unwilling to talk to police or make a formal allegation.

However, over the period of time Ms A was in hospital her eating and drinking improved and she put on weight; and her self-care improved. She repeatedly said that she wanted to return to live with her family members as well as having repeatedly said that she was obliged to return home 'to finish her assignment'.

- 4.7** Prior to Ms A's discharge from the hospital there was a great deal of activity amongst staff involved in the case and considerable confusion about what was the correct course of action. There was a focus on the displacement of the family members as 'nearest relative', which did not occur. The family members applied for Ms A's discharge, on the basis that she could be treated at home with community mental health support, and a Tribunal Decision upheld their request. Ms A then became an informal patient. Use of Deprivation of Liberty Safeguards was explored and was deemed unsuitable.
- 4.8** In April 2015 mental health and mental capacity act assessments (MCA) were undertaken. The Approved Mental Health Professional (AMHP) assessment, recommended Ms A should go home to the nearest relative, as the most appropriate and least restrictive option, citing the family's commitment to look after her, the statutory guiding principles and a discussion of the current state of the safeguarding investigation. The MCA assessment deemed that Ms A had capacity to decide to return home. Ms A was discharged into the care of her family with a risk assessment covering self-neglect and protective measures, and a discharge care plan specifying twice daily visits by the Crisis Team and Assertive Outreach Team.
- 4.9** Ms A had community mental health support when she was visited twice a day to monitor her medication and her well-being for several days. Subsequently the Crisis Team was informed that Ms A returned to Nigeria voluntarily. Safeguarding meetings and case conferences continued to review the safeguarding investigation and obtain more information. The 12<sup>th</sup> and final Adult Protection Case Conference Meeting concluded, on the balance of probability, that there was enough evidence to substantiate the allegation of modern slavery, following national guidelines and checklist from the Department of Health. This meeting recommended that the case be considered for a Safeguarding Adults Review because of 'serious concerns (about how Ms A) was discharged from the ward into the hands of the people alleged to have caused her harm'. This outcome of the final safeguarding case conference was communicated by letter to the family members.

## **5 Key themes and recommendations**

- 5.1** The four themes that were identified as areas of learning from the SAR were: Modern Slavery (Protection principle); Legal literacy and safe discharge from hospital (Proportionality and Accountability principles); Protection planning and risk (Prevention and protection principles); and Person centred working (Empowerment principle). Questions arising from these themes were discussed at the workshop in July 2016 and the output informed the recommendations from the SAR (see above).