BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult BB

Executive Summary October 2019

Background

Concerns regarding the way in which disclosures made by Adult BB were dealt with by multiple agencies were made to the Safeguarding Adults Review Sub Group (a Sub Group of Buckinghamshire Safeguarding Adults Board) by Buckinghamshire Healthcare NHS Trust. The referral raised concerns around the multi-agency response to repeat allegations made by Adult BB of rape by a member of staff employed by the residential/nursing home where she resides. Adult BB made this disclosure a number of times to different professionals however referrals to Thames Valley Police and Buckinghamshire County Councils Safeguarding Adults Team were delayed.

In September 2018 the Safeguarding Adults Review Sub Group considered that the criteria, as outlined in the Care Act 2014, was met and therefore a decision to convene a Safeguarding Adults Review was made.

It was decided that the review should maintain an underpinning principle of proportionality. It was decided that the review will seek to understand the circumstances leading up to the allegation made by Adult BB and to consider, as far as is possible, the learning arising from the response made by agencies to the allegation. The review aimed to promote multi-agency system learning, and not blame. The review is retrospective by nature and therefore the identified learning carried the benefit of hindsight.

Adult BB's Lived Experience

Adult BB is a 97 year old female who has a history of urinary tract infections and low sodium levels, leading to periods of increased intermittent confusion. Adult BB had been known to a number of professionals who were acting responsively to her presenting medical, care and safety needs. Adult BB receives residential care on a self-funding basis. Adult BB's daughter was involved in her care and advocated for her with professionals.

In the middle of July 2018 Adult BB was visited by GP1 at Care Home A. It is recorded that Adult BB had been presenting as unsettled for a couple of days prior and had described being in labour and being ready to have a baby, that there was blood all over the floor, that she was seeing her father jump out of the window, and being raped. At the time of the visit by GP1, Adult BB was presenting as calm and recognised GP1 and she repeated that she had been raped the day before. GP1 made a referral to the Multidisciplinary Day Assessment Service (MuDAS) as GP1 felt the hallucinations were due to an organic cause.

Two days later, Adult BB was seen by MuDAS who felt that Adult BB was experiencing delirium as secondary to a urinary tract infection. Antipsychotic

medication was suggested and a referral to the memory clinic was also recommended.

During the assessment carried out by MuDAS, Adult BB reported being raped by a night worker three weeks earlier. Adult BB was unable to explain exactly what had happened or provide a name for the night worker. Adult BB 's long term memory was recorded as good and that her memory is okay in between periods of confusion; it is further recorded that Adult BB's symptoms were improving. There was anecdotal evidence reported that the clinician advised Adult BB's daughter to inform Care Home A about the allegation.

Adult BB was discharged and Care Home A reported that Adult BB's daughter informed the home manager of her mother's allegation that afternoon; Adult BB s daughter provided a description of the worker as reported by her mother. Care Home A did not take any immediate action. Two days later the manager of Care Home A and the Deputy Manager met with Adult BB who provided a consistent description of the member of staff she alleged had raped her. At this point Care Home A suspended a member of staff and state they made contact with the police; however the police had no record of this contact.

On 23/07/2018 the Safeguarding Adults Team received two referrals relating to Adult BB's disclosure. One referral was made by Adult BB's daughter and the other referral was made by Care Home A. The Safeguarding Adults Team informed the Local Authority Safeguarding Manager who has responsibility for overseeing allegations against people in a position of trust. The Safeguarding Adults Team also informed the Local Authority Contracts Team. A decision was made to trigger an Adult Safeguarding Enquiry under section 42 of the Care Act 2014. On the same day Care Home A sent the Safeguarding Adults Team a statement provided by a member of staff who Adult BB had spoken to about the incident on 17/07/2018.

Thames Valley Police recorded that a call was made to them on 23/07/2018 by the manager of Care Home A. The police graded the call as requiring urgent attention. A detective was allocated the investigation and a joint decision was made with the Safeguarding Adults Team to carry out a joint visit to Adult BB the following day. Adult BB was seen but police records indicate that she was unable to describe the incident itself. After the visit to Adult BB both Thames Valley Police and the Safeguarding Adults Team made contact with Adult BB s daughter to provide updates.

GP4 was contacted by Care Home A on the 30/07/2018 where the Home was continuing to report Adult BB as continuing to be confused. As a result GP4 made an urgent referral to the old age psychiatry team. Adult BB was reviewed by the Old Age Psychiatry Team who visited her at the beginning of August 2018. Records held by Adult BB's GP surgery suggest that the Old Age Psychiatry Team reviewed records held by Care Home A and that the allegation of rape had been clearly documented and that Adult BB's daughter acknowledged her mother was experiencing "…many other distressing and disturbing hallucinations".

On the 02/08/2018 agency checks were sent by the Multi-Agency Safeguarding Hub to other agencies.

A further visit between the Safeguarding Adults Team and Thames Valley Police took place on the 20/08/2018. Adult BB continued to present with consistencies in her allegation and described the alleged perpetrator in the same way she had previously. The following day the allocated Detective emailed the Social Worker confirming that the Police intend to take no further action having exhausted all lines of enquiry including concluding there was no CCTV available, relevant members of staff had been spoken to, and that care notes had been obtained. The allocated Detective confirmed that Adult BB s daughter had been informed and was understanding of the Police position. The email made reference to the Officer continuing to be concerned as to why Adult BB was so worried about the male worker she had been describing. There was insufficient information available to conduct a meaningful interview with the alleged perpetrator.

Key Lines of Enquiry

The below Key Lines of Enquiry were specifically explored as part of the Safeguarding Adults Review;

<u>Was information sharing and communication amongst agencies carried out in a timely manner?</u>

This review has identified a number of opportunities where Adult BB did not benefit from timely information sharing and communication between agencies charged with promoting her wellbeing. This included;

- Adult BB had made consistent disclosures of abuse to a number of professionals who did not contact relevant services. Adult BB had made her initial disclosure to GP1 with Care Home A staff present on the 16/07/2018. Two days later, information – including details of Adult BB's disclosure – was handed over when Adult BB was seen at the Multi-Disciplinary Day Assessment Service. This information was not shared with the Police or the Safeguarding Adults Team until 7 days after the original disclosure was made; potentially 9 days after the alleged incident.
- A Social Worker requested support from Adult BB's GP to explore whether Adult BB required medical intervention around any potential sexually transmitted infections and for a conclusive view of her capacity in relation to consent for a referral for medical tests. It took 21 days before the Social Worker received a response from the GP. Contextually, it is important to note that at this point it was two and a half months after Adult BB made her initial disclosure.
- There was some evidence identified of good communication between agencies. At times this fell short of the standards expected. Given the delays in the referral process a safeguarding meeting would have been helpful. This would have enabled professionals to quickly gather all information, to plan

enquiries, to determine what capacity assessments were required and by who, and to begin forming a safety plan for Adult BB and other residents.

Was Adult BB 's mental capacity and best interests considered in line with legislative requirements?

Concerns around Adult BBs mental capacity to make specific decisions throughout this time, was a confusing picture. The review identified that at no stage had her capacity been formally assessed in relation to any element of the safeguarding and criminal enquiries. Some missed opportunities included:

1) Consent to engaging with the safeguarding adults process
2) Consent to an onward referral to the Sexual Assault Referral Centre
3) To consent to her daughter acting as her advocate
4) To consent to multi-agency information sharing
5) To consent to continue to reside at Care Home A
6) To make decisions about the care staff supporting her

There was evidence of professionals attempting to provide a view as to her mental capacity although in the absence of determining a lack of capacity, professionals have no alternative but to work within a presumption of capacity. The review identified that professionals were faced with an individual who was experiencing intermittent confusion of varying degree. Additionally she had a diagnosis of dementia and delirium. The grounds to formally assess Adult BB s capacity were clearly met. There were missed opportunities to enable Adult BB to make decisions or for decisions to have been made in her best interests.

Were correct processes followed by agencies receiving the allegation of sexual abuse?

This review has found that agencies did not follow agreed local protocols for allegations of sexual abuse made by an adult against a person in a position of trust. All professionals at the time considered Adult BBs allegation to stem from her presentation of confusion. This overwhelming dominant narrative meant that her consistent disclosure was not listened to or acted upon by her GP, medical staff from the Multi-Disciplinary Assessment Service, or care staff at Care Home A. Little consideration was given to other indicators of sexual abuse.

There was no referral to the Sexual Assault Referral Centre. Adult BB should have been given the option of accessing this service at the point she made her disclosure, which would have not only provided her with necessary support but also maximised opportunities for forensic evidence.

Adult BB was not given the opportunity to engage with the Police at the point she made the disclosure. Whilst the police carried out a thorough investigation in partnership with the Safeguarding Adults Team, they were unable to seek any forensic evidence due to the delay in receiving the information. A delayed referral

meant that the Safeguarding Adults Team could not give early consideration to the potential risk to others from a person in a position of trust.

What arrangements are in place for the care home provider to inform relevant commissioners of the allegation of sexual abuse?

Buckinghamshire County Council's Contracts Team were made aware of allegation made by Adult BB following information shared with them by the Safeguarding Adults Team on the same day they received a referral.

Were appropriate assessments, including risk assessments, carried out and did they refer to what should happen?

It is regrettable that health professionals involved and practitioners from Care Home A did not recognise or effectively assess the risks at the points where Adult BB disclosed sexual assault. A safeguarding meeting at the point of referral would have enabled a comprehensive early assessment of the risks and supported the development of an interim safety plan.

This review also identified that Care Home A had begun seeking statements from members of staff without considering the potential impact on other investigations. The Safeguarding Adults Team appropriately advised them not to continue with this.

Should advocacy have been considered or offered to Adult BB?

Adult BB benefited from the support provided to her by her daughter. Throughout the investigation there is evidence of both Thames Valley Police and Buckinghamshire County Council Safeguarding Adults Team keeping her informed. The daughter of Adult BB had also made a referral to the Local Authority the same day as Care Home A.

The Local Authority are under a duty to provide access to independent advocacy where a Safeguarding Adults Section 42 Enquiry is underway if Adult BB had substantial difficulty in being fully involved and if Adult BB had no appropriate person to support and represent her wishes. Adult BB's daughter continued to represent her views throughout agency involvement, including prior to the adult safeguarding enquiry.

Whilst Adult BB was represented by an appropriate person, there were no apparent attempts to ascertain Adult BB's views and wishes regarding advocacy. Additionally Adult BB was not supported to provide her desired outcomes from the safeguarding enquiry until the end, rather than obtaining these at the start of the process.

Areas of Good Practice

- Two joint visits between Thames Valley Police and the allocated safeguarding Social Worker.

- Despite forensic timescales having lapsed upon receipt of the referral, the Police explored all further lines of enquiry open to them.
- Upon receipt of the referral, the Local Authority Safeguarding Manager was informed that an allegation had been made against a person in a position of trust. Equally Thames Valley Police allocated their investigation to the Domestic Abuse Unit who holds responsibility for investigations relating to people in a position of trust.
- The Local Authority Contracts Team were made aware at the earliest opportunity which enables them to maintain oversight of concerns raised where there are implications for provider organisations.
- The Buckinghamshire Healthcare Trust Safeguarding Team recognised the possible multi-agency learning, including their own, and made a referral for a Safeguarding Adults Review to be considered.

Areas for Learning

- Delays in making a referral to the Police and the Safeguarding Adults Team impacted the timeliness of a response to Adult BB's disclosure, for example forensic timescales had lapsed.
- Throughout the period of the Safeguarding Adults Review, Adult BBs capacity was never assessed for any decision by any agency. This is particularly in reference to engaging in support from the Sexual Assault Referral Centre.
- Adult BB's presentation of confusion and at times hallucinations became the dominant narrative amongst professionals who first received her disclosure. This impacted on the curiosity of professionals to see her allegations in the context of other potential indicators of sexual abuse such as repeated urinary tract infections. Additionally professionals did not consider the consistencies in what Adult BB was saying and her persistence in making the disclosure.
- Adult BB's desired outcomes were not requested until the end of the Safeguarding Enquiry.

What Recommendations have been made?

Agencies have identified their own learning and will take forward single agency recommendations. The Safeguarding Adults Review has made a number of wider recommendations to the Buckinghamshire Safeguarding Adults Board. This includes;

1. Buckinghamshire Safeguarding Adults Board should complete a multi-agency audit into situations where allegations of adult sexual abuse are made by older adults and people presenting with confusion. The audit should specifically address practice quality, multi-agency contributions, timeliness, evidence of consideration being given to SARC and/or sexual health services, outcomes and how effectively the Mental Capacity Act was implemented.

2. Buckinghamshire Safeguarding Adults Board should establish an assurance mechanism to evaluate the effectiveness of the newly implemented multi-agency policy around allegations against people in a position of trust working with adults.

3. Buckinghamshire Safeguarding Adults Board should review practice guidance around undertaking Section 42 Enquiries, including when a safeguarding meeting should be convened at the point of referral. This should support multi-agency practitioners in determining what factors should lead to enquiries beginning with the structure and coordination that a safeguarding meeting promotes.

4. The Clinical Commissioning Group should provide assurance to Buckinghamshire Safeguarding Adults Board partners that the impact and outcomes of adult safeguarding training provided to health service personnel have been evaluated. The evaluation should consider how well embedded the following training topics have been embedded into practice;

- The multi-agency focus of adult safeguarding intervention
- The role of health service staff including the use of expertise and the limitations
- Professional curiosity, keeping an open mind and how health vulnerabilities increase the risk of harm
- Management of allegations against people in a position of trust
- The indicators of sexual abuse
- Individual and collective professional responsibility to refer matters of concern to the appropriate authorities
- Awareness of processes for following allegations of sexual assault including the role of the Sexual Assault Referral Centre

5. Multi-agency guidance should be developed around the pathways accessible for adults who are or who have potentially been survivors of adult sexual abuse. This should expressly outline the responsibility of all agencies to ensure survivors receive timely access to emotional and physical support.

6. In order to complement the multi-agency safeguarding adult policies and procedures, guidance should be considered for practitioners to support them when conducting joint safeguarding adult enquiries with the Police and where an allegation is made against a person in a position of trust.

7. For a task and finish group to be established – reporting into the Safeguarding Adults Board – to design a standardised assurance process for agencies to demonstrate how the Mental Capacity Act 2005 is implemented, adhered to, and embedded in practice. This should have an underpinning principle of ‘high support and high challenge’ so that the partnership is effectively holding each other to

account. Any assurance process designed should enable individual agencies to measure compliance and impact. Additionally it should identify areas of strength and improvement across the partnership.

8. Active promotion of the Sexual Assault Referral Centre and how it can be of benefit in cases of sexual abuse.

9. Information should be made available to practitioners about how the Equality Act 2010 relates to their work when providing services to adults at risk.

What happened next?

On the 14th August 2019 a representative from the Local Authority visited Care Home A to meet with the new Management Team. The new Management Team had been briefed about the safeguarding incident involving Adult BB. Managers at Care Home A recognised that employees may not have felt able to escalate concerns to the Police or Local Authority at the time of Adult BB's disclosures. They informed the Local Authority representative that they are encouraging an open and transparent culture.

Adult BB remains in Care Home A. It is reported that her mental capacity is not compromised when she is well and she continues to seek the support of her daughter when making decisions. Adult BB has been given the opportunity to seek alternative care, however this offer was declined as Adult BB is very happy and settled at Care Home A. Adult BB has not had a recent UTI and is able to manage her fluid intake sufficiently.

Adult BB does not receive care from the member of staff she made the allegation about. They are said to have a good working relationship now.