Safeguarding Adults Review

Subject: Rita
Age: 49

Report Author: Andrew Williamson

1. Introduction, Background & Circumstances Leading to the Review

1.1 Rita was 49 years old when she died at the Royal Devon & Exeter Hospital (RD&E) on 20th October 2017. She had been admitted to the hospital on 14th October 2017 following a 111 call by her partner as he was concerned about her apparent breathing difficulties. She did not recover consciousness. The initial Safeguarding referral from the RD&E outlined significant concern about her physical condition, a significant number of what appeared to be burn marks on her body and known use of crack cocaine & IV drug use.

1.2 An inquest opened on the 8th November 2017. At the inquest hearing on 14th August 2018 the following findings and determinations were made: The medical cause of death was infective endocarditis and Intravenous Drug Use. Rita had a history of illicit drug abuse and was known to inject intravenously. This led her to develop infective endocarditis, from which she died on 20th October 2017 at Royal Devon and Exeter Hospital. The Coroner concluded that Rita's death was drug-related.

1.3 Rita had moved to Okehampton in Devon from Cornwall in January 2007. She lived alone and had a partner with whom she spent a great deal of time. Rita's family lived in Hampshire and she had not seen or spoken with them for some time. Rita had a diagnosed mild learning disability and was known to a number of agencies:

- West Devon Homes/Devon and Cornwall Housing
- Devon County Council Community Enablement Team (CET)
- Devon County Council Okehampton Community Health and Social Care Team (CHSCT)
- Devon County Council Safeguarding Adults Team
- Devon Partnership Trust Intensive Assessment and Treatment Team (IAAT)
- Okehampton Medical Centre, Primary Care (Rita had two GPs during the period of this review)
- Devon and Cornwall Police
- Royal Devon and Exeter NHS Foundation Trust

1.4 Rita's lifestyle and relationship with her partner was chaotic. From November 2007 until July 2011 Police have a record of limited but consistent reports of domestic abuse between the couple. An incident occurred at Rita's address in November 2007 in which her partner was the offender and Rita the victim; however, it is noted that this incident may have been fuelled on either side by their issues associated with drug and alcohol misuse and that they both were mentally incapacitated as a result. The next day Rita refused to make a statement against her partner. In November 2009 there was a further report of domestic abuse and Rita's partner was cautioned. He was given bail conditions after this offence was charged. Rita was asked by the Police why she had not previously engaged with domestic abuse support services and she said that she had no credit on her phone. A separate incident occurred in March 2011 where Rita was the offender and her partner the victim; Rita had hit her partner in the nose. Neither would engage nor make a formal

complaint. Support from a domestic abuse support service was offered but not taken up.

1.5 From September 2015 health agencies report Rita was becoming reclusive and were being advised by neighbours that they only very rarely saw her outside the flat and said she feared going outside. The only way to get Rita to see her doctor was by the Primary Care Liaison Nurse taking her out in her car.

1.6 On 14th October 2017 Rita's partner contacted 111 as Rita had a red and inflamed heroin injection site, confusion and her respiratory rate had increased. Although this call had originated as a 111 call, following telephone triage it was deemed an ambulance response was more appropriate. SWASFT attended the property and a provisional diagnosis of sepsis was made and Rita was conveyed to the RD&E.

1.7 On 16th October 2017 the RD&E raised a Safeguarding Concern with DCC Safeguarding Adults Team stating that Rita has been admitted to the Intensive Care Unit presenting with serious signs of self-neglect including very poor hygiene and burn marks around her body that are consistent with heroin use and burns from cigarettes. There were further concerns surrounding Rita's partner and the role he may have played in Rita's current situation/supply of drugs. Rita died in hospital on 20th October 2017.

1.8 Devon Safeguarding Adults Board (DSAB) received a referral for consideration of a case for a Safeguarding Adults Review on 24th October 2017 in respect of Rita.

1.9 The Care Act 2014 states that a Safeguarding Adults Board (SAB) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Section 44 of the Care Act 2014 sets out the criteria for a SAR[1].

1.10 The Safeguarding Adults Review Core Group (SARCG) reviewed the referral for Rita on 5th February 2018 and it was recommended that the criteria for a Safeguarding Adult Review (SAR) was met which was then approved by the Independent Chair of the Devon Safeguarding Adults Board. The following principles should be applied by SABs and their partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

[1] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

- Professionals should be involved fully in reviews and invited to contribute their perspective without fear of being blamed for actions they took in good faith.
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.[2]

2. Methodology

2.1 The Care Act 2014 Statutory Guidance states that the process for undertaking a SAR should be determined locally according to the specific circumstances of individual cases; that the SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.[3]

2.2 The methodology used in this 'review' includes the following activities: collation of chronologies from relevant agencies and individuals involved with Rita, a panel consisting of safeguarding experts within the Devon Heath and Care community and an event to review learning with all relevant health and social care staff who knew Rita. The key learning points, and recommendations from this report and the learning event will inform an action plan.

2.3 Individual Management Reviews detailing their respective involvement with Rita were requested from the following agencies:

- Devon County Council Adult Health & Social Care
- Devon & Cornwall Police
- Royal Devon & Exeter NHS Foundation Trust
- Devon Partnership Trust
- Devon & Cornwall Housing
- Primary Care (Rita has two GP during the period of this review)

2.4 A multi-agency Learning event was convened on 6th November 2018 which included professionals from all agencies who all worked with Rita in the scope of this review. The purpose of this event was to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk. The event was facilitated by the Local Authority Safeguarding Practice Lead and the CCG Safeguarding Designated Nurse and included the Independent Report Writer, Andrew Williamson.

3. Process and Scope

[2] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
[3] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

3.1 Full Terms of Reference were agreed on 11th June 2018 and are included in Appendix 1. It was agreed that the scope of the review would take account of events in the life of Rita during the period from January 2014 – October 2017.

3.2 The SAR had three central objectives:

- to review and evaluate the context and circumstances leading up to the death.
- to learn appropriate lessons across organisations.
- to establish whether Rita's death raises any questions in relation to multi-agency working.

4. Family Engagement

4.1 The Care Act 2014 Statutory Guidance states that early discussions need to take place with the adult, family and friends to agree how they wish to be involved.

4.2 The Devon Safeguarding Adults Board (DSAB) sent an email and letter of introduction to Rita's sister on 30th May 2018 inviting her to contribute to the review. The letter requested that she give the names and contact details of Rita's mother and children to invite them to contribute to the review also. On 8th June 2018 Rita's sister responded to the letter asking what information was needed and also requesting information on what happened to the contents of Rita's flat. She included her telephone number in the email. A response was sent on 14th June 2018 informing her that the DSAB were looking for her views on how she felt organisations worked together to care for Rita. Rita's sister was asked if she would be happy for the Independent Report Writer, Andrew Williamson, to call her to discuss and she was also informed that DSAB did not have any information about Rita's flat or the contents; but that we would contact Devon & Cornwall Housing to establish if they could provide her with information. The DSAB office requested again that Rita's sister provide the names and contact details of other family members.

4.3 On 27th June 2018, Rita's sister responded confirming that she has spoken with Rita's mother and eldest son and that as a family they are unable to comment on the support Rita received whilst living in Okehampton as they were unaware of the issues. Rita's sister confirmed that the family would like to know the circumstances surrounding and leading up to the death of Rita. Rita's sister wrote that Rita was a *"vulnerable adult who sadly was let slip through the system. We know this won't bring her back, but we can hopefully try and make sure no other children/family go through what we have gone through."* Rita's sister confirmed that she wanted to speak with the Independent Report Writer.

4.4 The Independent Report Writer (Andrew Williamson) initially made contact with Rita's sister, by telephone on 10th July 2018. The sister advised that Rita had not had contact with her family for over ten years. Andrew Williamson explained the SAR process, the likely timescales for completion of the review and asked how the family would wish to be involved. Rita's sister confirmed

that she would be the point of contact for the family and would ensure that they are kept informed on the progress. Since the initial contact, the lead reviewer spoke with Rita's sister on a number of occasions to update her in terms of the progress of the review and to arrange for Rita's family to both view and comment on the report prior to publication.

4.5 On 25th October 2018 DSAB sent a letter to Rita's sister and Rita's mother, inviting them to meet with the Independent Report Writer and panel representatives. The letters also invited them to provide the names and contact details of other family members or to show them the letter by way of invitation. No response has been received to these letters.

5. Areas where Learning has Occurred

5.1 Communication and Information sharing

5.1.1 Rita had a diagnosed learning disability and was known to a number of agencies. Agencies use different recording systems which can inhibit information sharing and communication. It was felt that in order to communicate, understand and respond appropriately to risk for vulnerable adults with support needs, there needs to be a coordinated and collaborative response to sharing information.

5.1.2 In 2015 Learning Disability Services were redesigned and social care was taken out of what were joint health and social care learning disability focus teams. At the learning event, it was noted that there was a perceived impact on close working relationships and opportunities to collaborate on cases and share expertise arising out of the redesign of the service. Learning Disability Nurses described that they felt as though they were working in isolation in Rita's case without the expertise of trained social care staff and believed that a collaborative approach would have benefitted Rita.

5.1.3 Learning Disability Nurses described a real sense of loss due to dissolution of joint teams, they described it as being more difficult to engage with social care colleagues as they were no longer co-located. Previous albeit informal processes to share information and risk between agencies to support Rita, was lost when the two service were no longer co-located.

5.1.4 For 10 years Devon County Council (CH&SCT) has had established Core Group in place. The Core Group provides a forum for health and social care professionals across agencies to communicate about the most vulnerable people in their community. However, the focus of these forums has been on older adults and they have had a primary focus of supporting hospital discharge and preventing hospital admission. Staff did not consider the Core Group as a way of sharing risk information for Rita due to the focus being on older adults.

5.2 How the safeguarding referrals in respect of Rita were addressed in relation to her self-neglect.

5.2.1 Self-neglect is a category of abuse set out within the Care Act 2014. Self-neglect covers a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings. Section 14.17 of the Care Act Statutory Guidance in August 2016 notes that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.[4]

5.2.2 Rita's property was described by professionals as basic and sparse. The property was observed to be mouldy in 2014. The Primary Care Liaison Nurse reported that in 2016/17 furniture was blood stained due to wounds on Rita's body caused by IV drug use.

5.2.3 In April 2013 [pre-Care Act] a safeguarding referral was made by West Devon Homes [now Devon and Cornwall Housing]. The nature of their concerns were around Rita's self-neglect, misuse of drugs and alcohol and a disclosure they had received from Rita of a fear of being raped. The recommended outcome of this referral was for a social care assessment to be undertaken. The referral was passed to Mid Devon Adult Learning Disability Team who arranged to undertake a face to face assessment.

5.2.4 The assessment took place at the end of April 2013. Rita was living in privately rented accommodation provided by West Devon Homes. She confirmed during the assessment that she wanted to move to supported accommodation due to being targeted by others in the community which was threatening her tenancy. West Devon Homes staff explained that Rita finds it difficult to say "no" to people and there were a number of people coming to the property frequently which resulted in complaints from neighbours due to noise levels and drug and alcohol misuse. Rita described being bullied and targeted by individuals in the community and the behaviour of these individuals at her home address was threatening her tenancy. Rita described feeling depressed and overwhelmed by everything which had resulted in her staying in the house and becoming less independent. It was apparent that Rita is vulnerable and is easily exploited by others who do not necessarily have her best interests at heart. There was a lack of exploration of Rita's fear of being raped during this assessment which was a missed opportunity to safeguard her and to understand the actual risks.

5.2.5 Rita was assessed as being eligible for funded social care services and it was proposed that she would benefit from purposeful activities to get her out of the house and improve her mental wellbeing. Day Care Opportunities were arranged, initially for one day per week to provide Rita

[4] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

with stimulation and positive engagement. Rita never used this service despite there being evidence of several attempts made by professionals to support Rita to attend, so this support offer ceased.

5.2.6 Housing staff may often be well placed to identify adults at risk and in this case; it was housing staff who first raised concerns in April 2013. It may well have been the right decision at this time for a social care assessment to be undertaken as a proportionate response to the risk and due to the differing views in terms of the level of self-neglect. It is possible that housing staff felt unable to challenge the decision made at this time not to take further action under safeguarding. Devon & Cornwall Housing have introduced a property checklist to support all housing staff including contractors with assessing the condition of the property, evidence of neglect and welfare of the person. In addition, all staff now undertake safeguarding training.

5.2.7 In October 2015 [post-Care Act] a further safeguarding referral was made by Rita's GP. The nature of their concern was in respect of apparent multiple cigarette burns to Rita's lower limbs, IV heroin use, an infected hand lesion and poor mental health issues which impacted on her ability to manage her day to day living and safety. The concern was triaged by Devon County Council Safeguarding Adults Team, and the recommended outcome was for the concern to be closed. The rationale given for closure of the safeguarding referral was that the information received pertained to Rita's drug use and possible mental health issues in managing her day to day living skills and safety. It was felt that a face to face visit by the Primary Care Liaison Nurse who was already working with Rita was a more appropriate response as there have been concerns raised by Rita's GP in relation to the sensitivity required when discussing issues with Rita. The Safeguarding Social Worker made a referral to the Intensive Assessment and Treatment Team (IAAT). IAAT did not accept the referral as their criteria was not met but this was not fed back to the Safeguarding Team. The Primary Care Liaison Nurse did continue to visit Rita as requested by the GP.

5.2.8 If a referral is made between agencies and teams and this referral is not accepted, then it is essential that this is fed back to the referrer and steps are in place for the referring team to review their decision making. This emphasises the importance of agencies and professionals having an understanding of other organisations' roles and referral criteria.

5.2.9 Professionals reflecting at the learning event agreed that the 2nd safeguarding referral in October 2015 should have met the thresholds for a Section 42 safeguarding enquiry. A challenge was noted that there were differing views on the condition of Rita's property and level of self-neglect. That said, this appears to have been a missed opportunity to work in a collaborative way using safeguarding processes and investigation. Safeguarding processes in this case did not help Rita nor give confidence in a system to safeguard vulnerable people by ensuring that all

professional referrals are taken seriously, acted upon and that feedback is provided.

5.3 Engagement and Mental Capacity

5.3.1 During the scope of this review Rita did not appear to have any contact with her family. Her partner / friends / associates were also known to use illicit drugs. Rita appeared to be socially isolated, refusing to leave her home. There were concerns about the relationship between Rita and her partner and the role he may have played in the supply of drugs and self-neglect.

5.3.2 Information held by the Police, illustrates that there was a history of domestic incidents between Rita & her partner, which whilst concerning, according to the police, did not illustrate coercion. Rita's lifestyle and relationship with her partner was chaotic, though professionals reflected at the learning event that Rita's partner did appear to care for Rita.

5.3.3 Information held by the Police illustrates that when Rita was held in custody she disclosed on two occasions that she could not read and on one occasion that she could not read or write. Warnings/flags were not put in place and this was not taken into account when interacting with Rita. Police had no information that Rita had a learning disability.

5.3.4 It appears that the health and social care system supporting Rita was not sufficiently robust to be able to support Rita and although there were attempts to proactively engage by the GP, the Primary Care Liaison Nurse and by Social Care, this did not result in a positive outcome for Rita.

5.3.5 Health agencies reference non-engagement with Rita missing several health appointments offered. These appointments were frequently offered by letter despite Rita having poor reading skills. It may have been the case that health agencies were not aware of her reading difficulties. That said, the Learning Disability Team offered annual learning disability health checks and Rita was given these appointments via easy read leaflets.

5.3.6 Despite challenges with engagement being noted, there is evidence that Rita did give professionals slight opportunities to engage, for example, she advised the learning disability nurse to visit in the afternoon instead of the morning as she will be more alert by then.

5.3.7 All agencies agreed that Rita had capacity to make specific decisions about her life choices and health decisions and that Rita did not appear to wish to seek help for her addiction. There was the presumption of mental capacity and therefore no formal mental capacity assessment was completed. As professionals believed that Rita had mental capacity it was accepted that she was making unwise decisions. This possibly gave workers a way of ending involvement or having a 'hands off' approach due to reluctance to impinge on her human rights. There is always a need to

balance autonomy and unwise decision making with risk.

5.3.8 There is no evidence available to suggest that staff considered that Rita's ability to make capacitated decisions regarding her life choices and health decisions might have fluctuated. There are many factors that could lead to Rita's capacitated decision-making being compromised, including but not limited to; her variable emotional / mental health, poor physical health and infections, her difficulties associated with drugs and alcohol, as well as external pressures / influences. If there is reason to be concerned that an individual's capacity for a specific decision may be affected as is indicated in Rita's case, staff need to ensure that consideration of this is recorded and assessment outcomes are clearly evidenced.

6. Good Practice

6.1 The DSAB may wish to consider how organisations can be supported to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. Professionals who attended the learning event identified areas of good practice from their own and other agencies' involvement.

6.2 There was evidence of some excellent practice despite challenging systems. Notable practice included:

- A Student Social Worker persevered in working with Rita and was able to form a meaningful relationship. The same quality of relationship was observed between Rita and the Primary Care Liaison Nurse.
- There were proactive approaches by professionals. One professional went above and beyond their role in offering support, for example, taking bloods to the RD&E and offering to drive Rita to medical appointments.
- In spite of Rita closing the door, professionals kept the door open to services.
- Rita was offered annual LD health checks and was given appointments via easy read leaflets.

7. Conclusion

7.1 There is a general agreement from health and social care agencies who knew Rita on the key issues arising from undertaking this SAR and the areas where learning has occurred.

7.2 There is evidence of challenges in relation to communication and information sharing. There were no shared records, and this caused difficulties in sharing contemporaneous information and risk management. There needs to be a better way of communicating and sharing records across health and care systems to ensure that support is continually joined up and that risk is understood.

7.3 Information held by the Police illustrates that when Rita was held in custody she disclosed on two occasions that she could not read and on one occasion that she could not read or write. Warnings/flags were not put in place to communicate this information onward when dealing with Rita. Staff need to be clear when they should and can share information.

7.4 The outcomes of the two safeguarding referrals made by housing and health professionals were not to proceed to a section 42 safeguarding enquiry. There was a missed opportunity to work in a collaborative way under safeguarding. Further action under safeguarding would have supported information sharing between agencies and might have achieved a better outcome. Furthermore, the outcome of a referral from the Devon County Council Safeguarding Team to IAAT was not fed back to the Devon County Council Safeguarding Team. Had this have been fed back to Devon County Council Safeguarding Team then they could have reviewed their decision making.

7.5 Rita did not appear to wish to seek help for her addiction and there was an acceptance by staff that this was her choice. All agencies appeared to agree that Rita had capacity to make decisions about her lifestyle and health care. Professionals accepted that Rita was making unwise decisions. There is no evidence that consideration was given to the possibility that Rita's capacity in relation to lifestyle choices and health care may fluctuate and no evidence that a mental capacity assessment was completed.

7.6 There appears to have been a lack of multi-agency working to enable professionals to manage the risk post the dissolution of joint teams. Professionals reflecting at the learning event agreed that there needed to be a multi-agency risk management process to talk about people whose lifestyles might be described as chaotic and who are at high risk. That said, any involved professional could have called a risk management meeting in this case. It is possible that professionals did not do this as no one person felt they were holding the case or as a result had a compulsion to attend if such meeting was called. If such a process could be established this could ensure a way of communicating, recording and sharing information between the various agencies and enable a coordinated response to the presenting risks.

8. Recommendations

8.1 Whole system acknowledgement that when working with people with complex needs whom professionals, services and agencies find difficult to support; there needs to be joined up support and planning which ensures the most effective engagement to the persons unique circumstances.

8.2 There needs to be clarification and development of consistent terms of reference for forums across the health and social care system and the county e.g. Core Groups need to be used in a consistent way across the County and include all adults of concern regardless of age.

8.3 A multi-agency risk management forum should be put in place in Devon to consider cases of complexity and risk such as self-neglect and other high-risk situations, where staff are struggling with how to manage or reduce the risk. To support practitioners, a multi-agency risk management forum would require senior level representation and offer a fresh approach with creative solutions, access to specialist support and legal advice where appropriate.

8.4 A programme of awareness & education across all staff to ensure effective awareness of services available along with threshold levels. This would include referrals and information flow to/from the Safeguarding Team and information flow back.

8.5 Review Safeguarding processes to ensure:

i) An escalation protocol is developed and agreed and that professionals are aware of it through it being circulated widely.
ii) Staff are able to identify concerns in relation to self-neglect and have the confidence to act on their levels of concern knowing what to do about this.
iii) Staff are clear when they should and can share information.

Appendix 1

Terms of Reference
SAR Rita

1. Introduction

1.1 Rita was 49 years old when she died at the Royal Devon & Exeter Hospital on the 20th October 2017. She had been admitted to the Hospital on the 16th October 2017, following a 111 call by her Partner as he was concerned about her apparent breathing difficulties. Rita did not recover consciousness. The Initial Report from the RD&E outlined significant concerns about her physical condition, a significant number of burn marks on her body and Rita was known to have difficulties associated with IV drug use and crack cocaine.

Rita had been known to a number of Agencies and reports outlining their involvement will be reviewed. The referral to the Devon Safeguarding Adults Board was made by the Safeguarding Adults Manager, Devon County Council.

1.2 This Safeguarding Adults Review (SAR) is commissioned by the Devon Safeguarding Adults Board (DSAB) in response to the death of Rita. The review is conducted in accordance with the Devon Safeguarding Adults Board SAR policy and procedures (2017) which are underpinned by the statutory guidance requirements of the Care Act 2014 (section 44).

"The purpose of conducting a Safeguarding Adults Review is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk. The Safeguarding Adults Review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary. (DSAB SAR policy and procedures (2017) s4.1)

"Specifically, the purpose of the Safeguarding Adults Review is to:

- Determine what might have been done differently to prevent the harm or death;
- Identify lessons and apply these to future cases to prevent similar harm again;
- Review the effectiveness of multi-agency safeguarding arrangements and procedures;
- Inform and improve future practice and partnership working;
- Improve practice by acting on learning (developing best practice) and
- Highlight any good practice identified". DSAB 2017 s4.2

The purpose of a SAR:
"is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and

systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial". DSAB 2017 s4.4. and 4.5

1.3 Principles which inform SARs

SARs should reflect the six safeguarding principles: empowerment, protection, prevention, proportionality, partnership and accountability. The following principles should also be applied by SABs and their partner organisations to all reviews:

i. There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works, and to promote good practice.
ii. The approach taken to reviews should be proportionate. This could range from a single agency review to a multi-agency Safeguarding Adult Review, with an independent author and chair according to the scale and level of complexity of the issues being examined.
iii. Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
iv. Families' should be fully engaged and invited to contribute to reviews. They should be supported to understand how they are going to be involved, and their expectations should be managed appropriately and sensitively. (Care Act statutory guidance s 14.167)

In addition, agencies are under a legal duty as DSAB partners to cooperate in and contribute to the carrying out of a review under Section 44 of the Care Act 2014 with a view to:

a. identifying the lessons to be learnt from the adult's case, and
b. applying those lessons to future cases

2. Scope and specific area of focus of the SAR

2.1 The SAR will examine events in the life of Rita in the 3 years prior to her death. In addition, any notable involvement or engagement from agencies outside of this timeframe will be considered

Specific timeframe: 1st September 2014 – 16th October 2017

2.2 The areas of focus will be on how individual agencies followed agreed policies and procedures in working with Rita: how agencies worked together in identifying and addressing concerns regarding Rita's welfare, and how agencies and staff were supported by their organisations to follow agreed policies and protocols.

3. Methodology

The methodology used in this review seeks to promote a thorough exploration of the events prior to Rita's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

The methodology utilises a blended approach of systems-orientated models in order to maximise opportunities for learning in the specific circumstances of this review. Activities will include: collation of chronologies, individual agency reports, conversations with key staff, family and friends of Rita, examination of key documents, identification of key episodes, and, if indicated, an event to review learning with a relevant group of staff.

A SAR overview report will be produced including thematic analysis of findings, key learning points, and recommendations to the Devon Safeguarding Adults Board on any improvements identified in multi-agency working. The process will be supported by a SAR Panel which will include senior representatives of the agencies described below.

The review will be informed by the adult safeguarding policies and procedures in place during the timeframes within the scope of the SAR.

3.1 Family participation

Rita's family will be invited to meet with the independent reviewer to discuss the proposed terms of reference and scope of the review. They will also be invited to be interviewed further as needed to contribute background information for the Review, including information about Rita and her life.

A second meeting will be held with Rita's family once a draft of the overview report has been approved by the DSAB. Findings, learning and recommendations will be discussed in order for the family to question or comment prior to final draft approval at Board. A written draft will be provided to Rita's family prior to publication.

3.2 Chronology

Agencies involved will be asked to provide a chronology of significant events and safeguarding issues. This could include an event that falls outside of the timeframes if these are considered significant to learning.

When agencies have changed names, roles and responsibilities since the timeframes in scope, every effort must be made to identify records by the agencies involved and an account submitted regarding any records that cannot be found.

A report template, and a briefing on the expectations of an individual agency report writer, will be provided by the lead reviewer.

3.4 Conversations

Agency reports will be analysed to identify key individuals for follow up conversations or documents for further analysis. Individuals who have left agencies will be invited to contribute to the review as well as those still employed. Conversations will be conducted by the independent reviewer and an agency representative and follow the Social Care Institute of Excellence (SCIE) Conversation structures. Friends or family will be invited to bring a supporter or advocate to any conversation with the lead reviewer.

3.5 Key episodes

Key episodes will be identified from agency reports and conversations for deeper analysis.

Below are a set of initial questions which will form the basis of the individual agency report template. Further questions may emerge following analysis of the agency reports, and of the individual conversations, which can then be explored within the SAR Panel meeting or via other avenues as appropriate.

4. General questions underpinning the agency reports:

EVENTS: Critically analyse and evaluate the events that occurred, the decisions made, and the actions taken or not taken. Were there any missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn? When risks were identified, were plans made to prevent or mitigate the risk? Were agreed actions carried out? Were there any indications that practice or management could be improved? Try to get an understanding of not only what happened, but why.

POLICIES AND PROCEDURES IN PLACE AT THE TIME: Review the effectiveness

of policies and procedures (both single and multi-agency). Were staff aware of these policies and procedures? Did they have management support and training to follow these appropriately?

WHAT WAS HAPPENING IN THE AGENCY AT THE TIME: Were there periods of transition or limited resource/capacity?

INTER AGENCY WORKING: Were processes and communication effective between agencies? Did each agency understand the role and duty of others? Were professionals proactive in escalating concerns and providing effective challenge when appropriate?

SUPPORT TO EFFECTIVE WORKING: What supervision and management oversight was provided during the period of the SAR? Were these in accordance with the agency's policy and procedures?

IDENTIFY EXAMPLES OF GOOD PRACTICE, BOTH SINGLE AND MULTI-AGENCY.

IDENTIFY WHAT HAS CHANGED SINCE THE SCOPED PERIOD

4. Timetable for Safeguarding Adults Review:

Stage	**Timescale**
First Panel Meeting	29th May 2018
Terms of Reference Agreed	11th June 2018
Individual Management Reports Completed	9th July 2018
Second Panel Meeting	16th July 2018
Third Panel meeting	1st October 2018
Draft report completed	1st November 2018
Action Learning Event	2nd November 2018
Fourth Panel meeting	22nd November 2018
Final draft report presented to SARCG	6th February 2019
Final report presented to DSAB	5th March 2019

The Individual Management Reports (IMR) completed by agencies will consider the period between 1st January 2014 to October 2017 but any notable involvement from agencies outside this period will be reported

These Terms of References will be reviewed throughout the SAR and may be subject to change if appropriate