Safeguarding Adult Review

Adult B

Executive Summary

Introduction

This Safeguarding Adults Review considers the multi-agency involvement and support given to Adult B.

Adult B is a 54-year gentleman who has a diagnosis of Autism Spectrum Disorder and Asperger's Syndrome. Adult B's needs are complex and there are multiple agencies involved with care and support.

Adult B lived in supported housing schemes between 2010–2014, however in early 2014 the relationship between Adult B and staff at the supported housing scheme broke down and in line with Adult B's views and wishes was supported to move into their own property.

Since moving into their own property Adult B's living conditions presented a significant risk to health and safety, which had escalated over the years and as a result Adult B experienced a number of respite placements within different care homes.

Adult B raised concerns to multiple agencies that they had been neglected by services, feeling that no single organisation had taken a lead in providing care and had been passed between teams and agencies. Adult B felt that there was no consistency, and that practitioners supporting them did not have the required knowledge or skills in supporting adults who had autism.

A referral for a SAR was sent to The North Lincolnshire Safeguarding Adult Board (NLSAB) in November 2019, following concerns raised about the way in which partner agencies worked together to support Adult B.

The NLSAB Executive Group reviewed the referral as per the SAR Policy and Procedures, and agreed that the criteria for a Safeguarding Adults Review had been met. Although Adult B had not died and there was no suspicion or knowledge that Adult B had experienced abuse or neglect - there were concerns in relation to how partner organisations worked together, and it was felt potential lessons could be learnt and applied to future cases. The decision was endorsed by the SAB Independent Chair.

The review was conducted in the form of a Multi-agency Reflective Workshop. The purpose of this type of review is for agencies involved to meet and share their perspectives as a self-assessment of the multi-agency safeguarding arrangements and practice to identify improvements.

The aim of the review is to make a positive impact on frontline practice. The focus of the workshop was to reflect on the adult B's journey through and identify any opportunities for improved interface between the agencies.

The review considered the multi-agency involvement and support given to Adult B covering 2014 when Adult B moved out of supported living and into rented accommodation, through to 2020 when the review commenced.

Adult B's participation

Due to Adult B's ongoing mental ill health, it was not possible to directly include them within the review. Adult B's independent advocate was fully involved throughout the process and regular meetings were held between the SAR Lead and advocate.

The SAR was postponed on numerous occasions in the hope that Adult B's participation would be possible, however unfortunately this was not the case.

Emerging Themes and Learning Points from the Workshop

During the review it became evident that Adult B was passed from agency to agency due to not satisfying the criteria for the intervention of certain services. It was recognised that this was a barrier to positive engagement with Adult B and there was a need for a multi-disciplinary approach to ascertain which service could meet needs.

A reoccurring theme was that there was no coordinated approach from professionals involved in Adult B's care. Although there was clear evidence that collaborative working had taken place, it was felt that an identified agency, or practitioner, agreed by Adult B and all agencies to coordinate Adult B's care and support plan would have proved beneficial to all involved.

It is well documented that Adult B found change and meeting new people very difficult. There were many professionals involved in Adult B's care and support, the review established that there was not always a robust handover when professionals moved on. Adult B found this extremely difficult and reinforced their belief that services let them down and professionals were untrustworthy.

It was identified that some agencies were not clear as to other professionals' roles and responsibilities, or who else was involved in supporting Adult B, it was felt this issue may have led to barriers to sharing information.

There had been issues of communication and the sharing of information, but it was also recognised that a solution may lie in emerging high-risk management models such as the Vulnerable Adult Risk Management Policy and Guidance (VARM) - a protocol that has since been developed by the NLSAB.

There was no single clear multi-agency action plan in place to support Adult B to remain living at home which impacted on ensuring a holistic, collaborative approach was taken to support Adult B.

There was evidence of some professional disagreements as to whether Adult B had capacity in relation to their living environment, and the provision of care to meet needs. Although numerous multi-disciplinary team (MDT) meetings took place there was little evidence that the differences in opinion were explored. It was however recognised by all agencies that Adult B did present as having fluctuating capacity at times.

It was identified that professionals working with Adult B did not always have a clear understanding, or experience of working with people who have a diagnosis of Asperger's Syndrome and complex needs which led to anxieties for Adult B and practitioners who felt overwhelmed.

There were ongoing challenges in identifying appropriate, specialist health and care providers who could meet Adult B's needs, which caused delays.

Good Practice

The review identified several areas of good practice, it is important to highlight these as areas where learning can occur.

- Adult B was supported by an independent advocate who supported, represented, and facilitated Adult B's involvement within key processes. There was evidence of collaborative working between the advocate, practitioners within all agencies, Adult B and family members.
- There was evidence on many occasions as Adult B went into crisis situations, agencies came together and worked collaboratively around personalised care.
- There was evidence that Adult B was supported and encouraged to make their own choices regarding how they wanted their care to be delivered.
- There was evidence to suggest that as the case became more complex, a more co-ordinated approach was taken where information was more freely shared between professionals.
- Practitioners recognised the risks associated with Adult B's environment and timely referrals to the safeguarding team were made.
- Safeguarding Strategy Meetings were held, and robust Safeguarding Plans were implemented, there is evidence that Adult B was involved, and their views and wishes were listened to.
- There is evidence that practitioners understood the escalating complexities around the case, they articulated their concerns and were supported by senior managers within their organisations.

It is recognised that many of the lessons learned by individual agencies, on preparation for the SAR and for other internal purposes, have been promptly addressed by organisations

Recommendations

The following multi agency recommendations were made as a result of the learning in this case.

1. When working with adults who have autistic spectrum disorder, practitioners should be provided with training and education to ensure they have the relevant skills and knowledge required to effectively support those individual and their families. Organisations should consider involving adults who are autistic and their families in the creation and delivery of their training.

2. One identified professional should be the 'lead' in order to coordinate care and support when working with people presenting with complex needs, ensuring consistency and a joined up approach between multi-agencies.

3. Robust Care Plans are integral to the delivery of quality care and support, they must always be developed in partnership with organisations, individuals, and their families.

4. Front line practitioners and managers must undertake regular refresher training within their organisations in relation to the Mental Capacity Act 2005.

5. When a person with complex needs does not meet the threshold for services a multi-disciplinary meeting should be convened to establish which service or services would be the most appropriate service or services to provide support to the person.

6. Organisations should ensure that practitioners are given appropriate support from managers and/ or relevant commissioning leads when exploring the commissioning of specialist Autism services.

7. Organisations should ensure that there are processes in place for mechanisms to engage with adults who have Autism and their families in the production of policies and procedures.