

Safeguarding Adults Review for 'Ivan'

January 2024



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1. Introduction

Waltham Forest Safeguarding Adult Board commissioned this Safeguarding Adult Review (SAR) as partners believe that there are lessons to be learned and actions to be taken to do everything possible to reduce the risks to people in similar circumstances to Ivan in future. Ivan is a pseudonym used to protect his and his family's identity. This report is delivering on the statutory requirement to carry out such reviews as determined by the Care Act 2014.

1.1 Why this review is being carried out

Ivan went missing following several years in a residential establishment. He had a history of going missing from time to time. On the day he went missing, 23rd February 2023, he was attending a clinic, escorted by a carer to have his regular injections as part of his treatment. While waiting to be seen, he told his carer that he wanted to go outside to have a cigarette. He did not return. He went missing and tragically his remains were found on 24th March 2023 under a tent in Epping Forest. DNA analysis confirmed it was Ivan on 12th April 2023. Toxicology results showed that he had overdosed with morphine. Police are investigating how he came to have morphine in his system.

Partners have questions they want answered as to how this came about so that they can do what needs to be done to reduce the risk of this happening again.

1.2 Principles of this review

This review aims to establish if any improvements need to be made about how we work together with people in similar situations to Ivan using the following principles:

- The process aims to ensure sufficient rigour and transparency to get to the point of learning.
- Learning will have demonstrable impact on practice which aims to be pursued without blame or judgement.
- Only information relevant to learning is assembled and analysed.

A multi-agency analytical, reflective approach was used to enable partners to work together to agree on what has been learned.

2. How the review was carried out

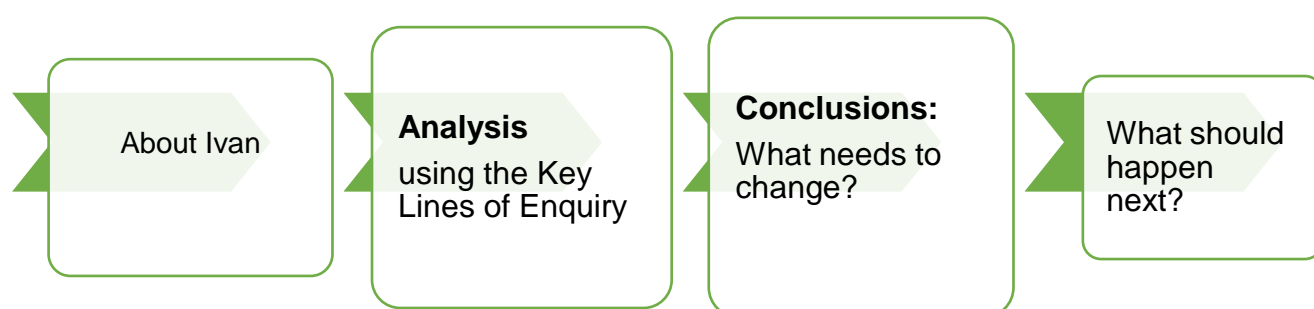
The Safeguarding Adults Board (SAB) commissioned an independent reviewer to carry out the Safeguarding Adult Review (SAR). The reviewer commenced the work by carrying out an active listening exercise, meeting with individual partners who represent their agency on the SAB or its associated subgroups to establish their perspective and understanding of these circumstances and their views about the scope and focus of the report. This exercise informed Key Lines of Enquiry, and these became the focus for relevant learning and reduced the risk of unnecessary duplication with other processes described below.

2.1 Partners involved

The following partners provided input to the key lines of enquiry:

- Metropolitan Police, Northeast Basic Command Unit
- Waltham Forest Adult Care and Quality Standards (Adults Social Care)
- The independent chair of the Safeguarding Adults Board
- Waltham Forest Integrated Commissioning managers
- Northeast London Foundation Trust (NELFT)
- Northeast London Integrated Care Board (ICB)

2.2 SAR report structure



2.3 Key lines of enquiry

These were agreed as important as they were the main questions that partners wanted answers to and they provided focus and structure to the learning.

- i. **What was life like for Ivan?** *Who was Ivan? What were his likes and dislikes?*
- ii. **How did his living arrangements come about?**
 - *How were decisions made about his living arrangements?*
 - *What arrangements were in place to keep him safe?*
- iii. The incident. **How was Ivan able to leave unnoticed and why did it happen?**
- iv. **Are there improvements to be made in how partners work together to respond to situations where a vulnerable person goes missing?**
- v. **Are there systemic improvements to be made?** *(Independent author's question)*

2.4 Scope and timescales.

This review focus is on the period of time Ivan:

- spent in the accommodation he was living in until he went missing.
- went missing until his remains were found and DNA identified him.

Partners were encouraged to contribute to our understanding of who Ivan was and what life was like for him regardless of these timeframes.

This report aims to add value to, and not duplicate the learning already underway from related processes described below:

- The serious incident investigation procedure carried out by NELFT
- The internal enquiry and any investigative and/or disciplinary procedures carried out by the care provider.
- Information the police can provide from the criminal investigation.
- The safeguarding enquiry carried out after the incident.
- Any other related processes.

All these processes inform this report. This report will be shared with the coroner and will help inform the inquest.

2.5 Engaging the family.

The SAR independent author wrote to the family in October 2023 inviting them to engage in the review process. At the time of writing the family had not yet responded. The family engaged in the serious incident report carried out by NELFT and may wish to be involved in the coroner's inquest.

2.6 Information gathering

Involved partners, listed above carried out individual management review reports (IMR).

NELFT had carried out a rigorous serious incident (SI) report which was accepted by the reviewer as an IMR.

Each partner also produced a chronology of significant events and each of these was integrated into one multi-agency chronology.

A workshop was held on 11th December 2023 to analyse all the materials produced and to carry out a multi-agency analysis, using the key lines of enquiry as a structure. Partners invited relevant staff from their agency to contribute to the workshop analysis, so the discussions benefited from the insight of managers, practitioners, and subject matter experts into the realities of everyday practice and management of experiences like Ivan's. Information shared at the workshop forms a substantial contribution to this report. Partners engaged in open and honest dialogue and presented their contributions, strengths, and areas for improvement and this led swiftly to an accurate understanding of the circumstances and to conclusions about learning.

3. Analysis

3.1 Key line of enquiry one

What was life like for Ivan? (Who was Ivan? What were his likes and dislikes?)

Ivan was a 69-year-old white British man. The staff providing residential care knew him well and provided insight into who he was, his likes and dislikes.

Ivan was polite, didn't say much, but was firm in his wishes. He was friendly and if he didn't understand something, he would ask questions. He liked his cigarettes. He enjoyed being taken to the barbers, to the shops for his cigarettes and soft drinks, and listening to music.

There is little information about whether he had a job, but he has indicated that he had worked as a baker at some point in his life.

It took quite a long time for people to get to know him, but he recognised people who worked with him regularly. He was described by some as a “loner” and friends said he liked to be out in the great outdoors. He tended to stay in his room as opposed to mixing with the other residents, but he appeared to be content with this situation. He was also offered regular opportunities to go out into the community with staff. He was known by the local shopkeepers and people in the neighbourhood. Ivan was under-weight and needed support and encouragement to eat. He had a cognitive impairment and muffled speech which made communication difficult for him which had led to frustration and verbal aggression. He also suffered from memory loss.

The serious incident report from NELFT describes significant bereavements in his life. His father died when Ivan was only 11 years old, and he lost a sister in his thirties in 1988. His mother died in her 80's in 2015. Following an incident at his sister's wedding many years ago he became estranged from his family.

According to the feedback from friends and family following his death, the key change for Ivan took place following a vicious street attack when he was 19 years old. Police reports indicate that there followed two suicide attempts resulting in medical treatment. One of these attempts involved him jumping off a bridge receiving serious injuries and he had since walked with a limp. He spent much of his adult life in institutions.

3.2 Key line of enquiry two

How did his living arrangements come about?

How were decisions made about his living arrangements?

It is understood that he lived with his mother and sisters as a young adult. He came to the attention of NELFT community mental health service in 1992, when he was diagnosed with Paranoid Schizophrenia at about the age of 38 years. In March 1993, he tried to jump off a bridge in an apparent suicide attempt and sustained fractures to his legs and spine and continued to suffer from tactile hallucinations. He was admitted to Whipps Cross Hospital and during this admission his mother and sister tried to visit him, but he refused to see them. From this point forward, it appears that he became estranged from his family and did not re-connect with them.

He lived in various residential care homes since that time and needed regular support with medication to keep his mental health stable and he received continuing support from the community mental health services team.

He came to reside at Waterside Lodge, a residential facility provided by Outlook Care in December 2018 following the closure of his previous provision. He was referred by his care co-ordinator and the place was commissioned by NELFT. The prioritising of locally based accommodation meant that it was the only place considered to keep him in Leytonstone with continuity of routines familiar to him. The Outlook Care IMR noted that he had a forensic history that included an incident where he had used a weapon and that in 2014, he had an argument with fellow residents. Historically he could be volatile in his behaviour, to the extent where he had damaged cars parked outside a previous care home, damaging furniture, windows and smashing the television when he had a relapse in his mental health. He was also reported to suffer from continuing auditory hallucinations and could be verbally aggressive. Staff at Waterside Lodge were aware that he was also at risk of going missing. This review has identified three missing episodes from two care homes since 2012.

- In October 2012, he went missing between 7 and 8am and returned of his own volition, telling staff that he had been to Epping Forest.
- In 2013 he went missing for five hours and returned telling staff that he went to Epping Forest and that his “mind went funny”.
- In March 2020 he went missing from Waterside Lodge, (the facility he was in when he finally went missing). He returned, again having visited Epping Forest. He was taken to Whipps Cross hospital for “medical clearance” where hospital staff thought he looked emaciated. The care home provided him with nutrition support.

The final missing episode was in March 2023 and is the focus of this review.

There was a seven-year gap between the first two missing episodes, a one-year gap between the second and third episodes, and a three-year gap between the third and fourth episode so there is no pattern or theme that could help to forecast a missing episode but, on each occasion, he went to Epping Forest.

What arrangements were in place to keep him safe?

Ivan was at times very content at Waterside Lodge but there was also a period where he was packing his bags and requesting to leave. He therefore needed regular assessments to ensure that he was not deprived of his liberty unnecessarily. Deprivation of Liberty Safeguards (DOLS) were in place for Ivan. See below for an explanation about DOLS.

“The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows some restraint and restrictions to be used – but only if they are in a person’s best interests and necessary and proportionate. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation. There are six assessments which have to take place before a standard authorisation can be given”. (<https://www.scie.org.uk/mca/dols/at-a-glance>)

At the time of the third (and final) DOLS assessment (March 2022 to March 2023), he was no longer objecting and said that he was quite happy in the home.

Outlook Care provided an account of how he was kept safe while in residential care and on his regular visits to the clinic to have his injections.

He had a crisis plan* in place and was subject to regular monitoring by his Mental Health Co-Ordinator. (*For more information on what a crisis plan is see [Planning for a mental health crisis - Mind](#))

He needed to be in a care home that enabled him to have some support and supervision throughout the 24-hour period to meet his safety and support needs. Waterside Lodge had 16 places and three staff available to residents throughout the day.

Ivan had risk assessments and support plans in place to address the following identified risks.

- Risk of disengagement with mental health care services resulting in a deterioration of his mental health and behaviour
- Risks to health and safety associated with leaving his home, wandering, or going missing.
- Financial exploitation
- Health and environmental risks from smoking.

Ivan's support addressed these areas as follows:

- Deprivation of liberty Safeguards (DOLS) were in place for Ivan as he was assessed as lacking capacity and awareness regarding risks associated with leaving the building and this may constitute a restriction or deprivation of his liberty.
- Maintaining his personal health and well-being including his diet and hydration, compliance with medication, access to healthcare and ensuring he was supported by his GP and Mental Health Co-Ordinator.
- Preventing any deterioration in his mental health by keeping contact with him during the day, encouraging social activities, supporting him at reviews, to be compliant with medication and engage with mental health professionals when needed.
- Supporting him to request money from his appointee when he wanted to purchase items for himself and accompanying him to the shops or other venues of his choice.
- Staff knowing where Ivan was and helping him plan his day, minimising the risk of him leaving his home without the support he needed from staff.
- Staff to accompany Ivan when he went out for appointments or social activities.
- Staff to report and follow the Outlook Care Missing Person Policy / Procedure if Ivan was missing. This requires the incident to be reported as per Outlook Care's Incident Policy.
- Staff checking in with Ivan to advise him on designated smoking areas if he was observed to be smoking in his room.

NELFT's most recent review of his care plan was in August 2022, and this included maintaining the same level of antipsychotic medications that he was on and to reduce the frequency of his depot injection. The risk assessment graded Ivan's understanding of risks to himself as low. He was deemed to be stable in his mental state due to the combination of antipsychotic medication he was prescribed. NELFT's report also noted the safeguarding arrangements made by Waterside Lodge for him to be accompanied by a carer when leaving the home for shopping, the barber or for his appointments.

Medication:

He was prescribed a depot medication to help stabilise his mental health. He had been prescribed Zuclopenthixol 200mg Intramuscularly since 2007 which was administered to him every three weeks since August 2022. Prior to which was two-weekly, until he died. Other medications included Olanzapine 20mg (daily at night); Carbamazepine 200mg (twice a day); Diazepam 5mg (twice a day); Procyclidine 3mg (twice a day) and Lorazepam 1mg as required. He had hypothyroidism and was prescribed Levothyroxine to help him manage the condition.

3.3 Key line of enquiry three

The incident: How was Ivan able to leave unnoticed and why did it happen?

At the time of drafting this report, police investigations are underway, and the provider has instigated investigatory procedures into the conduct of the member of staff who accompanied him. That staff member was on suspension when the workshop was held in December 2023. This report therefore will not make definitive conclusions about the actions or inactions by the individual care worker as to whether they constitute neglect or a failure in duty of care as both concurrent enquiries will draw conclusions about these issues. This line of enquiry identifies the facts as they relate to Ivan and conclusions are drawn to inform what can be learned to reduce the risk of this happening to a person in similar circumstances in the future.

The journey to the clinic and checking in seemed to be uneventful and there was nothing to indicate that Ivan was considering leaving. At the workshop, partners discussed at length his experience while waiting in the clinic. Some of them reflected on their observations of him and how he related to the care worker as they had viewed CCTV footage of him and the carer waiting in the clinic that morning. They described the body language as suggestive of a relationship that was devoid of warm interaction and could be possibly perceived as there being tension between them.

NELFT's report refers to the care worker saying that that she left him to rest her legs. He had gone out three times and on the fourth occasion he went missing. The care worker maintained that Ivan had remained in their line of sight throughout that time and that she was uncomfortable about passive smoking.

Those who had watched the CCTV footage, including the police, did not agree that he stayed within her line of sight.

There is no evidence to suggest that the clinic, (provided by NELFT) was aware of the risk of him going missing, although, with access to RIO, the recording systems, this information was available. The clinic providers identified that a new risk assessment would have informed them about this suggesting that he should have been on the "High-Level Risk Register" (HLRR) so that when he went missing the senior leadership team would have been alerted leading to co-ordinated plans and immediate action. The report from NELFT also suggests changes in the management of appointments at the clinic so high-risk cases are identified and prioritised so that they are seen quickly.

The carer was aware of the need to supervise Ivan when he went outside of the clinic to smoke. On the last occasion the level of supervision he required as per his support plan and risk assessment was not maintained by the carer because they returned to the waiting area.

Partners analysed this and agreed that it may have been possible for the carer to become complacent about his supervision as he had gone out the first three times and returned. There was also the possibility that he was testing her alertness on the first three occasions while considering going missing on the fourth, but this is speculation.

Partners considered Ivan's family's question to NELFT when they were undertaking their internal review, about why two people weren't in place to support him. A risk assessment had concluded that one person was enough to support him and the DOLS assessment was considered robust and an accurate reflection of his needs.

Partners also agreed that there are myths around the application and limitations of the DOLS process. Although the adult social care report showed a gap between DOLS assessments dates, and this is being dealt with by that organisation, the most recent DOLS assessments as it applies to Ivan, was appropriate. The DOLS process does not safeguard people from going missing, but the people who care for them can and in most circumstances do. There is therefore an agreed need to challenge the myths about DOLS application in practice, through training and awareness raising, particularly as new legislation may eventually replace the current process.

It is not possible to establish what motivated Ivan to go missing on that day. If there had been tensions between him and his carer and he had been waiting a long time, he may have intended to escape the tension and tedium of waiting and to return as he had on previous occasions that morning. The temperature on that morning was just 7°C so he preferred to face the cold and uncertainty involved in leaving, rather than staying in the clinic as he had done so many times before.

The frequency of his Depot injections had recently changed from fortnightly to every three weeks. Clinicians advised that this is unlikely to have affected his decision making.

3.4 Conclusion from the first three lines of enquiry

While partners have identified areas for improvement in managing high risk people coming to the clinic and de-mystifying the DOLS process, this is incidental learning and cannot be considered as direct or indirect causal factors that led to him going missing that day. The only conclusion that can be drawn is that Ivan went missing because he was not supervised in accordance with the agreed plans for him and that this was due to human error.

3.5 Learning from the first three lines of enquiry

One of the priority areas for the Safeguarding Adults Board is Mental Capacity and DOLS (which includes awareness raising and embedding better understanding by practitioners of DOLS) and this report indicates the importance of this. A review of the legislation has been delayed several times by central government, but the local Safeguarding Adult Board has a sound grasp of what needs to be done.

In addition to learning already identified by those contributing to this review:

Residential Care providers should put in place checking mechanisms for carers escorting people who are at risk of going missing *each time* they accompany them on visits outside of the establishment. Repeated reminders on each occasion could reduce the risk of complacency.

Commissioners of residential care services should include standards for risk management of vulnerable people at risk of going missing including procedures and training. These should be included in service specifications for residential care providers and associated quality assurance indicators used to monitor and measure compliance.

3.6 Key line of enquiry four

Are there improvements to be made in how partners work together to respond to situations where a vulnerable person goes missing?

The hours following Ivan going missing:

An analysis of partners' individual reports and discussions at the workshop show inconsistencies in their understanding of the timings in relation to the incident in the hours following Ivan going missing on 23rd February 2023.

The facts in relation to the initial hours following his going missing can be summarised below:

- Ivan is seen on CCTV footage leaving the building at 11.14 am.
- A media campaign refers to his "last seen entering a park in Walthamstow at around 11.50 am."
- He was identified as missing when he was called for his appointment at 11.51 am.
- Initial searching of the grounds was carried out.
- Management in Outlook Care were alerted at 12.18 pm.
- Police were informed at 1.21pm.

- The care co-ordinator was informed by the clinic at 2 pm.
- Police had incorrect and insufficient information and initially assessed the risk as medium. Later that same day, the information was adjusted, and the risk was escalated to High at 9.38 pm.

3.6.3 Learning from key line of enquiry four

Police guidance on this is helpful to inform the analysis: *“How the investigation is conducted in the first few hours (see golden hour) after the report is made to the police may affect the outcome”*. ([Missing person investigations | College of Policing](#))

The “golden hour” was lost, hampering possibilities of finding Ivan quickly. Ivan was not a fast walker and had a distinctive gait, so he was not difficult to identify or recognise. The police IMR suggests that the delays and inaccuracies in the information shared reduced the possibility of him being found and returned to his care worker. The NEFLT report refers to the wrong name and date of birth on the police Merlin form. The Police IMR identifies that records in Police and Waterside Lodge were inconsistent about this. The impact on Ivan meant there were serious delays.

It is likely that, as Ivan had gone to Epping Forest when he went missing before, that he may have been heading there on that day. The Epping Forest Website indicates that *“The Forest is made up of more than 50 distinct areas of woodland, grassland and other habitats which, together, span 2,400 hectares from Manor Park all the way out to beyond Epping”*.

(<https://www.visiteppingforest.org/things-to-do/epping-forest-p1389551>)

This is a very large area. A 10-hour delay in identifying that he was high risk, meant that he may have found his way deep into the forest by then and he became even more difficult to find.

3.6.3 Why was the “golden hour” lost?

There are a few factors explaining the delays.

The carer indicated that Ivan was last seen at 11.51 am. He was identified as missing at 11.51 am which is the exact time he was called in for his appointment at the clinic. CCTV footage shows him leaving the building at 11.14 am and this appears to be unnoticed for 37 minutes. The carer’s account is therefore inconsistent with the evidence and valuable time was lost. He was missing for two hours and seven minutes before police were notified. Ivan did not have a bank card, mobile phone, or digital footprint, so police work to locate him was “back to basics”, retracing his last steps, reviewing CCTV and sharing leaflets to anyone in the last place he was seen. The Police noted that the CCTV showed him exiting the centre through the front door, so valuable time was wasted searching for him around the building, which could have been spent taking the search outside to nearby local areas. The police deployed additional resources to support the search.

Safeguarding concerns were not raised in good time. This was due to communications failures. The residential care provider’s IMR indicates that the deputy manager communicated with the care coordinator in the mental health provider organisation. However they are unable to substantiate that the deputy manager completed the expected safeguarding report for Ivan.

The mental health provider’s report indicates that the care co-ordinator understood that the residential care provider was raising a safeguarding concern. There was another incident

that also needed the urgent attention of the care co-ordinator in those hours and days following the incident.

The care co-ordinator felt unable to re-prioritise her work so that she would have time to “notify Datix”. The NELFT’s report suggests that this procedure alerts senior managers and generates immediate risk assessment and information sharing with partners.

The Datix entry was eventually made on 15th March 2023, 3 weeks after he went missing and Adult Social Care’s IMR indicates that they were not informed about the incident until a meeting held on 16th March 2023.

All of these factors amount to a delayed and uncoordinated response. The golden hour was lost because:

- his leaving the clinic was not noticed.
- the initial response was to search the grounds instead of checking the CCTV footage.
- inaccuracy and delays in information sharing led to inappropriate risk assessment.

3.7 Conclusion from key line of enquiry four

Partners appear to have worked largely unilaterally in those first hours in their efforts to respond to Ivan going missing. Partners have identified in their IMRs the improvements that they, as individual agencies are making to become more effective as an organisation to respond swiftly and robustly to such incidents and this included revised individual agency missing persons protocols. When Ivan went missing, there did not appear to be a sense of urgency to share information *with each other at a senior level*, to assess risk, identify gaps and immediate blockages and help resolve them so that operational staff can be supported. Leaders need to grasp incidents of this nature swiftly and assertively. Incidents like this are rare and operational workers without training in this area will not know what to do. They will need leadership, guidance, and support in real time. Leaders should be expected to prioritise an incident of this nature and clear diaries to ensure cohesive management and to support operational staff to do the same.

It is obvious that Police need to be notified, but it would help partners to prepare a clear protocol for rapid response to such incidents, setting out clearly the expectations of any partner who identifies a vulnerable person who has gone missing from any setting, explicitly agreeing as partners on the following areas:

- The Herbert Protocol in Appendix 2 contains the complete set of essential information needed by police on one sheet for all persons who are at risk of going missing. In the main this is used for people with Dementia but there is no reason why this cannot be used for vulnerable people in residential care with enduring mental health problems and who have a history of going missing. A completed form like this could be taken on all escorted visits outside of the residential establishment and shared with all involved partner agencies who need to know about the risk.
- Response - being mindful of the range of partners who need to be involved, informed and engaged in a response. Police will lead on such a response but critical agencies, such as Adult Social Care at a senior level should be involved and informed immediately and without hesitation or delay. A rapid response meeting involving senior partner agencies should be held within hours of the notification while the operational imperatives are being carried out.
- Standards around timings in relation to notifying police and senior management.
- Accurate information about how to make an urgent safeguarding referral and what information is required and where to send it.

- Ensuring cases are escalated in all partners' agencies immediately. E-mails can do this, but they should always be followed up by a telephone call and pursued until human dialogue takes place, and information is clarified by each party.
- Agreeing Single Point of Contact for partners to use to share information.
- Supporting staff who normally work with the missing person to ensure their diaries are cleared to enable them to process and share information with appropriate authorities in good time.
- Multi-agency training for staff in understanding risk and responding appropriately and effectively when a vulnerable person goes missing.
- Ensuring CCTV footage is available at speed.

It is helpful to follow the principal that finding a missing person is led by Police but involves collective immediate and urgent action by all involved agencies.

3.8 The subsequent weeks after Ivan went missing

Ivan's remains were found on 24th March 2023 and DNA confirmation on 12th April 2023

Adult social Care first learned about the incident on 16th March and instigated an enquiry under S42 of the Care Act, a safeguarding enquiry. This prompted an enquiry into the safeguarding functioning of the provider as a whole and the production of an action plan which continues to be monitored by Adult Social Care services in Waltham Forest.

The NELFT report looked in to why there was no follow up with the Local Authority to confirm receipt of a safeguarding concern and have established that, at practice level, expectations of a response from the Local Authority to concerns are low.

Ivan was vulnerable to immediate risks. This was an urgent situation involving risk to life. In such circumstances, follow up with dialogue would ensure Adult Social Care are informed and taking appropriate action, liaising with Police, and considering the safety of others in the residential care provision. In these circumstances the sending of an e-mail is not enough to generate urgent action. The referrer, trained appropriately and supported with an agreed multi-agency protocol would follow this up immediately to ensure it has been received and clarifying information with a conversation.

In addition, partners need to consider together why expectations of a response from the Local Authority to those initiating safeguarding concerns are low. Whilst an immediate auto response system by Adults Social Care is in place, it seems that not all partners confirm receipt of this. It has been suggested that this could be due to different organisation's firewalls which should be further explored alongside reinforcing the expected standards around safeguarding concerns for both referrer and responder.

Had a human dialogue taken place with some urgency, this would have led to more immediate action.

Had senior leaders communicated with each other in the hours and days following Ivan going missing, this too would have generated multi-agency action and support from front line practitioners.

3.9 Conclusion drawn from the subsequent weeks after Ivan went missing

Individual agencies took steps to escalate to higher levels in their organisations in response to Ivan going missing. They did so in parallel and in general the steps taken were too slow and bureaucratic in nature and did not involve what was necessary for Ivan. He needed

human collective action driven by the urgent need to get him back to safety and this can be done if a local protocol is agreed, leaders are trained and well prepared, and staff are trained in how to respond.

The London Safeguarding Adults Board procedures do not seem to include a multi-agency protocol on vulnerable people who go missing and this should be considered.

3.10 Key line of enquiry five

Are there any systemic improvements to be made? (*Independent author's question*)

The SAB annual report 2022-23 clearly explains the work carried out to raise awareness about DOLS and the previously anticipated legislation around Liberty Protection Safeguards and describes good progress. It also describes a strong, focussed framework for provider concerns and how the partnership manages these ensuring the safety and wellbeing of residents in need of commissioned care. There is reference to a multi-agency peer support (Team around the Person Network) panel, which should align with safeguarding processes. Progress against a provider improvement plan is closely monitored and where lack of improvement compromises the safety of residents, actions are taken to remove the risk.

In conclusion, there is an understanding across the partnership of the need for scrutiny, challenge and appropriate response to safeguarding concerns in residential care.

The systemic improvement needed is in relation to providing high level leadership in developing a local protocol and understanding about risk management in relation to vulnerable people who are at risk of going missing and how to respond.

The SAB should reflect on this case and consider if there are improvements to be made to **the line of sight** it needs to monitor the effectiveness of safeguarding measures for vulnerable people in residential homes who are at risk of going missing and whether current governance arrangements are explicit.

4. Overall conclusions: What needs to change?

- I. **Safeguarding Adult Board partners should develop a clear protocol and toolkit for** rapid response, setting out clearly the expectations of any partner who identifies a vulnerable person who has gone missing from any setting and providing the necessary communications training and support to staff to equip and motivate them to apply it. The national framework published by the Home office (*Home office and missing people 2020*) is helpful in providing guidance on this. Locally partners need to explicitly agree on the following areas:
 - A readily available complete set of essential information needed by police on one sheet for all persons who are at risk of going missing, like the Herbert Protocol in Appendix 2. A completed form like this could be held in the provision and also taken on all escorted visits outside of the residential establishment and shared with all involved partner agencies who need to know about the risk.
 - Response- being mindful of the range of partners who need to be involved, informed, and engaged in an immediate response. Police will lead on such a response but critical agencies, such as Adult Social Care at a senior level should be involved and informed immediately and without hesitation or delay. A rapid response meeting involving senior partner agencies should be held within hours of the notification while the operational imperatives are being carried out.

- Standards around timings in relation to notifying police and senior management.
 - Accurate information about who to contact and how and what information is required.
 - Ensuring cases are escalated in all partners' agencies immediately. E-mails can do this, but they should always be followed up by a telephone call and pursued until human dialogue takes place, and information is clarified by each party.
 - Agreeing Single Point of Contact for partners to use to share information.
- II. The **Safeguarding Adult Board** should reflect on this case and consider if there are improvements to be made to **the line of sight** it needs to monitor the effectiveness of safeguarding measures for vulnerable people in residential homes who are at risk of going missing and whether current governance arrangements are explicit enough. This is particularly important when measuring the impact of the protocol recommended above.
- III. **SAB partners** should consider together **why expectations of those sharing safeguarding concerns with adult social care are low**. The reasons why some organisations do not receive a response to safeguarding concerns should be further explored alongside setting the expected standards around safeguarding concerns for both referrer and responder, to ensure appropriate responses are delivered and in good time.
- IV. **Residential Care providers** should put in place checking mechanisms for carers escorting people who are at risk of going missing *each time* they accompany them on visits outside of the establishment. Repeated reminders on each occasion could reduce the risk of complacency.
- V. **Commissioners** of residential care services should ensure that their commissioning specifications include standards for reducing risk and responding appropriately when vulnerable people go missing.

5. Appendices

5.1 Appendix 1: References and bibliography

- **The Care Act 2014:** <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>
- **Guide to the General Data Protection Regulation (GDPR 2018)**
- **Analysis of Safeguarding Adult Reviews April 2017 – March 2019:**
Local Government Association, December 2020
- **Woodhead C, Rona R, Iversen A et al (2011):** Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England. *Psychological Medicine*, 41: 363-72.
- **Public Health England 2015:** Local Initiatives: Safeguarding in Sheffield and Lewisham
- **Michelle Winter 2021:** Safeguarding Adults Review; Learning from the circumstances of the death of 'Peter'
- [Planning for a mental health crisis - Mind](#)
- [Deprivation of Liberty Safeguards \(DoLS\) at a glance | SCIE#](#)
- **Home Office and Missing People: Published October 2020 Revised August 2021**
- The multi-agency response for adults missing from health and care settings A national framework for England
- **College of Policing: strategic responsibilities:**
<https://www.college.police.uk/app/major-investigation-and-public-protection/missing-persons/strategic-responsibilities>
- **Waltham Forest Safeguarding Adult board annual report 22-23**
https://www.walthamforest.gov.uk/sites/default/files/2023-09/Waltham%20Forest%20Strategic%20Partnership%20Boards%20annual%20report%202022_23.pdf

5.2 Appendix 2: Herbert protocol

Herbert Protocol form

People with dementia sometimes get lost and go missing. If you care for someone with dementia you can fill in this form containing information to give to the police if the person goes missing.

This means you don't have to remember the information when you are under stress if someone goes missing. And it saves time, so the police can start the search sooner.

You can fill in this form on your computer or print it out and fill it in by hand. Keep it somewhere safe where you can easily find it if the person goes missing. You could give a copy to friends, family and neighbours. Keep this information up to date whenever something changes. You only need to give the form to the police if the person goes missing.

Details are helpful, but don't worry if you can't answer every question. There is space at the end of the form to tell us more if you run out of space for any of the questions. And you can always add another page to a printout or add something to an email.

The person's basic details

First name(s)	Surname	
Other names they go by (for example nicknames or aliases)		
Date of birth	Gender	Is their gender the same as at birth?
Nationality		Ethnicity
Husband, wife or partner's first name	Husband, wife or partner's surname	

Their contact details

Main home address, or best contact address

Any other addresses they might go to (for example a second home)

Mobile phone number(s)

Email address(es)

<https://www.met.police.uk/SysSiteAssets/media/downloads/central/advice/herbert-protocol/herbert-protocol-form.pdf>