Slough
Safeguarding Adults Board
Preventing abuse, protecting people

REPORT OF
LEARNING TOGETHER ADULT REVIEW

MRS EE

PREPARED FOR SLOUGH SAFEGUARDING ADULTS BOARD

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Preface

The following report uses the Learning Together (Fish, Munro & Bairstow 2008) systems methodology developed by the Social Care institute for Excellence in Serious Case reviews. The Slough Safeguarding Adult's Board and member agencies should take ownership and act in response to the findings from this Adult Review to put in place lasting improvements to services.

Recent DfE research (Brandon et al 2011) has raised questions about how effective SCR have been to date. Accordingly Slough Safeguarding Adults Board decided to trial the Learning Together Model using this case.
Summary of case
At the time of her death Mrs. EE was a 93yr old woman living with her son aged 58 in a Council flat with very limited contact with statutory services and in receipt of no services.

Mrs EE had been a tenant of Slough Borough Council for many years and prior to that her husband was the tenant. There was a long running dispute between the household and their upstairs neighbour which revolved around noise, usually at night.

Most contact between Mrs EE/EE's son and the Housing Department was via letter and these were usually about complaints by EE or EE's son about noisy neighbours. This was escalated on a number of occasions to Councillors and also to their MP. However both parties refused any attempts at mediation.

There had been intermittent Anti-Social Behaviour complaints by her neighbour upstairs over a long period of time about Mrs EE about noise nuisance (along with other complaints by the neighbour against other tenants in the building). In 2009 Housing served notice on Mrs EE as a means of improving Mrs. EE's engagement with the alleged noise issues. Mrs EE and her son strongly denied the allegation and spent some time trying to clear their name. The household was known to the Antisocial Behaviour Service for at least 9 years because of this.

Mrs EE never visited her GP surgery after 2007 and was rarely seen by anyone from the practice. Mrs EE continued repeat prescriptions for minor ailments via letter. Mrs EE refused any services offered by Adult Social Care on two occasions.

In June 2014 her son called an ambulance and the crew found Mrs EE in a poor state allegedly having lived in her chair for 4 years. She subsequently died in hospital of sepsis the next day.

Parameters and mandate

In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. Accordingly the SAR does not have terms of reference as a specific focus of analysis would be determined before the review process has begun. Following discussion by the Review Team a 'research' question was developed as a starting point for the Review. This was:

How do our systems support staff to allow service users and carers to make informed decisions around the risks posed by their behaviour?

The rationale behind this question was around how staff can work with people who have needs but whom choose not to engage, an increasing area of concern both in Slough and nationally. 'Self-Neglect' is addressed within the Care Act 2014 and it therefore seemed sensible to examine this difficult area of work.

The Review Team set the parameters for detailed analysis on the period between October 2011 and June 2014 when Mrs EE died. However in order to provide a context and address any longer term patterns of behaviour the history of Mrs EE and her son's involvement with services was examined.

In what ways does this case provide a useful window on our systems?
This was a difficult case for the Review Team as it has a number of unusual, even unique aspects which were hard to separate out from the systemic issues. However the case provided a useful window on the system because a number of important multi-agency processes occurred during the time period which concerned Mrs EE. This allowed an opportunity to explore common dilemmas and tensions staff face when they have to determine between allowing people to make 'unwise decisions', support and intervention with people who do not wish to engage with services.

It should be noted that in order to keep the Report succinct typically only one example is provided from the case but in many instances this was only one of many examples.

Findings

Finding 1: Communication and collaboration in longer-term work

The assumption from professionals is that other services will 'keep an eye' on people even after their case is closed due to non-engagement and will refer back if risks escalate, but as there are no formal systems for monitoring people who disengage from services, in reality risks remain unknown.

Summary

There are no formal systems in place for monitoring people who disengage from services, meaning that we do not know about their reasons for disengaging, and eventual outcomes. Because of the way systems are designed, cases are closed rather than reviewed or monitored. This leaves staff hoping that someone in another service will raise the alarm if circumstances change but no clear pathway or expectation that this will happen.

Recommendations

That the Board produce multi-agency guidance and agreement for working with people who do not engage, which is linked to the Multi Agency Guidance on Managing Risk.

That individual agencies review their internal guidance on how they work with people who do not wish to engage, specifically where there are concerns about risk.
That all multi-agency meetings include details of on-going monitoring arrangements and re-engagement plans, including when cases are to be closed and there are concerns about unmanaged risk.

Finding 2: Communication and collaboration in longer-term work

The specific remits of the various panels for discussing cases means that there is no clear route for escalation to consider alternative options for people who do not fit a defined category of need leading to no safety net for professionals

Summary

When professionals become stuck in a case, they may need the support of a multi-agency panel or meeting to help to move things forward. However, in Slough these panels have very specific remits, meaning that cases which do not easily meet usual criteria are more likely to close a case under the presentation of declining services or non-engagement because they do have any alternative. This is a missed opportunity to offer a multi-agency oversight into cases to provide objective reflective challenge and board acknowledgement and awareness of potential people and their families who may remain to be at risk by non- engagement.

Recommendations

That a review is completed of the various multi-agency meetings which are already in existence, with the purpose of producing guidance for staff regarding which process is most appropriate for specific cases. This should include referral routes and potential outcomes from each process.

That the Board consider how using an “At Risk” pathway may strengthen the routes available to a range of staff; it may consider, on completion of the above recommendation, that this is not required.

Finding 3: Communication and collaboration in longer-term work

In Slough there is no public health promotion of common health problems affecting older people (e.g. continence, lack of mobility), leaving family carers and professionals with limited understanding of the risks involved in managing them effectively

Summary

Because both family and professionals do not understand the risks associated with common health issues for older people such as lack of mobility or continence, this leads to professionals less likely to be more insistent about the support that could be offered and family more likely to refuse services offered.
Recommendations

That representation is sought from Public Health on the safeguarding adult's board. That Public Health co-ordinate a response to this finding which results in information to the public and front-line workers regarding common preventative strategies for older people, particularly in regard to pressure wounds.

That the Board reviews and publishes a response to it's' responsibilities with regard to prevention

Finding 4: Service user and carer -professional interaction

In initial contact, professionals are focused on what they can provide, so they tend not to prioritise issues that are outside their role, even if they are very important to the service user, resulting in disengagement by the service user.

Summary

Professionals must necessarily keep a focus on their primary role and not be distracted from this. However if services are to truly provide person centred services, there must be some adjustment made to address the main concerns of the service user first in order to prevent disengagement and reduce risks.

Recommendations

That each agency provides evidence of how it provides a person-centred response to those who require care and support, with particular attention to how the views of the person are heard and responded to.

Finding 5: Response to Incidents

There is a lack of clarity about the relationship between safeguarding adult and domestic abuse procedures, particularly in non-stereotypical domestic abuse cases, leading to risks not being investigated thoroughly.

Summary

Staff in Slough find it difficult to address situations where an adult who has care and support needs may be being harmed or abused by an intimate partner or close family member in such a way as could also be defined as domestic abuse. In order to mitigate risk, careful consideration is needed to determine the best approach to follow in circumstances such as possible intergenerational abuse.

Recommendations

That each agency reviews the Domestic Abuse training provided to its front-line staff and consider whether this is adequate for their level of work.

That Slough Safer Partnership presents the Slough Domestic Abuse Strategy to the Board, with a specific focus on training and multi-agency working

Finding 6: Tools

In Slough Adult Social Care there is a pattern whereby the lack of a written standard operating procedure and quality assurance process means that there is over reliance on individual managers' experience and initiative, leading to inconsistent and poor governance and few escalation routes.

Summary

Staff require policy and governance system to guide their practice and understand their professional accountability. The lack of these leaves it open for anyone to miss or not complete an allocated task and a matter of luck if a manager discovered this. Equally without the infrastructure of policies and standard operating procedures services and roles can be at risk of overloading and not being able to meet an agreed standard of work thus making it difficult for organisation to hold people or department to account.

Recommendations

That Adult Social Care review existing processes in place to support managers to ensure that management instructions have been completed.

That Adult Social Care provides assurance of current safe processes to the board.

That Adult Social Care provide assurance to the board of robust governance systems which effectively monitor quality, including audit of individual case management, supervision and task allocation systems.

Finding 7: Management Systems

In Slough staff tend to gravitate towards known 'willing' workers' in other services rather than follow multi-agency procedures which can lead to an over reliance on individual staff.

Summary
Staff use their local knowledge of services and who they know will be helpful to them rather than clear multi-agency pathways when they need to access other services. Whilst this is often positive in building close relationships, it can mean that inappropriate knowledge or expertise is accessed or services where staff have not been helpful in the past are avoided.

This means that service users may not receive the most effective services for their needs. A balance between developing willing workers and having appropriate pathways that other agencies are understand and use must be maintained.

Recommendations

That links between agencies are reviewed and/or developed to ensure that front-line workers have a clear understanding of how to access, refer and communicate with other agencies, without being solely reliant on individual workers.

5 IMPLEMENTATION PROGRESS

Since the completion of this Learning Together Safeguarding Adults Review the report and its Action Plan have been discussed at a multidisciplinary agency forum prior to its presentation to the Slough Safeguarding Board.

Presentation of review to the Safeguarding Board and receipt of action plans each agency.

There is guidance in place for Adult Social Care staff relating to finding 6. Reflective feedback to the practitioners who were involved and evaluation of the benefits of using a systems methodology approach; the value of directly involving frontline practitioners has been recognised.

It is pleasing that recommendations following this review dovetail with other strategic developments; for example, the Domestic Abuse Strategy and Public Health. Public Health, Neighbourhood and Housing Services and Community Safety are now represented on the safeguarding adult's board.

The safeguarding adult review panel, a sub group of the safeguarding adult's board will continue to monitor the implementation of the recommendations and report progress to the board.