Nottingham City Safeguarding Adults Board

NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review: Adult C

Executive Summary for publication

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1. Introduction

1.1 Criteria

A Local Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

1.2 This SAR report should be read alongside the SAR report for Adult D. The SARs for Adult C and Adult D were carried out simultaneously by the same report author but published as separate reports.

2. <u>Decision to hold a Safeguarding Adults Review (SAR)</u>

2.1. The Independent Chair of the then Nottingham City Adult Safeguarding Partnership Board made the decision to undertake a SAR on 6th July 2015. The decision to hold a SAR was based upon the view that there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult; that the adult was still alive and that the SAB knows or suspects that the adult has experienced serious abuse or neglect. This SAR relates to a case of false imprisonment and assault, in the context of the new safeguarding category of modern slavery

2.2. This review has been jointly commissioned with the Nottinghamshire Safeguarding Adults Board (NSAB) although Nottingham City Adult Safeguarding Partnership Board, which has now been renamed the Nottingham City Safeguarding Adults Board (NCSAB) is the lead SAB.

3. Methodology

3.1. The methodology for this SAR has been developed to ensure the learning is gained in an effective and timely way, in line with the Care Act 2014 requirements. Key aspects of the process included:

- Multi-agency chronology (factual log only)
- Case summary & appraisal
- The formation of a SAR panel (comprised of City and County SAR subgroup members plus additional agencies) to consider agency submissions and agree Overview report
- Practitioner event

3.2 Hayley Frame, Independent Reviewer, was appointed to undertake the SAR.

4. <u>Organisations involved in the SAR</u>

4.1 Organisations involved in the SAR were as follows:

- Adult Social Care – Nottinghamshire County Council
- Adult Social Care – Nottingham City Council
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital Trust
- Ashfield and Mansfield Clinical Commissioning Group
- Housing Aid – Nottingham City Council
- A Nottinghamshire District Council
- Nottinghamshire Police
- East Midlands Ambulance Service
- Framework Housing Association
- Nottinghamshire Healthcare NHS Foundation Trust

5. Lessons learned

5.1. A number of themes/areas of learning have arisen from the review of this case. These can be summarised as follows:

- A lack of professional curiosity and a reliance upon self-reporting and the need for a disclosure of abuse
- Recognition of and response to safeguarding concerns and indicators of abuse
- Professional assumptions made as a result of diagnostic labels and gender bias.
- Working with adults who are perceived as hard to engage
- Interagency communication and silo working

5.2. ADULT C presented to very many professionals over the scoping period of this review. However these presentations were largely connected to ensuring that his immediate needs were met i.e. if he was in pain or in need of shelter. Most presentations were at night, to out of hours services. ADULT C also moved between the City and County Council boundaries which added to the fact that his health, housing and social care needs were never fully addressed.

5.3. A theme which emerged was how to analyse the risk presented to an adult who seeks services at times of crisis but does not appear to wish to engage. Potential opportunities were lost by not having multiagency discussions that captured the input of health, police, housing, voluntary sector, and social care.

5.4. ADULT C did not engage with professionals to address the underlying issues which were affecting his wellbeing. It is evident that ADULT C was protective of his abusers. It is likely that as a result of coercive control, ADULT C felt unable to engage with agencies.

5.5. A lack of professional curiosity meant that despite frequent assaults by unknown assailants and evidence of physical abuse, ADULT C was not viewed by some as an adult at risk of harm. Conversely, as a result of mislabelling, others did view ADULT C as an adult with vulnerabilities, due to mental health issues and learning disabilities, the existence of which is not evidenced within the records.

5.6. This area has been explored within the SAR panel and within the practitioner event held as part of this SAR. A number of factors were felt to have influenced professional judgement including assumptions that are made about young male homeless men with injuries with a history of mental health and substance misuse problems. He would provide explanations for his injuries that alleviated professional concern for him and his presentation often reinforced stereotypes of homeless young men and assumptions that are made about non engagement. The additional vulnerabilities and risks to homeless people were not explored in any depth.

5.7. ADULT C was presumed to have Mental Capacity in accordance with the Mental Capacity Act 2005 and at no point was it established otherwise. Therefore ADULT C had the right to make unwise decisions, such as discharging himself from hospital against medical advice. The review has questioned whether ADULT C's ability to make decisions was compromised due to the coercion and control exercised by his abusers. Coercion and control became a statutory offence in December 2015.

5.8. A significant area of learning arising from this review is how practitioners work with deception as it is evident that no agency was aware that ADULT C was being abused.

6. Recommendations for the NSASPB and NSAB:

- The Board is to seek assurance from agencies, including the third sector, that awareness has been raised with the workforce through:

    a) relevant and appropriate channels regarding modern slavery. This should include the full range of situations that could indicate modern slavery.
    b) relevant and appropriate channels regarding indicators and impact of coercive control
    c) existing safeguarding training continues to reinforce professional curiosity and identification of a person as an adult at risk and requiring services, and ensures a link to the risk of modern slavery.

- Learning arising from this SAR will be disseminated via appropriate learning events
- The case to be referred to the strategic leads for modern slavery in the City and County in order for the learning to assist in the development of a strategic approach to modern slavery.

7. This report and its recommendations were accepted by the NSAB on 17th November 2016 and the NCSAB on 7th December 2016 subject to some very minor revisions which have been signed off by the Independent Chair of NCSAB.