Northamptonshire Safeguarding Adults Board

Learning from Safeguarding Adult Reviews

Key findings and learning from Safeguarding Adults Review - Ref 019 - 'Jonathan'

The Purpose of a Safeguarding Adults Review (SAR) is to promote learning and improve practice where there is concern that partner agencies could have worked together more effectively to protect the adult. A SAR will not investigate or apportion blame but seeks to support professionals to adjust practice in light of the lessons learnt from the review process.

Sharing Learning from both local and national SARs and other reviews is a key priority for Northamptonshire Safeguarding Adults Board (NSAB).

SAR 019 – 'Jonathan' evaluates multi-agency responses concerning the death of 'Jonathan' who sadly died in December 2019.

The timeline of the review was determined as being from 1st January 2019 to the date of Jonathan's death on 31st December 2019.

Following the completion of this SAR an action plan is put in place with key multi-agency and single-agency recommendations and actions for organisations involved with the case. Progress will be monitored via the NSAB Quality & Performance and SAR Sub Groups.

This learning briefing summarises the key findings and recommendations from the review.

Managers should discuss this briefing with their teams to ensure that the learning is used to enhance existing good practice and to make changes where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded.

The Overview Report and Executive Summary were recently published and are available on the NSAB website.

Note: NSAB is also referred to as 'the Board' throughout the recommendations in the report.

The Safeguarding Adult Review (SAR)

The independent author and the SAR panel selected a hybrid approach, using a combination of detailed chronologies from partner agencies, a practitioners' event and individual agency reflective questions in order to support a fully inclusive, focused and balanced review.

The review set out to understand the following:

- The degree to which agencies applied professional curiosity in the assessment of Jonathan's challenging behaviours and circumstances.
- The degree to which services were coordinated to address safeguarding concerns and prevent the escalation of health and social care needs and harm through timely assessments.
- How Jonathan's history was taken into account and the professionals' understanding of this and the degree to which making safeguarding personal was utilised.
- How Jonathan's health and social care needs were managed and understood within the intersections of his housing needs and history of homelessness.
- Whether a person-centred approach was undertaken to understand his wishes and desired outcomes.
- The degree to which mental capacity and risk and needs assessments (including the use of advocacy) were appropriate and whether they were done in a timely manner.
- How the Mental Capacity Act 2005, Housing Act 1996, Homelessness Reduction Act 2017 and the Care Act 2014 were applied, including their appropriateness and effectiveness.

Case Narrative

Jonathan was living in a hotel at the time of his death. He died aged 46 on 31st December 2019. Jonathan was found deceased in the hotel room by a Social Worker carrying out a welfare check who contacted the Police and Ambulance Service. The cause of death was found to be Coronary artery thrombosis and Coronary atherosclerosis.

Jonathan was considered to have multiple vulnerabilities and risks which were further complicated by homelessness; in particular, rough sleeping. Jonathan had spent many nights sleeping on the streets, including during the cold winter months. Jonathan had frequent visits to emergency departments and a history of offending and imprisonment. Despite regularly coming to the attention of a number of statutory services as an adult experiencing street homelessness and significant physical and mental health conditions, his housing, health and care and support needs, including risks, were not readily acknowledged.

It was possible to illustrate the degree to which Jonathan's life course exemplifies that of an adult facing multiple exclusion homelessness (MEH), which is defined as: *"People who have been 'homeless' and have also experienced one or more of the following additional domains of deep social exclusion – 'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems) or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)."*[1]

Findings

- There was a lack of professional curiosity around understanding Jonathan's complex needs and homelessness. Jonathan's history was not taken into account and the professionals' understanding of this was not considered. It can be concluded that the principle of making safeguarding personal was not adopted.
- Transitions between services and institutions, such as from prison and admissions to, and discharge from hospital, were not appropriately managed, which includes not implementing the 'duty to refer' on most occasions where it was known that Jonathan was homeless.
- There was a general lack of service coordination to address safeguarding concerns and prevent the escalation of health and social care needs and harm through timely, coordinated assessments.
- There were missed opportunities to use powers and duties within the Care Act 2014, Housing Act 1996, Homelessness Reduction Act 2017 and Mental Capacity Act 2005.
- Risk management pathways including NSAB's Adult Risk Management Process (ARM) were not utilised, which suggests that this was not embedded in practice.

Good Practice

- There were many examples of determined efforts to engage with Jonathan and relieve him of his homelessness, including instances of human kindness and compassion from agencies and members of the public alike. This included providing Jonathan with food and clothing.
- Engagement with the family by the social worker to find out about Jonathan the person, this included professional curiosity with regards Jonathan's behaviours during an assessment, and displaying concern about 'sudden' changes to his presentation.
- Positive practice was evidenced between the social worker, probation and community based services to arrange a suitable time/place to meet Jonathan to begin a social care assessment.
- The housing officer was persistent when working with Jonathan and included many occasions of adopting a rights-based approach to secure social care assessments and multi-agency involvement.
- Policing teams regularly supported Jonathan to hospital to receive treatment for physical health concerns and raised notifications with adult social care/safeguarding.

[1] Fitzpatrick, S., Johnsen, S. and White, M. (2011) 'Multiple exclusion homelessness in the UK: Key patterns and intersections', Social Policy and Society

General Observations

- Poor safeguarding literacy regarding people experiencing MEH, including a lack of confidence in instigating, managing and coordinating high risk cases, like Jonathan.
- Normalisation of high levels of risk, leading agencies to not question how Jonathan had become homeless or exploration of his multiple conditions and vulnerabilities.
- Numerous situations where agencies took a passive approach in relation to Jonathan, including lack of case oversight, coordination and leadership.
- Opportunities to protect Jonathan were regularly missed, often as a result of professional pre-conceptions of care and support needs and risk, including a narrow interpretation of policy and the relevant legislative provisions and principles.
- A lack of purposeful and effective multi-disciplinary working to address Jonathan's complex issues which were not just confined to a housing issue. This included a failure to implement a meaningful and personalised plan of action, poor hospital discharges and a failure to assess his care and support needs.
- Opportunities to understand repeating patterns of crisis and use of emergency services were routinely missed but often perceived as isolated incidents.

Key Points for Learning

- There is learning for all agencies in relation to addressing safeguarding concerns to prevent the escalation of health and social care needs and harm through timely, coordinated assessments and protection planning for people experiencing high levels of risks like Jonathan.
- There is learning for all agencies to establish regular meetings where information can be shared, and decisions made for people experiencing MEH. There needs to be a comprehensive and explicit approach to risk assessment as an essential component of practice, and include a focus on proportionate risk management.
- It is important that practitioners pay close attention to a person's mental capacity, carrying out capacity assessments where indicated, particularly where an individual consistently disregards high levels of risk to themselves or others. The potential impact of impaired executive brain function on decision-making may also need to be considered.
- There is learning for all agencies in relation to transitions between services and institutions, such as from prison and admissions to and discharge from hospital. This should include understanding when the duty to refer under the Homelessness Reduction Act 2017 is triggered.
- It is important that practitioners learn the lessons from SARs, both in their own locality and elsewhere, and draw on this developing evidence base to inform their own practice.

Recommendations

1. Receive from the Chief Housing Officers Group (CHOG) a review of practice and decision-making regarding priority need for housing applications.
2. Receive from Adult Social Services[2] and Housing, a joint multi-agency protocol on assessment and service provision with respect to homeless people with care and support needs.
3. Conduct a multi-agency case file audit of section 42 enquiry threshold decisions where homelessness or risk of homelessness is a factor and to agree proposals for service development based on the findings.
4. Receive from Adult Social Services[3] a review of their professional oversight and management of safeguarding alerts to ensure that they are compliant with agreed standards. This should include assessment of risk, appropriate recording which captures professional judgement and collective agreement where a person's wellbeing is influenced by multiple agencies.

[2] As of 1st April 2021, Northamptonshire County Council's Adult Social Care ceased to exist and was replaced by West Northamptonshire Council and North Northamptonshire Council Adult Social Care.

[3] see footnote 2.

Recommendations	
5.	Receive assurance and evidence from relevant agencies involved in this review that processes are sufficiently robust that ensures the 'duty to refer' under the Homelessness Reduction Act 2017 is being activated when the responsibility arises.
6.	Receive from the Chief Housing Officers Group (CHOG) the local homelessness strategy/strategies together with assurances that the strategy/strategies addresses those experiencing multiple exclusion homelessness.
7.	Receive from Northamptonshire Adult Social Care[4], NHS Northamptonshire Clinical Commissioning Group, Northampton General Hospital and Kettering General Hospital a review of co-operation regarding hospital discharges and proposals to improve communication, assessment and service provision with an emphasis on joint assessments for homeless people.
8.	Receive from Northampton General Hospital and Kettering General Hospital suggestions for how the safeguarding teams inside a hospital can be made aware of homeless people in a timely and effective manner.
9.	Conduct a multi-agency case audit to answer the question of how embedded in practice is the ARM procedure, with particular focus on the timeliness for carrying out an ARM and the use of lead agencies to coordinate services and risk management plans, with proposals brought forward to address the findings. The findings should include proposals from agencies with regards to establishing more regular meetings where information can be shared, and decisions made for people experiencing multiple exclusion homelessness.
10.	Receive assurance and evidence from all agencies involved in this review that risk management processes have been reviewed and amended where necessary in relation to people experiencing multiple exclusion homelessness. Assurance should evidence that structures are sufficiently robust to ensure agencies understand each other's roles and responsibilities and include mechanisms that allow for effective operational relationships to develop across practice disciplines.
11.	Receive assurance and evidence from all agencies involved in this review that training and knowledge gaps in respect of multiple exclusion homelessness, referrals and thresholds for section 42 Care Act 2014 enquiries and section 9 care assessments, Mental Capacity Act 2005 assessments and the Homelessness Reduction Act 2017 have been addressed.
	The recommendations are reproduced in full in section 9 of the SAR 019 Overview Report

You can find the published summary on the Northamptonshire Safeguarding Adults Board Website

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[4] See footnote 2.