Key findings and learning from Safeguarding Adults Review (SAR) 024 – Adult A

December 2023

1. Executive Summary & Sharing Learning

This learning briefing summarises the key findings from the Safeguarding Adults Review (SAR) concerning the care of Adult A, which aims to identify both good practice and areas for improvement. We kindly request that managers discuss this with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary.

The purpose of a SAR is neither to investigate nor to apportion blame to individuals or organisations but seeks to:

a. Establish what lessons can be learnt from the circumstances of a case in which professionals and agencies work together to safeguard adults.
b. Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
c. Review the effectiveness of procedures both of individual organisations and multi-agency arrangements[1].
d. Improve practice by acting on the findings and developing best practice across organisations.
e. Improve inter-agency working to better safeguard adults.
f. Make a difference for adults at risk of abuse and neglect.

2. Background to Adult A

2.1 Adult A was a 51-year-old woman who was admitted to Kettering General Hospital (KGH) on 12th September 2021, following an emergency call to her home address. East Midlands Ambulance Service (EMAS) attended Adult A's address and found her to be in a severely malnourished state, covered in dirt, with insect bites on her body and headlice. On admission to KGH, she was also found to have other physical health issues. KGH raised a safeguarding concern to North Northamptonshire Council (NNC) on the same day.

2.2 On 13th September 2021, Adult A sadly died following a deterioration in her condition.

2.3 Adult A was a grandmother and had lived with three generations of her family until her admission to hospital. Adult A's children appeared to have been her carers and she had several physical health conditions. Information supplied by her family indicated that she had not left her home address for a significant period and had not even been downstairs from her own room for several months. Her living conditions were also cause for concern, being cluttered and dirty. Adult A had a long recorded history indicating that she would often fail to engage with services. There was also information available to professionals that Adult A was potentially vulnerable to cuckooing and that controlled drugs were being supplied from her home address.

2.4 Several agencies were involved in supporting the different members of Adult A's family, but they were predominantly supporting her children and grandchild and despite referrals being made to the Multi-agency Safeguarding Hub[2] (MASH), and later to NNC's Adult Social Care (ASC) department, the information contained within them did not identify that she was self-neglecting or that she may have required a different response. Professionals were not sufficiently curious about Adult A's situation and did not address the family's complex needs in a holistic manner.

2.5 A SAR referral was made to Northamptonshire Safeguarding Adult's Board (NSAB) by KGH on 11th January 2022 in relation to concerns around how agencies had worked together to safeguard Adult A and a SAR was commissioned on 21st March 2022 under Section 44(1) of the Care Act 2014. The review examined a period of time between 1st June 2021 and 13th September 2021 but also included some significant events outside of this period.

[1] The SAR will consider any completed investigations and/or enquiries and use the information to enhance the review and avoid any unnecessary duplication.

[2] Multi-agency Safeguarding Hub (MASH) arrangements in Northamptonshire are for children's safeguarding referrals.

3. SAR Findings

3.1 Safeguarding children, young people and adults is a collective responsibility and whilst professionals have individual roles and responsibilities within their organisations, there remains a duty for every professional to consider the safeguarding needs of all people they encounter in their role.

3.2 Adult A's safeguarding needs were not sufficiently recognised by professionals despite there being information that was obvious about her situation. The seriousness of her physical condition and her home environment was seen by professionals and referrals were made into the MASH, but the information about Adult A was either missed or not given the priority it needed, therefore the family were not provided with an adequate response.

3.3 Professionals coming into contact with Adult A did not recognise that she was self-neglecting. Self-neglect is a complex problem that is very challenging to address and all professionals should understand the problem and the pathways that are available for support and advice.

3.4 The review highlights the need for professionals within all organisations to work collaboratively, to share appropriate information, and to develop joined up co-ordinated responses. This is particularly important in social care to ensure that situations involving both children and adults at risk are approached in a holistic manner. While the focus of professionals was mainly towards Adult A's children and grandchild, the children's safeguarding process did provide an opportunity for Adult A's situation to be recognised and responded to.

3.5 The deployment of several professionals into one household can create a difficult and confusing situation for the practitioners as well as the service users. Greater connectivity between teams could assist in professionals understanding terminology, thresholds and where support can be accessed.

3.6 Timeliness of referrals, raising concerns, quality assessments and responding appropriately is also a feature of this review. There were delays throughout the period covered by this report. Earlier recognition and assessment of Adult A's situation may well have triggered a response that led to a different outcome for her.

3.7 Practitioners reported feeling overwhelmed by the complexity of the situation. Effective supervision and support can greatly assist in identifying the specific issues at play and exploring solutions.

3.8 The review highlights that there were several alternative avenues of support that could have been accessed to potentially assist professionals engaging more effectively with Adult A, for example a referral to Northamptonshire Fire and Rescue Service (NFRS) in relation to her home conditions and potential hoarding, or use of the Adult Risk Management (ARM) process to assist in managing the complexity of her situation. These were either not considered or known about by the professionals involved.

3.9 Difficulty in engaging with individuals and families and maintaining effective relationships is also a frequent problem for services. It can be a serious issue and lead to greater risks for both adults and children. This needs to be recognised by professionals and again discussed with supervisors to identify what strategies might work. Developing guidance to assist front line staff in strategies to help them engage with individuals and families should be a priority.

3.10 Adult A's main concern seemed to be keeping her family together and this was sometimes at her own expense in terms of looking after her own physical health. Upon emergency admission to hospital, it was apparent that she had severe weakness and wasting of her body caused by chronic illness. Adult A's circumstances, behaviour and complex family needs were extremely challenging but there are several missed opportunities identified in this review.

3.11 NSAB and its partners have developed a significant amount of policy and guidance to support professionals in their roles. This review has identified that despite the information being readily available to staff, procedures and guidance are not understood and opportunities therefore missed.

4. Learning in relation to roles and responsibilities and identifying safeguarding

4.1 There were several opportunities where a different response could have been elicited had the information relating to Adult A been appropriately considered and the significance identified.

4.2 In January 2021 one of Adult A's family experienced a significant medical event and a referral was made to the MASH. Whilst predominantly focused upon this particular member of the family, the referral contained information that Adult A was suffering from various physical ailments and was also visibly dirty and unkempt.

4.3 On 4th May 2021 an occupational therapist (OT) made a referral to the MASH concerning the suitability of living conditions of Adult A's address in relation to the family member that had experienced a medical issue. Adult A was reluctant to leave her bedroom and there was evidence of drug use by her teenage son.

4.4 A further safeguarding referral was made on 6th June 2021 to the MASH in respect of the poor home conditions. No further action was taken as the family were being supported by a Strengthening Families worker.

4.5 The OT made her second safeguarding referral to the MASH on 8th July 2021, which again included details of Adult A's frailty as well as continuing concerns around the home conditions. The OT made a comment to the report author that Adult A had a huge stomach at that point, which the OT was extremely concerned about. She also said that she felt quite overwhelmed with the complexity of the family's situation.

4.6 A visit to Adult A's home was made the following day by a Northamptonshire Children's Trust (NCT) social worker but the focus of this enquiry was directed to one of Adult A's children. However, recognising that Adult A required some support, it was agreed that the SW would refer Adult A to Adult Social Care. This was not done however until 9th August 2021.

Key Learning Points

1. Professionals need to consider safeguarding in its widest sense and in respect of both adults and children, recognising that whilst their individual role may relate to one aspect of the family, they also need to be alert to each family member to recognise whether there is potential evidence of abuse or apparent neglect and to take appropriate action.
2. Referral routes into different services such as NFRS need to be clear and accessible to front line professionals.
3. The NFRS Hoarding Protocol should be promoted across all agencies to provide front line professionals with a clear understanding of the issue and the support available.
4. Professionals need to continue to develop their legal literacy, plus their understanding and awareness of each other's roles and responsibilities, terminology, and thresholds to access the appropriate support. This could be achieved through joint learning events, Continuous Professional Development events or case studies.

5. Learning in relation to information sharing, adopting a holistic approach and recognising vulnerability

5.1 There was a wealth of information available to agencies that identified Adult A's vulnerability, deteriorating health and frailty. The complexity of the family's needs included poor living conditions with a threat of eviction, potential neglect and self-neglect, physical illness and disability, criminality, drug use, potential exploitation, plus a lack of engagement with education. With all these interlinking issues, a coordinated response was required to address them.

5.2 Between 2011 and January 2021, there were 16 incidents recorded in about Adult A's family with Northamptonshire Police. There were six pieces of intelligence recorded relating to the supply and use of controlled drugs at her address and a suggestion that she was being taken advantage of by her children and/or their associates. Adult A was herself a drug user and a controlled drug was found in her room on the day she was admitted to hospital. There was a lack of professional curiosity about this information.

5.3 NNC Housing Department received an application from Adult A on 9th June 2021 which contained significant detail about her physical condition and requirements. This was information that could have been requested by other professionals.

5.4 The information contained within the referral made to ASC on 9th August 2021 did not contain any information that identified Adult A's vulnerability.

Key Learning Points

1. A "Think Family"[3] approach to the safeguarding of all members of Adult A's family was essential in these circumstances. Professionals involved with each member of the family needed to take every opportunity to identify their complex needs, recognise the risks and ask questions. By being open minded and curious this can assist professionals in making informed decisions and thinking outside of the box as to what support would make a difference to the family and how to keep them engaged.

[3] Think family – Is an approach to help professionals consider all members of a family with complex needs to work collaboratively to secure better outcomes.

2. A range of options are available to support families with complex needs including potential cuckooing and exploitation. Professionals need to be aware of how to access local arrangements to refer appropriate cases, and information regarding the Community Safety Partnership's cuckooing forum should be circulated to all agencies to help raise awareness.
3. Local authority housing departments should consider contacting other agencies involved with individuals and families to assist in building a comprehensive picture. Conversely, social workers/social care practitioners conducting assessments can request information from housing authorities and health authorities to build a detailed picture of need.

6. Learning about barriers that prevented professionals identifying the issues and accessing support.

6.1 The numbers of professionals involved with the family and a lack of co-ordination were identified as a frustration leading to concerns that the family were not receiving the right support.

6.2 There were some issues apparent with the access to historic information due to changes of IT systems within ASC.

6.3 Practitioners reported issues with time constraints in completing enquiries and being able to follow up on referrals and a general concern articulated in relation to the capacity to deal with the volume of assessments required for care and support within ASC leading to a backlog of cases.

6.4 The different terminology and thresholds evident between children's and adult social services created confusion and there was a lack of knowledge of each other's processes.

6.5 A barrier evident through Adult A's behaviour in routinely failing to attend appointments or not answering other forms of communication were both anticipated and expected by professionals and she had in effect, developed a way of behaving that professionals anticipated and accepted as normal behaviour.

Key Learning Points

1. The barriers around information sharing experienced by NCT and NNC's ASC ought to be easily resolved between the two teams and access issues escalated to senior managers to unblock.
2. Ensuring that staff within NCT and NNC's ASC have the knowledge of how to request and access data is also an important learning point as NNC state that it is common practice that organisations do not have access to each other's information. Supervisors and managers in both NCT and NNC, should ensure that their staff know how to make requests for information.
3. Terminology, thresholds for intervention and support and understanding of other teams' practices and more cross team working, or specific training/awareness should be considered particularly by statutory safeguarding teams.
4. Timeliness of assessments is critical to the quality of assessments and is relevant in both child and adult safeguarding. Subsequent referrals to other support or services should also be made without delay.
5. NNC ASC should ensure that as part of their processes for monitoring and managing waiting lists for the assessment of peoples' care and support needs, that cases identified initially as low or medium priority are kept under review to identify if risks alter.
6. "Working Together guidance" states that where a practitioner makes a referral in relation to a child's welfare they should always follow up their concerns if they are not satisfied with the response. It is the view of the author that it would seem best practice to adopt the same approach in relation to the referral of concerns to other statutory services, in this case ASC.

7. Learning and the engagement of Adult A with services

7.1 Adult A had a history of non-engagement with services.

7.2 Adult A had been registered with her GP since 2016 but had not been seen in person since 2018. Letters from her GP in relation to appointments for blood tests and reviews were unopened and ignored. There was a missed opportunity when Adult A contacted the GP surgery on 15th July 2021, which Adult A reportedly said was following an assessment by social services. The GP advised Adult A to contact the surgery to arrange for a home visit which she failed to do.

7.3 The professionals involved with Adult A's grandchild and the strengthening families programme all reported difficulties in engaging with her.

Key Learning Points

1. While many health agencies, including acute and community providers, will have policies relating to patients who do not attend appointments, practical guidance developed by some Safeguarding Adults Boards[4], suggests that following repeated cancellations or not attending appointments there should be further exploration of the situation, including consulting with other agencies already involved with the individual to identify whether there are any apparent risks of abuse or neglect. The purpose of such policies is to reduce any risks to patients by promoting engagement, help in identifying safeguarding concerns and ensuring follow up. The GP surgery involved in this review should give consideration to the development of a policy to address these issues.
2. All agencies involved in the safeguarding of adults at risk need to develop strategies to help initiate and develop engagement. Identifying which professional has the most effective relationship with the individual, maintaining consistency and attempting to identify the individual's motivation are all key elements to effective strategies and for agencies to work in a coordinated way. A short aide-memoir or similar document may support more positive approaches from professionals and provide useful guidance.
3. Professionals should also consider the use of an advocate or intermediary in similar situations who may be able to provide the trusted route into engagement with the family and assist in maintaining that relationship.
4. Supervisors of staff play a key role in supporting front line professionals with challenging cases where individuals and families are difficult to engage. They should provide appropriate support and guidance to help identify and suggest various strategies which can improve the engagement.

Good Practice

Two of the practitioners involved with Adult A's family demonstrated tenacity and determination in their attempts to engage with Adult A and her family. They recognised an issue and made personal visits as opposed to relying on phone calls and texts. They also went over and above their own roles by clearing an area of the house and assembling equipment to assist the family.

8. Learning in relation to self-neglect

8.1 Professionals did not recognise that Adult A was self-neglecting in respect of her own physical health and her home environment. Self-neglect can be difficult to identify and complex to resolve. A Section 42[5] Safeguarding enquiry is not necessarily the right response to all situations and the involvement of other services may be more appropriate when working together to identify solutions. E.g. The ARM process for high-risk cases or self-neglect pathway.

Key Learning Points

1. Professional curiosity, multi-agency working together and collating the softer intelligence may have led to a better understanding of what was happening in Adult A's home. It is an unusual situation to find a person not leaving the house or leaving her bedroom for a two-year period and this could have been explored further.
2. Working with people who self-neglect can be extremely challenging for professionals not only in terms of identifying the issue initially, but in understanding the root cause and accessing the right support. Therefore the support and supervision of front-line staff is essential and escalation of concerns should always be an option where professionals consider they are not being provided with the right level of support to respond to the presenting issues.
3. Ensuring that all front-line professionals and supervisors have an effective knowledge of what constitutes self-neglect and how to respond should be a consideration arising from this review. Nationally self-neglect safeguarding concerns are only reported in low numbers yet research indicates a significant amount of SARs relate to self-neglect. Northamptonshire Police have reported to the review that they have updated their self-neglect toolkit which may be useful for other agencies to consider.

9. Learning in relation to Adult A's children being recognised and supported as carers

9.1 Both of Adult A's children identified themselves as her carers but only the younger one was referred to Northamptonshire Young Carers (NYC) for assessment and potential support. However the quality of the information provided to NYC was substandard and built a delay into the process. NYC also found Adult A was difficult to engage with and this resulted in no assessment being made of her carers needs.

[5] Of the Care Act 2014

9.2 It is important that professionals recognise the importance of providing appropriate information to all other agencies when referring or signposting individuals or families for support. NYC service did not understand the complexities of this family, did not co-ordinate with any other social care practitioner or other agency involved which had they done may have led to a different approach in terms of engaging with the family.

10. What has changed?

Northamptonshire Police

- Northamptonshire Police reported to the review that it was likely that when intelligence was submitted regarding Adult A's address being used to deal drugs by other people that Adult A was not recognised as being vulnerable. The force has since re-introduced Neighbourhood Policing Teams (NPT) and have identified that families similar to Adult A's will be identified as a force priority. Should similar information be identified NPTs would be tasked to complete safeguarding/cuckooing visits to the family. The NPTs also attend the monthly cuckooing meeting chaired by NNC.
- The force also identified the need to ensure officers and staff understand and implement professional curiosity and training is now provided for new starters, investigator courses, and leadership courses. Part of this training includes requirements of Public Protection Notices[6] (PPNs), one of which is that parents must be added. Senior Referral Officers will now ask an officer to adjust a PPN if the parent(s) is not linked, as well as requesting confirmation that the parent is informed of what has happened and how are they going to safeguard the child.
- A "parent flag" is also now included on a person's details so that Officers can identify nominals[7] who are parents and then put in appropriate safeguarding measures.
- An updated "neglect toolkit" has been shared with public protection officers to support them in their decision making around neglect cases.
- All identified safeguarding occurrences will now be subject of a supervisory review to ensure that PPN's are correctly submitted, and that any crimes are clearly identified.

Northamptonshire Children's Trust (NCT)

- NCT has reviewed the use of the escalation process for all partners who wish to raise concerns about practice and thresholds. A positive challenge [escalation] process was utilised by Strengthening Families colleagues in respect of decision-making in MASH in this case and this resulted in review of the decision in question and led to the referral being taken forward through assessment.
- In relation to the 'Think Family' approach, NCT management has invited two principal social workers to attend an NCT managers meeting to discuss 'Think Family' and specifically how to raise issues to WNC and NNC Safeguarding Adults colleagues (including self-neglect cases).
- NCT has publicised 'Think Family' guidance in the department's Newsletter and linked this to a prior SAR outcome to ensure this detail is understood and change(s) in practice can be evidenced because of these parents' deaths.

Northamptonshire Healthcare Foundation Trust (NHFT)

- There was no immediate contact between NHFT and Adult A, however, changes in the service are as set out below but are not due to this review.
- The Safeguarding Team advocates a Think family model and therefore children and adult specialist nurses now work in unison and not in divisions.
- Level 3 Adults Safeguarding training has commenced which advocates the "Think family" approach, but also all the areas of learning documented in the report.
- The Trust is in the process of reviewing the service supervision policy.
- The Trust has also commenced two outreach programmes, for adult community services and with the 0-19 years Health services. This details learning from reviews and exploration of current challenges.

[6] A Public protection notice is an information sharing document that records safeguarding concerns about an adult or a child which are shared with partner agencies to inform a multi-agency response.

[7] Nominal – individuals who have come to police notice as offenders, suspected offenders or whose details have been recorded for another policing purpose.

Northamptonshire Fire and Rescue Service (NFRS)

- The Hoarding Framework Training session was delivered to eighty partners during the NSAB Week of Learning in June 2022, to launch the new procedure for the County. Also, a Hoarding Framework Partnership Event was delivered and attended by 120 partners to discuss how to embed the new Hoarding Framework further.
- Individual partner training sessions have also been delivered on hoarding, hoarding framework and self-neglect to any partners that request input, monthly sessions have been delivered to the NHS, Children's Partnership, GP's, Office for Police, Fire and Crime Commissioner Early Intervention Teams, Family Support Hubs, Occupational Therapists and Social Prescribers.
- The Hoarding Framework is available on the NSAB Website and Fire service Website, and many partners have also included it on their Intranets for staff to access.
- Internal training on self-neglect has been provided to all fire crews, fire staff and officers. Self-neglect case studies have been written and shared internally and externally for learning. Self-neglect referrals have increased because of the training that has been delivered.
- All NSAB policies, guidance and learning is shared throughout the organisation through the internal Safeguarding Management Group, which is Chaired by the Chief Fire Officer. Supervisory training sessions are also delivered and internal communications used to ensure all staff and operational crews are aware of SAR Learning points.

North Northamptonshire Council (NNC) – Adult Social Care (ASC)

- A new risk matrix document has been developed which also includes guidance on the prioritisation of cases. The new risk assessment will be reviewed regularly in line with practice and feedback so that it can be adapted as necessary.
- ASC are working closely with the locality hubs to address the high demand and working to make improvements in other areas in relation to practice, processes and training. Regular mass duty days are used to ensure that all outstanding cases are allocated and risks reviewed appropriately. Principal staff will screen cases and priority cases are actioned.
- ASC are looking to implement new guidelines around allocation times for cases and as part of their wider service delivery improvements, reviewing their current operational model to provide higher team resilience.
- A review of the decision making for safeguarding cases is also underway to ensure all decisions are appropriate, timely and accurately recorded.

11. Recommendations

1. All agencies involved in this SAR should provide assurance to NSAB to demonstrate that they are implementing a "Think Family" approach to safeguarding, and that the NSAB and Northamptonshire Safeguarding Children's (NSCP) shared policy for raising concerns about vulnerable children and adults is implemented appropriately and if not, should assure NSAB how it will raise awareness of both the policy and the approach with frontline practitioners.
2. NCT and NNC should review both their safeguarding arrangements and safeguarding training to ensure that there are joined up and effective working practices. This is to ensure that NCT and NNC staff have an appropriate level of knowledge and can develop a coordinated response to safeguarding concerns that are identified in complex family situations. Evidence of these arrangements should be provided to NSAB.
3. NCT and Northamptonshire Police should review and assure NSAB that their safeguarding processes are carried out in accordance with Working Together to Safeguard Children guidance and should conduct a case audit to address two specific areas – i) demonstrating their approach to gathering quality information includes the child, parents and any other adult living within the household to ensure that assessments are of a high standard, ii) identifying and demonstrating understanding of the barriers and enablers to providing a holistic response to complex safeguarding concerns.
4. All agencies involved in this SAR should provide assurance to NSAB that the newly launched NFRS Hoarding Protocol has been disseminated to their frontline staff.
5. NSAB should develop guidance for front line professionals (including voluntary sector organisations) to understand why individuals and families do not engage with services and identify strategies that work.
6. NNC should assure NSAB of its action plan and timescales currently being implemented to address the issue of high demand in relation to people who require assessment for their care and support needs and to ensure that risks are being appropriately identified, regularly reviewed, and managed.

7. All agencies involved in the review should provide evidence to assure NSAB that self-neglect and the self-neglect pathway are fully understood and utilised appropriately by their front-line staff. Evidence should include what training is delivered, numbers of recorded cases of self-neglect and the usage of the ARM process and evidence of case audits.
8. NCT should provide assurance to NSAB that where individuals are identified as young carers, appropriate and timely assessments are conducted, including considering their needs and those of the parent.
9. NYC should review their procedures to ensure they are timely and effective in gathering sufficient quality information on which to assess the young carers needs and provide an appropriate service.
10. The partner agencies of NSAB should provide assurance to NSAB about how they disseminate, implement and monitor the use of NSAB policies and guidance.

This review provides the opportunity to make improvements in professional practice and system processes across agencies. However, there are key themes within this review that were evident in a previous SAR completed in 2018 in Northamptonshire in relation to individuals who do not engage with services, identifying and managing self-neglect and use of the ARM process. This review must provide the impetus for agencies to improve their practice in the areas identified.

Useful Links

NSAB Self Neglect Pathway

NSAB Policies & Procedures - ARM Toolkit

Northamptonshire Safeguarding Adults Board

One Angel Square, Northampton, NN1 1ED

T: 01604 365681 E: NSAB.NCC@northamptonshire.gov.uk W: https://www.northamptonshiresab.org.uk/