Northamptonshire Safeguarding Adults Board

Multi-Agency Case Audit

Key findings and learning from Multi-Agency Case Audit
Adult Risk Management (ARM) 'Alan' – March 2022

The Purpose of a Multi-Agency Case Audit (MACA) is to review specific cases/themes to identify good practice, and to support professionals to adjust their working practice in light of the lessons learnt from the audit. MACA complements other activities outlined in the Northamptonshire Safeguarding Adults Board (NSAB) Quality Assurance Framework, such as single agency audits. Themes for MACA are agreed by NSAB's Quality & Performance Sub Group in line with the NSAB Strategic Plan.

MACA is carried out by way of a detailed audit where a case/cases is/are analysed in a meeting of professionals from key agencies.

Sharing Learning

Following the MACA, a detailed action log is developed that includes any recommendations including those for NSAB's Strategic Board. Progress is monitored via the NSAB Quality & Performance Sub Group.

This briefing summarises the key findings from the review and managers should discuss this with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded, and where it has been shared.

Multi-Agency Case Audit

This MACA was scheduled in light of the Safeguarding Adult Review (SAR) 019 'Jonathan', Recommendation 9.

The audit reviewed four cases where individuals were subject to the Adult Risk Management (ARM) process, and this learning briefing relates to case 4 where it was felt there was the most learning.

This briefing case relates to a 57 year-old gentleman who was considered to be in the Multiple Exclusion Homelessness (MEH) cohort. He was known to have complex needs (anti-social behaviour, drug addiction, mental & physical health issues, and was subject to exploitation by a local drug gang), and was supported by many separate agencies.

For the purposes of this learning briefing, the gentleman will be known by a pseudonym, 'Alan'.

Agencies were asked to provide details of their involvement between 1st May 2021 to 30th October 2021 and to include a summary of significant events prior to this timeline.

Fourteen agencies/teams completed an audit for the case, including:

Keystage Housing (HAARP), Rilwood Surgery *(via NHS Northamptonshire Clinical Commissioning Group),* Northampton General Hospital, Northamptonshire Fire & Rescue Service (NFRS), Northamptonshire Healthcare Foundation Trust (NHFT), Northamptonshire Partnership Homes (NPH), Northamptonshire Police, Substance to Solution (S2S), and various departments from West Northamptonshire Council including: Adult Social Care, Housing Options, Housing Options and Advice Team (HOAT), Single Homelessness & Street Outreach, and Temporary Accommodation.

Note: As the individual was based in the West Northamptonshire locality, he was not known to Kettering General Hospital or North Northamptonshire Council's Adult Social Care.

Case Overview

- Alan was well known to various housing teams from 2019. It took eight attempts to complete a housing application as he did not supply any supporting documentation or provide photographic evidence/benefit information. It was also noted that he was often difficult to engage with as he had no mobile phone. During later contact, some agencies were informed that he had a terminal illness, but this was found not to be the case.
- In September 2019, Alan was known to Housing Options Daventry, following his admission hospital in relation to a suicide attempt. They were not invited to the ARM meeting as the case had been passed to Northampton, but they should have been informed.
- There were previous public protection notices and safeguarding concerns raised in 2020, but they were deemed 'no further action' as Alan was presumed not to have needs for care and support. However, this can only be determined after a section 9 assessment is undertaken, and there is no record of this occurring.
- In January 2021, Alan was residing with his father, and following a referral from East Midlands Ambulance Service (EMAS) in respect of hoarding[1], clutter, excessive smoking, and potential fire risk, Northamptonshire Fire & Rescue Service (NFRS) attended the property, but were unable to gain access. In light of the fire clutter risk rating, NFRS should have been invited to the ARM meeting.
- In May 2021, Alan accessed the 'Hand Up'[2] service at the Hope Centre for food and substance misuse support. At this time, he was squatting at an address in Northampton.
- In July 2021, Alan was placed in a guesthouse following his father's death. It was suspected that he was using the property to take drugs, and he was subsequently asked to leave. There were also reports of issues with a drug gang in the area and being attacked with a baseball bat.
- In September 2021, Alan was moved to further temporary accommodation (TA), but again, there were reports of anti-social behaviour, drug use and high footfall to the property. During a home visit, the property was found to be in very poor condition and he agreed to clean it up, but in early October, the property was found to have deteriorated again with needles and drug paraphernalia lying around, and he was given immediate notice to vacate the property and provision for accommodation at HAARP was made available.
- Accommodation at HAARP was secured on the same day as notice was given on 7th October 2021, with a planned pathway to return to Midland Heart, but Alan didn't present himself until the 11th October 2021 (at the time, agencies were not aware of Alan's whereabouts). He disclosed that he had been a victim of a physical attack and had sustained injuries, and that he was fearful about not being able to stay in temporary accommodation as he would lose the drug gang £5,000 per night, and was therefore concerned about what harm they might do to him.
- On 12th October 2021, Alan completed an assessment with CGL, Substance to Solution (S2S), to begin opiate substitute treatment. During the assessment, he was advised to attend A&E due to a swollen right hand, but he refused. He was however, seen by a CGL nurse working with NHFT. At this point, he agreed to seek help following a discussion about the potential risks if the hand wasn't seen to.
- Also on the 12th October, Alan was referred to the Crisis Café for support after he said he had been kidnapped and beaten up over the weekend.
- On the 13th October 2021, Alan saw his GP who advised him to go to A&E as he had lost sensation in his hand. An appointment with the fracture clinic was made for the 15th. Later the same day, a full statement was given to the police, where he informed them that he was attacked by a gang as he told them they could no longer use his temporary accommodation. He suffered 3 broken bones and other injuries in the attack.
- On the 15th October 2021, Alan suffered a seizure at HAARP. Emergency services attended and the out of hours GP prescribed an Epi-pen. He was then taken to A&E as his medical records were 'locked', and he returned to his accommodation the following day. It was confirmed that his seizure was due to epilepsy.
- The ARM meeting took place on 18th October 2021 at HAARP. The level of risk was identified as high. The meeting was well attended, but there were key agencies not in attendance such as the Police and the GP *(unsure from the audit whether they had been invited or not).* Alan participated in the ARM, but during the meeting, he experienced more seizures. With his consent, the meeting continued. On the same day, he suffered further seizures and was taken to hospital via ambulance.

[1] Northamptonshire Hoarding Framework

[2] Hand Up is a crisis homelessness support service addressing issues such as food, personal hygiene, benefits, bank accounts, money management, and advocacy for housing support. Service users also have access to substance misuse workers that form part of the PHE MDT Rough Sleepers Team.

Case Overview

- On the 20th October 2021, and during Alan's stay in hospital, West Northants Council were made aware by his family that there were concerns of fraudulent activity on his bank account by the suspected gang, as his bank card was reportedly stolen in September and reported to the police.
- On the 27th October 2021, Alan sadly passed away.

Findings and Key Points for Learning

1. Safeguarding Concerns and Exploitation

- It was noted in the Adult Social Care audit, that concerns raised in 2020 included being threatened by a gun, people coming to the property, and significant health issues. The auditor was unclear why a safeguarding notification or enquiry wasn't undertaken.
- Despite Alan's complex needs, there was a lack of safeguarding concern raised by agencies, particularly in relation to potential cuckooing at his home, and despite evidence of possible exploitation. In fact, an agency who was aware of safeguarding concerns in September 2021, did not submit a referral as Adult Social Care had responded to say they were meeting with Alan two days later. However, he wasn't at the property when they visited, so this was a missed opportunity to safeguard him at that time and he remained at risk and continued to suffer abuse from others.

2. Multi-agency / Adult Risk Management (ARM) Meetings

- The ARM (Adult Risk Management) was only carried out once Alan was removed from a property of concern and into alternative accommodation. Due to his complex needs, it was seen as a missed opportunity for agencies not to have met previously.
- ARM has only recently become more embedded in housing teams, previously there had been an over-reliance on adult social care to lead on ARM meetings. *Training has since been delivered to address this gap.*
- The Police and Probation do not appear to be routinely invited to ARM meetings.
- Despite a list of agency safeguarding contacts on the NSAB website, not all agencies are aware of this.

3. Recording of ARM

- Not all agencies keep a central record of ARMs they have undertaken or been involved in, and this needs to be addressed. This is particularly true for Northamptonshire Police.

4. Information sharing

- There was a great deal of agency activity, but this was not joined up until the month of Alan's death.

5. Mental Capacity Act 2005

- The law states that practitioners must assume that someone has capacity, and when in doubt, a Mental Capacity Assessment should be undertaken. It is unclear from this audit whether Alan had capacity to make decisions or not. From recent audit activity, assessing mental capacity is a recurring theme, and there appears to be a lack of professional judgement recognised by agencies able to undertake assessments. If in doubt, refer to the Mental Capacity Act Code of Practice.

6. Professional Curiosity

- There was a lack of professional curiosity in respect of trauma, mental and physical health for Alan.

Good Practice

1. Alan participated in the ARM meeting.
2. Housing officers worked very hard to support Alan during 2021.
3. ARM training has been delivered by Adult Social Care, West Northamptonshire Council to the Single Homeless & Street Outreach. Further training is being arranged for the Locality Housing Options Teams.
4. Since the delivery of ARM training in October 2021, HAARP has been involved and led on 4 ARM meetings since November 2021.
5. In 2022, Keystage Housing formed an Adult Risk Board to better support individuals being exploited.
6. CGL – Substance to Solution – new starters are introduced to the ARM process as part of induction. Multi-disciplinary and team meetings are used to discuss safeguarding practice, procedures and support with learning and embedding of ARM to all practitioners.
7. The ARM Oversight Panel was formed to support agencies with the ARM process and referrals. The panel is attended by senior officers and key decision makers.

Recommendations

1. To improve multi-agency working, colleagues should ensure that a member of the Police Adult Safeguarding Team is invited to ARM meetings, particularly where there is evidence of exploitation, abuse or coercion.
2. Colleagues should provide sufficient notice of ARM meetings to colleagues, particularly GP practices, to support their attendance.
3. To ensure appropriate representation at meetings, when Housing are informed of an ARM, they should ask colleagues to check whether other locality housing teams have been involved and forward invitations as necessary.
4. There was a request from colleagues to better understand agency roles and responsibilities, particularly in relation to Housing. The Quality & Performance Sub Group will gather this information and share with colleagues and on the NSAB website.
5. To improve working practice, Assistant Directors for Housing should ensure the Adult Risk Management process is embedded into business as usual practices.
6. All agencies should ensure that attendance at ARM meetings is recorded effectively and shared with the central monitoring hubs each quarter.
7. In order to build confidence and working practice, colleagues should familiarise themselves with the information available on the NSAB website including the ARM Toolkit, safeguarding contacts, and multi-agency policies & procedures.
8. Assistant Directors for Safeguarding and Wellbeing to consider a central administration function to improve the effectiveness of the ARM process.
9. The Quality & Assurance Sub Group should seek assurance that Commissioning in both North and West Northamptonshire Councils review the breadth and reach for Advocacy within the county as part of a review for the next contract requirements.
10. As non-attendance by some partners appears to be a regular occurrence at ARM meetings, particularly when the ARM has not been arranged by Adult Social Care, the ARM Oversight Panel should consider how attendance can be improved, for example, would a centralised administration function support this?

The recommendations will be discussed at the NSAB Quality & Performance Sub Group in respect of lead agency, deadline for actions, and recording in a composite action log. All actions will be monitored through to completion.

Useful Links

Northamptonshire Hoarding framework

Mental Capacity Act Code of Practice 2005

NSAB Safeguarding Agency Contact Details

NSAB Policies & Procedures – ARM Toolkit

NSAB Policies & Procedures - Self-neglect Protocol

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