Safeguarding Adults Review
7 Minute Learning Summary

West of Berkshire Safeguarding Adults Board
Reading, West Berkshire & Wokingham

Adam

Adam had been living in supported accommodation in the West of Berkshire, commissioned by a London Local Authority (LA) for a number of years. The provider specialises in supporting adults with complex needs, working with people with Learning Disabilities and Autism.

Adam needs were complex and from an early age Adam and his parents were supported by Children's Social Care. Adam's parents were estranged but both were very involved in Adam's life. Prior to his current placement, a number of long-term placements for Adam had failed and there was disruption to Adam's childhood and early life. Adam was admitted to a specialist autism unit in a psychiatric hospital. His parents raised concerns about Adam's treatment and support in this unit.

Due to his complex needs Adam lacked capacity to make decisions about how his care and support is delivered an advocate was appointed support in making decisions in Adam's best interests.

When Adam moved into his new home in the West of Berkshire, it was the view of Adam's advocate, his father and professionals that Adam was happy in his new placement, the use of restraint had been significantly reduced and Adam had formed a strong bond with his main carer. This view was not shared by Adam's mother who raised concerns about the way Adam was treated and how the care provider sought to blame him for his behaviour when distressed, rather than accepting that this was due to the standards of his care.

8 years after Adam moved into supporting living there were concerns raised about a significant change in Adam's behaviour, which coincided with Adam starting to suffer a pattern of physical injuries. Whilst his carers explained that the injuries were caused by Adam's own behaviour, his mother raised concerns that he was being abused by his carers.

The care provider highlighted that Adam's behaviour was deteriorating and asked for support from the Intensive Support Team, however this was not progressed as Adam's mother objected. This then became part of an ongoing application in the Court of Protection.

Adam's mother felt that her concerns were not being addressed and as a result placed a covert recording device in his residential accommodation to monitor the actions of his carers. The recording identified that he was being abused and this was reported to the police who immediately informed the LA. A police investigation into the allegations commenced, in addition to a safeguarding response led by LA and following the principles of Section 42 of the Care Act 2014.

The Safeguarding Adult Review (SAR) identified that there was learning for the partnership in regards to how it responded to the concerns raised by Adam's mother, there were missed opportunities to safeguard Adam at an earlier time from the abuse he was subjected to.

Learning

Finding 1 – Out of Area Placements – Understanding and Responding to Safeguarding Concerns
Out of area placements make it more challenging to identify emerging safeguarding concerns and to provide an effective response. In order to improve this a person centred approach is required, in addition to a greater level of multi-agency working.

Finding 2 – Information Sharing
The lack of information sharing affected the quality of safeguarding and reduced the ability of agencies to protect Adam from further abuse. A greater understanding of the need to share information is required for the effective management of future complex cases.

Finding 3 – Management of Complex Enquiries
A new partnership protocol for the management of complex enquiries would greatly improve the efficacy of multi-agency safeguarding investigations. This should be supported with a training and development programme for professionals involved in such multi-agency enquiries.

Finding 4 – Family Engagement
Professionals did not understand the underlying reasons for Adam's mother's concerns and why she had developed a different opinion to others about what was in Adam's best interests. This prevented a consensus being developed, affecting the services provided to Adam.

Thankyou for taking the time to read this practice note. If you would like to provide any feedback or have any questions regarding the Board please contact: Lynne.Mason@Reading.gov.uk

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Safeguarding Adults Board
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7-minute Learning Summary

Safeguarding Adults Review Adam

Out of Area Placements Reviews

It is important that all professionals working with individuals are consulted when completing reviews.

The commissioning LA carried out annual reviews of Adam's placement, but the views of professional from the agencies (for example Adam's GP) who were working with Adam was not sought. This led to a lack of information sharing and prevented the opportunity to develop a joint understanding of what was happening in Adam's life. Had there been a greater multi-agency involvement in the reviews, then it is likely that safeguarding concerns would have been understood at an earlier stage.

The Board is developing a best practice guide for out of area reviews. The aim of this document is to provide clarity and best practice guidance to staff when they are carrying out reviews for people who are placed in out of area supported living, residential or nursing home care.

Information Sharing

When the criminal allegations were raised, the decision was made by the police not to share detailed information with LA for the purpose of the Safeguarding Enquiry. GDPR was given as the reason for this. The police were of the view that Adam was safeguarded as the carers had been removed from supporting Adam, so the information did not need to be shared.

A decision by the police was also made that the LA were not to share details of the abuse allegations with the care provider, in case this alerted the alleged perpetrators and harmed the investigation. For this reason the LA were unable to progress the Section 42 enquiry until the criminal investigation concluded.

The decision not to involve the care provider more fully in the safeguarding response meant that they were prevented from understanding what was happening to Adam and were unable to address the underlying cause of their staff's behaviour.

For guidance in regards to information sharing there is a Pan Berkshire Safeguarding Adults Information Sharing Protocol in place.

Professionals should refer to the Boards escalation process if they are concerned that decisions around information sharing is negatively impacting on a safeguarding enquiry.

Trauma Informed Approach

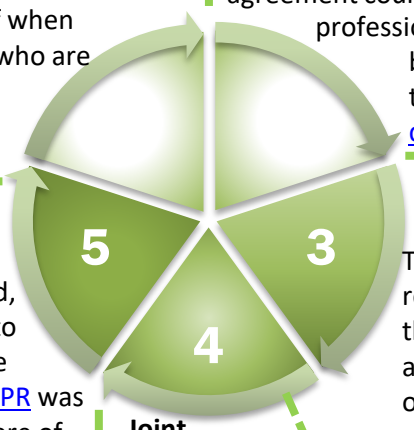
Over the years a difference in opinion developed between Adam's mother and others on what was in Adam's best interests, in regards to his living arrangements and support plan.

The commissioning LA worked with Adam's parents to seek a consensus, however these ultimately failed and led to a number of court hearings to decide on what was in Adam's best interests. Causing added distress to Adam and complications to professionals working with him.

There was a missed opportunity in how agencies worked with Adam's mother to understand how and why these differing views had developed. There would have been great value in taking a trauma informed approach to identify and understand the concerns of Adam's mother.

Over the years Adam's mother had raised a lot of concerns about how Adam was being treated, and she felt that her concerns were dismissed. As a result Adam's mother developed a view that agencies were protecting the care agency and therefore lost all confidence in their abilities to protect Adam.

A consensus of opinion will not be possible in every case, however Adam's case identified that once it is clear that agreement could not be reached it is beneficial for professionals to take a more proactive approach to best interest decisions, such as considering the request to appoint a personal welfare deputy, to prevent future disagreement.



Joint Safeguarding and Criminal Investigations Protocol.

When working on joint investigations the SAR identified that it would have been beneficial for there to have been a protocol in place for professionals to follow.

In response to this learning the Board are producing a Joint Safeguarding and Criminal Investigations Protocol. Which will be used when there is an criminal investigation being followed in addition to a safeguarding enquiry.

The priority of any safeguarding enquiry must be to safeguard the individual(s).

If issues are faced when working with other agencies professionals are asked to consult with their line manager for support and guidance. The escalation process should be used to address any concerns identified.

Importance of relevant history when making Safeguarding Decisions

The LA responsible for safeguarding Adam received a safeguarding concern outlining that Adam had been hurt by his carers. The assessment of this safeguarding concern only considered the information contained within that specific concern and did not fully consider the information known to both LA's. Following an explanation provided by Adam's carers the matter was closed with no further action.

The assessment of this safeguarding concern should have involved a greater level of professional curiosity and as a result an opportunity to identify abuse was missed.

The SAB are seeking assurance from its LA partners that there are adequate systems in place to fully gather and consider a person's history in their response to safeguarding concerns.