Report for: Adults and Health Scrutiny Panel, 8th February 2018
Item number:

Title: Learning from a Safeguarding Adults Review (SAR): Robert

Report authorised by: The Independent Chair of Haringey Safeguarding Adults Board

Lead Officers: Helen Constantine, Strategic Lead Governance and Improvement, Adult Services

Rebecca Waggott, Governance and Improvement Officer, Adult Services

Ward(s) affected: All

Report for Key/ Non Key Decision: Non Key Decision. To note

1. Describe the issue under consideration

1.1 Under the Care Act 2014 Haringey Safeguarding Adults Board (HSAB) has three core duties:

- developing and publishing an annual strategic plan setting out how we will meet our objectives;
- publishing an annual report which sets out what we have achieved; and
- commissioning safeguarding adults review (SAR) where serious abuse or death has occurred and learning can take place.

1.2 In February 2016, Haringey SAB's SAR Subgroup commissioned a SAR into the circumstances leading to Robert's death, as the threshold for a SAR under Section 44 of the Care Act 2014 was met.

1.3 The SAR was carried out by an Independent Reviewer using:

- Individual Management Reviews by Adult Social Services (ASS); Homes for Haringey (HfH); Metropolitan Police; North Middlesex University Hospital NHS Trust; One Housing Group (key support provider).
- Information provided by the HfH Vulnerable Adults Team.
- Notes and a telephone conversation with Robert's GP.
- Information from a meeting with Robert's family and family friend.

1.4 The SAR Robert report was published on the SAB's webpage in July 2017. The report identified a number of areas of learning for the agencies involved in supporting Robert and made six key recommendations.

1.5 An action plan was put in place following the publication of the SAR Robert report, addressing the report's recommendations. This action plan will be monitored by the SAB's SAR Subgroup until completion.

1.6 Circumstances leading to the SAR Robert:

- Robert was diagnosed with Foetal Alcohol Syndrome and was referred to as having a learning disability.
- He lived with his father in a Homes for Haringey (HfH) managed property, as his father's registered carer.
- Robert's father died in July 2015 and Robert was reported to be suffering low mood and depression, and was on anti-depressants.
- In December 2015, HfH turned down Robert's application for the Grant of a Tenancy due to lack of evidence of exceptional reasons.
- On 6 January 2016, Robert was served a Notice to Quit the property. Later that day, Robert was found hanged.

1.7 SAR analysis:

- An inquest into Robert's death recorded an open verdict, with the cause of death asphyxiation by strangulation; further recording that Robert was full of sorrow about the death of his father and full of worry about his future.
- The SAR Subgroup considered that agencies may have failed to take into account Robert's vulnerability and whether they could have worked more effectively to seek to protect Robert.
- Although HfH considered Robert to be vulnerable, at the time of the HfH Decision Panel, there had been no completed assessment of his vulnerability or his care and support needs.
- There was a delay by Adult Social Services of about 3 months to consider the referral for an assessment of Robert's needs and a delay in HfH referring Robert to HfH Vulnerable Adults Team (VAT).
- It is not certain that an assessment of needs would have made any difference to the grant of tenancy decision.

1.8 SAR learning: Homes for Haringey

- Lack of face-to-face contact with Robert and his sister led to poor quality information about Robert's needs being provided to the Decision Panel.
- Personal contact with Robert and his sister may have resulted in a more thoughtful way of delivering the Decision Panel outcome. Robert received a letter informing him of the unsuccessful outcome six days before Christmas.
- Alternative housing options involving independent living/housing support were not adequately explained to Robert and his sister.
- Robert's needs assessment was delayed/deficient as HfH staff were not clear about the referral pathways into Adult Social Services and the HfH Vulnerable Adults Team.
- Staged implementation of new allocations policy and staff training may have impacted on function of Decision Panel.
- Staff may not have been familiar with the Mental Capacity Act: taken for granted that Robert's sister could represent him. Crucially, relevant enquiries of mental capacity could have resulted in Robert having an assessment of his needs and vulnerability.
- Delays in communication between agencies, including a delay in the Vulnerable Adults Team processing a referral from key support service.
- Staff did not appear familiar with Care Act 2014 safeguarding guidelines. There was an opportunity to refer Robert for an assessment when his sister reported that he was suicidal but this was not acted upon.

1.9 SAR learning: Adult Social Services

- Delays in communication between agencies, including 4 week delay in passing GP referral from the Safeguarding Adults Team to Haringey Learning Disability Partnership (HLDP).
- Community Mental Health Team may have been more appropriate to respond to GP/key support referral, and decision should have been made sooner by the HDLP.
- Lack of coordination between frontline staff from different organisations trying to support Robert.
- Lack of understanding of which services were the most appropriate to support Robert. The referral pathways need to be clear to all staff involved in dealing with adults who may be vulnerable.

1.10 SAR learning: Housing Related Support

- Robert's key support worker did not consider he had a learning disability. He recognised Robert was vulnerable but the main risk was noted as potential homelessness.
- Key worker reported no concerns about Robert's independent living skills but did not clarify the support needed to facilitate this. This appears to have been fundamental to the decision by the HfH Decision Panel not to grant Robert a tenancy.
- Support worker's referral to VAT and HDLP stated that Robert had 'severe depression' but no reference was made to him being at risk of self-harm, nor that Robert was being evicted, which would have been picked up as a trigger for an urgent response.
- Completion of referral forms should be more thorough and consistent to avoid ambiguity when making referrals.

1.11 Improvement actions: Homes for Haringey

- Multi-agency protocol in development, setting out roles and responsibilities of HfH, ASS and other agencies. Workshop held in May 2017 with staff from different agencies to seek feedback.
- Housing Decision Panel procedure/composition reviewed. ASS staff now attend the panel where vulnerability is an issue.
- Home visits now carried out for tenancy requests in lieu of succession to better understand people's needs and vulnerabilities.
- Staff given guidance on preparing reports to the Decision Panel.
- Notice to Quit procedures now require tenancy management officers to meet with the tenant and support worker before serving the NTQ. Information leaflet developed to support this.
- Period for serving NTQ can be extended for grieving or vulnerable tenants.
- Staff received training from Mind bereavement counsellors.
- Safeguarding Adults policies and procedures updated, and regular safeguarding adults training in place, covering mental capacity.
- A Tenancy Management restructure has introduced a specific group of caseworkers who deal with more complex cases.

1.12 Improvement actions: Adult Social Services

- ASS have contributed to initial work on the development of a multi-agency protocol and workshop setting out referral pathways.
- New performance management framework tracks performance in responding to referrals and timeliness of assessments across ASS.
- Case file audits monitor timeliness of assessments, overseen by Principal Social Worker.
- First Response Team redesigned to streamline approach to referrals, supported by 2 OTs and 2 social workers.
- Refreshed supervision policy in place to support case management.
- Staff receiving training on the Care Act 2014 and Care and Support Assessments.
- HLDP launching new Target Operating Model to enhance capacity to respond to crisis/urgent mental and physical health needs.

1.13 Improvement actions: Housing Related Support

- Safeguarding and incident reporting policies and procedures updated with HRS providers in 2015/16.
- All services cyclically reviewed using Supporting People QA Framework criteria, including support planning and safeguarding.
- New HRS Risk Management Framework being developed.
- HRS contract review with key support provider and internal review taking place, informed by SAR findings.
- Key support provider introduced additional information form to record relevant info, views or observations at initial assessment.
- Key support referral and assessment forms merged to ensure all information recorded on one form to get a comprehensive picture of people's needs and risks.

1.14 To address some of the lessons learned from the SAR Robert, Homes for Haringey has enhanced staff training in particular areas and an inter-agency pathway workshop was held in May 2017 to provide greater clarity about the pathways into services for Council and Homes for Haringey Teams involved in safeguarding processes.

1.15 The SAR Subgroup is responsible for ensuring that wider findings and lessons learned from SARs are disseminated to partners and staff in relevant agencies. As such, it is proposed that 2 half-day workshops are held for SAB partner agencies to consider learning from the Robert SAR in the context of the learning themes identified by London ADASS in the Learning from SARs Report. It is also recommended that this is followed by workshops for frontline staff from relevant agencies to disseminate learning from the Robert SAR and to launch the multi-agency protocol developed in response to this learning.

1.16 The SAR Subgroup also delivered a learning presentation, on request, to the Haringey Suicide Prevention Group in November 2017 to share learning from the Robert SAR.

2. Recommendations

To note

3. Reasons for decision

Not applicable

4. Alternative options considered

Not applicable

5. Background information

Section 44 of the Care Act 2014 requires the Safeguarding Adult Board (SAB) to arrange a Safeguarding Adults Review (SAR) when a case meets the statutory criteria: that is that when an adult in its area dies as a result of abuse or neglect whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; or if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. SABs may arrange a SAR in other situations where it believes there will be value in doing so.

- **Section 44 of The Care Act 2014**
- **Paras 14.122-137 Care and Support Statutory Guidance issued under the Care Act 2014**
- **Para 2.9 London Multi- Agency Adult Safeguarding Policy & Procedures**
- **Haringey Safeguarding Adults Review Procedure**

PURPOSE

The purpose of the HSAB SAR Sub-group is:

- to consider referrals of any case which may meet the statutory criteria and to make decisions on this basis;
- to make arrangements for and to oversee all SARs;
- to ensure recommendations are made, messages are disseminated and that lessons are learned.

PRINCIPLES

The SAR Sub-Group will operate according to the 6 principles cited in the Adult Safeguarding Guidance of the Care Act (2015). It will:

- Recognise that SARs are not inquiries into how an incident happened or who is culpable. This is a matter for Coroners, criminal courts and other relevant bodies respectively to determine, according to the specific issues of the individual SAR;
- Act in a manner that promotes the confidentiality of all of those involved in the process and which recognises the sensitivity of the information being shared;
- Retain a vulnerable adult focus to its work and have a regard to racial diversity, language, culture, sexual identity, age and gender in its approach to all its activities.

6. Contribution to strategic outcomes

Strategic Priority 2: Enable all adults to live healthy, long and fulfilling lives

Objective 5: All vulnerable adults will be safeguarded from abuse - we will work with our partners to protect adults in vulnerable situations and ensure that residents will have increased awareness of the early signs of potential abuse.

7. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

The report is for noting

Finance and Procurement

The report is for noting

Legal

The report is for noting

Equality

The report is for noting

8. Use of Appendices

N/A

9. Local Government (Access to Information) Act 1985

The Care Act 2014