ADULT C Safeguarding Adult Review (SAR)

Executive Summary
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Executive Summary

Introduction

i. Adult C is a forty-one-old female who identifies as biracial, her paternal ethnicity is Romani, and she resides in the area covered by LSAB. She has had contact with health and social care services since childhood and has a complex health and well-being presentation which includes several physical and psychological health conditions.

ii. Adult C has been known to mental health services in the local area since 2016 and has several psychiatric diagnoses, several of which she disputes. She also has an established diagnosis of Autistic Spectrum Disorder (ASD) which impacts upon how she experiences and interacts with her social environment and people, including multi-agency help-seeking behaviours.

iii. Adult C has experienced much of her contact with services, both in childhood and adulthood, as dismissive and unconcerned. Adult C cites numerous examples of harm that has occurred during her life, that she has brought to the attention of public services, and which she experiences as non-responsive during each episode.

iv. As part of the initial consultation process Adult C was asked what her desired outcomes for this process were and she included several desired outcomes, including – that those who had failed to safeguard her at key points are accountable for their actions and to ensure her experience means agencies will learn, and work with people rather than in opposition to them. These outcomes are reflected in both the analysis and events within this SAR process. It appears that non-action and both actual, and perceived, failures to protect, is a key theme in Adult C's experiences of service contact throughout her life.

Context

v. This Safeguarding Adults Review (SAR) was commissioned by Luton Safeguarding Adults Board (LSAB), in accordance with section 44 of Care Act 2014. The review was undertaken in accordance with the statutory requirements (Care Act Statutory Guidance, last updated 2022, para.14.162-14.173) and as per the requirements of the pan-Bedfordshire multi-agency safeguarding policy and procedures (2017; section 9).

vi. Within this framework, LSAB has a duty to commission a SAR to review the case of an adult in its area who has needs for care and support (regardless of whether the Local Authority (LA) provides support to meet those needs) where:

   a) there is reasonable cause for concern about how the SAB, members worked together to safeguard the adult, and
   b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect; or
   c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In the case of Adult C, (a) and (c) are both applicable, and as such, the LSAB SAR sub-group agreed in January 2021, to progress Adult C’s case to a SAR.

vii. The completion of a SAR is to ensure that the relevant lessons are learnt and that professional multi-agency safeguarding practice is improved, and to do everything possible to prevent the issues in question happening again. This report aims to provide a detailed analysis of all findings and recommendations for the SAB arising through learning from the case of Adult C.

viii. The purpose of this SAR was to examine practice issues and collate information and analysis from across the agencies and stakeholders who had been involved with Adult C during three specific time periods. The aim was to analyse and address four key areas of practice in the current system, and identify any lessons that could be learnt for future multi-agency working practices, these areas where:

1) How multiple agencies, who are being contacted by a complex patient, can work more effectively together to deliver a consistency of approach, and achieve good outcomes for individuals requiring multi-agency safeguarding response.
2) How pathways and multi-agency arrangements can be improved to better support complex vulnerable people and provide consistency and adherence to best practice guidelines in relation to providing a robust multi-agency safeguarding response across the Luton partnership.
3) How Autism and physical disabilities can be recognised effectively by all agencies within the safeguarding partnership, and reasonable adjustments made accordingly to facilitate involvement in safeguarding enquiries and plans.
4) The treatment and responses to Adult C within the specified periods of time, to analyse this and identify if lessons that can be learnt in relation to both multi- and single-agency responses to the individual concerned.

ix. Full terms of reference were developed and agreed with both Adult C and the SAR panel overseeing this review in January 2022, and these are provided in appendix 1 to this report.

x. It was not feasible or practicable to attempt to undertake an analysis of 40 years continuous service contact within the remit and projected timescale of this SAR process, as such, the timespan to be examined was identified and agreed with Adult C as part of the planning process and covered the following periods of service contact.

i. 03/06/1981 – 21/12/1984: Children's Social Care
ii. 01/01/1995 – 31/12/1996: Children's Social Care
iii. 01/01/2018 – 01/01/2022: Adult Health & Social Care

In addition, the period of 1990 – 1992 was included at the document review stage at the discretion of the independent reviewer as this included specific disclosures and responses that correlate with the initial periods identified.

xi. Adult C has been consulted throughout this SAR and her voice and views are reflected throughout the analysis and narrative. The independent author has spent a total of ten (10) hours discussing the case with Adult C via MS Teams chat, plus additional email correspondence, between January and July 2022. Where the author is aware that Adult C dissents with the opinion presented, this has been clearly noted and additional narrative provided to clarify the issues or concerns she has raised.

xii. The following methods were employed within this review:

- Agency Chronologies provided by partner organisations.
- Consultation and involvement of Adult C, including submission of written records and complaint letters covering contact episode 3.
- Interview/Consultation with Adult C's main supporter.
- Independent Management Report (IMR) agency submissions (see appendix 2 for reflective template) from all involved organisations.
- Thematic document review by independent reviewer of case records, statutory reports, chronologies and IMRs documenting the identified contact episodes.
- Compilation of multi-agency chronology by independent reviewer
- Practitioner RCA workshops (2).
- Preparation/presentation of SAR report draft to SAR panel.
- SAB Learning Event (1).
- Final Report and Recommendations.

xiii. The following agencies have contributed to this SAR process:

- Luton Borough Council – MASH
- Luton Borough Council – Adult Safeguarding
- Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group/Integrated Care Service (BLMK CCG/ICS)
- East London NHS Foundation Trust (ELFT)
- Bedfordshire Police Service (BPS)
- Bedfordshire Hospitals NHS Trust.

- Healthwatch Luton (HWL)
- Luton Children & Families (Bedfordshire Social Services 1981 – 1996)

Safeguarding Principles

xiv. To ensure that her voice and views were reflected, and the relevant events were encompassed and clarified, a series of conversations, totalling approximately just under 10 hours between January and July 2022 have been spent in conversation with Adult C. Where the reviewer and Adult C's views differ, or where Adult C refutes any information or statement provided by the reviewer, this is noted in the report.

xv. A preventative approach to both Adult C's ongoing care and support, or to this SAR process has been difficult to achieve due to the entrenched nature of some of the risks and responses considered, however where possible recommendations have been highlighted to support a preventative approach being established in terms of the overall multi-agency response to safeguarding Adult C going forward.

xvi. When considering a proportionate response in this case the need to identify root causes to make evidence-based recommendations needs to be balanced against Adult C's presenting level of distress and the wider demands placed on professionals and services. The specifying of timescales and enabling focus on reflection in the IMRs was designed to minimise the burden of additional work for those involved and allow for targeted analysis of key events.

xvii. Adult C states that she had not been protected across several of the events and time periods considered, and this experience is one which requires partnership collaboration to mediate and find a workable solution using the identified learning from this review process.

xviii. The principle of partnership is central to this review, with Adult C's perspective forming a central focus, and her involvement and feedback from the key

agencies informing the review methodology and considered within the subsequent analysis process.

xix. Due to the extent of contact with services over the last 4 decades it was important to ensure that the panel overseeing this process was representative of the various agencies involved but formed of professionals who did not have a working knowledge of Adult C's case in practice The purpose of a SAR is not to apportion blame, and as such consideration of individual roles and motivations are not in focus

Background to Adult C

xx. Adult C has been known to Local Authority (LA) services since birth, she is one of four children to JG. The family moved to Luton / Bedfordshire in 1981 when Adult C was 11-weeks old. The first recorded contact with services in the LSAB area was 20/08/1981, when the then Bedfordshire Social Services received a referral from Luton Women's Aid.

xxi. Adult C was open to Children's Social Care (CSC) and listed on the NAI register from 1981 to 1985, when she was removed from the register. Between 1985 and 1990 the family had limited contact with services, however in January 1990, shortly after the breakdown of JG's (mother) relationship with RS (partner 2), Adult C was referred to Children's Social Care (CSC) once more and between 1990 and 1998 a range of disclosures made, concerns raised, difficulties and conflicts reported, between Adult C, JG and RS that were investigated or supported under either Child Protection or Child in Need processes.

Episode 1 1981 – 1984

xxii. Adult C was placed on the NAI register, transferred from the original LA to Bedfordshire in October 1981, and monitored at various intervals by CSC from then until February 1985. Throughout that time there remained consistent themes in relation to JG's parenting capabilities and the risk this posed to Adult C; firstly, as a toddler, and then latterly as a teenager. Low level concerns were

a feature of Adult C's initial contact with services. Nine injuries of a similar nature were observed in this timespan,

xxiii. Between 1984 and 1995 Adult C and the family had sporadic contact with services, and whilst not identified by Adult C in the scoping for this SAR the period of 1990 – 1995 provided details of several service contacts which continue the themes and concerns identified in episode 1.

Episode 2 1995 - 1996

xxiv. Adult C was considered a Child in Need under section 17 of the Children Act 1989 at this point in her service contact. In November 1992 Adult C's case was closed and it is at this point the first significant disclosure is made, within three weeks of closure a referral for child protection had been made by the school nurse due to concerns relating to Adult C's general welfare. For Adult C this apparent lack of curiosity, which included acceptance of RS as a protective factor meant that the physical and sexual abuse she experienced in her teenage years (particularly 1992 – 1996) was not recognised as quickly as it could have been.

Episode 3: 2018 – 2022

xxv. Adult C has been in contact with police and local mental health and social care services since approximately 2016 for the purposes of this episode, with initial referrals being made to MASH by Bedfordshire police during 2016 and 2017 in response to Adult C's report of stalking and harassment.

xxvi. Adult C was open to the community mental health team from 2016, and by May 2018 she was open to the well-being service, but her case had been closed by the secondary mental health system.

xxvii. Between October 2018 and June 2021 numerous section 42 enquiries were referred and undertaken, some as stand-alone processes and others combined into a single referral.

xxviii. Over the third episode under consideration, Adult C has received six different diagnoses from four consultant psychiatrists, under the label of 'mental health', with her complaints being considered part of her mental health presentation by police, a position that was/is reinforced by both mental health and MASH practitioners via anecdotal information rather than agreed upon via a robust diagnostic process. This appears to be a common feature underpinning the response of the involved services. The responses and sanctions applied by services in the third episode examined in this SAR highlights a repeating pattern for Adult C, which can be traced back to her very early contact with services. Adult C experiences the strategies agencies are applying to boundary and contain her presentations as unfair and a threat to her safety and reacts accordingly.

Analysis

xxix. Adult C's conviction that services do not protect her and in fact serve to do her harm appears to have been interpreted in the local system as a persistent complainant which resulted in local police identifying her as 'in the radar of SIM'. Serenity Integrated Mentoring (SIM) is an approach that has been trialled and rolled out across approximately 50% of national forces, with the aim of reducing responses across public services for those with mental health problems and funnelling individuals into the mental health system rather than providing universal service responses.

xxx. Much of the work in the development of children's social care practice nationally over the last three decades has focused on some of the key issues that are evident in this case, and current/recent reviews are still identifying some of the issues raised in today's practice. In Adult C's case the key issues and failings, based on the evidence of what works in children's social care that is now available to us, included:

- Observations of the child recorded but not analysed: in
- Accepting perceived 'trusted adults' as a protective factor without further assessment.
- No evident attempt to engage with the child or obtain their views.

- Accepting care givers explanations without further curiosity of presentation, incidents, and injuries.
- Not seeing the Child alone.

xxxi. In each of these areas practitioners and managers from children's social care were able to identify where practice has developed and the assurance measures that are now in place as standard in practice to prevent and provide an early help response, with clear monitoring and escalation processes to ensure situations such as that experienced by Adult C as a child and young person would not be the case for those requiring social care support and protection in current practice.

xxxii. As both Adult C and the various organisations that submitted evidence for this SAR have highlighted, there were numerous alerts and referrals for s42 enquiries during the third episode. One of Adult C's complaints to the LA and Mental Health Services relates to how these are managed and actioned by the agencies involved.

xxxiii. One of the key issues identified in the most recent episode, and which Adult C and several of the involved partners have identified as a continuing difficulty, is the coordination of care and support. Adult C continues to require support and treatment across several health and social care services, and whilst services confirm that she has been provided with a copy of her support plan which includes a named lead professional, Adult C reports continuing conflict with her care coordinator which impacts upon how her care and support is managed on an ongoing basis.

xxxiv. The robust care coordination of Adult C's case would make a significant difference to both her experience and how she accesses and responds to professionals. There is evidence in the relationships Adult C has formed with various individuals (for example CCG/ICB representatives, SAB representatives) that there is the capability for the development of a more productive working relationship for all parties, however the current pattern, which includes a lack of

clarity in terms of responsibility and routes of communication, is serving to maintain the conflicts rather than resolve them.

xxxv. In several agency responses, reference to the development of a communication plan to inform Adult C's management and access to the various services is made. Involvement of Adult C in making these plans has been variable, however in each case, it appears that Adult C has experienced these plans as being 'done to her'. Greater levels of collaboration, where Adult C is directly involved in developing solutions would potentially change this experience for her.

xxxvi. Communication and the sharing of information and updates is one area that has brought Adult C and the various organisations into regular conflict and remains to be an issue.

xxxvii. Adult C is an articulate individual, however her ability to self-regulate is severely impaired, and when she feels not listened to or otherwise dismissed by any service or individual, a fight response appears to be triggered which results in increased contact and increasingly forceful objection from Adult C.

xxxviii. Adult C presents with literal and concrete thought processes, she ruminates on issues until she feels they are resolved, and her fixation on holding people to account for failing to protect her can be traced back to early contacts with public services and the abuse and neglect she experienced from those who were supposed to protect and nurture her, mean that she requires regular communication and the delivery of any actions agreed with her to manage her anxiety in relation to the matter concerned.

xxxix. Areas such as multiple diagnosis is unhelpful as these have led to inconsistent service responses, again reinforcing the patterns of insecure attachment and relationships that have played such a significant role throughout her life.

xl. A great deal of the distress and anxiety Adult C has expressed to services during her periods of adult service contact, is characterised by her placing a series of

complaints to the various agencies and escalating her contact when she perceives that service to be dismissive or defensive in their response.

xli. As Adult C has an established diagnosis of Autism, it is reasonable to assume that communication and cognitive processing are areas that need to be accounted for in service contacts and communication. It does not appear that this occurred.

xlii. There are several key points in the most recent episode where decisions were made that shaped the negative experiences of both adult c and those staff involved, these were

- CMHT pass diagnosis to Police colleagues who record this.
- Police colleagues decide to arrest Adult C for Wasting Police Time.
- A referral for a mental health act assessment is made.
- Adult C's stalking complaints are not prioritised by police.

xliii. Each of these points including wider considerations and perspectives and there was a lack of direction and shared ownership in the responses of each of the agencies involved.

Was Adult C Safeguarded?

xliv. Whether Adult C was safeguarded is a key question from this process and the conclusion from this review is that the answer depends upon which party's perception is being considered. Adult C does not experience the support she receives as safeguarding her; Some of the involved services state that all attempts to ensure her safety are, and continue to be, responded to. I am unable to comment on the current situation, however for clarity, the view that whilst agencies repeatedly state they have evidence to support their position this is not supported by the evidence submitted and the level of engagement and due respect for the process or perspectives beyond the immediate system stakeholders. As such it is my view that whilst Adult C's expectations on services

may be unrealistic, the services responses and how plans are managed does not and did not safeguard Adult C in the time periods specified in this report.

xlvi Adult C's early life had been characterised by insecure and unstable attachments. Her experience of care givers was one which was dismissive, avoidant, and blaming, and whilst public services in her early years provided a protective factor, in her later years this changed and Adult C began to experience the services themselves as abusive due to being unable to respond to her expectations. Some of the actions and decisions taken by those involved during this time served to reinforce this experience and rather than leading to Adult C feeling that she had been safeguarded.

xlvii. Each agency has sought to minimise and channel the volume of help-seeking behaviour, in most instances a single point of contact has been identified, however in several instances that contact point has been identified and then for a variety of reasons (including staff leave, sickness or leaving the service) is then not available. In her complaints and contacts with services, Adult C acknowledges that her level of frustration as a result of feeling unheard and dismissed, results in behaviour that could be interpreted by the receiver as persistent, critical, and challenging, and whilst complaints are often directed at individuals, the bigger issue is accountability within the system, which includes how organisations are held to account when things go wrong.

Recommendations

Recommendation 1: *Undertake a local training needs analysis in relation to comorbid complexities and agree/develop a multi-agency training and development programme to meet development needs in relation to Autism, Trauma and Positive Communication. With the aim of improving practitioner capability and confidence as a means of improving local multi-agency management of complex issues across several service areas.*

Recommendation 2: *Care Coordination for complex cases where several agencies*

are involved is essential if people are to be supported and engaged in the process. This is in local policy but does not appear to be delivered in practice, and as such multi-agency arrangements, which include mediation and consultation with Adult C is required urgently in relation agreeing the most appropriate means of coordinating her care and support arrangements and setting out the expectations and boundaries of those arrangements.

Recommendation 3: *Mediation between Adult C and Local services is urgently required, the issues and conflicts detailed throughout this analysis continue in the current contact between the two parties. This is not tenable and working relationships have broken down to the point that Adult C refuses to be contacted. It may be possible that with mediation and a plan that is constructed **with** Adult C is now required, if there is an option to repair these relationships. If this is not possible, Adult C is still entitled and eligible for adult social care and mental health support and is receiving an adult social care package of support, as such the LA and its partners will need to identify a way in which their duties continue to be effectively discharged, and the support package is regularly reviewed, with the aim of developing a working relationship with a care coordinator that is a more positive experience for both Adult C and the staff involved.*

Recommendation 4: *Debriefing of staff in frontline services is required as part of standard practice, and a process needs to be put in place that ensures regular single and multi-agency debrief opportunities, reflective supervision and support is available in case where individuals may be having significant conflict with an individual using the services.*

Recommendation 5: *De-escalation and positive communication training that draws on trauma-informed practice as a core of its content is worth further consideration. Supporting front line practitioners to explore meaning behind behaviour and the impact of trauma on an individual's responses would likely improve both professional resilience and staff capability to build and sustain effective working relationships with individuals who are perceived as challenging or otherwise difficult to engage.*

Recommendation 6: *How adult services work with carers is highlighted in this, and other, SAR reports. In response to this theme the board may wish to consider a thematic focus on the involvement and working relationships with carers across the partnership as a strategic objective for future years to ensure this area retains to focus it requires.*