Safeguarding Adults Review
7 Minute Learning Summary

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

Sandra

Sandra was 65 years old at the time of her death in 2022, having died in hospital from a sepsis infection acquired from an injury received in her home. Prior to her death, she had been living independently in a flat provided by a local housing association and had been registered with her local GP practice since 2014. She was seen frequently at the practice; however the surgery were not aware of the concerns other agencies had about Sandra's safety.

Sandra had a number of long-term health issues including obesity, orthopaedic problems, and poor mobility. Whilst Sandra's health issues were supported by her GP and wider NHS services, who found it difficult to engage Sandra with this support. There was a pattern of her not attending or arranging appointments and then being discharged from services without the intended support being provided.

Sandra had two children with whom she was in contact, including a son who suffered from poor mental health and himself had significant needs. Due to his vulnerabilities, she felt compelled to support his needs despite this severely affecting her own wellbeing. Sandra was also in contact with her sister and brother-in-law, who continued to support her up until the point of her death. Sandra's sister would visit her regularly to help with daily tasks.

The first concerns for Sandra's safety were raised in 2013, with a report that her son had moved into her flat after being evicted from his own accommodation. There were concerns about him physically assaulting her, causing damage to the flat, and moving in a large volume of possessions that made it difficult for her to move around and access rooms. Shortly after these concerns were raised, Sandra was evicted from the property due to its condition and was supported by the local authority in being rehoused. She was provided a flat with a single occupancy tenancy and a condition that no other person should reside with her. During the subsequent years a number of further safeguarding concerns were raised about Sandra, all with similar themes relating to the risk of abuse from her son and the condition of her flat. Concerns included her son taking over her flat, whilst exposing her to physical, emotional, and financial abuse.

During early June 2022, Sandra received a minor injury in her home that became infected and led to her hospitalisation. Following her admission her condition continued to deteriorate and she died on 12th June. At the time of her death, she was actively being supported by Adult Social Care, following a safeguarding concern received in November 2021. This support had involved the provision of a social worker from the Social Work Assessment Team, which is intended to deliver a short-term service over a six-to-eight-week period.

The West of Berkshire Safeguarding Adults Board conducted a Safeguarding Adult Review to understand how different agencies worked together to safeguard Sandra, and to identify lessons to improve our systems, practice and partnership working.

Learning

- **Finding 1** – The Assessment of Safeguarding Referrals and Social Care Prevention Pathways

Improvement is required in the way that referrals and contacts are initially assessed and allocated for further social work. New prevention pathways are required to ensure that social work teams are structured and resourced to manage cases of differing complexity.

- **Finding 2** – The Quality-of-Care Act Assessments and Management of Risk

Social workers and managers need further guidance in how to prepare person centred Care Act assessments and safeguarding plans.

- **Finding 3** – Multi-Agency Information Sharing and Planning

There is a need to promote the current multi-agency arrangements to share information and develop joint safeguarding plans. This should include improving the understanding of when a referral would still be appropriate in the absence of consent.

- **Finding 4** – Developing Professional Curiosity

Agencies have identified how a greater level of professional curiosity by their staff would have helped to better identify vulnerability and improve the submission of safeguarding referrals.

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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7-minute Learning Summary

Safeguarding Adults Review Sandra

The Assessment of Safeguarding Referrals and Social Care Prevention Pathways

The assessment of safeguarding concerns needs to be person centred, fully considering the person's relevant history and any relevant partnership information, seeking to understand the underlying causes of their needs. Each assessment should examine the outcomes of previous cases and seek to understand what worked well and what may need to be done differently to prevent further referrals. A key part of the assessment process should be the use of formal strategy discussions.

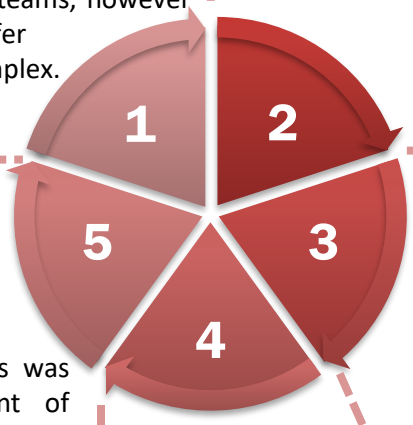
Safeguarding cases need to be allocated to a social work team which has the capacity and expertise to manage the specific case. In order to provide a continuity of service there should be an intention to prevent the unnecessary transfer of cases between teams, however pathways will always be needed to transfer cases if circumstances become more complex.

The Quality-of-Care Act Assessments and Management of Risk

Although cases progressed to the appointment of social workers and the completion of Care Act assessments, this still did not deliver successful long-term outcomes for Sandra.

In examining why, it was clear that assessments and action plans again focused upon the presenting issues of hoarding and the condition of the flat, rather than understanding and addressing the underlying causes.

In the latter stages of Sandra's life, she had withdrawn from personal contact with her social worker, who was not able to arrange a face-to-face visit. The risk of this disengagement was not fully identified and therefore a plan to manage it not developed. The social workers had never involved Sandra's sister in any care assessment planning, this may have helped to improve contact and manage the risks. Section 11 of the Care Act may also have been considered, which provides a duty to undertake a care act assessment without consent in certain circumstances.



Multi-Agency Information Sharing and Planning

The failure to make use of existing processes to share information and develop multi-agency planning was a theme throughout Sandra's case. This was evident within the initial assessment of referrals at the 'front door' and continued during Sandra's Care Act assessments. The social workers and managers who worked with Sandra identified the lack of strategy discussions and other multi-agency meetings as a key learning theme.

The police and the health services had information that was not known to the social workers, which was therefore not considered when assessing Sandra's needs and in preparing risk assessments. Similarly, the social workers held information that should have been shared with other agencies, such as the commission of crimes against Sandra, the extent of Sandra's vulnerabilities, and the care needs of Sandra's son.

Had multi-agency strategy meetings been held, then a holistic approach to Sandra's and her son's needs may have been taken, with a variety of agencies contributing to safeguarding plans. Social care and the health services may have supported her son, whilst the police and housing provider may have used their powers to ensure that he was removed from Sandra's flat. The GP could have flagged Sandra as vulnerable on the practice databases and utilised the practice care coordinator to provide Sandra with enhanced support and to support the social workers with the safeguarding plan.

Developing Professional Curiosity

The partnership reflected upon their response to incidents involving Sandra and have identified how a greater level of professional curiosity by their staff would have helped to better identify vulnerability and improve the submission of safeguarding concerns.

Professional curiosity is a term used in safeguarding to describe the proactive approach of staff looking for safeguarding concerns. It means not taking things at face value and seeking clarity around a situation.

It is a combination of looking, listening, asking direct questions, checking our and reflecting on information received.

Mental Capacity Act

Whilst working with Sandra the social workers did not have any concerns about her capacity to make informed decisions, but as she continued to disengage from their support a decision was taken to complete a Mental Capacity Act assessment. However, this assessment did not take place because of a lack of available capacity within the team and a presumption of capacity led the social worker to conclude an assessment was not a priority.

The fact that safeguarding concerns continued to recur may have indicated that Sandra was not able to make effective decisions about her own care and the completion of a capacity assessment would have been appropriate.