Warrington Safeguarding Adults' Board Safeguarding Adult Review Executive Summary in respect of Adult A, who died in 2015

Introduction & Purpose

The Care Act 2014 introduced a duty upon Safeguarding Adult Boards (SAB) to arrange for a review of a case, involving an adult in its area with needs for care and support, under certain circumstances. Namely, if an adult dies or is thought to be permanently harmed (physically and/or psychologically) and there are concerns regarding abuse or neglect in that individual's case. The legislation also laid out the ability of SABs to arrange for a discretionary review in other cases where there was felt that there may be lessons that can be learned and that learning applied to prevent future cases.

This Safeguarding Adults Review (SAR) was commissioned by Warrington SAB following the suicide of a 23-year-old woman in 2015. At the time of her death the practice required under the Care Act 2014 was to be introduced within a matter of weeks and so the revised Safeguarding Adults Review (SAR) process was considered when a decision was made to take the case forward for review. Warrington SAB formed a multi-agency panel which concluded that while the circumstance of this death did not clearly meet the eligibility criteria for a SAR, a review would provide opportunities to learn from and where indicated, improve practice by exploring how agencies worked together to support this adult. Therefore a discretionary SAR was agreed by the Board.

The Board agreed that the Social Care Institute for Excellence (SCIE) 'Learning Together' review model was the most appropriate methodology in this case. Learning Together is a systems approach to understand multi-agency professional practice. The goal is to move beyond the specifics of the particular case, such as what happened and why, to identify the deeper underlying issues that are influencing practice more generally. It is these generic patterns that are explored as 'findings' or 'lessons' from the case. The process looks at the safeguarding system through the examination of a specific case which provides a 'window on the system'.

Due to the involvement of Children's social work professionals with this case it was agreed that the SAB would undertake the review but involve the relevant Children's social work professionals and members of the Warrington Safeguarding Children Board (WSCB). It was recognised that learning may be relevant to both safeguarding boards and so it was agreed that findings would be shared and progressed with both.

At this time the Independent Chair has, in consultation with the SAB, identified that publication of the full SCIE report would be potentially harmful to the surviving family members of Adult A as the level of detail may make Adult A recognisable to the local population and younger family members. Thus, it was agreed that a summary focused on learning would be made available to share lessons learnt across the multi-agency partnership within Warrington and the wider national SAB network.

Facts of the case

The case review identified concerns related to domestic abuse, substance misuse and concerns in relation to deteriorating mental health. The review identified, from professionals and family members' accounts, that Adult A was extremely vulnerable due to witnessing an assault as a child and going on to have episodes of missing from the family home. Whilst

this occurred prior to the development of Missing and Exploitation[1] services both locally and nationally there are indicators that vulnerabilities in these areas existed. Adult A later became homeless at the age of 16 and pregnant with her first child. Subsequently, Adult A had regular contact with Children's social work professionals from around 2009 onwards. Adult A went on to have four more children and for the majority of that time, her children were assessed as being Children in Need and services were provided. Ultimately, the children were removed from her care and placed with family members due to continuing concerns around their wellbeing.

During the time frame focused on by the review (a 9 month period spanning 2014 - 2015) Adult A had experienced a high risk domestic abuse relationship having been severely assaulted when pregnant with her fifth child leading to criminal prosecution of the perpetrator. Following the birth in 2014, referrals into mental health services began as a result of concerns about her low mood and anxiety. Professionals from mental health services, and a growing number of different organisations, were subsequently involved with her in varying degrees until her death in 2015. This review has sought to explore those interactions to identify any lessons that can be learnt for practice in Warrington.

Review Process

A Review Team made up of senior agency lead reviewers was established to work with the independent SCIE Reviewer. The SAR set out to answer two key questions that would ensure maximum learning and improvement action to prevent future deaths or serious harm occurring again;

- *How well do agencies in Warrington understand how a vulnerable adult's history with unresolved issues places particular responsibilities on those services to engage and support that individual?*

- *Do agencies in Warrington need to identify and develop services to support vulnerable parents whose children have been removed?*

This was done by bringing together the Review Team with a group of front line practitioners. Information was collated and analysed from a range of sources including interviews with professionals and family, the coroner's investigation and individual agencies' chronologies, investigation reports and service records. The two groups supported the independent reviewer to gather additional information as the review progressed in order to maximise learning from the exploration of practice in the case. This informed the final SCIE report, the findings of which are summarised below.

Summary Findings

The Care Act Statutory Guidance, section 14.139, states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again

Whilst the conclusion was that there may well be opportunities to help adults in Warrington in the future who are in similar situations to Adult A, - there does not appear to be one area of practice or lack of action that would have significantly changed the outcome for Adult A.

[1] Services in relation to Child Sexual Exploitation and Missing from Home have grown in the last decade in light of the growing understanding of the scope of Child Sexual Exploitation. The Warrington area processes can be accessed here for further guidance and information on local procedures.

Instead the independent reviewer identified 3 areas where change may lead to improved professional responses for similar cases in the future.

In the SCIE Learning Together[2] methodology, findings are categorised using a six-part typology. This enables SABs to identify the underlying issues that cause the most difficulty in their local system. The six categories used are:

- Tools
- Professionals' interactions with service users, carer(s) and family members
- Management systems
- Response to incidents / crises
- Longer-term work
- Innate human biases (cognitive and emotional biases)

Each of the findings identified in the SAR lays out the evidence identified by the Review Team to illustrate that these are not one-off issues, unique to this case. For each finding, evidence was explored to show how the identified issues may be regarded as systemic and provide a practice environment that creates risks to other adults in the future. There were three findings in the safeguarding practice "system" in Warrington from this review;

Finding One (longer Term Work): *Thresholds in Warrington mean that vulnerable men and women whose children are going through the child protection process miss the opportunity of their own allocated worker when they need support in their own right as early as possible - with the consequence that their needs are unmet*.

The Care Act, with its principle of supporting the wellbeing of adults, is one measure against which Warrington SAB asked questions about the inclusiveness of current services and how they promote wellbeing. The prime issue raised was the absence of an allocated worker to support Adult A work her way through the options available. Nationally, thresholds for receiving service/support mean that adults involved in child protection processes, unless they are identified as having eligible care and support needs of their own, are ineligible for their own support worker, and this issue is one that Warrington shares with every part of the country. Whilst there were a multitude of professionals involved and advocacy was offered to Adult A there was no one specific professional dedicated to support her to respond to the range of offers of intervention and to enable her to focus on the issues around parenting. It became apparent that Warrington did have a variety of services which were offered however it was questioned whether these had sufficient flexibility and tenacity to engage her. She had known vulnerabilities and difficulties in maintaining contact with these services. It was identified that commissioned services needed to be more flexible rather than criteria-driven. In particular services to support women having children taken from their care was identified as an area that warranted further consideration to ensure that it was in line with other emerging best practice models nationally.

Finding Two (professionals interaction with service users): *Professionals in Warrington do not often gather complex histories, because of the pressures on their time, with the result that the impact of past abuse and current risk is not fully understood.*

The review found that agencies and the professionals who work for them do recognise the importance of traumatic history in the current life of vulnerable adults in Warrington. What is more difficult though is engaging those adults and using the information about the past to inform future work with them. It was only when professionals came together for the review

[2] This is a model for reviewing serious cases either within safeguarding adult or children contexts. The model has been developed by SCIE and can be commissioned by SABs as one of the available methodologies for reviewing serious incidents. For further details of the model and its development by SCIE see http://www.scie.org.uk/children/learningtogether/about.asp

that they began to learn of the full extent of trauma suffered by Adult A in her life. Each professional in the Review Team endorsed the view that Warrington was becoming aware of a growing number of vulnerable adults who have experienced trauma. Professionals in Warrington report that they are seeing growing numbers of teenagers moving into adulthood who are affected by trauma in their childhood and adolescence. At the same time, professionals' workloads leave them with limited time to gather information from adults at risk about their experiences of trauma, and they are even more constrained in having time to analyse and plan the support that responds to traumatic past experience. This means current risk may not be fully understood, and the at risk adults' needs remain unmet. This prompted the SAB and WSCB to recognise the need to explore services around trauma generally and around supporting parents with children likely to be identified as needing alternative carers/taken into the care system.

Finding Three (longer term work): *When legal frameworks do not seem to allow information-sharing about risk, then multi-disciplinary discussion about the best professional to engage the service user and co-ordinate services does not routinely happen in Warrington - creating the risk that a vulnerable service user can be overwhelmed and driven away by the services offered.*

Sometimes adults only come into contact with services when they are in crisis. The review found that Adult A was offered at least 50 appointments during the period under review. In Adult A's case, all the professionals working with her reported that they lacked confidence to share information with each other because they saw her level of risk as being insufficiently high to work within current protocols to permit them to do so without her permission. From this case it was recognised that the view of professionals was that without the work they were doing being governed by one of three frameworks, the Mental Capacity Act, the Mental Health Act, or Safeguarding, they felt unable to share information about risk relating to some adults. It was only during the review that certain details became known to the wider group of professionals trying to engage with her. This meant that professionals were often trying to engage her with a limited view of her needs and background issues. This highlighted the need for a lead professional to effectively engage with an adult who may be in contact with multiple services and with very mixed motivations about what support they want. Multi-disciplinary discussion is key to gaining a more holistic picture and identifying the best lead professional to engage and coordinate services. However, for this to happen barriers perceived by professionals working within current protocols need to be addressed. Thus, the SAB was focused on what work could be undertaken to support professionals to work within current legal information sharing requirements but ensuring that adults are empowered to engage effectively with the services available.

Conclusions and Next Steps

At the start of this review, there was a question about the range of support services for vulnerable parents who have had their children taken into the care system. During the review it became apparent that Warrington has a variety of services, however the question was whether these were sufficiently personalised and flexible to meet the needs of the most vulnerable people. This highlights the need to consider opportunities to commission services that reflect more of the need to be flexible rather than criteria-driven, and to respond to trauma in line with evidence of what works from emerging research and practice.

The review also provides evidence that staff do recognise the importance of traumatic history in the current life of a vulnerable adult in Warrington. What is more difficult though is finding the time both to engage those adults, and to use the information about the past to inform future work with them. Sometimes this is because these adults only come into contact with services when they are in crisis. Secondly, professionals cited shrinking resources and the very high demands on their time, along with the increasing numbers of adults who have

experienced trauma, who are complex to work with, as the other barrier which stops them from working with trauma in the way they believe would be more effective.

In order to support the Warrington SAB identify next steps the SCIE review posed questions for the SAB to consider and respond to before taking action. These questions have been reviewed by the SAB and the practitioner and reviewer groups and can be seen in Appendix A. This consultation has led to the development of an action plan to ensure lessons are learnt from this review and that action is taken to make appropriate changes to the systems in place. Please see Appendix A for the SAB action plan to respond to this review in 2016-17. This plan will be managed by the SAB Safeguarding Adult Learning and Review sub group to ensure leads are allocated, progress is maintained and where necessary issues are escalated to the SAB for response.

This Report has been shared with the family prior to publication to ensure they were aware of the findings of the Safeguarding Adults Review and how the Warrington Safeguarding Board will monitor the plans and actions of the relevant agencies to respond to the findings. The family did not want to make any specific comments about the Report but they were keen to stress that that what they hoped for was that the learning from this Review will be used to improve support for others who may be having difficulties similar to those experienced by their family member.

Appendix A: Multi-Agency Action Plan

SAR Finding	Questions posed by Independent Reviewer for Consideration	Proposed Action	Expected Differences
1: Thresholds in Warrington mean that vulnerable men and women whose children are going through the child protection process miss the opportunity of their own allocated worker when they need support in their own right as early as possible - with the consequence that their needs are unmet. (SCIE category Longer Term Work)	**WSAB:** What does the Board already know about the systems that enable professionals to offer person-centred care in these situations?	Review of cohort data to identify clearly the demand and needs of the group, including the following: 1) How many cases are coming into 5BP services with pre proceedings cases? 2) How many of these are 1 off assessments and how many lead to ongoing treatment 3) How many are coming more than once 4) How many parents are being referred in such circumstances (i.e. children potentially going into care)	Data will identify scale and needs of the group to better inform possible response options to the Board
	With competing priorities, how does this safeguarding risk compare with others that the Board is considering?		
	How might the Board measure the future impact of practice in this area?		
	WSCB: How far do professionals see the needs of a child who has already had a child themselves?	The SAR executive summary to be shared with the complex families board for consideration of the Complex Families initiative role in this area	Reduction in troubled families cases having multiple children removed in the future
	Services for children who go missing or are at risk of sexual exploitation have developed greatly - how different does the Board think outcomes are today are for this group compared with ten years ago?	Seek assurance from Missing from Home and Child Sexual Exploitation and Trafficking Strategic Group that the current processes would have recognised and responded to these needs if currently presented.	Reassurance regarding current Missing processes
	What related learning from any current children's safeguarding initiatives in Warrington could go forward for further joint consideration with the Safeguarding Adults' Board?	Joint LSAB/LSCB development day 2016	Annually identified joint working initiatives to improve outcomes for children and adults with care and support needs

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2: Professionals in Warrington do not often gather complex histories, because of the pressures on their time, with the result that the impact of past abuse and current risk is not fully understood. (SCIE category Professionals' interactions with service users)	**WSAB & WSCB:** Has either Board taken a view before about the sufficiency or appropriateness of services for early life trauma that can in turn prevent the very negative outcomes for adults who experience it?	Review of mental health services and identification as to whether or not the provision of services at early intervention and prevention level is sufficient to prevent young people/adults coming back into the system with significant or entrenched mental health issues	Robust preventative mental health services in place locally to provide advice, guidance and support to the community to prevent escalation of needs in children/young people and adults
	Do Board members recognise the picture given during this review of a growing cohort of young adults affected by childhood trauma, with resulting high levels of need?		
	How could the initiative around chronologies in children's services be a basis for discussion between both boards around transition and trauma?	Lessons to be shared from the SAR with the Transition groups by WSAB members and reflected on as the groups look at making sure they recognise all wider transition cases.	Transition processes are developed with consideration of lessons learnt
	Might Board members consider moving the age at which some transition processes from children's to adults' services happen, so that they are more responsive to young adults who either have vulnerabilities or in Care Act terms, are adults at risk?		

SAR Finding	Questions posed by Independent Reviewer for Consideration	Proposed Action	Expected Differences
	Information about the effectiveness of projects elsewhere, such as PAUSE, is beginning to emerge. How might this learning be brought into Warrington? And What work is being done in Warrington to prevent multiple children from one family going into care?	The Children's Department has recently developed an Edge of Care focus which includes an Intensive Intervention Service. This works with families to address skill deficits to avoid children needing to be removed and includes an outreach programme working evenings and weekends with teenagers where family relationships may be in danger of breaking down and leading to care placement. The service aims to impact by preventing care proceedings being required and its effectiveness will be evaluated. Although there is a service that works with parents whose children have been placed in care in Warrington, PAUSE is being received well in areas that it has been introduced nationally and the WCSB will be asked to consider the findings with a view to appraising the benefits and feasibility of investing in a similar approach.	A demonstrable impact on the overall numbers of children being removed, as well as from the same parent(s)
	With the pressures on practitioners who work with multiple adults who have experienced trauma, are there any actions that the Boards could put in place to support these professionals?	Boards to seek assurances from partner agencies about robust support processes in place for staff, such as supervision or counselling, via a survey of agencies to see what support responses are available for staff. Promote AMPARO support service in the sharing of lessons learnt so that all agencies are aware of the services available and that they will work with professionals not just family members.	Clear visibility that support processes are in place in WSCB/WSAB agencies Wider awareness and increased use of local bereavement support services.

SAR Finding	Questions posed by Independent Reviewer for Consideration	Proposed Action	Expected Differences
3: When legal frameworks do not seem to allow information-sharing about risk, then multi-disciplinary discussion about the best professional to engage the service user and co-ordinate services does not routinely happen in Warrington - creating the risk that a vulnerable service user can be overwhelmed and driven away by the services offered. (SCIE category Longer Term Work)	**WSAB:** What do Board members already think about barriers to information sharing?	WSAB Guidance for practitioners on Information Sharing at multi-agency level for complex needs cases is produced	Professionals report greater confidence & clarity in complex cases
	Do board members recognise the view of professionals that without one of three frameworks - the Mental Capacity Act, the Mental Health Act, and safeguarding, professionals feel unable to share information about risk relating to some adults?		Practice audits show appropriate activity & positive feedback from service users
	Are there new local agreements, for example all agencies signing up to an assessment process form that might help - or do these already exist?	Aide Memoir for professionals to promote all agencies to request certain pertinent information when initially assessing clients. Considering the benefits of a client information passport	Better coordination of service appointments to support service users visible within practice audits
	What do Board members think about the idea that professionals could automatically come together as a matter of course to discuss risk if they identify all three risks of drug and alcohol use, domestic abuse, and mental health problems in the life of an adult they are working with?	Development of Multi-agency meeting guidance to support professionals to convene multi-agency meetings outside of Social Care processes when needed	Increase in local multi-agency meetings across the partnership (not safeguarding or social care led) leading to improvements in engagement of service users that are struggling to engage