

# Learning from the AA Safeguarding Enquiry (CLDS)

## Executive summary

This briefing shares learning from a recent safeguarding enquiry in CLDS after a young man with severe learning disabilities, AA, was found alone at home in a state of neglect following the sudden death of his father and sole carer. There were no statutory services in place as his father had disengaged from previous contact with CYPDS and their case had been closed, despite some previous safeguarding concerns about AA's personal care. As such, a handover did not take place between CLDS and CYPDS when AA turned 25, and no review of this was triggered.

The enquiry identified significant learning around non-engagement and the need for more robust case closure processes. Recommendations include the need for specific non-engagement guidance for over-18s to be developed, based on advocacy, relationship-based practice, multi-disciplinary working and risk assessment, which were under-utilised in this case, and incorporating tools such as Family Group Conference and the High Risk Panel. It also identified the need for increased use of formal mental capacity assessments, advocacy, and the exploration of carer needs, including the need for GPs to be aware of these. More robust handover processes are required for people expected to move from one service to another, including a mechanism to review closed cases without current services, and it was recommended that practitioners share information with GPs when cases are closed for ongoing monitoring, especially where there have been safeguarding concerns.

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## Pen Picture

This briefing aims to share learning from a safeguarding enquiry completed by Camden Learning Disabilities Service (CLDS) in June 2020. AA, was a 26 year old young man with severe learning disabilities, limited verbal communication skills, epilepsy, cerebral palsy and reduced eye sight. He was also a wheelchair user. AA lived with his father (BB) who was his sole carer. A safeguarding enquiry into neglect and psychological abuse was conducted after BB passed away suddenly and AA was left in the flat on his own unable to summon help or to care for himself. Our retrospective review identified significant learning around case closure processes and non-engagement issues.

## Case summary

In February 2020 AA's half-sister, CC, called the Police after she was unable to gain access to the home where AA and his father BB lived. When police forced entry to the property BB was found to be dead and AA was found in a severely neglected state, having been unable to care for himself or take his epilepsy medication, which could have been life threatening. There were concerns that AA may have been alone for several days without support, but it was later established that BB had passed away on the same day that AA was found by police. AA was moved to Breakaway while longer term plans were made for his future living arrangements.

A safeguarding enquiry was conducted to understand the circumstances which had led to this situation, including

- what contingencies had been in place for AA's monitoring given a lack of contact with the family
- a lack of statutory services in place and previous concerns raised about how BB was managing AA's care needs
- whether this was preventable through an alternative approach to working with AA, BB and any networks involved.

Parallels were also drawn with The City and Hackney Multi-Agency Case Review for CMM concluded in March 2018 where a 4 year old child with a learning difficulty died of starvation a fortnight after his mother died unexpectedly at home. That review recommended a "greater focus on the needs of the family and a response that is fundamentally driven by a safeguarding first approach".

## Summary of findings

- A timeline was developed from 2011 to 2020, identifying what was known about AA, and, in particular, a detailed chronology of contact between 2016 and 2018.
- Assessments documented between 2011 and 2018 confirmed that AA had a severe intellectual disability requiring most of his needs to be supported, as he was unable to avoid many everyday risks, and required constant supervision. His father provided all care, but concerns had been raised by AA's college in 2016 and 2017 about how BB was managing AA's personal care.
- AA had input with Camden's Children and Young People Disability Service (CYPDS) but was closed in February 2018 due to non-engagement by his father, with no formal services in place. AA had finished his college course and the EHCP (Education, Health & Care Plan) had ended. He was last seen in June 2017 when there were some concerns raised about his hygiene. Welfare checks were attempted prior to closure in 2018 but no contact was achieved, and there was no contact with his GP or wider family to establish his level of vulnerability at the time of closure.
- AS AA was closed to all services, a handover did not take place between CLDS and CYPDS when AA turned 25, and no review of this was triggered.
- Concerns about disengagement by BB stemmed back to 2013-2014. BB did for a time develop a good working relationship with a specific social worker from CYPDS but, when she left, found the subsequent turnover of social workers difficult, making it hard for him to build a trusting relationship with any one person. He reportedly felt that the social workers who followed did not understand their family dynamic and felt that his views weren't being heard, perceiving practitioner focus to be on moving AA to supported living or respite.
- AA's views were not ascertained. Mental capacity assessments around AA's care and treatment were not completed and there were limited attempts to obtain his views. No referral was made for advocacy.
- There appeared to be little recognition of AA's half-sister CC and her role, despite her providing significant support to the family and helping BB to care for AA in recent years. A family group conference was not used to produce a family led plan or explore AA's wider support networks, which would have identified this.
- BB's needs as a sole carer and an understanding of his health were not fully explored.
- AA and his father were last seen by his GP in June 2018 but BB was not flagged as a carer on the GP's records, which would have provided another opportunity to review the situation. This was especially important as BB was experiencing health issues affecting his ability to care for AA. Concerns were also noted about BB's blood pressure, that he'd experienced a stroke in 2011 for which he was not taking his prescribed medication, and he was described as a heavy drinker.

## Learning

- Normally at the age of 23-25, young people's Social Worker support moves from CYPDS to CLDS and are discussed in joint meetings. In this case, AA didn't move because he wasn't receiving support from services. No mechanism was in place to review the decision to end contact or closure of the case, or check in with BB and AA.
- There currently isn't any non-engagement guidance in place over for 18's to guide practitioners or ensure consistent practice. Developing a guidance for adults around non engagement would need to include the use of advocacy, risk analysis, multi-agency working, proportionality, relationship based practice and the use of Family Group Conference where appropriate. Camden's High Risk Panel could also be used to discuss concerns about closure where risk remains or reconsider the engagement strategy in cases where people are not engaging.
- The case highlighted the importance of relationship based practice, and the importance of continuity of worker. The many changes of workers in this case contributed to a breakdown in trust and engagement between the family and social services, as well as BB's view that workers had their own agenda and his views were not heard. This highlighted the need to work with service users to understand the root cause of non-engagement. Within CLDS relationship based practice is the foundation which supports people to build trust and therefore engage on difficult issues.
- All agencies need to ensure that the person's voice is heard even if the person has no, or limited verbal communication skills and complex needs, and fulfil the duty to refer to advocacy when required. Additionally, advocacy may be needed if there is a difference in opinion or where the person doesn't have the ability to advocate for their own needs and wishes.
- The role of Family Group Conferencing must also be recognised and utilised in exploring issues of non-engagement, capturing the views of the person and their family, and identifying wider support networks that could help mitigate risks.
- There were missed opportunities by a number of professionals who had contact with AA and his father to re-engage them with social services, including community physiotherapy and occupational therapy, and his GP.
- All agencies could have contributed to more effective and safe information sharing. On closure, practitioners should share information with the GP if this is the only point of contact and alert the GP as to any safeguarding concerns relating to their patients.
- GPs need to ensure that carers are flagged on their records and offer consistency whenever possible with a named GP for carer health checks to reduce the risk of a carer or carer issue being missed and therefore a missed opportunity to engage in a different way.

## Recommendations

### Handovers, closure processes and information sharing

- Robust handover mechanisms are required for people we support who are expected to move from one service to another, eg CYPDS to CLDS, including a mechanism to review cases without current services and decisions relating to closure.
- On closure, practitioners should to share information with the GP if this is the only point of contact and also alert the GP as to any safeguarding concerns in regard to their patients. All services should ensure a handover and case closure letter is sent to the GP.

### Non-engagement

- Non-engagement guidance over for 18's needs to be developed, including the use of advocacy, risks analysis, multi-agency working, Family Group Conference and potentially the High risk Panel where needed.
- Relationship based practice and having a consistent worker involved in the planning, delivery, and monitoring of care wherever possible is crucial to building engagement.

### MCA and Advocacy

- The person's voice must always be captured as far as possible even if the person has no, or limited verbal communication skills and complex needs.
- Advocacy must be utilised where needed to ensure their wishes are known, distinct from the views of their carer's, especially where there is a difference in opinion between the family and professionals.
- Mental capacity assessments must be completed to establish whether the person is able to make their own decisions, and the best interests process followed where capacity is lacking. The person's views must still be captured even when they lack capacity.

### Carers

- GPs need to ensure that carers are flagged on their records and should offer consistency wherever possible with a named GP for carer health checks, to reduce the risk of carer identification or a carer issue being missed.
- Carer needs and risks should be fully explored and identified as part of safeguarding and assessment.

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