‘Ms L’ LEARNING BRIEFING
MAY 2024

Isle of Wight
Safeguarding Adults Board

OVERVIEW

In December 2021, a Safeguarding Adult Review was jointly commissioned by the Isle of Wight Safeguarding Adults Board and Southampton Safeguarding Adults Board to review professional involvement received by an adult who suffered severe abuse and neglect whilst living in Southampton and subsequently moved to the Isle of Wight.

The individual (named Ms L to preserve anonymity) had medical conditions which made both communication and physical movement extremely challenging. Whilst having mental capacity to make her own decisions, Ms L was reliant on family members and carers to meet daily care and support needs and to aid communication. Over several years, Ms L was subject to coercive control, abuse, and neglect by those in a position of financial power and attending to her care needs.

The review was conducted by an independent lead reviewer to consider how agencies work together to safeguard adults in and across both areas.

SUMMARY OF THE CASE

Ms L has Cerebral Palsy and requires intensive assistance to meet her daily living and communication needs. Ms L has mental capacity however is reliant upon a communication board to share her views. Family members and carers were often used as advocates during home visits and assessments.

Ms L lived in Southampton with the support of a live in carer and attended a day centre twice a week. Between November 2015 and February 2020, nine separate safeguarding concerns were raised, consisting of neglect, financial, physical, and psychological abuse. When concerns were raised, most of these resulted in some action being taken through informal social care visits, which did not include clarifying Ms L’s safety or attempting to speak to her without her family and live in carer being present.

In August 2019, the carer informed social workers that she was intending to move to the Isle of Wight, at this time, Ms L was seen and seemed keen to move with her, however the suitability of the move and proposed property was never established, either prior to, or after the move, and Ms L was never spoken to alone regarding this.

Concerns were expressed about Ms L’s welfare and in particular claims that the live in carer and a family member were in a relationship, but these were not investigated adequately during the subsequent planning for her transfer of care to the Isle of Wight. Records of assessments were shared, however there was no sharing of information about the nine safeguarding concerns raised.

Shortly before Ms L moved to the Isle of Wight in March 2020, she was seen by a Practice Nurse at her GP surgery, who noted pressure ulcers and advised care to be arranged. However, due to the move and a delay in registering with a new GP, this was not known to local health services and therefore was not followed up.

Further concerns were raised regarding Ms L’s physical condition and the neglected home environment and through July and August 2020, four additional safeguarding concerns were

noted. During the period between these concerns, Ms L was visited by several community nurses however her condition continued to deteriorate as each agency believed that other agencies were acting. Following an admittance to hospital, Ms L weighed four stone and was suffering from several injuries.
For the first time, Ms L was seen and communicated with independently, it was at this time she reported the abuse suffered and her desire to not return to live with either the family or live in carer. After a period of hospitalisation, Ms L recovered and is living as independently as she can, where she feels settled, happy and safe.

LEARNING IDENTIFIED / QUESTIONS FOR PRACTITIONERS:

→ Coercive Control

Where an adult cannot independently communicate their own views and relatives and/or carers are used to facilitate discussions, there is a risk that the adults voice is omitted from the process. Alternative methods of communication support should be considered to enable appropriate and safe involvement of the adult, without the family or carer being present, to avoid adverse influence from others. Practitioners may wish to consider the impact on an adult's ability for free and independent decision making in situations where they have capacity but struggle to express themselves.
Where adults rely on others to attend appointments but fail to attend, this should be defined as 'was not brought' rather than 'did not attend' and should be escalated prior to closing the adults' case. The escalation includes liaison with other services who are in contact with the adult and consideration of safeguarding duties where carers may be neglecting their duty of care by not bringing the adult to the appointment.

→ Continuity of Care

When transferring responsibility for Adult Social Care and Health between areas, there is a risk that the receiving body accepts these without evaluating ongoing suitability or safety. Adequate details of any relevant risks/safeguarding concerns should be provided to the incoming authority so that an adequate assessment of their health and care needs can be completed. That this also includes consideration of whether there are relevant lawful grounds to share information with or without the adult's consent as part of the transfer of care process. Incoming authorities may also wish to consider visiting the adult to assess the suitability of the new home environment.

→ Persons in a Position of Trust

Safeguarding concerns about the conduct of persons in a position of trust can be difficult to address, they require professionals to carefully consider how best to involve the adult, their family, and carers through a planned and structured multi-agency S42 Safeguarding Adults Enquiry Process. Records of such concerns should be clearly recorded as a 'Safeguarding Concern' for a 'Person in a Position of Trust' so they can be collated to enable a pattern to be established.

Adults who employ their own personal assistants via direct payment or personal health budget, should be provided with information on how to raise a safeguarding concern, specifically as part of the Persons in Position of Trust (PiPoT) guidance.

LINKS FOR BEST PRACTICE AND FURTHER TRAINING

- Making decisions on the duty to carry out Safeguarding Adults enquiries | Local Government Association
- Making Safeguarding Personal toolkit | Local Government Association
- Revisiting Safeguarding Practice (Updated March 2022)
- Safeguarding adults | SCIE
- Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance (April 2023)
- Domestic Abuse Statutory Guidance (July 2022)
- Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England
- 4LSAB Roles and Responsibilities Guidance
- 4LSAB Framework for Managing Allegations Against People in a Position of Trust