SOCIAL LANDLORDS CRIME AND NUISANCE GROUP
ANNUAL ASB CONFERENCE

ADULT SAFEGUARDING

Imogen Parry
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Independent Safeguarding Adults Consultant and Trainer for the Housing Sector
‘The role of housing in preventing and addressing adult abuse is neglected in legislation, policy, practice and research’

Report of the joint committee on the draft Care and Support Bill, March 2013, para. 163.
Scope of presentation

- Adult safeguarding – from ‘No Secrets’ to the Care Bill
- Why all housing staff need to engage in adult safeguarding
- Disincentives and barriers to engagement
- My research on lessons for housing providers from adult Serious Case Reviews – three internal and three external
- Overcoming partnership working difficulties
  - strategic
  - operational
‘No Secrets’, DH, 2000, is the current non statutory framework in England for adult safeguarding.

Following lengthy consultation (DH and the Law Commission), adult safeguarding will soon have a legal basis, as set out in the Care Bill 2013 (formerly the draft Care and Support Bill 2012):

- Safeguarding Adults Boards (SABs) required in all areas
- Requirement on local authorities to make enquiries (or ask others) when an adult with care or support needs may be at risk of abuse or neglect
- Safeguarding Adults Reviews (previously called Serious Case Reviews, SCRs) must be commissioned by the SAB if an adult dies as a result of abuse or neglect

See the Action on Elder Abuse website for further information:
http://www.elderabuse.org.uk/Mainpages/Aboutus/aboutus_campaigns.html
No Secrets (2000) referred to ‘vulnerable adult protection’

Most documents since the mid 2000s now refer to ‘adult safeguarding’ which reflects a broader remit, including:

- prevention and raising awareness
- helping people to protect themselves (empowerment)
- access to justice
Issued in May 2011 and May 2013

Set out adult safeguarding principles:

- **Empowerment** – presumption of person led decisions and informed consent
- **Prevention** – it is better to take action before harm occurs
- **Proportionality** – proportionate and least intrusive response appropriate to the risk presented
- **Protection** – support and representation for those in greatest need
- **Partnership** – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting abuse
- **Accountability** – accountability and transparency
Why all housing staff need to engage in adult Safeguarding

- Safeguarding links to other agendas that housing is (or should be) involved in:
  - anti-social behaviour
  - crime reduction
  - domestic abuse
  - health and well-being......

- Lots of vulnerable adults/ adults at risk live in general needs housing, not ‘just’ sheltered and supported housing
Disincentives and barriers for housing to be involved in Safeguarding

- Weak regulatory and legislative responsibilities (eg No Secrets refers only to sheltered and support housing staff)
- Housing staff funded through Supporting People have training; other housing staff aren’t covered
- Lack of reporting (alert/referral)
- Problems of partnership working
A review of the circumstances of the death of a vulnerable adult if abuse or neglect was suspected.

‘The overriding reasons for holding a review must be to learn from past experience, improve future practice and multi-agency working’ (ADASS and LGA, 2013)
Critiques of adult SCRs comment on their:
- lack of: legal foundation, common format or threshold, obligation on agencies to cooperate *(to be addressed by Clauses 43 and 44 in the Care Bill)*
- **failure to disseminate learning**
- sometimes poor quality

Some previous attempts at thematic analysis of adult SCRs

No-one, as far as I know, has looked specifically at themes and lessons relevant to housing....
Only one quarter of 152 upper tier English councils had published SCRs on their websites.
Out of 70 publicly available adult SCRs, 21 were relevant to housing.
Half the 21 subjects lived in specialist housing (or received specialist housing services), half lived in general needs housing.
9 of the 21 cases had an ASB dimension and of these, 7 had a learning disability, 7 were murdered or had committed suicide.
Thematic analysis identified 6 themes/lessons (A-F).
My critique of published housing related SCRs

8 of the 21 SCRs contained inadequate detail on:

- The role or actions of housing providers
- The monitoring role of supported and sheltered housing staff
- The importance of the quality assessment framework under the Supporting People programme
- A disconnection between the analysis of housing providers’ input and the recommendations for housing
My critique of published housing related SCRs

Some SCRs were impressive in their observations about the role of housing:

- Mrs JT (Dorset)
- Gemma Hayter (Warwickshire)
- Cynthia Barrass (North Tyneside)
- Adult A (Bury)
The ASB caseworker was commended for her ‘leadership and professionalism in dealing with a prolonged neighbour dispute involving several vulnerable tenants in close collaboration with colleagues in partner agencies’.
Nine SCRs with an ASB dimension

- BANES, 2013: ‘PQ’
- Bury, 2010: ‘Adult A’
- Cornwall, 2007: Steven Hoskin
- Leics, Leics and Rutland, 2008: Fiona Pilkington
- Luton, 2011: Michael Gilbert
- Stockport, 2011: Martin Hyde
- Surrey, 2010: ‘CC’
- Tameside, 2011: David Askew
- Warwickshire, 2011: Gemma Hayter
The 21 housing related SCRs: internal lessons for housing providers

A. Poor data base of vulnerabilities (7 cases of which 4 had ASB dimension)
B. Poor contract/support monitoring (6 cases of which 1 had ASB dimension)
C. Narrow focus/poor understanding of safeguarding/not referring (12 cases of which 6 had ASB dimension)
‘Commissioners cannot organise the improvement of services unless they know quite a lot about the people using them’

A. Poor data base of vulnerability

- Failure by landlords to record the vulnerability of all tenants was a contributory factor to the eventual death or serious harm of the subjects.
- The reasons for these poor data bases included:
  - not understanding the nature of vulnerability
  - not asking the right questions
  - not recording the answers
  - not having an adequate IT system to record vulnerabilities.
- In some cases, even where vulnerabilities were recorded, there were problems with the incompatibility of the data with other agencies’ systems.
B. Poor support/contract monitoring

- Although most SCR discussion on contract monitoring focuses on failures by Adult Social Care (ASC), housing agencies can also be culpable.

- The monitoring role of housing staff was often not made clear in the SCRs but this role is recognised in the Quality Assessment Framework of the Supporting People programme
Approx 3,000 safeguarding referrals or alerts are made by housing staff – this is only 0.04% of the approx 8 million adults living in social housing – surely this is under-reporting?

Failure to refer abuse or hate crime into safeguarding was a contributory factor in the deaths or serious harm of 12 individuals.

The reasons for this failure included:

- a narrow, uninformed focus by the housing provider
- different definitions of vulnerability
- erroneous belief that consent of the victim is always necessary
- incorrect assumption that evidence is needed before making an alert or referral
- inadequate policies regarding service refusal and insufficient understanding of the Mental Capacity Act 2005
- poor practice in offering accommodation to victims rather than addressing the abuse through safeguarding procedures.
D. Exclusion of housing from information sharing/assessment/monitoring (13 cases of which 7 had ASB dimension)

E. Thresholds too high/ failure to capture low level concerns (7 cases of which 4 had ASB dimension)

F. Problems with Adult Social Care: assessments (including risk, capacity); diagnosis; choice (18 cases of which 9 had ASB dimension)
D: Exclusion from information sharing

‘The duty to share information can be as important as the duty to protect patient confidentiality’

‘Support Officers were not seen as professional by social care colleagues. A support officer made a referral to ASC and was asked to leave the resultant meeting, even though she was an alerter and had a lot of understanding of the situation. Housing is outside the loop at present.’ (Steven Hoskin/Cornwall)
‘There was a lack of oversight or clear co-ordination between housing support services and other adult social care services. Though the front line support workers probably knew Gemma better than anyone else, there is no evidence of other health and social care agencies seeing them as playing a key role.’

(Gemma Hayter/Warwickshire)
‘There was considerable concern amongst members of the SCR panel that an individual could potentially have a serious mental health and forensic history and pose a threat to the community, but that housing might know little or nothing about this.’ (CC/Surrey)

‘Stockport Housing’s input was not sufficiently complemented by other agencies... The effectiveness of information sharing was limited.’ (Adult A/Stockport)
These cases illustrate, some very explicitly, that negative professional attitudes by ASC staff towards housing staff can be a factor in the exclusion of housing from partnership working and information sharing.
Overcoming information sharing problems – tips for housing staff

- Know about and use all relevant multi-agency information sharing protocols
- Set up multi-agency meetings to improve these protocols and address problems
- Increase awareness and understanding of role of housing staff
- Ensure that decisions are being taken at the right level within your organisation and within Adult Social Care
E. ASC referral thresholds too high, failure to capture low level concerns

- For particular focus on ASB, see the cases concerning Fiona Pilkington, Martin Hyde, David Askew and Gemma Hayter.
- The threshold issues in the 7 cases support the argument in favour of low thresholds that responding to low level concerns (that include harassment) helps to prevent serious harm or death.
If told that the alert or referral cannot be accepted (as it doesn’t meet their referral threshold or their definitions of abuse or vulnerable adult/adult at risk), consider:

- checking what their policy says on referral criteria and definitions. Is their interpretation open for discussion?
- reconsidering the facts of your referral – have you left something out and/or underestimated/downplayed the risks?
- ask if they have a mechanism for gathering information on apparently low level cases, especially where there is an emerging pattern of referrals (quote Pilkington, Hayter)
- asking for advice on how to handle the situation yourself or via other agencies

If the case is not accepted and investigated, refer again if circumstances and risks change

Ensure that decisions are being taken at the right level in your organisation and within ASC
‘Steven’s ‘choice’ to terminate contact with ASC was not investigated or explored with him, or other key agencies involved in his care, even though such choices may compound a person’s vulnerability; may be made on the basis of inadequate or inappropriate information; or result from the exercise of inappropriate coercion from third parties.’ (Steven Hoskin/Cornwall)
F. Quotes from SCRs on problems with Adult Social Care: choice; assessments (including risk, capacity); diagnosis (2)

- ‘The presumption of capacity under the MCA 2005 does not mean that professionals are exempt from asking challenging and searching questions in relation to individuals who are making choices that are problematic. The presumption of capacity does not exempt authorities and services from making robust assessments where a person’s apparent decision is manifestly contrary to his well-being.’ (Michael Gilbert/Luton AND Adult A/Stockport)
F. Quotes from SCRs on problems with Adult Social Care: choice; assessments (including risk, capacity); diagnosis (3)

- ‘A key finding from this review is how an alcohol dependent individual, with serious health issues and in need of safeguarding was consistently viewed as making lifestyle choices.’ (Ms Y/Torbay)

- ‘The housing agency make repeated attempts to refer Gemma to Adult Social Care but were told that she did not have a learning disability and had capacity to make her own choices.’ (Gemma Hayter/Warwickshire)
F. Problems with ASC risk and capacity assessments; diagnosis

- Failures of assessment, diagnosis and multi-agency working were contributory factors to the death or serious harm of the individual.

- Common themes included:
  - failures to assess capacity or risk; assumptions rather than assessments
  - the need for effective multi-agency working that led to holistic assessments (which were focused on the victims, not their families)
If you are told ‘it is the person’s choice’ (eg to refuse services/intervention/proceed with prosecution) or that ‘they have capacity and the right to make unwise decisions’ consider:

- Was the person coerced?
- Is anyone else at risk?
- Has there been a proper and recent capacity assessment on this issue?
- Could there be an over-riding duty of care?
- Has the person been accurately and recently diagnosed (eg learning disability or mental health issues) and risk assessed?

Particular attention should be paid if:

- their circumstances have deteriorated and/or
- their needs have increased or are very complex and/or
- there is a sudden change in behaviour ie ‘an escalating problem’

Ensure that decisions are being taken at the right level in your organisation and within ASC
‘It is puzzling that there appears to be no coherent strategy for disseminating the findings of inquiries and no national collection of data emerging from inquiries relating to vulnerable adults’ (Aylett, 2008)

‘There is scant evidence that the lessons to be learnt from SCRs are disseminated at local, organisational levels’ (Flynn et al, 2011)
Some explanations of why lessons from SCRs aren’t learnt - generally

- Under recognised complexity of safeguarding:
  - Sensitivity of issues
  - Matters of capacity, consent, confidentiality, autonomy
  - Absence of a reliable research base sustaining practice
  - Challenges of inter-disciplinary working
  - Tensions between different models of adult protection

- Often intractable partnership working difficulties:
  - Lack of or uncertain commitment to safeguarding by different agencies
  - Insufficient funding of safeguarding work, partly due to the lack of specific legislation and weak status of ‘No Secrets’
  - Lack of clarity about roles and responsibilities
  - Insufficient information sharing
  - Different priorities and delays in decision making

(Adapted from Penhale et al, 2007)
Some explanations of why lessons aren’t learnt – by housing

- Lack of local and national incentives for housing to engage in safeguarding
- Lack of strategic approach to safeguarding by senior managers in housing
- Low risk of a serious case happening?
- Large housing associations work across dozens of councils with varying practices
- Lack of detailed/knowledgeable focus on role of housing in published housing related SCRs
Summary of strategic action needed to address internal and external problems

- Ensure **effective** housing representation on SAB, MAPPA, MARAC, MASH, CSP etc

- Housing providers should:
  - Improve customer profiling, including general needs
  - Consider employing internal Safeguarding leads
  - Train **ALL** staff, regularly, in adult Safeguarding and the Mental Capacity Act 2005
Action needed – operational (1)

- Training of a wide range of staff, including refuse collectors, maintenance and gas servicing staff eg:
  - North Tyneside (following SCR regarding Cynthia Barrass)
  - Broxtowe Council (following a ‘rule 43’ report from Coroner regarding the suicide of a young woman reaching the limit of her tolerance of anti-social behaviour of neighbours)
  - Adactus, Greater Manchester (following the death of a child killed by her mother)
  - Wakefield and District Housing
  - Coast and Country, Redcar and Cleveland
Accessible policies on adult safeguarding, information sharing, service refusal....

If the ‘tips’ aren’t sufficient, senior managers may need to help staff with assertive challenges to:
- Negative attitudes by other professionals
- Exclusion from strategy meetings
- Failures of information sharing
- Delays
- Poor assessments
- Definition issues

Raise awareness with tenants; preventative approach
Preventative approach with tenants: identify adults at risk - use research quoted in No Secrets consultation

- Risk of abuse increases with age, isolation, lack of social networks, cognitive loss, mental health needs and frailty. These groups are most likely to report being subjects of neglect, abuse and harm. These groups may need a particular focus for prevention work.

- People who are isolated or socially excluded are more vulnerable to abuse, more likely to be targets of anti-social behaviour. They have few people to talk about what is happening to them, to help them recognise they are being abused, to get help.
Final words......

- Legislation alone will not address the many complex issues around adult Safeguarding.
- Multi-agency working in general and Safeguarding in particular raise complex issues, for housing and for all agencies.
- Housing is often neglected in multi-agency work on safeguarding, despite the contribution that front line staff can make.
- Housing agencies must improve their tenant data bases.
- Focus must change from safeguarding training for ‘just’ housing support staff to all housing staff.
- Adult Social Care and housing staff must meet locally to identify and address barriers and to promote best practice.
- Identify and acknowledge the good practice already happening.............
Please contact me:

- To request more information on my research
- For a list of my published articles on housing and safeguarding
- To pass on good practice
- To improve my three sets of tips
- With any general queries:
  - email: imogen.parry@btopenworld.com
  - tel: 07774 838825 or 01920 870384