Southampton Safeguarding Adult Board

Safeguarding Adult Review

Name - Anna   Date – April 2024

Safeguarding Adult Review

Learning from the life of Anna

Patient care is more than just healing -- it's building a connection that encompasses mind, body, and soul. If you could stand in someone else's shoes . . . hear what they hear. See what they see. Feel what they feel. Would you treat them differently?"[1]

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[1] "Empathy," the Cleveland Clinic 2013

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1. Introduction

1.1 Anna was 86 years old when she died in hospital. She spoke Punjabi and did not speak English. Her daughter was her carer and acted as her interpreter. Her death was tragic and distressing. Descriptions of her physical state at the time of her admission to hospital are harrowing to read and deeply affected practitioners and managers involved in this review.

1.2 There are lessons to be learnt for the multiagency system from the circumstances of her life and death. It is hoped that identified learning during the process of the review and in this report will in some small way bring meaning to her life and ensure that others are less likely to suffer in the same way.

1.3 Southampton Safeguarding Adult Board recommended that the circumstances of Anna's life and death met the criteria for a Statutory Safeguarding Adult Review and identified that there was learning relating to how agencies worked together.

1.4 A key and major finding of the review is the concern of practitioners that 'this is still happening' for families of different and diverse ethnic and cultural backgrounds. There is therefore a sense of urgency to learn from Anna's experiences.

1.5 The review raises serious and profound questions for further action and consideration:

- Providing care and working with diversity and people who are different,
- Accountability and oversight of funded packages of care
- Empathy and walking in someone else's shoes,
- Cultural bias

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm because of abuse or neglect and there is cause for concern about how agencies worked together. Southampton Safeguarding Adults Board (SSAB) commissioned an independent author for the review. The author is independent of SSAB and its partner agencies.

3. Methodology

3.1 This SAR was carried out using principles from Time to Think , an appreciative inquiry approach and approaches from the SCIE work on rapid reviews. Information and learning were drawn from a combination of narrative reports and chronologies from each agency with a learning event of practitioners and agencies who had been involved in Anna's care and support. The primary purpose is to learn lessons and to use the learning to drive and sustain change.

3.2 Appreciative Inquiry looks at what is good, what works and for example what we'd like to do more of. This is different to traditional approaches of reviewing practice where the focus is often on what went wrong and what should be done differently. As an approach, Appreciative Inquiry does not apportion blame; instead, it seeks to understand what has happened, within a framework that is participative, collaborative, embraces professional curiosity and challenge, and focuses on what works well and what is valued.

3.3 Time to Think is based on the work of Nancy Kline who identified a set of behaviours that generate the finest thinking. These are known as the Ten Components of a Thinking Environment.[2] Attention, Equality, Ease, Appreciation, Encouragement, Feelings, Information, Difference, Incisive Questions, Place. When all 10 are working together there is real transformation in thinking and collaborative working.

4. Key Lines of Enquiry

The focus for this SAR is on learning about the barriers and enablers to developing a whole system response to supporting families with carers who themselves may have care and support needs, and diversity and culture. This involves:

I. The impact of ethnicity, knowledge of cultural competence and unconscious bias. What is helping and hindering organisations to achieve safe and person-centred care where families:

- Have diverse ethnic and cultural backgrounds
- Do not speak English as a first language

[2] The Ten Components

- Use family as interpreters

II. Understanding of when to raise a statutory safeguarding concern and assessment of safeguarding risk

- Given that multiple agencies reportedly had concerns, what might have been the barriers for people and the reasons that this case was not referred to SSAB sooner?
- What mechanisms /processes might have helped?
- What support, supervision, and training is provided to funded care agencies to know how to identify, and raise, safeguarding concerns for Anna.

III. What are the organisational factors that make it harder or easier for agencies when family members who are caring for a relative have care needs of their own? What about capacity/self-neglect?

- Understanding about mental capacity assessments for both carer and client Were there any assessments or evaluations made about Tilia's capacity to act as Anna's main carer? Was this reviewed at any point during agency involvement with the family?

IV. Understanding the lived experience and voice of people we are working with and their carers/family.

- It was noted that Anna's children made decisions on behalf of Anna that were not in her best interest. Was the voice of Anna, along with her views and wishes, captured by agencies involved in her care?
- Was she given the opportunity to speak with agencies alone, without her family present?
- What involvement took place with family members?

5. Family Involvement

5.1 The author would like to offer condolences to Anna's family and her daughter Tilia, who kindly agreed to speak about her mother, Anna. Thanks are also given to Tilia's social worker who accompanied her and supported her in a most sensitive way. Tilia was able to shed more light

into Anna's life and spoke about how loving and caring Anna was to her children. Anna enjoyed going to her church which was Punjabi speaking.

5.2 Tilia saw herself as the full time carer for her mother and yet in our conversation was unclear of the implications and what this meant for either herself or her mother. We know that following Anna's death a comprehensive care and support assessment was completed by the social worker which demonstrated Tilia's own health and support needs.

5.3 The meeting with Tilia sadly highlighted the findings in this review that it would have been difficult for Tilia to have provided care to her mother. Tilia did not at times fully understand questions and yet would present as independent , responding 'yes' to everything. She did not have an understanding of her mother's needs or her own health needs. Fortunately, Tilia is now receiving good support and has a plan for appropriate accommodation.

5.4 The meeting highlights a most serious issue in that Tilia's own needs are not hidden and have been as neglected as her mother's. However, not addressing Tilia's needs put her mother at risk.

6. Reflection on Anna's life

6.1 We know with hindsight that Anna died in tragic and difficult circumstances, at the age of 86, with severe and ongoing neglect, leading to physical deterioration. The descriptions of her final days in hospital are distressing and speak about maggots and matted hair. She had been sleeping in her chair, as was her custom, but for over a month did not move from the chair, and neighbours reported hearing her banging on the floor and crying.

6.2 Anna lived in a two-bedroom warden supported flat with her daughter Tilia as her carer and joined at various times by her son and another daughter. It was cramped and cluttered.

6.3 Anna spoke Punjabi and could not speak English. When an interpreter was used by the Police she spoke about fear of her son and wanted him to leave. On another occasion with an

interpreter, she spoke about how her son had 'beaten up' her daughter. At most other times Tilia was acting as interpreter. We must reflect on this and how this felt for Anna.

6.4 Anna had a package of care funded by the council from 2014 to provide personal care at times and some household cleaning. This was increased and decreased at various points.

6.5 Anna had decreasing mobility and sometimes was able to stand using a Zimmer frame. However, Anna lived in a flat that was cluttered; her bedroom had boxes piled high and it was unlikely that she would have been able to get in with her Zimmer frame.

6.6 The kitchen and other rooms had not been cleaned for long periods and there was a smell noticed by neighbours and the warden. Anna could not use the bathroom because of the hoarding and for a long time had a commode in the main living area with no privacy.

6.7 Anna had frequent sore and 'fungating' breasts and pressure area needs.

6.8 Anna had 4 children and we know that 3 of her children may have learning difficulties. Agencies were not fully aware that her children had support needs.

6.9 Anna had several services involved in her life at various times, community nursing; primary care; adult social care; care agency; and a warden. She also attended a local church.

6.10 Anna and Tilia were on a waiting list for a flat with extra support.

6.11 We know that there were 6 safeguarding enquiries raised between 2017 and 2021 and that Care Act assessments were completed at a number of points. These highlighted that Tilia was not able to care appropriately for Anna and affirming that both Anna and Tilia had care and support needs. The response was to provide a package of funded care. There were no formal safeguarding enquiries following the closure of social care involvement in 2022, even though concerns remained.

6.12 The potential concerns about Tilia were not shared consistently and did not impact on decision making about risk when safeguarding enquiries took place. We know that Tilia had health

conditions which were not shared during Anna's life in any assessment or safeguarding process.

6.13 *An emerging theme is that the voice of Anna was not heard. She was sadly invisible in plain sight.*

7. Findings and Learning

7.1 There are challenging themes from this review which open a window into the wider system.

7.2 They require us to look closely at our own values and their impact on practice and organisations. We must also think about the nature of funded care and the responsibility of commissioners to provide a framework of accountability to safeguarding both the carers and the individual receiving care.

Patterns of interactions with families where:

- English is not the first language.
- Sometimes the family do not allow access, or are not in for weeks.
- Family are carers with their own complexities.
- Independent / private care agencies.
- Assumptions are made about culture and religion.

7.3 In Anna's life we see patterns emerging that were not clear to people at the time. Each safeguarding concern was seen as a new crisis and a fresh event with hope that this time the situation would improve. In the midst of everything was an elderly lady whose health was declining and not able to communicate except through her daughter.

7.4 **Information sharing and communication**

7.5 As far back as 2016, Anna's daughter Tilia was described as 'having care and support needs.' There was no further assessment of care and support and no discussion about an assessment of her mental capacity. Further to this, it was only after Anna's death that a thorough assessment was undertaken with Tilia, and this revealed significant health conditions which

had not been raised during the review in any information received. This information was not shared in any safeguarding meetings .

7.6 Tilia had not seen her GP for medication for these health conditions since 2019. It is highly possible that this had an impact on her health and wellbeing and her ability to provide care. In addition, Tilia had not been able to ensure that her mother had regular access to her GP since 2019. The meeting between the author and Tilia highlighted quickly that Tilia did not appear to have an appreciation or understanding of either her mothers' health needs or her own, other than to say that her mother was 'poorly'. If this information had been known and shared it might have had implications for her support of her mother and might have prompted an increased level of concern about her ability to provide care . It would also have been an opportunity to work with Tilia to access support for her own health needs. Clearly, there was no sense of curiosity or even compassion from numerous services about Tilia and how she was managing her life. Meeting with Tilia was a sad moment as it demonstrated that she had been invisible and as stated above she was not able to articulate an understanding of what had happened or her own needs.

7.7 For most of the times, such as in the home, Tilia was the main interpreter, and she was very proud about this when speaking with the author. This was reinforced in the placement service plan which recommended using Tilia as the interpreter. Concerns were documented that Tilia may not have been translating accurately, but it is not clear what this means. Could it have been simply that she did not understand what was being asked? On a few occasions it was suggested during the review that there was in fact some element of 'disguised compliance' on the part of Tilia. However, this seems highly unlikely and, in any case, if there was concern about inaccurate translation this should have prompted use of a translation service. This further emphasises the lack of curiosity and the impact of bias.

7.8 Attempts were made at times apparently to use telephone interpreting unsuccessfully and the carers did not at that time have a diverse workforce or access to Punjabi speaking carers. The care plan was not provided in a suitable language. No explanation was provided to Tilia about her mother's health needs. It was assumed that because she 'appeared independent' and would respond with a 'yes' that this indicated full understanding.

7.9 During safeguarding enquiries an advocate and interpreter was provided for Anna. She stated that she wanted her daughter to look after her, and an assumption seems to have been made that she understood what this meant. No further probing or questioning took place to determine further understanding, or to establish what being safe meant to her. These would have been opportunities to explore with Anna about her own concerns. We know that her son had 'threatened' to put her in a care home if she did not give him money.

7.10 **Cultural and Unconscious Bias**

7.11 *Unconscious bias refers to a bias that we are unaware of, and which happens outside of our control. It is a bias that happens automatically and is triggered by our brain making quick judgments and assessments of people and situations, influenced by our background, cultural environment, and personal experiences.* [3]

7.12 A major finding for the system is the need to further explore the impact of unconscious bias in practice. Previous SARs such as SAR Issy[4] have documented the impact of bias on delivery of person centred and compassionate care. SAR Issy found that practitioners developed 'tunnel vision' in pressured environments which prevented them from fully 'seeing' the person and family in front of them. '*Professionals who are perfectly sensitive and compassionate in other settings, failed to respond with compassion'*.(SAR Issy)

7.13 There was desensitisation to Anna's situation and presentation, and to Tilia, preventing a curiosity about how Tilia was providing care. This possibly led to some optimism each time the home was decluttered and had a deep clean. It became a continuous cycle of cleaning and then rapid deterioration; a superficial response which ignored the concerns and patterns, and the accelerating deterioration.

7.14 This 'tunnel vision' and bias prevented agencies from asking further questions and stifled professional curiosity. The pattern of events was not seen and when the key was not available in the key safe for example and repeated cancellation of appointments by Tilia, this reinforced

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[3] 2013 Unconscious bias Definition

[4] SAR ISSY

a negative view about the family as 'not engaging' rather than looking beyond the surface. Sadly, it meant that Anna was lost in plain sight.

7.15 The impact of racial bias and lack of insight about cultural competence underpins the findings. This was raised forcibly by practitioners at the learning event – '*if this was a white family would this have happened*'. This is a serious and alarming comment especially when taken alongside the comments from practitioners who participated in this review that this may be happening now and will definitely happen again.

7.16 A collision of circumstances took place reinforcing assumptions and impacting on the management of risk, decision making and information sharing. Two people's lives were affected leading to tragic circumstances. For example, concerns about the smells coming from Anna's flat were not reported because of 'fears' that this might look like racism. The outcome therefore was that nothing was reported, and we now know how Anna was screaming and banging on the wall to no avail. Safeguarding meetings focussed on the need to declutter and provide deep cleans rather than unpick and pull together concerns that had been raised and how they impacted on Anna's health, safety, and well-being. There was, as so many reviews sadly highlight, a lack of professional curiosity. The domiciliary care provider did not have any direct conversations with Anna and saw 'smiles' from Anna as understanding and consent. Plus, the domiciliary care provider did not have any staff in their team's representative of their client group. This is beyond the role domiciliary care provider and is a systemic failure.

7.17 Ultimately, this led to a deterioration in Anna's health, her isolation and loss of dignity, and the continuing lack of attention to Tilia's needs.

Questions for SSAB and partners

- What can be done to prevent professionals from becoming desensitised to risk where people do not readily engage in support offered?

7.18 A recent roundtable discussion at the LGA about discriminatory abuse and practice acknowledged as a serious concern the absence of cultural competence in practice – particularly around ethnicity and race[5]. The report highlights the importance of assessing where staff are on the unconscious/conscious competence ladder.

[5] LGA Roundtable Discussion discriminatory-abuse-self-assessment-tool14-july-2022

7.19 The very nature of unconscious bias implies that professionals may be unaware of their own biases or unable to recognise it which may lead to underlying prejudice or discriminatory abuse. There is therefore a potential link of some importance between discriminatory practice and discriminatory abuse, whether intentional/unintentional. The LGA has developed a self-assessment toolkit to enable and promote more discussion and recognition in practice and across organisational leadership.[6]

7.20 **Thinking Fast and Thinking Slow**

System 1: Operates automatically and quickly, with little or no effort and no sense of voluntary control. Fast thinking, impressions, associations, feelings.

System 2: Requires a concentrated and reflective thought process. It's mobilised when the stakes are high, when we detect an obvious error, or when rule-based reasoning is required. Slow thinking, effortful, and deliberate.

7.21 Daniel Kahneman is known for his work on Thinking Fast and Thinking Slow - and his description of two systems at work in decision making. His view is that most of the time we operate in System 1 thinking, and do not give ourselves time to pause and reflect. This opportunity to think is captured in the Thinking Environment[7] which is a powerful framework to generate thinking. Such approaches are needed in busy pressured environments where the implications of decisions have consequences for people's lives.

[6] LGAJuly2022discriminatory-abuse-self-assessment-tool-safeguarding-adults

[7] thinking-environment

7.22 This has implications in terms of decision making as key facts may be missed or be more subject to bias. For example, pausing and having a reflective 'system 2 ' response might reveal more dynamics in the family such as disguised compliance.

Questions for SSAB

- Is the SSAB assured that partners are aware of the impact of discriminatory practice on the adult?
- How well do multiagency and supervision systems identify innate/unconscious bias? How does this impact on safeguarding decisions?
- How is the SSAB assured that differences in languages and cultural difference (real or perceived) are broached? How can professional curiosity, unconscious bias and equality and diversity be addressed in discriminatory abuse?

7.23 **Funded care**

7.24 Packages of care (POC) are agreed by the local authority where there are care and support needs.

7.25 Until a SAR is agreed, as in the case of Anna, the local authority commissioning team are not automatically made aware of any concerns about families in terms of safeguarding.

7.26 Under current arrangements, once a funded POC is in place, it is the responsibility of the provider to report changes or concerns to the Local Authority (the commissioner). In the case of Anna there is no record of the provider reporting increasing concerns in relation to the property, such as smells, property unkempt, Anna and Tilia refusing personal care or reports of 'non-entries', in which the care agency was refused entry throughout 2022. Prior to this the provider did raise safeguarding concerns as per the multiagency processes but this does not automatically alert the commissioner.

Questions for SSAB

- What information is used to agree closure of cases such as social work and downgrading packages of care?
- What are the implications for contracts for funded care?

7.27 Funded packages of care commissioned through the Local Authority are reviewed annually. The last review for Anna was completed in December 2021; therefore, Anna was not due a review at the time of her death. It is unclear what information is used in a review and how concerns are shared.

7.28 **Translation and Interpreting services**

7.29 Practitioners raised concerns about the availability and accessibility of face to face and telephone interpreting services. There was no professional challenge about the continued use of a family member even when concerns had been raised about the accuracy of translation. There was good practice in safeguarding meetings with the presence of an advocate and an interpreter.

7.30 **Mental Capacity Assessments**

7.31 It has been evident in this review that there was no clear and consistent approach to undertaking a mental capacity assessment. Capacity was 'established' in terms of financial decision-making following concerns about Anna's son and daughter having access to her funding. However, a number of factors were not considered such as the impact of potential coercive control when her son was present and the fact that Anna was often spoken with when Tilia was in the room.

7.33 There was concern from agencies that Anna's family were not necessarily making decisions in her best interests. However, it was 'established' that Anna had capacity as above. Capacity can fluctuate and change and depends entirely on the decision to be made at the time it needs to be made.

7.32 **Interface with statutory safeguarding**

7.33 There were 6 statutory safeguarding section 42 enquiries between 2017 and 2021 and a further enquiry raised by the hospital staff at the point of Anna's final admission to hospital. Health partners, including the GP were not present at the meetings. Each meeting documented identical concerns:

- Cancellation of visits by funded carers

- Key not in the keysafe – therefore no access
- Deterioration of living conditions/hoarding and smells
- Family spending long periods in other areas such as Birmingham with family
- 'Signs of self-neglect'
- Picture of discrepancy in information provided by Tilia about her mother's mobility and general physical health- such as sore breasts
- Concerns about ability to be a carer and own care and support needs

7.34 The outcome of the statutory safeguarding meetings was invariably to organise a deep clean and then latterly to request a housing move. In March 2022 the allocated social worker was withdrawn after 3 years - *'social workers have not been able to implement a behaviour change'* . This was not a multiagency decision. It would have been useful to have called a professionals meeting/multi-disciplinary meeting, to gather views and any new facts. The comment suggests an element of 'drift' and hopelessness, and a real need to review safeguarding supervision processes. Plus, Tilia and her needs were unnoticed.

7.35 A multi-agency meeting at the closure stage is useful to ensure that the risk has been sufficiently reduced or removed before being closed. In Anna's situation there were no risk management arrangements in place.

7.36 Where there is no change for the better, professionals may struggle to know how to proceed. This is well documented in safeguarding work with families, in which the circumstances of families and sense of hopelessness are mirrored by the practitioner. This requires a clear supervision process of high challenge and high support. Although it is documented that the social worker received supervision it would be helpful for the local authority to understand how decisions were reviewed given the long-standing nature of concerns.

7.37 The review highlights the importance of risk management and having in place triggers to explore other options, such as the inherent jurisdiction of the High Court [8] when there has been no improvement, the risk to a person remains high, and the person does not lack decision-making capacity. This is a complex area and yet fundamentally is about promoting the wellbeing of the adult in any safeguarding arrangements (as defined in Section 1 of the

[8] reat-safety-net-the-inherent-jurisdiction-and-vulnerable-adults/4DD9C095EB9D807DBA116E8958AAD630

Care Act) and will include the consequences of both intervening and not intervening. As Brindle, Jawaid and Kennedy (2022) have stated; '*there is a delicate and challenging balance between protecting those at risk and respecting their autonomy'*[9] Nevertheless, no such discussions took place, and the case was closed.

7.38 Safeguarding Section 42 enquiries should not be closed down prematurely before there has been a risk analysis based on the available information and key professionals consulted, a rationale for the decision made should be evidenced, recorded, and communicated to the referrer and individual. Several safeguarding enquiries between 2017 and 2021 were submitted from the domiciliary care agency who did not always receive full feedback.

When professionals feel stuck

- What are the options available? What would be proportionate?
- What would trigger warning signs for further intervention? What about inherent Jurisdiction?
- What would be the trigger for large scale inquiry?

7.39 Full consideration was not given during statutory safeguarding enquiries to the suitability of or ability of Tilia to care for her mother. Even though concerns are documented there was no assimilation of this information or analysis of the risks to influence the outcome of safeguarding enquiries or further questions about family dynamics. It was complicated by the fact that Anna did not have an opportunity to speak through an interpreter.

Questions for SSAB

- What assurance do partners have that will be a discussion about statutory inventions when there are no other options?
- What assurance do partners have about the process when a case is 'stuck'?

8. Summary

8.1 There is so much learning from the final few years of Anna's life. There was a vast amount of information documenting long standing concerns from at least 2014 about hoarding; smells

[9] great-safety-net-the-inherent-jurisdiction-and-vulnerable-adults/4DD9C095EB9D807DBA116E8958AAD630

in the property, Tilia's ability to care for her mother and her own care and support needs. Plus, factual evidence about Anna's health deterioration and decreasing mobility. The living conditions were squalid and cramped and it seems clear to us with hindsight that there was no understanding of loss of dignity .

8.2 However, multiple systemic factors were at play in determining outcomes, not least the impact of cultural and unconscious bias which may have paralysed decision making and led to both Tilia and Anna becoming invisible.

8.3 The ever-present themes of professional curiosity and safeguarding supervision processes that promote critical thinking also run through the findings. This points to crucial challenge and learning for the whole system in terms of developing a system that is truly trauma informed and aware.

8.4 The specific concerns about understanding unconscious and cultural bias are challenging areas and will require more understanding by the system of the impact of discriminatory practices.

8.5 There are other themes about both the balance between monitoring and support for domiciliary care providers. More robust reviews should be part of the monitoring process. This should include safeguarding concerns about a family and an assurance that domiciliary care providers have an escalation process when they remain concerned about families and have not received feedback from adult social care.

8.6 There was an expectation that once the social worker had been withdrawn that the domiciliary care provider would flag deterioration in the home and be able to identify changes in health. This was unrealistic and the reality is that carers entering people's homes have limited time, training, and opportunity to build relationships. In Anna's case the package of care was reduced significantly anyway in spite of the continuing concerns. Tilia described the care provided to her mother as a 'cup of tea in the morning'. This raises serious questions about similar arrangements in which the domiciliary care provider is the only agency in contact with very vulnerable families.

8.7 There are of course wider discussions about funding of packages of care and support for workers who provide the care. What does this tell us about the value that society places on the care and wellbeing of our most vulnerable communities? Lack of funding to deliver adult social care is beyond the scope of this review and yet it must inevitably play a part in outcomes.

Questions for SSAB and Partners

- Whose role is it to monitor what happens in a home -the domiciliary care provider or the commissioner of the service?
- How is quality of care provided?
- What do we think is good enough?

8.8 The need to monitor domiciliary care providers is a significant area and will require contracts and monitoring processes to be strengthened.

8.9 Finally, we must not forget that the care we provide is about the human connection based on empathy, dignity, and compassion.

Whether her carer/ daughter had learning difficulties or not, the real question is if this woman was our 86-year-old mother, would we think that was an acceptable way to live (or even die), and would we have wanted those involved in her case to act in a coordinated way with some sense of urgency, so her dignity and wellbeing was made a priority? Would we not think it reasonable that in her twilight years, as she grew older and more frail, she had a right to be kept clean, fed nutritious food, and made more comfortable? **Question given to the author**

9. Next Steps and Recommendations

Recommendation 1 Addressing Cultural Bias and Discriminatory Practice[10]

- The SSAB should develop guidance for culturally competent practice which is shared through learning events and briefings. The SSAB should develop this in partnership with cultural

[10] Aligned with SAR Gainbir Southampton SSAB 2023

community groups in the city and consider developing a SSAB one minute briefing guide on this subject.

- It would be helpful for the SSAB to consider use of the LGA Discriminatory Practice Self-Assessment toolkit or a similar tool to explore the understanding of practitioners and managers about discriminatory abuse and discriminatory practice. This should include elements such as unconscious bias, cultural competence and discriminatory practice.

  It is not advisable for any services to use family members as interpreters by health and social care services. Professional interpreter services should ideally be used for individuals who have care and support needs that they cannot manage independently. This will support the SSAB to be assured that the voice of the individual is heard. The SSAB should develop a one-minute guide on this subject with relevant links to language line and other resources.

Recommendation 2 Statutory Safeguarding

- Actions should be taken to ensure that there is maximum attendance by the right professionals at statutory safeguarding meetings (recommendation in SAR Olivia 2023), in this case health staff were not included.
- When a case closure is planned, or a statutory safeguarding enquiry is closed, there should where possible be a discussion with the referrer – unless the need for confidentiality prevents this – to advise on next steps and ensure that all information is shared.
- The SSAB should seek assurance about what processes are in place to assist practitioners when measures put in place following care assessments and statutory safeguarding action plans do not lower risk. The SSAB should seek assurance about what processes are in place to assist practitioners when measures put in place following care assessments and statutory safeguarding action plans do not lower risk. This is from concerns raised that the lack of any improvement or change led to closure of the case for Anna rather than a look at what was happening and discussions with other agencies, and some sense of being stuck and hopelessness. The fact that measures were put in place then once withdrawn the cycle repeated did not figure in decisions to look any other means to support Anna. This led to her being left with her daughter and the care provider.

Recommendation 3 Delivering Packages of care that are monitored and safe

- Ensure that the person is involved and communicated with about their care directly by the care provider

- Review what pathways are in place for domiciliary care providers to follow up with Adult Social Care and NHS Services when there are concerns about a person who has deteriorated.
- The SSAB should seek assurance that the review of the service provider by the local authority has been completed and actions agreed.

Recommendation 4 Interpreting and translation services

- SSAB to seek assurance as to the availability and use of interpreters when the first language of an adult with complex needs is not English.

Recommendation 5 Carer Assessments

- Vital information about the health of the main carer was not known - the SSAB should seek assurance that agencies prioritise the need to reassess or assess carers where there are statutory safeguarding concerns.