Redbridge Safeguarding Adults

Redbridge Safeguarding Adults Board (RSAB)

Safeguarding Adult Review (SAR)

Overview Report
SAR 'Christopher'

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1 Summary of the events

Christopher (pseudonym) was a 31 year old white man who was placed by the London Borough Barking and Dagenham (LBBD) in supported accommodation in Redbridge in February 2021. Christopher was diagnosed as having a mild learning disability and autism spectrum disorder.

On the 31 August 2022 he moved out of the accommodation and sadly his body was then found in the River Thames on the 5 September 2022. The Coroner recorded the cause of death as unascertained.

2 Timeframe under consideration

The Redbridge SAB requested a review of the events following Christopher's placement in Redbridge in February 2021 and the circumstances immediately prior to this transfer.

3 Records

Unfortunately, there is only one record available from the Supported Living Provider (SLP) that accommodated Christopher in Redbridge, this record relates to events on the 31 August 2022 when Christopher left his supported accommodation in Redbridge. The SLP has closed down and commissioners in LBBD have been unable to secure any records. LBBD have also been unable to ask SLP staff members to participate in this Review for the same reason. This is an issue as during this period no agency, other than the National Probation Service (NPS) and this provider, had direct contact with Christopher and in the majority of contacts staff were unable to engage with Christopher and SLP staff were used as a proxy. It is important to record that the NPS who saw Christopher in person on 15 occasions between September 2021 and August 2022 did not identify that they had any concerns as to his welfare. It has therefore been very difficult to ascertain the definitive circumstances in which Christopher lived from 26 February 2021 – 31 August 2022. There is information in the reviews held by LBBD that indicate that Christopher's physical care needs were being met and that he was mostly independent in these matters, but other aspects of Christopher's life are not visible. Whilst this may have been Christopher's choice, the lack of any records means that we cannot be certain. This will be explored further later in this report.

4 Chronology detailing the involvement of the agencies

This Review will consider the role of the following agencies/services in Christopher's support.

- The placing authority, LBBD, who were responsible for Christopher's social care prior to his move to Redbridge and up until his sad demise.
- Christopher's specialist mental health care was provided by NELFT Barking and Dagenham Team until the 18 March 2022, when his care was as per routine transferred to NELFT Redbridge.
- Christopher received support from other agencies including General Practice (GP) and the NPS. The reviewer has considered the records from these agencies and concluded that are not material to the review. That being said the GP Records are full and comprehensive and indicate a significant contribution to multi agency working.

In discharging their statutory responsibilities the agencies under consideration undertook the following actions.

4.1 NELFT Barking and Dagenham (NELFT B and D)

The Consultant Psychiatrist held review meetings and discussions about Christopher on the following dates:

09/02/2021 Telephone consultation with Christopher's Support Worker and subsequent ad hoc Multi-Disciplinary Team (MDT) meeting to consider Christopher's behaviours

30/04/2021 Christopher was discussed at a Community Treatment Review meeting.

13/05/2021 Telephone consultation with Christopher and his support worker.

28/05/2021 Christopher was discussed at a Community Learning Disability Team (CLDT) review to which he was invited but declined to attend. Meeting proceeded.

28/09/2021 NPS approach the Psychiatrist for information. Christopher withholds consent.

23/11/2021 Telephone consultation with Christopher's Support Worker. Christopher declined to attend.

10/01/2022 Process of transfer to NELFT Redbridge commences.

18/03/2022 Transfer meeting held where Christopher's secondary health care transferred to NELFT Redbridge.

4.2 NELFT Redbridge (NELFT R)

25/03/2022 NELFT Redbridge Learning Disability Nursing Team undertakes initial assessment by phone and speaks to staff in the supported accommodation only.

25/04/2022 NELFT Redbridge Occupational Therapist undertakes screening assessment call with supported living staff member. Christopher not present.

04/07/2022 First meeting with the NELFT Redbridge Psychiatrist on Teams, Christopher was unable to attend .

4.3 London Borough of Barking and Dagenham Adult Social care (LBBD)

19/12/2020 Whilst living in Barking and Dagenham Christopher was reported for Common Assault at his supported accommodation. Victims asked for it to be recorded but for Christopher not to be arrested. This was described as racial abuse in a subsequent recording. Police report this to the Council as a Merlin. No action is taken.

20/12/2020 Notes indicate a review was held but there are no minutes available. Note indicates that Christopher wanted to move.

25/02/2021 Christopher calls his Social Worker (SW) to ask to move. SW calls the supported living setting to ascertain what was happening.

26/02/2021 Web based 'virtual' review with Christopher and staff present carried out by the SW and manager.

26/02/2021 Christopher left the premises with all his belongs around 11:00 but returned around 20:00. Christopher entered the office space by breaking the office door and inadvertently injured a staff member. Christopher was seen taking off his file for the second time. Christopher was arrested, detained, and charged. Christopher has a court date set.

28/02/2021 Christopher was released by the police, but his current accommodation in LBBD refused to take him back due to his challenging behaviour. Christopher moved to Ilford (Redbridge), where it has been reported that he was happy.

03/03/2021 Social Worker called Christopher to invite him the Community Treatment Review. Christopher refused to attend.

24/05/2021 Vocational Support worker tried to contact Christopher but was unsuccessful.

28/05/2021 'Virtual' Care and Treatment Review (CTR) meeting (now called MDT meeting as Christopher chose not to attend).

23/06/2021 Call from the SLP provider to say that Christopher wants to change his social worker. There are several other requests but no action is apparently taken.

29/09/2021 Email to SW from NPS seeking information on Christopher. Christopher does not consent to this information being provided. Legal advice indicates that withholding is appropriate.

30/10/2021 SW advises Probation Officer that he has closed his involvement and that they should contact the Intake team for further information.

18/03/2021 LBBD represented at NELFT Transfer Meeting.

23/03/2022 SW completes review of Christopher's care package virtually and then visits placement, but Christopher had left.

12/05/2022 Review of Care Plan completed by a Social Worker.

17/08/2022 Notified by care provider that support worker has seen Christopher carrying items from his room in bin bags.

31/08/2022 LBDD notified that Christopher had moved out of his accommodation. The Supported Living care provider based in Redbridge commissioned by LBBD and NELFT Emergency Duty Team.

4.4 Further key events(in chronological order)

4.4.1 Metropolitan Police Service (MPS) recording

19/12/2020 Christopher reported for Common Assault at his supported living. The victims asked for Christopher to not be arrested and for the matter to be recorded. MERLIN and CRIS information shared with MASH. This should have triggered a consideration of a Safeguarding referral and an urgent review.

27/02/2021 Christopher was reported by his supported living accommodation for the offences of Common Assault and Criminal Damage. He was arrested and charged with the offence on 28 February 2021 and then bailed. Police also completed an Adult Come to Notice (ACN) Merlin report. This should have triggered a consideration of a safeguarding referral and an urgent review.

4.4.2 National Probation Service (NPS)

02/09/2021 Christopher was sentenced to 12 month Community Order on 02 February 2021 with,12 months, probation supervision and being excluded from attending his previous care home in Dagenham. He was found guilty of causing criminal damage and assaulting a worker.

09/09/2021 Induction Appointment for Christopher.

16/09/2021 Planned Office Visit - Initial Sentence Plan Interview

24/09/2021 Planned Office Visit - Initial Sentence Plan Interview

27/09/2021 E-mail communication to SLP.

01/11/2021 Planned Office Visit-Routine Supervision

29/10/2021 Planned Office Visit-Routine Supervision

08/11/2021 Contact from the previous LBBD Social worker informing that now Christopher is settled and does not want any contact from them that the case is closed.

26/11/2021 Planned Office Visit-Routine Supervision

23/12/2021 Planned Office Visit-Routine Supervision

21/01/2022 Planned Office Visit-Routine Supervision

18/02/2022 Planned Office Visit-Routine Supervision

18/03/2022 Planned Office Visit-Routine Supervision

22/04/2022 Planned Office Visit-Routine Supervision

20/05/2022 Planned Office Visit-Routine Supervision

20/06/2022 Planned Office Visit-Routine Supervision

20/07/2022 Planned Office Visit-Routine Supervision

24/08/2022 Planned Office Visit-Routine Supervision

01/09/2022 Order Expires - Completion of Sentence

4.4.3 MPS recording

05/09/2022 The body of Christopher was found floating in the River Thames near to Westminster Pier. When his body was recovered from the water police found two 2kg weights (dumbbells) attached to each hand. His hands were not tied together.

4.5 Other Chronologies

Chronologies were received from the NPS, the GP, MPS, LB Redbridge and several other organisations, but none of the records indicated any significant issues that the SAR should consider. The NPS was able to engage with Christopher effectively and he was seen in person on 15 occasions between September 2021 and August 2022. Christopher's refusal to consent to sharing information from Health and Social Care is not adversely commented upon in these records.

4.6 Reviews undertaken by organisations prior to the SAR being commissioned

The following Information Sharing Reports and Chronologies were requested and utilised in the preparation for this SAR:

- NELFT Redbridge CLDT (Information Sharing Report and Chronology);
- London Borough of Redbridge Adult Services;
- Parkview Medical Centre;
- Barking, Havering and Redbridge University Hospitals Trust;
- Barts Health NHS Trust;
- Metropolitan Police Service (Internal Management Review (IMR) and Chronology); and
- LBBD produced an Information Sharing Report and Chronology with a further two updates following clarification. LBBD do not appear to have conducted an IMR following Christophers sad death.

5 Initial analysis

When approaching this SAR, it is important to firstly provide analysis of the key events in Christopher's care in the period under review. There is no indication that Christopher's disappearance and sad demise was linked to the care that he received. There is, however, a limitation to this assertion in that the only agencies that saw Christopher in person during the period under consideration, were the NPS and the SLP.

NPS saw Christopher in person on 15 occasions during the period from September 2021 to August 2022. There is no indication in any of these visits that Christopher was suffering harm or at risk.

The Probation Officer notes that " His attendance at his appointments was good. It was however difficult to engage with him throughout with ongoing records indicating that it was very difficult to have any discussion with him due to his autism and other learning difficulties. That he did not want to engage, and it was very difficult to get any meaningful conversation."

We do not have access to the records of the SLP or to the staff so have to rely on the information they provided to a review done remotely on the 12 May 2022 and when the LBBD SW attempted to see Christopher in person and he had already left the building.

This issue aside, it is clear that Christopher clearly faced some challenges in his life and on two occasions during the scope of this review, was placed in circumstances where he responded with aggression and this aggression led to a criminal conviction. This indicates that Christopher's rights were at risk of being compromised. We therefore need to focus on how effectively statutory services responded to Christopher's wishes and needs to realise his life ambitions and ensure that he remained safe.

Christopher's family were approached but declined to participate in this Review.

6 Methodology

This review utilised the SCIE Safeguarding Adult Reviews In Rapid Time (SARiRT) methodology.

This involved the creation of a SAR Panel, production of an initial analysis and workshop session to develop the initial analysis into a framework. The workshop sessions were held on 26 February 2025 and 4 March 2025. The information detailed below indicates the output from that process including agencies service improvements and the outcome of discussion. For ease of reference the information is structured around the key line of enquiry.

7 Key Lines of Enquiry (KLOE)

The Redbridge SAB asked the Independent Reviewer to consider the following four questions and the purpose of this learning exercise is to ask colleagues what additional measures can be recommended to ensure that future care is more optimal.

7.1 How was Christopher enabled to live the life he wanted to and have access to appropriate health and care

7.1.1 What would good look like?

Critical to enabling Christopher to live the life he wanted would be a clear picture of Christopher aspiration's, wishes and needs. Where statutory agencies struggled to engage Christopher, alternative methods should have been utilised which were acceptable to him and these alternatives should have been recorded.

7.1.2 Policy Areas considered in this review

7.1.2.1 Assessment and care management.

The processes both within and between agencies needs to ensure that in every case the persons wishes and needs are clearly recorded and where the person lacks capacity or where agencies have difficulty engaging appropriate alternative measures are utilised.

In this area this the following learning has been identified

Learning Point provided by LBBD: Utilisation of a Care Act Advocate - *Christopher had severed ties with his family, and there was no influential familial person to support his engagement with services.*

The LBBD Adult Social Care (ASC) service will record all attempts to explore the use of Care Act advocate support or named professional to facilitate engagement and support. Although 'Christopher' routinely voiced what his wishes and feelings, the advocate might have served as a bridge between services and 'Christopher' and gaps between the last request and the need for an advocate, could have been met with a review of whether Christopher would again benefit from an advocate.

Consideration should have also been made to recording on 'Christopher's file, who else 'Christopher' may have wanted to advocate for him, whether formally or informally.

We will be looking at our procedures for supporting a client's referral to 'Talking Therapies' where clients choose to permanently avoid communications with their family.

Learning Point provided by LBBD: Audit around hearing the patients voice *– NELFT Redbridge have collected data on this via a number of methods, including 5x5 (friends & family questionnaire), a qualitative patient feedback form, hospital passport/care plans.*

This analysis has also identified that Christopher's physical health was not considered by processes and that improvements in systems have now been put in place to address this.

When referral is received for the nursing pathway, physical health needs are identified, and a physical health assessment is attempted. The NELFT-wide Standard Operating Procedure (SOP) for Physical Health Reviews for People with Learning Disabilities has been updated to state the procedure protocols around this.

Learning Point : Importance of Face to Face Contact

Medical staff in NELFT B and D identified that engagement with Christopher although not face to face in recent times, had offered sufficient contact to manage the diagnosed health conditions. They have also reviewed processes and as well as routine individual review meetings for people who are on the Dynamic Support Register or the C(E)TR) framework , there are weekly Referral and Allocation meetings (RAC) where people who are experiencing difficulty are discussed in a multiagency forum. LBBD SWs regularly attend those meetings.

7.2 How well did national and local policies and procedures support Christopher ? Specifically: Medication , Mental Health Act , CTR, Care Act, Safeguarding, DNA procedures and Mental Capacity.

7.2.1 What would good look like?

Each of these statutory processes have a formal structure and purpose. Effective use of these procedures would be indicated by a clear record of decisions about utilisation and then subsequent robust recording.

7.2.2 Policy Areas considered in this review

7.2.2.1 Medication

The issue of medication prescription and administration was the subject of considerable discussion and intention by the statutory organisations. In discussion with the lead Psychiatrist in NELFT B and D it was identified that there had been a sensitive exploration of the use of prescribed medication and that this process had reached a proportionate and safe conclusion.

No Learning Points Identified in discussion but issue taken forward to the Assurance Framework.

7.2.2.2 The use of the Mental Health Act 1983

Use of the Mental Health Act was primarily considered by NELFT B and D in late 2020 and early 2021 when there were significant issues arising at Christopher's accommodation. However there seemed to have been almost parallel conversations between NELFT B and D , the SLP and the social worker. This could have been part of a robust risk management approach. In a workshop session the Consultant Psychiatrist responsible for Christophers care in Barking and Dagenham identified that the potential use of the Mental Health Act had been effectively and appropriately considered.

"Christopher's presentation warranted a multidisciplinary discussions as to the appropriateness of use of the Mental Health Act 1983. Forums which discussed this included RAC and DSR meetings. The collective view was that a mental health act assessment was not seen as a useful tool in his management and could be counterproductive "

No Learning Points Identified in discussion.

7.2.2.3 Referral to Mental Health Services

Learning Point provided by LBBD :Mental Health Assessment/Psychological referral:

LBBD have identified that Christopher's various incidents indicated a need for a mental health assessment. Refer clients to psychologist or Talking Therapies for therapeutic intervention and support.

However these needs were an intrinsic component of Christopher's needs and should have featured more fully in the assessment in care management process, ideally as a joint account across health and social care.

7.2.2.4 Community (Education and) treatment review (C(E)TR)

Christopher was identified as needing support within the NHS Dynamic Support Register, Community (Education and)Treatment review process. This was good practice as it ensures that the person(with their consent) receives the right level of co-ordinated care.

In June 2021 there was a review held under the CETR process, but this became a more informal event as Christopher declined to attend.

CETR Guidance indicates that:

C(E)TRs are based on a set of principles that are summed up in the word PERSONAL:

1. **P**erson centred and family centred
2. **E**vidence based
3. **R**ights led
4. **S**eeing the whole person
5. **O**pen, independent and challenging
6. **N**othing about us without us
7. **A**ction focused
8. **L**iving life in the Community.

Care (Education) and Treatment Reviews The role of health and social care providers. Version number: 1 First published: September 2018

Given the lack of access to the minutes of the meeting it is hard to establish how well these principles were enacted. The salience of the person's involvement is emphasised in more recent guidance which indicates that if the person refuses to attend the meeting on two occasions this should be escalated to the Integrated Care Board (ICB) to address. The following guidance on C(E)TRs indicates the importance of the person being represented.

"2.4.3 Where consent is not given Each local system should have a process for:

• Explaining the implications of this decision to the individual (or their representative) and exploring the reasons for it with them and recording these. They should be assured that withholding consent will not affect their current care provision or any resources they are entitled to and be made aware that they can change their mind at any time.

• Checking whether the person has adequate support from an advocate, or would benefit from this, to explore their options, rights and decision-making.

• Considering alternative approaches to independent review of a person's care, e.g. a desktop review with input from those with clinical expertise.

• Regularly reviewing and recording the person's wishes to ensure that they have an opportunity to participate in the process should they change their mind.

The responsible commissioner should escalate any person who declines a C(E)TR on two or more occasions to the ICS oversight panel (see section 18)."

Dynamic support Register and Care(N education) and Treatment Review Guidance 2023.

Learning Point Provided by NELFT: Whilst it is clear following discussions with NELFT Barking and Dagenham colleagues that Christopher had been appropriately if in a somewhat self-limiting way engaged, best practice under the C(E)TR guidance requires a clearer focus on the individual.

7.2.2.5 Actions under the Care Act 2014

There are significant issues arising from a consideration of the social work responsibility arising from the Care Act. In summary the primary responsibilities that obtain here are:

- ensuring the person is able to participate in the process in particular by considering advocacy;
- assessing need;
- developing a Care Plan;
- arranging care and support to meet the needs identified in the Care Plan;
- undertaking reviews of the success of the Care Plan;
- working in partnership in particular with the NHS to ensure that the person receives optimal care; and
- a requirement regarding safeguarding and service commissioning (addressed later in the report).

Learning Point provided by LBBD: Processes for engaging with people.

LBBD have already identified that the arrangements made to engage Christopher were suboptimal and that processes for engagement will be reviewed.

The same applies to the process of care planning where again there are clear objectives defined for supporting Christopher in activities of daily living but the wider components of Christopher's life are not robustly explored or planned for. Provision is made on one occasion for a Vocational Support worker to work with Christopher, but this was declined.

LBBD have already identified that supporting people to ensure that their voice is heard is an area of development.

7.2.2.6 Arranging care and support to meet the needs in the care plan

Support planning and commissioning will be addressed at a later point in this report.

7.2.2.7 Risk Assessment and management

Whilst there is evidence in the NELFT and Barking and Dagenham recordings, there does not appear to have been a timely integrated approach to risk management and assessment for Christopher. This is particularly important in this case as it is difficult to contextualise Christopher's choice not to engage as it relates to safe decision making.

No Learning Points Identified in discussion but issue taken forward to the Assurance Framework.

7.2.2.8 Safeguarding

The events of December 2020 and February 2021 give rise to significant concern about Care Act Section 42 responsibilities. On both occasions care staff should have been or were aware of the violent incidents that occurred and either raised a Safeguarding or recorded why they did not .

Learning Point Provided by LBBD: Review Safeguarding procedures to ensure an optimal response: LBBD identify that in December 2020, there was an incident where the police sent a Merlin report indicating that Christopher had assaulted staff members, but the staff did not wish to press charges.

We recognise that although this was not explicitly documented, Christopher remained to be vulnerable adult due to his care and support needs, even against the backdrop of concerns pertaining to Christopher being an alleged perpetrator of harm. We will subsequently ensure that will consistently record our acknowledgement of client's vulnerabilities within all safeguarding

incidences, whether the client is deemed to be the victim, survivor or perpetrator. Any planning to mitigate risk will also include our approach to safeguard the client from their self or others, using our strengths based model of working.

Where there are concerns (however minor) around a provider's capacity to de-escalate incidences, we will meet with the provider to review expectations and plans for securing the resident's best interests. We will also make it a prerequisite that care providers are provided with relevant training on behaviour management, before we commission or procure their services.

The Merlin that was received was treated as a safeguarding contact. However, on screening, did not meet the Section 42 safeguarding threshold, therefore our risk management approach ensued. On reflection and in light of Christopher's history of vulnerability, a more detailed conversation with Christopher around his experiences leading up to the incident, may have resulted in a different approach to how we managed this safeguarding incident.

Given the salience of safeguarding processes and the lack of identification all agencies should consider reviewing the safeguarding processes as they apply to people with similar needs to Christopher.

Learning Point provided by LBBD - Engagement with Clients:

When a client disengages or chooses to exercise their right to withdraw from support, Adult Social Care leans on a MDT for support. This is often done with respect to the client's wishes and feelings. In the case of 'Christopher' our efforts to support him as a MDT where unsuccessful and led to a lot of drift and delay as several risk areas could not be addressed without his agreement.

As above, LBBD will now work closely with our legal team to explore cases where there is a need to override client consent in reducing any risks to them or others.

Again, a referral to the Safeguarding Adult Complex Cases Group (SACCG) may have helped to mitigate some of the risk at a more senior level. This will now be a primary consideration in cases of high complexity, such as that of 'Christopher's'. Information and how to refer to the Safeguarding Adults Complex Cases Group can be found at this link https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/safeguarding-adults-1

The Complex Cases Panel is in the process of being widely advertised across LBBD partnerships, so that both internal and external services have an understanding of their remit and ability to present a case, where there are challenges that cannot be solely managed by the responsible team / service.

We are now looking at an approach towards working closely with placement providers and clients to ascertain the client's whereabouts, mood and capacity to work with practitioners on any given day. This would ensure that we have a better understanding of the client's capacity to work with services on any given day.

LBBD have also identified that the safeguarding process has also been strengthened through the new appointment of a Head of Safeguarding and Principal Social Worker role.

7.2.2.9 Recording Consent Decisions in Safeguarding Cases

Another area which requires exploration is awareness of the law particularly where service users are subject to prosecution. The Probation Service approached the Council for further information about Christopher's circumstances in late 2021, the Council sought Christopher's authority to share information. Based on a phone conversation with Christopher this authority was not given. This decision is not questioned, but best practice requires full recording of the matter.

Learning Point: Best Practice in in Safeguarding guidance is detailed in SCIE Guidance

https://www.scie.org.uk/safeguarding/adults/practice/sharing-information/

If a person refuses intervention to support them with a safeguarding concern, or requests that information about them is not shared with other safeguarding partners, their wishes should be respected. However, there are a number of circumstances where the practitioner can reasonably override such a decision, including:

- the person lacks the mental capacity to make that decision – this must be properly explored and recorded in line with the Mental Capacity Act
- other people are, or may be, at risk, including children
- sharing the information could prevent a crime
- the alleged abuser has care and support needs and may also be at risk
- a serious crime has been committed
- staff are implicated
- the person has the mental capacity to make that decision but they may be under duress or being coerced
- the risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference referral
- a court order or other legal authority has requested the information.

If none of the above apply and the decision is not to share safeguarding information with other safeguarding partners, or not to intervene to safeguard the person

- support the person to weigh up the risks and benefits of different options
- ensure they are aware of the level of risk and possible outcomes
- offer to arrange for them to have an advocate or peer supporter
- offer support for them to build confidence and self-esteem if necessary
- agree on and record the level of risk the person is taking
- record the reasons for not intervening or sharing information
- regularly review the situation
- try to build trust and use gentle persuasion to enable the person to better protect themselves.

If it is necessary to share information outside the organisation:

- explore the reasons for the person's objections – what are they worried about?
- explain the concern and why you think it is important to share the information
- tell the person who you would like to share the information with and why
- explain the benefits, to them or others, of sharing information – could they access better help and support?
- discuss the consequences of not sharing the information – could someone come to harm?
- reassure them that the information will not be shared with anyone who does not need to know
- reassure them that they are not alone and that support is available to them.

If the person cannot be persuaded to give their consent then, unless it is considered dangerous to do so, it should be explained to them that the information will be shared without consent. The reasons should be given and recorded. The safeguarding principle of proportionality should underpin decisions about sharing information without consent, and decisions should be on a case-by-case basis.

7.2.2.10 Process where people are unable to attend

Following Christophers transfer from NELFT Barking and Dagenham to Redbridge, the services were no able to meet with Christopher face to face.

Learning Point provided by NELFT : Did Not Attend procedures needed to be reviewed in NELFT Redbridge

The NELFT Redbridge team identified in their IMT that this needed attention as a result *NELFT Redbridge reported that audits took place in line with an action plan. Focus on DNA's and patterns. Redbridge CLDT Consultant implemented a monthly meeting with her medical secretary to go through DNA's and caseload*.

7.2.2.11 Mental Capacity

Whilst Mental Capacity is both time and context specific and there is some evidence that some decisions were supported by this framework , there seems to me to be a lack of a longer term and overarching approaches to supporting Christoper in decision making. For example in respect of where he wanted to live there is some evidence of this being explored but not in a comprehensive way where Christopher's wishes are fully explores and recorded. Too often his refusal to engage with the staff was taken as the end of the matter. Another example has been provided where Christopher refused to consent with information being shared with the NPS.

Learning Point: All partners need review their approaches to recording and if necessary determining mental capacity.

7.3 What can be learned from the arrangements that supported Christopher moving into Redbridge in February 2021?

7.3.1 What would good look like?

Any transfer of care from one setting to another should commence with a comprehensive reassessment of the person's needs with a full exploration of the reason for the move and systems to assure that the new provision is appropriate. The new provider should be fully involved in the process and there should be a comprehensive process of handover from existing services. In this case a good model is illustrated in the process of handover between the LBBD Learning Disability Team and the Redbridge Team. Although there were some areas of weakness the broad principles are well illustrated.

In Christopher's case however, the preceding events from December 2020 make this more complex. The challenging behaviour evidenced in December 2020 and the crisis move in February 2021 create both an argument for early comprehensive reassessment but also have the inevitability of a crisis response. In any event even in crisis a comprehensive reassessment soon after a move should have occurred. The C(E)TR was possibly the place for this but the lack of minutes make this difficult to judge.

7.3.2 Policy Areas considered in this review

7.3.2.1 Transfer of care arrangements

There could have been a more co-ordinated response to the December 2020 incident and it was evident that things were escalating in February 2022. There was some discussion and work between NELFT B and D , LBBD and the provider to try to manage the situation , including use of the Mental Health Act, but normally there should be a well-oiled escalation involving all agencies to try to minimise the effect of these situations as they are a routine if not regular occurrence across the group of people the service works with. Why did this not occur in this case ?

Once the emergency move had been made a CTR process was also initiated which was good practice but how might processes under the Care Act also have been used here?

Learning Point Provided by LBBD : Revised Arrangements post Section 75 Agreement

LBBD identified that joint working arrangements were reviewed following the ending of the Section 75 agreement between the Council and NELFT B and D. The Section 75 arrangement created a partnership arrangement for the management of staff across both health and social care and its cessation led to greater clarity and accountability within the individual organisations. The author has

been unable to ascertain the date that the Section 75 was ended, which leads to uncertainty as to the date of implementation and hence the impact of any improvements.

Health colleagues have identified that there has been a recent improvement in joint working as Social Workers are now routinely attending the weekly Resource Allocation Committee (RAC) meetings organised by NELFT Barking and Dagenham.

Although not directly under consideration the London Borough of Redbridge and NELFT Redbridge continue to operate under a Section 75 agreement, but this is not for consideration within this SAR.

7.4 How did Interagency communication, co-operation and commissioning systems support Christopher ?

7.4.1 What would good look like?

Virtually all the guidance provided to health and social care organisations emphasises the need for systems and processes to support interagency working and cooperation. Critical to all of these processes is that the voice of the person at the centre should be visible at all times and where it is not possible to ascertain this, that alternative measures are in place to ensure that the person is safe and appropriately supported. Commissioning systems should also demonstrate transparency and openness and ensure that the services that are arranged safely and dynamically meet the person's needs.

7.4.2 Policy Areas considered in this review

7.4.2.1 Quality Assurance

Learning Point Provided by LBBD: Quality Assurance and Information Sharing: *LBBD learnt 'Christopher' was placed outside the borough and that the provider had gone out of business and unreachable to part take in the SARs.*

LBBD understands the importance of being able to access records, for as long as is reasonable to do so, and in accordance with GDPR and client confidentiality. "We are currently reviewing a procedure, that ensures that allocated teams are regularly kept abreast of the welfare and day to day functioning of vulnerable clients whilst we are supporting them". We are also looking at ensuring that this procedure allows the commissioning team to access service user information from a provider, even if the provider has ceased operating.

7.4.2.2 Making suitable placements

Learning Point provided by LBBD: Suitability of the placement*:* 'Christopher' was placed within a provision, that was later deemed unsuitable, for a number of reasons. The placement was made by our out of hours service which is managed by our health colleagues. However, when the allocated team became aware of the placements being a 'dual Children's and Adult's' placement, 'Christopher' was approached about the suitability and a move to a more suitable provision. 'Christopher' declined.

LBBD are undertaking a piece of work with our commissioning team to address our expectations where the placement of vulnerable clients are concerned. This is not limited, but includes, ensuring that residents are placed in suitable accommodation, and that escalation is progressed to the highest senior out of hours manager / leader, where there are significant concerns around the capacity to locate a suitable placement.

We will also be looking at our service procedures for reviewing and responding to the suitability of placements, wherever a placement has been made outside of the allocated teams' authorisation.

Should the refusal to change placements have taken place today, we would utilise the support of our Safeguarding Adults' Boards' – Safeguarding Adult Complex Cases Group (SACCG), in considering a multi-disciplinary and multi-agency approach to meeting 'Christopher's accommodation needs in a manner that safeguards him and other'.

We acknowledge the importance of legal input in cases where a resident exercises their right to refuse a change or additional support. We have now included a mandatory approach to seeking legal advice from our legal team wherever these ethical dilemmas may arise.

Learning Point provided by LBBD: Commissioning Specialist Support Services: As low/lack of engagement with services was becoming an issue, the risks of 'Christopher' self-neglecting, would have likely increased.

In considering our commitment to 'making safeguarding personal', 'Christopher' may have benefitted from specialist support around the needs that were most important to him. Starting with the needs that he considered to be of higher importance, may have encouraged buy-in within the areas, that we as professionals felt were equally as, or more important where safeguarding and risk of harm were concerned.

A referral to our Complex Cases Group / Panel, may have again helped to explore and resolved some of the pertinent issues.

Learning Point provided by LBBD: Supported Accommodation– LBBD to separate clients whose primary health needs are LD and ASD from those with mental health disorders as per existing procedure to reduce friction and unsettlement. Commissioning systems should also demonstrate transparency and openness and ensure that the services that are arranged safely and dynamically

meet the person's needs. The above measures are robust but would benefit from a wider review to capture any other related weaknesses in process.

Learning Point provided by LBBD: Sensory Assessment: - For clients with Autism Spectrum Disorder(ASD) who appear unsettled or repeatedly request to be moved, despite indicating that their sensory sensitivities have reduced, LBBD to consider referring them to a GP or a specialist occupational therapist for an integrated sensory assessment.

8 New Issues Identified during the Workshop discussions

It was identified that two other issues would benefit from attention.

1. The increasing prevalence of people being placed in non-regulated supporting living services by other councils. This is not a material factor in this case The concern was that local teams are not aware of these placements until a safeguarding arises and that the unregulated status makes addressing quality or safety issues very difficult.
2. Participants identified that in general the relationships were stronger between agencies operating in the same territorial area compared to situations such as Christophers where arrangement crossed borough divisions. The participants requested that examples of best practice be identified for consideration locally.

Both of these issues are being progressed and improvement suggestions will be presented at completion of the final report.

9 Creation of an Assurance Framework

The analysis within this SAR indicates that there are a number of related issues that taken as a whole would give assurance of a fully safe system. To give the Safeguarding Adult Board assurance that these issues are being addressed an Assurance framework has been developed. This framework should be populated by participants to indicate how systems and processes have been improved. The improvements should be consistent with the organisation's routine quality assurance processes and the participant organisations are being asked to share their high level indicators with both Redbridge and Barking and Dagenham Safeguarding Adult Boards(SAB) to enable this assurance to be regularised. The author proposes that the SAR report should not be concluded until the SAB receives this assurance and asks both SABS to build in a review day in 6-12 months' time , where the author will explore the improvement journey utilising the Assurance Framework.

Redbridge SAB - SAR 'Christopher' - Assurance Framework Template

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
1	The Voice of the Individual	How does you organisation ensure that the picture of the individual is visible at all times and that their voice is always heard.	NELFT Redbridge	Audit around hearing the patients voice – we have collected data on this via a number of methods, including 5x5 (*NELFT Friends & Family Survey),* friends & family), a qualitative patient feedback form, hospital passport/care plans & outcome measures NELFT have launched its new values, which was co-produced with cares and patients: we are kind, we are respectful, and we work with our communities. This is complimented by a new overarching Trust Strategy which aims to strengthen co-production and empowerment, tackling inequalities, promoting health lifestyles and improving accessibility. NELFT service user involvement Representative are also members of a number of groups, i.e. the Patient Safety Incident Group (PSIG), where Patient Safety Incidents are discussed. They are active members and will contribute towards discussion in relation to practice, service user empowerment and the patient's voice. In addition (NELFT have local IPCEP (Involvement Patient/Carer experience partnership) forums, which meet with Service leads regularly and ensure that users voices are heard. NELFT	Where are audit findings presented internally within NELFT . Is there an audit schedule in place featuring regular audits of "The Voice of the Individual" Require evidence of "New Values" and Trust Strategy Terms of Reference of PSIG Attendance Log at PSIG Terms of Reference of IPCEP Attendance Log of IPCEP	

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				have paid Lived Experience Peer Support Workers in their LD and MH teams.	Structure Chart of LD and MH Team	
			LBBD	*The LBBD ASC service should record all attempts to explore the use of Care Act advocate support or named professional to facilitate engagement and support. Although Consideration should have also been made to recording on 'Christopher's file, who else 'Christopher' may have wanted to advocate for him, whether formally or informally.* *We will be looking at our procedures for supporting a client's referral to 'Talking Therapies' where clients choose to permanently avoid communications with their family.*	As part of the SLA with providers, LBBD will ask client and or providers to directly make the referral to TT and feedback monthly or as required. Feedback is solicited from relevant clients who have used advocacy support. There will likely be better outcomes and less disagreements with the clients. Reviewing the feedback from relevant clients, practitioners and advocates will help evaluate its effectiveness. All LA staff have received training regarding case work's comprehensive recording in accordance with best practice, safeguarding and GDPR protocols. Adherence to this is assured through	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
					direct line management and oversight and through case work audits providing two tiers of scrutiny. This ensures that all attempts of engagements are captured, and any risks mitigated. Evidence of • Case Work Training Records • Case Work Audit Findings (Report) • Forum where audits undertaken are presented for presentation/discussion	
2	Medication processes	How does your organisation ensure that where medication compliance in an issue that this is resolved across the agencies	NELFT R RBBD	- Psychoeducation to service user, family and care provider - Easy read leaflets on medication - Medication side effects rating scale - MCA process with reasonable adjustments - If lacks capacity, then BI meeting involving all agencies If capacious, then therapeutic work addressing compliance RBBD Where a Care Act assessment / review, identifies medication non-compliance as an issue, a referral to NELFT to review medication will be	At weekly RAC meetings, the concerns are discussed by a wider MDT professionals with backgrounds in health and social care to properly support the client and quality assure relevant interventions and explore wider range of options on how the medications can be administered. Evidence of : • Sample of RAC meeting minutes • Easy Read leaflets on medication	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				made regardless of the client's location or placement.	• Medication side effects and rating scale • Evidence of BI meetings • Evidence of referrals to NELFT to review medication	
3	Assessment and Care Management	How does your organisation monitor the assessment , care planning and review process to ensure timely and robust work?	LBBD AS	The Care Act provides the governance framework within which LBBD MHA social services are delivered. Performance is monitored through tiered management scrutiny, case audits, and robust data analysis with robust Directorate oversight and accountability.	Monthly inter team case audits and quality assurance. LD service carries out six audits per month and other adults' services also does the same. Evidence of monthly inter team case audit findings and evidence of presentation/assurance/scrutiny	Yes
4	CTR and DSR process in Health	How does your organisation monitor the clinical assessment and review process to ensure timely and robust work?	NELFT	NELFT B and D have revised the RAC and DSR process. NELFT RB: DSR meeting involving ICB commissioners, health & social care professionals are held bi-monthly to discuss RAG rated individuals and to trigger a CTR if required. CTR needed at any other time is triggered by care co. High risk, complex needs service users are discussed in fortnightly Complex case discussion meeting and case tracker meeting. Red cases are discussed in CCD. When risk is reduced, then it goes to case tracker meeting as Amber so that ongoing review takes place until green.	Evidence of • the revised RAC and DSR process • Minutes of bi-monthly meetings (anonymised) • Minutes of fortnightly complex case (anonymised) • Case Tracker	

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
5	Interagency working and communication.	How do the Organisations ensure that their support processes are co-ordinated and that where people are at risk that interventions are co-ordinated	NELFT and LBBD AS	In addition to the daily routine communications, both partners work collaboratively through formal mechanisms such as CTR, CPA, RAC, complex cases panel, and CTR QA meetings. This process ensures issues and concerns are identified early and appropriate risk mitigations and treatment measures are put in place NELFT CLDT's work together to ensure clear process for referral and seamless handover between their teams when a service user moves to a different area. Redbridge CLDT have internal processes for referring within the team to other disciplines for MDT input if required. If any concerns or risks are identified with the placement or in any other area of care, staff will liaise with the responsible agency or funding authority to ensure these are addressed. LBBD The CPA and Care Act governance frameworks provide the statutory oversight and feedback loop into both NELFT and LBBD respective pathways, ensuring clarity of agency roles and responsibilities.	The CPA and Care Act governance frameworks provide the statutory oversight and feedback loop into both NELFT and LBBD respective pathways, ensuring clarity of agency roles and responsibilities. Evidence of: • Redbridge CLDT internal processes for referring within the team to other disciplines for MDT input if required. Any evidence to support the below. If any concerns or risks are identified with the placement or in any other area of care, staff will liaise with the responsible agency or funding authority to ensure these are addressed.	Yes
6	Risk Management	How is risk assessment and response managed robustly within and across agencies ?	LBBD and NELFT	Through risk assessments, LBBD will identify appropriate mitigations together with the identified agencies responsibility of mitigating the risks and assign. The MDT complex cases panel hosted by LBBD provides a further tier of scrutiny and oversight in	Adherence to statutory guidance, robust scrutiny and management oversight. Evidence of:	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				whole systems management and accountability of risks. This forum sits alongside MARAC and MAPPA The expectation in NELFT is that a risk assessment will be completed at first assessment within the service. NELFT are in the process of moving from risk stratification to a risk formulation model, which supports a move towards the patient centred approach. Training is being rolled out to all clinical staff across the Trust. NELFT have a process for High Level Risk Reporting (HLRR) whereby service users who are considered to have unmitigated high level risks, are discussed at a senior level in the Trust for joint approach and oversight.	• Risk assessment at first assessment within the service (NELFT) • Training programme for risk stratification to a risk formulation model • Process for High Level Risk Reporting (HLRR) (NELFT) and any evidence of joint approach / oversight and risk mitigation	
7	Safeguarding	How does your organisation assure that your staff and those you commission are aware of their responsibilities for Safeguarding under the Care Act 2014	NELFT, LBBD AS	In LBBD, we now have a statutory safeguarding lead and a Head of Service who is the statutory lead officer for safeguarding, performance and quality assurance together with being the principle social worker for adults. This cluster of comprehensive statutory roles ensures compliance with statutory duties and the PAN London safeguarding protocols. All staff are aware that safeguarding is everybody's and they are responsible and accountable to safeguarding all adults and children when harm and abuse have been suspected or alleged. All staff receive safeguarding training.	Through robust data analysis and scrutiny, the HOS /PSW identifies trends, risks and monitors mitigations to ensure MSP is in accordance with pan London Protocols and statutory instruments. Evidence of: (NELFT LBBD) • Data analysis/ trends and MSP workstream audits • Training compliance / Training Strategy and monitoring of training • Practice sessions held by HOS for	Yes.

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				LBBD provides mandatory safeguarding training tiered to entire work force with social workers undertaking detailed mandatory practice updates every 6 months. This is supplemented and interspaced with comprehensive practice sessions led by HOS for Safeguarding/Principal Social Worker. In NELFT All staff are aware that safeguarding is everybody's and they are responsible and accountable to safeguarding all adults and children when harm and abuse have been suspected or alleged. All staff receive safeguarding training at their induction and directed to the NELFT safeguarding policies and procedures. The NELFT safeguarding team are reviewing the level 3 safeguarding adults and children classroom (in place) training. The revised training will start from April 2025. The NEL ICB have offered to peer review our training. The safeguarding policy review has also commenced. The NELFT safeguarding team have increased their visibility and are now placed based. The safeguarding team offer one-to-one or group support to staff when they have a safeguarding	Safeguarding/Principal Social Worker System and management oversight ensure all areas of statutory compliance are highlighted and thresholds are adhered to. Evidence of : • Impact of increased viability • Offer of 1:1 supervision / group supervision	

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				query about a case. Being place-based is also an opportunity to promote safeguarding and shared learning. The safeguarding team also attend senior leadership meetings and present a monthly safeguarding report.	• Attendance list for Senior Leadership meetings identifying presence of safeguarding team • Monthly report (anonymised if required)	
8	Mental Capacity	How does your organisation ensure that mental capacity processes are robust	NELFT, LBBD	B and D AS Learning: As above, we will now work closely with our legal team to explore cases where there is a need to override client consent in reducing any risks to them or others. In LBBD, all MCA work is captured through an online pathway with management oversight of a service manager and CSW who's dual focus is mental capacity act and mental health act compliance. LBBD does not operate a waiting list or backlog in relation to these areas of work and the level of oversight and scrutiny together with robust management audit and oversight ensures that statutory timelines are achieved. In relation to complex cases presenting with legal challenges we have a dedicated barrister to provide legal oversight and direction. NELFT: The Trust Mental Health Act lead also leads on MCA as part of her portfolio. The MCA leads offer advice and guidance to all staff. The	S39A advocate is employed if SU does not appear to have capacity. Statutory compliance enables LBBD to measure work done against the guidance and if there is a deficit we work to seal the gap. Evidence of: • Case discussion with Legal Team • Online Pathways for MCA • Robust Management Audit Schedule and forums/meeting minutes where findings are presented for discussion/scrutiny Evidence of: • Number of cases requiring Barrister legal oversight and direction	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				team also offer trust-wide drop-in sessions to all staff. The MCA lead also completes audits on MCA and DoLS to ensure practice is in line with the Trust MCA policy and to identify areas for further development. The MCA lead is a member of the NELFT safeguarding assurance group, and the Safeguarding Learning Operational group.	• Impact of advice provided by NELFT Trust Mental Health Act lead • MCA Audit Findings and meeting minutes showing scrutiny TOR for NELFT safeguarding assurance group, and the Safeguarding Learning Operational group.	
9	Where services find it difficult to engage with people appropriately	How does your organisation ensure that where people do not participate in processes that this is a safe and based on a capacious decision?	NELFT, LBBD	Where client engagement is not forth coming, LBBD undertakes unannounced visits together with partners or individually An MDT meeting will then explore risks, identify potential mitigations and discuss options for Interventions under the MCA/MHA, as appropriate with referral to the complex cases panel were considered appropriate. Early identification of the client's choices in respect of advocacy, named person, or (a designated individual. NELFT: All staff complete mental capacity act training & assessments. Staff will involve nominated carers or advocates and discuss best interest if the person is unable to make a decision. Risk is assessed in staff MDT meetings. All risk identified as high will be escalated by the	Client re-engages with services In the event of DNA, LBBD will discuss it at RAC where MDT will come out with weighted actions or interventions and explore options available. Evidence of: • MDT meetings exploring risk • Referral/s to Complex case panel (anonymised) • MCA Training Strategy • MCA Training compliance • Impact of Training • Minutes of MDT meetings identifying risk assessment	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				MDT via the High Level Risk Reporting system and consider safeguarding. The NELFT Safeguarding Team are currently leading on reviewing the Missed Appointments Policy with operational leads and Patient Safety Incident team. If someone misses an appointment with the Redbridge CLDT, there will be an attempt to contact them to find out why they did not attend, and they will be offered another appointment. If the case is deemed high risk, and emergency appointment will be offered. Regular DNAs with minimal risk will be offered the earliest available slot. People who consistently DNA will be discussed with the MDT for a management plan.	• Risk escalation to the High Level Risk Reporting system and consider safeguarding. • Update on progress to date re Missed Appointment Policy • Missed Appointment Flowchart	
10	Commission-ing services	How does your organisation ensure that the services commissioned as a result of care planning are appropriate and that due diligence has been followed particularly in respect of Data Protection.	LBBD	All commissioned services are underpinned by either individual placement agreements or, more usually, wider direct or framework contracts. These contracts are all underpinned by the Council's standard Terms and Conditions which are robust in respect of GDPR. Contracts are routinely monitored for compliance through either routine contract monitoring OR via our Provider Quality and Inspection Team who, as part of their visiting regime routinely check policies, procedures and that matters of compliance are in place. LBR have a Supported Living Framework (SLF) for MH & LD. This has been through a rigorous tendering process with all checks	PQ&I Visit Feedback and Quality Assurance findings. Annual Reviews. Contract Review Meetings. Social Work visits.	Yes

	Issue	Description	Agency affected	Action Being taken	How do you know this is effective?	Can this be reported to the Safeguarding Adult Board as assurance?
				completed around CQC and other compliance, and brokerage & commissioning teams remain involved with the oversight of these placements. Alternative placements may be commissioned by the ICB, who complete similar checks and assurances. There are challenges when people are placed in accommodation outside of their local area, as this may mean that alternative or unregulated provisions may be used, and communication across agencies may break down or be more difficult.		

10. Recommendations

The following recommendations are made to the Redbridge SAB and Barking & Dagenham SAB:

1. That the Boards requests the LBBD to clarify the precise date the Section 75 agreement with NELFT ended and when the service improvements that are referenced in the report were made.

2. That the Boards adopt the Quality Assurance Framework contained in report (Section 9, page 20). This Framework seeks assurance from LBBD and NELFT in the following areas of health and social care policy and procedure:

    - the 'voice' of the individual;
    - medication processes;
    - Care Act Assessment and Care Management;
    - the Community Treatment and Dynamic Support Register Processes;
    - interagency working and communication;
    - risk management;
    - safeguarding;
    - Mental Capacity;
    - 'Did Not attend' (DNA) Processes; and
    - commissioning services.

3. That the Boards request impactful indicators from LBBD and NELFT to enable effective assurance to be secured.

4. That the Boards request the Author to undertake a review of progress against the Assurance Framework in six to twelve months.