Brent Council response to Adult E SAR report

The purpose of a Safeguarding Adults Review (SAR), particularly one where circumstances such as the Coroner' Inquest, have caused a considerable delay to the process, is to ensure that all parties involved have learned lessons. It is therefore important that the SAR clearly identifies the issues from the perspective of each organisation involved, and subsequently identifies that those organisations have recognised and addressed those issues. It is particularly important that the SAR identifies systemic issues, i.e. where different organisations have not worked together to support and safeguard vulnerable adults, and how those systemic issues should be addressed to ensure that individuals in the future are better safeguarded and supported.

The council recognises the unique challenges in producing this SAR, including the challenge of completing the work during the Covid-19 pandemic, and that this limited the author's ability to engage with individuals and organisations to test understanding of the issues and gather further information. However, the council also recognises that the SAR process for Adult E has now been ongoing for over 3 years, and that during this time and particularly as required for the inquest held into Adult E's death, there have been multiple reports and sources of information produced that the author has been provided with as source information. This information has been produced by all organisations involved in the Adult E SAR, and when viewed collectively it provides a rich picture of the issues relating to Adult E and the subsequent learning and actions undertaken by the organisations involved.

The SAR report provides an overview and insight into the seven overarching questions developed for the interim SAR and subsequently utilised to complete the final SAR. The council fully accepts the findings and recommendations of the SAR and has implemented actions that go beyond the SAR recommendations in the majority of cases. These are set out in the attached report.

Due to the unique circumstances surrounding the production of this document, the council feels it is important to add additional information which the author may not have been aware of due to the extended timescales and the limited interaction the author has been able to have with key staff. The council has therefore included the full assurance report provided for the lead member for adult social care after the inquest, and some summary points of note in relation to the SAR document below.

We believe it is important to clearly identify the lessons learnt by different organisations, and the actions they have taken, whilst clearly identifying any gaps, in order to provide the family of Adult E, and the Safeguarding Adults Board, with assurance that all organisations involved have identified the lessons to be learned, and to set out how each organisation will respond to implement the learning.

Therefore, the attached report sets out the summary of the issues in relation to Adult E's case, as identified by the council, and what the council has done to address these issues and ensure such a situation cannot happen again in the future.

Internal Review of the Council's Learning

Purpose of this report

Adult Social Care carried out a review, immediately after Adult E's disappearance. However, following the inquest into Adult E's death on the 4th-7th November 2017, ASC reviewed both the coroner's conclusions and the details of the case in order to provide assurance that the department has fully considered the issues and responded appropriately. This is particularly important in light of Adult E's family's feedback at the inquest that they were not convinced by the summary of actions put in place as presented at the inquest.

The report is split into five sections:

- Section 1 – background
- Section 2 – overview of the 3 key issues
- Section 3-5 – detail addressing each of the 3 key issues.

Each of the sections about the key issues sets out the detail into four sub-sections:

- What should have happened in response to each issue identified
- What actions were implemented post incident
- New and additional actions (i.e. actions agreed in response to the coroners' feedback), and;
- Continuous improvement actions (i.e. actions that have been taken not directly in response to this incident, but which nonetheless support improvements in the key areas identified).

Section 1: Background

An immediate review of the case file of Adult E was completed once the department became aware of Adult E's disappearance. However, this review was intended primarily to assure the immediate identification and safeguarding of any other individuals in Extra Care Sheltered Housing (ECSH) who had dementia and a high risk of walking with purpose (otherwise known as 'wandering'). This focused on a review of all individuals living in ECSH at that time, to identify anyone at high risk of wandering and implement an immediate ban on placing individuals with dementia and/or a risk of wandering in any scheme that did not have a suitable front door alarm system. The review group also worked with ECSH providers and staff to design and implement a checklist for referrals to ESCH and other immediate actions were also put in place as set out in the relevant sections below.

The review identified that Adult E's case would be likely to meet the criteria for a Safeguarding Adults Review (SAR) by the Brent Safeguarding Adults Board (BSAB), so a referral was made to the Case Review Subgroup (CRG) who considered the referral and agreed a SAR would be the appropriate response. Because of this, a more in depth review was not undertaken within the department at that time.

The BSAB Chair met with the family prior to commissioning the SAR to agree the terms of reference. The family were clear that their main objective was that they wanted to understand what had happened and to be assured that lessons had been learned and that this would not happen to any other family in the future.

However, although the BSAB Independent Chair commissioned the review and an independent reviewer had begun work on the SAR, we were then informed that a Coroner's Inquest would also be held, and in discussion with the family and the BSAB, we agreed to defer the SAR until the Inquest was completed. In parallel, the Chair requested the department provide details of our initial review and response to assure himself that any immediate safeguarding risks had been identified and addressed.

Unfortunately, there were 3 postponements by the Coroner's Court to the date of the Inquest, meaning that it was over 2 years before the Inquest was finally held.

On reflection, both the department and the Independent Chair recognise that although this was discussed at the BSAB and at the Case Review Group, at each point of postponement we should have discussed and reviewed the decision internally on how to progress. This is a learning point that will be formalised into any future SAR processes going forward.

The Strategic Director, Operational Director and Independent Chair met to discuss the feedback from the inquest and to identify any gaps in our response. Additionally, the Operational Director has met with the ASC Departmental Management Team, all Deputy Team Managers, and all Team Managers to discuss the learning points from the case. The Head of Commissioning and Market Management held a Provider Forum with all ESCH provider on the 13th November 2019 where the case and learning points were also discussed.

Section 2: Summary of the 3 key issues

Due to the seriousness of the case and the issues raised, the department has reviewed the summary feedback from the council's legal department, which captures the key issues identified by the coroner alongside the coroner's verdict. These are set out in summary below:

1. The Council did not respond to the provider's concerns generally, but particularly in the last two weeks prior to Adult E going missing for the final time. This highlights two key issues:
    - The robustness of procedures to understand urgency of files and triage, and
    - How is case handover managed, including the supervision process.

2. The quality of the social work practice:

    - General training around Mental Capacity Act (MCA) and Best Interest Assessment (BIA), and what happens when family have Legal Power of Attorney – the coroner focused specifically on Social Worker B's lack of understanding around the interplay between his legal duty and the situation where the family hold LPA. This included a view that he was too focused on the family's opinion.
    - Professional judgement. The coroner cited two specific examples of this;
        a. The incident in 2016 where Adult E was found wandering near the M1 when Social Worker A was his social worker
        b. Social Worker B and the Council's primary consideration should have been Adult E's safety. His view was that the Council were fixated on adopting the least restrictive option and were not active in our response.
    - The coroner also noted significant issues around recording and record keeping throughout. This specifically included Best Interests' meetings not being recorded formally, but rather being recorded in case notes. Key meetings were recorded in case notes, but not formally minuted

3. Clarity of roles and responsibilities – this case highlights the importance of social work, commissioning and providers all understanding each other's roles and responsibilities, and how critical the communication between these different groups is to deliver actions, particularly as people in those roles change.

Issue 1 – actions in the final two weeks

The Council did not respond to the provider's concerns generally, but particularly in the last two weeks prior to Adult E going missing for the final time. This highlights two key issues:

- The robustness of procedures to understand urgency of files and triage, and
- How is case handover managed, including the supervision process?

What should have happened?

A number of things failed during this period that would not have happened if core social work practice had been followed. During the time period this occurred, the mechanisms for management were that cases were allocated to an allocated worker (ASW) to be managed. The ASW is either an SO2 Care assessor or PO2 qualified social worker. Case allocation was done by a Deputy Team Manager (DTM), which is a PO4 grade, and they are supervised by a Team Manager (TM) at PO7. The Team manager reports into a Head of Service. DTMs and TMs do not hold cases, their primary role being to supervise, support and manage social workers and care assessors. All social workers and care assessors should have a minimum of one supervision session monthly, but also sit within their teams at the civic centre and have access to daily guidance from the team manager, deputy team manager and head of service if required. This is true of all teams across the service.

In the Complex Care Team referrals were screened by DTMs and allocated according to urgency. The Complex Teams usually operate with a waiting list of between 4-8 weeks before allocation, and therefore screening of referrals is vital to ensure urgent cases are prioritised.

A core part of the DTM role is oversight and management of the social workers that they supervise, including knowledge of the cases and caseloads. During this period we would have expected that the ASW would have had a supervision with his DTM prior to going on sabbatical, and this should have included a full handover of all his cases, including open cases, open actions and high risks. It should then have been the responsibility of the DTM to re-allocate the open cases according to priority. We would also have expected the TM and DTMs in the Complex Care Team to be triaging referrals routinely and to ensure that the Out of Office protocol was reinforced with a worker going on a sabbatical, and that there was a clear message regarding how people could contact us in his absence.

Actions implemented post incident

Team Managers, who are responsible for triaging referrals to identify priority or high risk cases and team managers, report monthly to the Head of Service using an agreed dashboard created by the performance team on backlogs and allocations. This information is also reviewed monthly for all teams by the Operational Director through supervision with the Head of Service.

All TMs and DTMs have discussed and agreed a handover approach, which has been recorded in a formal protocol, circulated to all staff and is available on the ASC sharepoint site, which is the repository of all departmental guidance and protocols. All staff, including new starters, are made aware of the share point site and how to access it and are asked to familiarise themselves with the protocols held there.

In cases of absence, DTMs are responsible for reviewing caseloads and triaging the cases of the absent staff member for reallocation depending or urgency, risk and likely length of

absence of the worker. DTMs have all received training in supervision, with a specific focus on their responsibility to understand the risk levels and high priority actions for the staff that they supervise. Further, a supervision template has been produced and agreed in consultation with staff, and training for all staff on supervision is provided. Supervisions are now recorded in a more uniform and consistent manner, with supervision notes being held on the shared drive so that they can be accessed by anyone at an appropriate level (Team Manager and above). Spot audits are undertaken throughout the year to check supervision notes and files for quality and consistency by all team managers.

The 'out of office' response protocol was reinforced with all staff reminding them to provide the contact details for a manager within the team if an urgent response is needed, and a further requirement for all DTMs and TMs to check staff out of office messaging if any staff member is unexpectedly absent was added to the protocol.

The backlogs in all teams have been significantly reduced since 2017, and specifically additional short term capacity was brought in to reduce the backlogs in Complex Care. There is now no backlog, but there is a short wait for allocation of maximum 4 weeks after cases have been triaged and according to urgency.

New and additional actions after coroner's inquest

All Team Managers maintain a spreadsheet of high-risk cases to be discussed in monthly supervisions with their Head of Service. Each Head of Service escalates any high risk cases with outstanding actions to the Operational Director in monthly supervision. The Principal Social Worker and Head of Safeguarding undertakes a random audit of cases from the high risk register on a quarterly basis and completed one case a quarter with the Lead Member for Adult Social Care.

On-going work is happening to determine if Merlin referrals from the police can be managed through an automated process although this is a London wide issue and is proving difficult to resolve. The corporate digital transformation team is supporting this. In the meantime, a new triage system has been implemented in the Safeguarding Team, whereby a Duty Social worker triages all Merlins from the police and ensures they are actioned or closed as appropriate.

The Operational Director met with all Heads of Service, Team Managers and DTMs to provide an overview of the issues, and reinforced all the core practice issues. Team Managers briefed all teams. All Team Managers now meet with a member of the Adult Social Care Departmental Management team, on a monthly basis, to discuss practice and process issues.

The Principal Social Worker holds monthly practice forums based on a specific case to support social workers to develop their skills through reflective practice, and every team hold one reflective practice meeting each month as a minimum. The practice forum focusses on issues that have been raised as part of a SAR, or that are raised as ongoing concerns identified by TMs or Heads of Service, including frequent reviews of issues around Deprivation of Liberty Safeguards (DoLS) and tenancy, MCAs and working with and understanding LPA and the family role. Any ongoing issues are then picked up by the Principal Social Worker and training is commissioned for staff on that issue through the newly created Skills Academy.

In April 2020, the department launched the first Adult Social Care Skills Academy in London, with 6 co-produced skills pathways that staff can access. All staff must follow the core skills

pathway which includes training and learning through a variety of methods covering the core skills all social workers should have. This pathway include both MCA and DoLS, as well as a specific taught course on risk assessment and risk mitigation and a module on supervision.

Continuous Improvement actions

The Head of Urgent Care who came into post in Jan 2018, manages the ASC Duty Team and has monthly performance meetings with the Brent Customer Services (BCS) team. Protocols have been put in place through these meetings with BCS for escalating contacts that are urgent, with the BCS team escalating all urgent concerns to the ASC Duty Team as well as highlighting on Mosaic.

The Head of Safeguarding and Transformation came into post in Feb 2019, and as part of the safeguarding peer review process undertook a review of safeguarding to complete our self-assessment in April 2019. As part of this, the system where alerts raised by the provider were closed with no further action because the case had an allocated worker was changed, and the Safeguarding Team has a new Team Manager and the roles in the team have been reviewed and revised.

Separately, the safeguarding process has been revised to ensure compliance with the pan-London safeguarding protocol. This went live in October 2019. Any Alerts are no longer closed due to having been allocated to a worker and this has been in place since May 2019.

The new safeguarding process has been inspected as part of the safeguarding peer review, which confirmed that the revised process for management of ‘Alerts’ is robust.

Issue 2 – Quality of Social Work Practice

The quality of the social work practice:

- General training around the Mental Capacity Act (MCA) and Best Interest Assessment (BIA), and what happens when family have Legal Power of Attorney (LPA) – the coroner focussed specifically on Social Worker B's lack of understanding around the interplay between his legal duty and the situation where the family hold LPA. This included a view that he was too focussed on the family's opinion.
- Professional judgement. The coroner cited two specific examples of this;
    a. The incident in 2016 where Adult E was found wandering near the M1 when Social Worker A was his social worker
    b. Social Worker B and the Council's primary consideration should have been Adult E's safety. His view was that the Council were fixated on adopting the least restrictive option and were not active in our response.
- The coroner also noted significant issues around recording and record keeping throughout. This specifically included Best Interests' meetings not being recorded formally, but rather being recorded in case notes. Key meetings were recorded in case notes, but not formally minuted.

What should have happened?

Between 2015 and March 2017, Social Worker A, a qualified social worker completing her Assessed Social Work Year (ASYE), managed Adult E's case. During this period the case was managed well, with extensive evidence of Social Worker A diligently following up concerns with the care provider, GPS provider and family, and often going the extra mile to ensure Adult E's care was both safe and the best option for him. After each incident of reported wandering Social Worker A requested the daily logs from the GPS provider showing Adult E's activity for the preceding weeks to identify patterns, causes and whether the GPs tracker was working, and after each report of a wandering incident from the provider Social Worker A convened an Multi -disciplinary Team (MDT) to review his care and amend if required. Social Worker A's management of Adult E's case was as we would expect, both in relation to the standards expected of a qualified social worker, and in respect of what is required of social workers under the Care Act (2014).

However, it must also be noted that the coroner did highlight the wandering incident in July 2016 where Adult E was found near the M1. This incident took place while Social Worker A managed the case. A review of the case history shows that she raised this incident with her line manager and team manager, and received advice from them in relation to how to proceed. However, it was not escalated any further. Due to the seriousness of the incident, at this point the risk should have been reviewed by an MDT and although it is difficult to predict the outcome of a meeting that did not happen, it is likely at this point an MDT would have recommended that the placement be reviewed for suitability and a community DoLS .

A meeting between the social worker, family and care provider was convened to review Adult E's care plan; however, this did not include any representation from the safeguarding team, which would be expected after such an incident. Both the family and care provider were clear at this meeting that the desired outcome was for Adult E to remain in his accommodation. After discussions with her manager Social Worker A concluded that as the agreed additional care hours had not been put in place at that time and that the GPS had not been properly charged, the correct response was to implement those actions and review again in a month. This was also in accordance with what the family stated they wanted to see happen.

Social Worker A acted as we would have expected her to act at this point, and sought advice from her line manager. It is difficult to second guess the professional judgement of her

manager at this point, as there is not a full record of this discussion and how the manager reached the conclusion they did in order to give this advice. However, based on the fact that a full MDT had not been convened to discuss the case, and based on the seriousness of the incident, it is reasonable to suggest that most managers would recommend advice from the safeguarding team should be sought at this point, and that as a minimum a risk management plan should be produced and implemented. Regardless of the lack of MDT and the risk management aspect, we would have expected the manager to advise that a Community DoLS be sought at this point, which they did not.

Social Worker A implemented the agreed actions and there were no further incidents for four months, with regular checks with both the provider and family reporting on two occasions that Adult E seemed to have settled and they had no concerns and all parties were happy with the care plan and care.

Throughout her management of the case, Social Worker A responded to every communication from the family and provider within 3 days, usually on the same day, and followed up and documented every action and meeting. This is what we would expect to see in terms of professional practice and responsiveness. Social Worker A was promoted within the department into a new team in October 2016, and contacted the family to inform them that she was moving role and that because Adult E was settled with the care plan working well, she was closing the case at this point and referring it to the review team for an annual review. This is normal practice and is what we would expect to have seen. However, the process whereby complex cases are closed by social workers in order to be passed to review, once stable, does not allow for flexibility for particularly complex cases (where individuals have fluctuating needs) to be re-opened without re-allocating the case. The council now recognises that for some individuals, there is likely to need to be ongoing, if sporadic, engagement due to changes in need or people with degenerative conditions getting worse. At this time, there was no flexibility in the process for social workers to retain access to cases after a period of settled behaviour.

The case was allocated to Social Worker B in June 2017. As a qualified social worker, we would have expected Social Worker B to review the case notes of the case, review previous information and assessments and make contact with the family and provider to visit Adult E. There is evidence that Social Worker B did make contact with the family within three days of the case being allocated, however he failed to contact the provider until the end of June despite the provider requesting an MDT on the 5th of June and subsequently chasing this on the 23rd June. We would have expected to see Social Worker B making contact with the provider within the same timeframe as he did the family, particularly where the provider has requested an MDT, and this did not happen in this case.

Social Worker B met with the family, provider and Adult E on the 26th June 2017, and at this meeting it was clearly identified that Adult E's wandering was again increasing and that both the provider and family had concerns, although the family still stated that they would prefer Adult E to remain at the placement, if possible. Deprivation of Liberty Safeguards (DoLS) were discussed and both the provider and family agreed that this was now necessary. However, in contrast to the previous ASW, actions were not followed up after this meeting with the same speed and persistence. Although some attempts were made by Social Worker B to have a front door alarm fitted to the scheme, he subsequently went on a three month sabbatical on 21st July 2017 with outstanding actions such as the DoLS being in place or the front door sensor being fitted, not having been completed. We would have expected to see actions such as a DoLS and the door sensor, which were important actions to mitigate risk, being prioritised and completed. We would further expect that prior to the worker going on sabbatical, a full handover note of all his cases and any outstanding actions (particularly urgent actions) should be completed and each case and action discussed at a supervision had over meeting with his DTM. A case transfer note was on file from Social Worker B, but

no allocated worker was identified and the transfer information is sparse and with no sense of prioritisation of actions to be completed. It is not clear whether there was a formal handover of his cases to his supervisor, or whether his supervisor triaged and allocated his open cases in his absence, as this is not recorded.

Actions implemented post incident

All ESCH cases were reviewed to identify whether there were any individuals with dementia and a wandering risk who were in schemes without front door alarms.

A checklist has been implemented for front line workers to use, prior to nominating an individual for extra care. This asks for consideration of any risks, particularly wandering, and was put in place as part of the initial review completed by ASC.

The need for specific training in MCA and BIA was identified as an ongoing focus and has been in place since early 2018. This was acknowledged in our safeguarding self-assessment and supported by the findings of the independent peer review.

New and additional actions after coroner's inquest

Since the inquest, all ECSH providers have been asked to highlight any cases of residents that they feel are high risk and these have been reviewed by the Supported Living Commissioning Team Manager. Each case was allocated to a Placement Review Officer to undertake a review or produce an agreed risk management plan, as appropriate. Of the 6 cases identified by providers, none of the individuals had dementia symptoms or were at risk of wandering.

The Adult Social Care (ASC) department requested that the BSAB commission an independent audit of ECSH placements following the inquest. This audit took place in January 2020 and focused on providing assurance that the Extra Care Supported Housing (ECSH) model was being used appropriately in the London Borough of Brent. It also sought to identify any local trends or risks which were not being managed appropriately. A list of the last 40 placements made into ECSH were given to the auditors who selected 20 cases at random to audit, with the requirement that at least one case from every ECSH living scheme would be reviewed.

The audit concluded that "*the auditor found no major areas of concern, or widespread systemic issues",* in relation to the audit of the 20 recent placements in the Brent Extra Care Supported Housing model. The audit found the correct legal processes were being followed and there was evidence of effective management oversight of cases, as well as some excellent recording by committed practitioners.

ASC then requested a further audit be undertaken around complex cases in ECSH to provide assurance around how these were being managed. The audit (February 2020) reviewed 6 randomly selected cases (from a total of 15 that were identified across all ECSH schemes by social workers and ECSH providers). The audit concluded "*There was no evidence of any systemic issues in the 6 cases audited. There was good evidence of multi-agency involvement to mitigate risks and effective care planning."*

TMs and DTMs have been briefed to ensure high risk cases are discussed with their manager and a spreadsheet is maintained in all teams identifying high risk cases.

All staff have now received training in DoLS and the new DoLS process, and all staff have received training is risk management. Risk assessment and management training is ongoing and has been embedded in the learning curriculum for all social workers.

As a result of the Inquest the Principle Social Worker (PSW) reviewed the training to ensure it covers MCA, where there is an LPA already in place, and commissioned a specific training course for social workers addressing LPA and DoLS. Training to address LPA and managing tenancy has since been added to the Skills Academy programme.

Continuous Improvement actions

Working with staff, the Principal Social Worker and Transformation Team have designed and launched an ASC Skills Academy in April 2020. The Skills Academy is managed and overseen by a dedicated Skills Academy officer. The Academy offers 6 skills pathways, but all staff must follow as a minimum the Core Skills pathway, which includes training on MCA, DoLS, risk assessment and mitigation and supervision. This is mandatory for all staff and the new supervision template and protocol includes a section for supervisors to discuss learning and development with all staff at each supervision session.

A new supervision template and protocol was also co-produced, along with a practice framework, both of which were launched in January 2020. Additionally all staff have been on Strengths Based training which has been co-produced and delivered by the Social Care Institute for Excellence (SCIE), focusing on risk assessment as the core of the approach. This training was interrupted by the Covid Pandemic, but has been reinstated in August 2020.

Risk management was also identified as a departmental priority: in the departmental plan, as part of the Adult Social Care transformation programme, and as a priority for the Principal Social Worker (PSW). A task and finish group of staff, lead by the Head of Complex Care and supported by the PSW was set up in May 2018 to design and produced a more systemic approach to risk management. This has now been embedded in all of the Adult Social Care service user records ('Mosaic') and all DTMs and TMs have been briefed by the PSW on the importance of checking risk as part of supervision of cases.

Risk assessment and risk management and the need for training was also identified as a priority (as part of our safeguarding self-assessment) and this has been commissioned and delivered.

A qualified and experience social worker has been recruited into the Supported Living Commissioning service to work on community DoLS within ECSH and training on community DoLS delivered for all staff.

In preparation for the new Liberty Protection Safeguards, a review of the DoLS process was commissioned in Jan 2019, we have redesigned our internal processes and delivered training all staff, beginning in July 2019.

The Safeguarding Adults Manager now has oversight of the DoLS applications and maintains an overview of the process as well as providing advice and guidance for staff.

Issue 3 - Clarity of Roles and Responsibilities
Adult E's case highlights the importance of good communication between social work, commissioning and providers services and each having an understanding of their individual and collective roles and responsibilities, , particularly as people in these roles change.

Overview of roles and responsibilities
This case highlighted a number of areas of confusion where different people involved in Adult E's care were not clear what their own role and responsibility was, but also what the role and responsibilities of partner organisations or professionals.

The ASW should have been the individual responsible for overseeing Adult E's care, and ultimately should have been working in his best interest to balance his safety with his wellbeing. This includes making decisions regarding his care, based on evidence and following the legal framework (the Care Act 2014). The coroner noted that this should have included making decisions for Adult E that may have been contrary to his families' views and wishes, regardless of them holding LPA.

The request for a door sensor was sent by the ASW to the commissioning service, which suggests that he was not clear about the respective roles of commissioning and social work. There was no need for commissioning to be involved as this would have needed to be put in place by the housing provider. The care provider could, and should have been made responsible for liaising with the housing provider to get the door alarm fitted, with the role of the ASW being to check and assure this had been done.

The Care Provider was commissioned by Brent Council but also holds a CQC registration which requires them to ensure concerns are properly escalated, although we accept we have a responsibility to make that as simple as possible. Although the provider attempted to contact the council during the two week period before Adult E went missing, under their CQC registration they were responsible for ensuring his safety as well as escalating if they had significant concerns, and CQC noted this in their evidence to the Inquest. The provider was also responsible for ensuring the GPS tracker was charged, and for implementing the care plan, including the night time check, which the Coroner noted was not undertaken on the day of Adult E's disappearance.

Actions implemented post incident
Anyone who has been assessed as having a regular risk of wandering will not be placed in an Extra Care placement that does not have sensors in place and activated on the individual's front door. Brent Council now have 5 schemes with 74 flats that have sensors in place to specifically meet the needs of people with dementia that have a risk of wandering.

ECSH providers have improved pre-admission assessment documents that clearly highlight known risks, including wandering, and these contribute to the care and support plan and risk assessment. Brent Council have undertaken unannounced contract monitoring to review the documentation around all tenants that have a known or historical risk of wandering.[1]

All providers have been reminded of their responsibility to alert us when there is an issue of escalating risk with an individual. If they are not able to get an immediate response, or the issue is urgent, they should contact their Placement Relationship Officer or Supplier Relationship Manager or escalate to the Commissioning Contracting and Market Management Team Manager as an alternative route of escalation. Providers have been told that for urgent issues they should receive a response the same day, and that if they do not they should follow the escalation protocols. This was followed up in writing with providers, and they were

[1] Due to the Coronavirus pandemic the unannounced contract monitoring dates have been reduced in terms of frequency

reminded that all ECSH providers have the ability to increase care hours for an individual at risk on a short-term basis without any approval needed from the council.

New and additional actions after the coroner's inquest

A provider forum was delivered on the 13th Nov 2019 for ECSH providers where the issues from this case were discussed. In addition, a pilot scheme was agreed to support individuals with challenging behaviours to access the community through employing a Community Access worker. This is in response to the issues with this case where it was difficult to provide day activities to appropriately engage and fulfil the physical needs of Adult E.

Adult Social Care now have a regular ECSH provider forum, chaired by the Head of Commissioning and there are regular discussions on the role of the care provider and their responsibilities in relation to liaising with and managing housing issues with the housing provider.

Together with Brent Council housing staff, the Head of Commissioning now meets with housing providers on a quarterly basis, to discuss and resolve any concerns or issues and to increase their understanding of their role in relation to vulnerable adults. Safeguarding training was arranged for housing providers in 2020 but, due to the Covid Pandemic, this has been re-scheduled for May 2021.

As a result of the Inquest and audits undertaken, a revised ECSH flow chart has been produced for social workers to support their understanding of roles and responsibilities. This has been supplemented by regular briefing sessions within departmental meetings.

Continuing Improvement actions

A review of commissioning was completed in Dec 2017. The key change implemented after this review has been the creation of specific Supplier Relationship Manager (SRM) roles who are responsible for managing specific providers and acting as their single point of contact for any issues.

This means ECSH providers are all managed within the Supported Living and Accommodation Team, with a named SRM. Working to the SRMs are Placement Relationship Officers (PROs) who will have an holistic overview of the strengths and challenges for any provider, and help to understand the appropriateness of placements. .