West of Berkshire Safeguarding Adults Board

Briefing no. 4 – May 2021

Welcome to the West of Berkshire Safeguarding Adults Board briefing. The West of Berkshire Safeguarding Adults Board meets four times a year and discusses how agencies should work together to keep adults at risk of abuse or neglect safe in Reading, West Berkshire and Wokingham.

The main objective of the Board, as set out by the Care Act 2014, is to gain assurance that local safeguarding arrangements help and protect adults with care and support needs who are at risk of or experiencing abuse. The Board aims to make sure that all the organisations involved have effective safeguarding policies and procedures and work together in the best way possible to protect adults at risk. The three core duties of the Board are to:

- Publish an annual strategic plan;
- Publish an annual report; and
- Conduct Safeguarding Adults Reviews of serious cases in specific circumstances.

Our Board last met in March 21 where we endorsed a Safeguarding Adult Review (SAR) Margaret which identified learning regarding risk management. A professional review about Nigel, a person who may have benefited from a more co-ordinated approach from agencies. Learning from both has been published and more information can be found further on in this briefing.

We agreed that an Executive Group will be formed to meet between full Board meetings to help to support the implementation of our future priorities. The first meeting of the executive was held in May 21 and we plan to endorse 3 year strategy at our Board meeting in June 21.

Contact the Board

If you would like any further information on the Board, please contact the Boards Business Manager Lynne Mason:
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or on 07718 120601

Our Websites:

Home | Safeguarding Adults Board (sabberkshirewest.co.uk)
Home Of Berkshire Safe Guarding For Adults (berkshiresafeguardingadults.co.uk)

National analysis of Safeguarding Adults Reviews Key Messages for Practitioners

The national analysis of Safeguarding Adult Reviews (SAR) was conducted by the Local Government Association (LGA). The study analysed the findings of 231 SARs completed over a 2 year period. The key messages for practitioners identified in analysis was:

- Shortcomings in practice have an immediate and direct impact upon the individual, and there is important learning for practitioners to apply to their own direct work. It is also the case that features in other domains- resources and time pressures, information-sharing, case coordination, poor guidance and aspects of the national legal and policy context – can impact on direct practice. It is important that practitioners are alert to this and escalate concerns about ways in which their own effectiveness may be compromised.
- When working with an individual, it is important that practitioners pay close attention to mental capacity, carrying out capacity assessments where indicated, particularly where an individual consistently disregards high levels of risk to themselves or others. The potential impact of impaired executive brain function on decision-making may also need to be considered.
- Explicit and comprehensive risk assessment is an essential component of practice, as is a focus on proportionate risk management.
- Factors such as poor case coordination and information-sharing, pressures on staffing and workloads, availability of commissioned resources, and absence of management scrutiny, training and guidance, compromise the effectiveness of safeguarding but they also have a direct influence on how practitioners in any one agency approach their work with an individual. Practitioners' awareness of these systemic factors can assist them to take appropriate actions, for example contribute actively to interagency coordination and information-sharing, and to escalate difficulties to the appropriate domain.
- It is important that practitioners learn the lessons from SARs, both in their own locality and elsewhere, and draw on this developing evidence base to inform their own practice.

The full briefing note providing more context around the key messages for practitioners can be found **here**.

The Board have a page dedicated to learning from SARs: **Safeguarding Adults Reviews | Safeguarding Adults Board (sabberkshirewest.co.uk)**

Margaret – Safeguarding Adult Review
Margaret a lady in her nineties lived in sheltered accommodation and was known to several agencies. Margaret received serious burns after a fire in her property. It is not clear how or when Margaret received her injuries, as Margaret has been unable to communicate this. It is thought that these burns were due to smoking. Learning was identified for the partnership regarding fire risk management and responding to burns.

A Practice Learning Note in response to the learning from this SAR has been created and can be found **here.**

Domestic Violence and Abuse Prompt West Berkshire Health Services
The Berkshire West Clinical Commissioning Group have produced a tool to aid practitioners to understand/establish the level of concern they may have following discussions with an individual. The documents can be found **here**.

West of Berkshire Adult Safeguarding Threshold Guidance Published in April 2021 is a document that has been created by Reading Borough Council, West Berkshire Council and Wokingham Borough Council, to support a shared understanding of thresholds for adult safeguarding. It supports decision-making around when the threshold for raising a safeguarding concern is met. The document can be found **here.**

Best Practice Guide for roles and responsibilities in Safeguarding Enquiries – published May 21
The Pan Berkshire Policies and Procedures Subgroup have produced a best practice guide for the partnership outlining the role of the Enquiry Officer and the 'accountable person' in a S42 enquiry. Please note that the 'accountable person' may be referred to as a Safeguarding Adults Manager or (SAM) Designated Safeguarding Managers (DSMs). The guide can be found **here.**

Nigel – Professional Review Learning
The professional review identified that agencies supporting Nigel worked in silos which made it difficult to identify and respond to his circumstances as self-neglect. Nigel was not presenting to agencies in a way that is identified as typical in someone who is self-neglecting and on face value Nigel appeared to be engaging with services. A multi-disciplinary approach in responding to the safeguarding concern raised would have been more appropriate and may have led to a better outcome for Nigel. As each agency had different pieces of information which would have formed a more comprehensive picture on how Nigel was managing and engaging with services.

A case study has been produced and details what each agency knew about Nigel individually, in chronological order, and how they responded in order to demonstrate what a multi-agency approach would have possibly identified. Please take the time to consider this case and reflect. Are there any individuals that that may benefit from a multi-agency response/discussion?

The case study can be Found **here.**

Henry – Safeguarding Adult Review
Henry lived alone, he used to be the main carer for his mother and sister, both had passed away. Henry's neighbour Iris contacted all agencies who knew Henry, to share her concerns about Henry's ability to look after himself. The following lessons where identified in agencies response to Iris's concerns:

- Henry's case was closed by Social Care practitioners incorrectly
- A Multi-agency approach to supporting Henry to manage risks to was not considered
- The risk of fire identified at Henry's home was not considered as a risk to others and appropriate action was not taken
- There was no consistency with the professionals who were visiting Henry, or consideration of advocacy
- The risks around possible financial abuse was not identified by the professionals visiting Henry

The Practice Learning Note can be found **here**.

Graham – Safeguarding Adult Review
Graham had care and support needs and was assessed as lacking capacity in regard to his needs. Graham lived at home with his wife Ava and they were struggling to cope at home. Opportunities to raise safeguarding concerns were missed and Graham continued to be supported under the care management pathway. Graham was admitted to hospital with pneumonia, sepsis and 4 pressure sores, he passed away shortly after admission.

The SAR identified learning in regards Making Safeguarding Personal, Advocacy, Safeguarding Procedures, Mental Capacity Act and Professional Curiosity and Challenge. The SAR and Practice Learning Note can be found **here.**