Safeguarding Adults Review (SAR)

Vihad

Commissioned by
West of Berkshire Safeguarding Adult Board

Reviewers: Peter Suggett

Endorsed by the West of Berkshire Safeguarding Adult Board – February 2025

1	Introduction and Background
1.1	Section 44 of the Care Act 2014 places a statutory responsibility on Safeguarding Adult Boards' (SAB) to conduct a Safeguarding Adult Review (SAR) into certain cases under certain circumstances. A SAB is required to arrange a Review where there is reasonable cause for concern about how the SAB, and its members or some other person with relevant functions involved in the case worked together and, either the adult at risk died and the SAB knows or suspects that the death resulted from abuse or neglect. Or, the adult is alive, and the SAB knows or suspects that they experienced serious abuse or neglect.
1.2	The West of Berkshire Safeguarding Adult Board has accepted the request for a Safeguarding Adult Review (SAR) to be conducted into the circumstances surrounding the death of Vihad. Vihad had been struck by a vehicle having recently been discharged from a hospital. At the time of his death, he was in his mid-fifties.
1.3	The SAR panel agreed that the situation met the Care Act Safeguarding criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk.
2	The purpose of the review
2.1	• Establish what lessons can be learned from the circumstances of the case • Review the effectiveness of the procedures and processes of the agencies involved • Analyse how organisations work together • Analyse and expand upon the findings of the various reports • Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes or policy • Facilitate a practitioner's event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented
2.2	This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of Vihad whilst he was receiving treatment in the months and weeks prior to his death.
2.4	Finally, the SAR will consider, based upon responses from the organisations involved, if there are gaps in the service delivery for adults which can be identified from this case.
2.5	Partner reports were received from each of the organisations involved, a template was provided which included the following details: • Full chronology

	• A narrative of service involvement over a four-year period. • A description of the specific service provided to Vihad between those dates. • Any significant factors which impacted upon the actions or decisions taken. • An evaluation of how services were delivered to Vihad. • Lessons learned including a judgement of the level of service received when compared against policy, procedure and practice standard. • Recommendations for action.
3	Methodology and process information
3.1	The author was appointed to undertake the SAR in June 2024.
3.2	A combined chronology was supplied to the author from the agencies involved including: • Out of area Health Care Trust • Out of area GP Practice • Out of area Local Authority, Adult Social Care • Out of area Police Force • Thames Valley Police • Berkshire Healthcare NHS Foundation Trust – Learning Disability Team, Crisis resolution home treatment team, common point of entry • GP, Chatham Street Surgery • South Central Ambulance Service • Reading Borough Council, Adult Social Care and Common Point of Entry • Royal Berkshire NHS Foundation Trust
3.3	The family of Vihad were contacted by the SAB board manager who notified them that a review was being undertaken and that an independent author had been appointed. They were asked if they wished to meet with the author, however at the time of writing this report they had declined that offer.
3.4	Following the initial review of all the information, a number of themes were identified that the author considered were key elements of the care Vihad received prior to his death. These fell into the following categories: • Management oversight • Understanding of risk • Information sharing • Use of risk management pathways • Cultures • Does the current safeguarding system support practitioners to consider cases holistically?
3.5	The author met with the safeguarding leads for Reading Borough Council (RBC) as well as Berkshire Healthcare Foundation Trust (BHFT). This allowed the author to clarify how partnership working

	was undertaken within the community and foundation trust setting, as well as discussing the safeguarding issues in this particular case.
3.6	A practitioner learning event was held in September 2024. This event involved front line staff and was facilitated by the report author. In order to allow the maximum number of staff to participate in the event it was run via Microsoft Teams.
3.7	It was made clear at the outset of the learning event that it was to be conducted in an environment where staff would feel free to express themselves, without fear of being blamed for any apparent failings. The intention was to learn from the circumstances of Vihad's care and treatment in order to identify those elements that worked well and highlight areas that required further improvement.
3.8	The combined chronology and an explanatory letter were circulated to all participants prior to the event so that everyone was clear about the aims and objectives of the session.
3.9	The event involved a summary of the timeline of events leading up to Mr Vihad's death, followed by a series of questions which the participants were asked to comment upon relating to the six themes previously identified.
3.10	Delegates were asked to consider the circumstances of Vihad's death and, when thinking about a particular categories, consider: • What went well? • Even better if … • How to improve learning
3.11	There was excellent participation from all candidates during the session and a number of key issues were highlighted and discussed. These are described in more detail within the body of this report.
4	Background
4.1	The chronologies provided by key agencies detail Vihad's history going back four years prior to his death. What can be seen from the information available is that he had well documented mental health issues, which included being diagnosed with a learning disability and mental health concerns.
4.2	In order to better understand the interactions between the various agencies and departments involved in the care of Vihad, a combined chronology was produced. This provides a timeline of events and describes the contact and care that took place prior to his death. Some of key entries are summarised below.
4.3	In **April 2020** Reading Borough Council (RBC) were made aware that Vihad had moved to the Reading area, having previously lived in a supported living placement out of area. Thames Valley Police (TVP) informed them that Vihad had moved to his cousin's address. This was apparently in breach of a current Sexual Harm Prevention Order (SHPO), which forbade him from living at any address where children were present.
4.4	Just prior to moving to Reading, the out of area Supported Housing provider had reported Vihad as being a missing person. He was eventually located by police in London and was collected by his

	cousin and taken back to an address in Reading. This was contrary to the terms of his SHPO.
4.5	He was eventually returned to his home which was out of area, however by **May 2020** Vihad had moved permanently to Reading.
4.6	In **May 2020** Adult social care made contact with Vihad to undertake a needs assessment. At this time the Covid 19 lockdown was in effect and as such working practices had been adapted to take into account the restrictions.
4.7	There are then several instances recorded in the chronology when Vihad is reported as a missing person. He is subsequently found in various locations including Wales and London and on the hard shoulder of a motorway as well as a railway track.
4.9	In **August 2020** an Assessment of Needs (Care act 2014) was completed by a RBC social worker. It was assessed that care was being provided by Vihad's cousin.
4.10	**November 2020** referral made by social worker to BHFT Community Team for People with Learning Disabilities (CTPLD). The RBC social worker has received information from out of area agencies, but this is not requested by CTPLD.
4.11	**November 2020** Assessment of needs completed, no care and support plan arranged, referral to community resources for social and day activities.
4.12	During this time Vihad presented himself at Royal Berkshire Hospital on several occasions. A referral had been made by the RBC social worker to BHFT psychology services and Vihad was on a waiting list to be assessed. Requests continue to be made to out of area Learning Disabilities team for further information about Vihad's previous history.
4.13	Requests are made by the BHFT Psychology team for previous notes in preparation for Vihad's forthcoming initial assessment meeting.
4.14	**August 2021** Vihad presented himself to Prospect Park Hospital and was subsequently seen at home on the same day by a member of the crisis team.
4.15	**August 2021** contact between CTPLD and out of area Learning Disabilities team during which background and history of Vihad is discussed. He had been assessed as having a moderate learning disability and was identified as being at risk of others taking advantage of him.
4.16	**September 2021** no further information had been received from out of area Learning Disabilities team and as a result the referral to BHFT Psychology team in was closed due to lack of supporting evidence.
4.17	Numerous missing person reports are recorded during this period which generate a safeguarding enquiry. This results in Vihad being supplied with a GPS tracker; however, the family decline a carer's assessment.
4.18	**January 2022** Reported missing, a GPS tracker he had been given had apparently run out of battery. Vihad was located eight days later having been admitted to hospital in outer London. A vulnerability

	risk assessment completed and passed to Adult Social Care. Vihad's cousin asked for a support worker to help.
4.19	**January 2022** urgent referral from GP to BHFT Common Point of Entry (CPE) team for further review as Vihad was considered to be at risk. Contact was made by CPE team with cousin and previous care out of area was discussed. At this time no further information had been received from the out of area agencies. A telephone assessment was subsequently undertaken with Vihad and his cousin. The assessment concluded that CTPLD would be the more appropriate pathway. A referral was submitted.
4.20	**March 2022** A home visit was undertaken by an RBC social worker. Vihad appeared isolated and the social worker concluded that he needed activities to engage him during the day. The social worker identified that he required a care package as he appeared unclean and had no food in the house.
4.21	**March 2022** Vihad did not appear for his psychiatric assessment.
4.22	**May 2022** TVP report to RBC Adult Social Care that Vihad had left the country in contravention of his SHPO.
4.23	**June 2022** Vihad was offered a trial place at two-day centres. No place was subsequently offered to him because he failed to engage during the visit and his cousin was late to collect him.
4.24	**June 2022** Vihad was found by police walking on hard shoulder of a Motorway. A vulnerable adult report was submitted by an out of area police force. The case was discussed as part of the Reading CTPLD Multi-Disciplinary Team (MDT) meeting and an urgent psychiatric assessment was arranged.
4.25	**July 2022** A psychiatric assessment was conducted, and a review of presenting needs and risks was completed. As a result, his medication was changed. Risks regarding travelling and getting lost as well as walking on train tracks were identified. However, there is no evidence that a plan was devised regarding how these risks were to be mitigated.
4.26	Between **July 2022** and **October 2022** there were a total of seven (7) missing person reports recorded. The length of time that Vihad was missing varied from a few hours up to seven days. The places he was eventually located were Northamptonshire, Staffordshire, Hertfordshire, Essex, London. On some occasions the GPS tracker was helpful in helping to locate him.
4.27	**October 2022** concerns were raised by the GP in a letter to CTPLD about the risks to Vihad travelling by train and presenting at emergency care. The GP requests psychiatric advice regarding possible treatment.
4.28	**November 2022** Vihad was found in London, he alleged that he had been assaulted by his cousin. He was returned to Reading by police, subsequently withdrew the assault allegation and was returned home. A safeguarding concern was raised and a S42 enquiry completed and referral for an Advocate made. A Public Protection officer was tasked with monitoring for signs of abuse.

4.29	Vihad continues to regularly be reported as missing as well as presenting at A&E complaining of abdominal pains.
4.30	**December 2022** Mental Capacity Assess and Assessment of Needs undertaken. Vihad was assessed not to have capacity on the question of where he would live, he expressed a preference to live with his family in Reading and this appeared to be the outcome that was reached without a best interest decision recorded. He continues to regularly present himself at A&E departments.
4.32	**August 2023** Psychiatric outpatients' appointment. Vihad was identified as being at high risk of absconding and it was recommended that a travel and financial assessment be completed by Occupational Therapy so that a support plan could be devised. Assessment completed by CTPLD and support provided by a RBC Social Worker.
4.33	**September 2023** Vihad was found in Midlands by British Transport Police (BTP) confused and with no money. He was returned home by BTP. A safeguarding concern was raised but does not appear to have been processed through the correct pathway.
4.34	**September 2023** Vihad's case was discussed at CTPLD MDT and it was agreed that a referral would be made to Occupational Therapy (OT) and the learning disability nurse. OT to conduct a travel and financial assessment. The social worker states that there is a lack of engagement from Vihad and his cousin.
4.35	**September 2023** Vihad's cousin contacted RBC Adult Social care and informed them that he could no longer cope with looking after his cousin. He requested that his cousin be considered for a placement in supported living
4.36	**September 2023** Vihad was arrested at Heathrow airport for breach of security having been found trying to tailgate passengers to get through security. Upon his arrest he claimed that he hears voices telling him to travel.
4.37	**September 2023** his case was discussed at CTPLD MDT as the risks with his wandering had increased. Vihad's cousin is no longer able to provide the necessary support and requests a supported living placement. The fact that Vihad has a current SHPO appears to complicate the provision of a placement. The social worker is to progress; however, the service is still awaiting full records from out of area agencies.
4.38	**September 2023** email from Psychiatry identifying increased risks and suggests that a better assessment could be conducted if Vihad was admitted to a ward as in in patient
4.39	**October 2023** Home Visit by RBC Social Worker and colleague. Concerns are expressed about Vihad's mental state and risks identified and escalated through Approved Mental Health Professional (AMHP)service, Public Protection Unit (PPU), CTPLD and psychiatry. Vihad's cousin alleged that Vihad had strangled him a number of times, frequently refused entry to the address and he had

	concerns regarding a group of young Asian men apparently using the home and dealing drugs.
4.40	**October 2023** MDT was held to assess the ongoing risk to Vihad. An action plan is devised which includes Care Act and Mental Capacity Act assessments, drug testing and home visits.
4.41	**November 2023** CTPLD MDT held as the Heathrow airport court case has been discontinued. There was a discussion around referring Vihad to FIND and Change Grow Live charities. An Email had been received from out of area agency outlining the process for obtaining Vihad's psychiatric records.
4.42	**October 2023** Vihad's allocated social worker applied for funding for three home visits a day as well as funds for meals. This had not been actioned at the time of his death.
4.43	**October 2023** CTPLD MDT held to discuss the action plan. FIND referral was declined as it was considered to not be appropriate. A Care Act assessment was to be undertaken by the RBC social worker. Several attempts were then made to visit Vihad at home, but he was not present when the social worker attended. There was no answer on the phone from either Vihad or his cousin.
4.44	**December 2023** Call from neighbour concerned about Vihad's welfare and states that he often to be seen outside his address in the cold. He frequently climbs in through the window to gain entry
4.45	**December 2023** An allegation of assault was made by Vihad's cousin against Vihad however, he would not support a police investigation.
4.46	**January 2024** CTPLD MDT held as a neighbour had raised concerns of neglect.
4.47	**January 2024** Vihad is reported missing by his cousin.
4.48	**January 2024** Vihad was discharged from a hospital outside of Berkshire but was struck by a vehicle shortly afterwards. He sadly died of his injuries.
5	Summary of events and findings
5.1	Having reviewed the chronologies, what is clearly apparent is that there appeared to be big gaps in the information provided about Vihad once he had moved to Reading from another area. Whilst the author would have expected to have seen a clearly defined handover from one authority to another, including a structured meeting and transfer of notes, this did not take place. Right up until his death there are entries within the computer records where professionals are still requesting information from out of area psychiatric and social care departments.
5.2	In addition, there appear to be other factors which may have impacted upon the smooth transfer. It became clear during this review that the implementation of Covid restrictions may have adversely affected service delivery. Vihad moved to the Reading area right at the start of the pandemic when restrictions were at their most severe. There are also notes within his file's indicating that communication with Vihad and his cousin was often challenging.

5.3	Within the review material there are examples of good work taking place to help and support Vihad, from a number of different agencies. This activity occurs every day and is undoubtedly successful with the majority of patients. Clearly, the rate of success is greater when the patient is co-operative and a good communicator but is less effective when they are not as receptive to the offers of support. This then makes the situation more challenging for the professionals involved.
5.4	From both the laypersons and professionals' perspective an obvious question to ask would be, who is co-ordinating and leading all of this activity? Health and Social Care services have a responsibility to ensure that adequate care and support is provided to patients and that these services are properly co-ordinated. On the whole this system works well, however, it only requires one small breakdown in communication, or a lack of grip and a vulnerable person could easily fall through the net. This appears to be what happened with Vihad.
5.5	A summary of findings for each of the key themes identified is outlined below.
5.6	**Information sharing**
5.7	What became apparent during this review is the fact that there is no single department that co-ordinates the system of partnership/multi agency working. The system is reliant upon community based staff passing on referrals to the right service, who then implement their activity. If this is not done correctly there is the risk that the service is unaware that they need to provide care/support to a patient within their area. This can lead to vulnerable patients lacking the necessary support.
5.8	One of the complicating factors in this case was that Vihad moved from out of area to Reading. The ideal scenario in those circumstances would be that there was a full handover from out of area agencies to Reading including a meeting between professionals and the supply of patient notes. This ensures that there is a smooth, efficient transition and would have meant that Reading professionals were fully conversant with the Vihad's history. For some inexplicable reason this did not occur in this case. Throughout the chronology there are references to professionals continually making contact with out of area services in an attempt to obtain Vihad's patient notes, unfortunately without success.
5.9	Within the practitioner learning event a member of staff stated that they felt like out of area agencies were relieved to be 'rid of him'. The author has not been provided with any explanation as why this handover of patient record took so long (3 years) however, it is clear that this undoubtedly hampered the efforts of RBC Adult Social Care and BHFT Psychiatric services to fully assess Vihad's needs. There is an entry within the chronology from BHFT psychiatric services cancelling an assessment of Vihad's psychiatric condition due to a lack of information being forthcoming.
5.10	Sec 7 of the care act outlines what a handover from one area to another should look like. Clearly if professionals are not in possession of all the facts, then their ability to care for and treat

	patients is diminished. Equally, their ability to undertake full risk assessments or ensure that people are properly safeguarded is inhibited. However, despite the lack of handover, clinicians needed to respond to the ongoing risks they were presented with.
5.11	Additionally, there were comments made by staff from RBC Adult Social Care about a perceived lack of information provided by Thames Valley Police (TVP) in relation to the numerous instances when Vihad had gone missing. Staff described an informal process whereby they would contact a named single point of contact (SPOC) within TVP to obtain further details about a missing person. If that SPOC was off, they stated there was no other formal way of getting further information until the SPOC returned to work.
5.12	The viewpoint expressed by staff appears to be at odds with the recognised systems in place to support staff dealing with vulnerable missing people namely, Multi Agency Safeguarding Hub (MASH) and Missing Investigation Support Team (MIST). Both teams have a role in helping and supporting professionals obtain information from outside partners (Police, prison probation etc.). The fact that staff who attended the learning event had no knowledge of their function clearly demonstrates a need to update guidance given to staff and further promote the role of these teams to professionals.
5.13	The ideal solution would involve a computerised system whereby professional, internally and externally, could share information about vulnerable people which could be accessed from a single portal. However, it is accepted that this would ultimately be constrained by budgetary considerations.
5.14	**Management Oversight**
5.15	The level of supervision and support given to staff should be commensurate with the type of work being undertaken when considered against the experience and quality of the staff involved.
5.15	A very good post incident chronology was completed, which outlined and assessed the contact between Vihad and professionals prior to his death. The chronology identified that there had been some good multi agency working that had taken place, but also that there were some missed opportunities to engage. It was observed that time constraints and staffing levels also have an impact upon the quality of care provided.
5.16	Practitioners from RBC shared at the learning event that the level of staffing was at a low level and had been for some time. When asked about the level of support and supervision they received they stated that in fact this had improved during the Covid lockdown as managers utilised online programmes (MS Teams) to stay in contact with staff.
5.17	However, it was mentioned by RBC staff that during the period under review there was a perception that managers were 'managing' but not 'leading'. Staff cited a lack of supervision and what they described as a 'continual cycle of change 'as resulting in a lack of continuity within team structures. This was allied with poor leadership.

5.18	In addition, some of the restructuring in RBC had rationalised and combined separate teams and staff felt that this resulted in a loss of expertise, with staff moving on or being lost during the re-structuring.
5.19	A lack of clear leadership and support for staff will undoubtedly impact upon the moral of teams, which in turn impacts the quality of work undertaken. With increased workloads there is clearly a risk that the quality of care provided by professionals will be reduced as they become more task orientated due to the increased pressures they are faced with. Undoubtedly the need for good management and leadership becomes more pressing when faced with these circumstances.
5.20	On a positive note, the staff interviewed did state that the recent changes to the RBC's structure had produced better lines of management and supervision. They felt more confident that they were being better supported by permanent middle management and were reassured that there was now a Principal Social worker in place.
5.21	**Understanding of risk and use of risk management pathways**
5.22	It was highlighted during the practitioner learning event that during the period under review, staffing levels amongst the RBC teams was often at a low level.
5.23	The risk that arises when staffing levels are low is that staff can become *"task orientated"* in that they were too intent upon satisfying the care plan for individual patients and were not holistic enough in their approach. In essence the working practice becomes *"complete the care plan objectives*" and then move onto the next patient? This is undoubtedly a risk when there are insufficient staff who are faced with a large workload.
5.24	As has previously been stated, the handover of Vihad's care from out of area agencies to Reading was poor. This meant that the staff who were undertaking needs assessments and psychiatric assessments of Vihad were doing so without being in possession of his full history or all of the facts. His case was not straightforward, as he was the subject of a SHPO which limited his placement options and impacted upon the day care he could receive. His case was described by one professional as 'not being unusual', however when you included the complication of his offender history, propensity to go off roaming, covid restrictions, day care services being closed and poor communication between professionals and Vihad and his family, it feels like it was a perfect storm of factors.
5.25	The initial review highlighted that there appeared to be no reference within Vihad's records that his case had ever been discussed during supervision, or that senior managers were aware of the complex case. He is however the subject of several Multi-disciplinary Team (MDT) meetings.
5.26	Safeguarding concerns are mentioned on a number of occasions, including a reference to 'cuckooing' within the chronology however, there does not seem to be any evidence to suggest that these were escalated or acted upon by professionals. The author would expect to

	see that entries within records of this type would trigger some sort of formalised response, but this not appear to have happened until towards the latter part of 2023.
5.27	Assessments of Vihad's capacity were undertaken at various stages as a result of his interactions with professionals. In addition, there are entries that confirm that Care Act assessment of needs was also completed by social workers.
5.28	The question that then arises is did he have the capacity to make decisions about his care and treatment? Were staff fully aware of all the circumstances of his case, including him regularly going missing and his numerous appearances at the A&E department. On various occasions he was assessed as NOT having capacity but there does not appear to be a subsequent best interest record to address his care needs and in the absence of this, professionals have not followed the MCA.
5.29	Perhaps then the matter to be addressed should be; if the system of assessment, referrals and interventions is acceptable for the vast majority of patients, what should be done when professionals are faced with a case that is particularly challenging and falls outside the realms of what might be considered to be 'usual'?
5.30	It would seem appropriate that in these instances a formal MCA assessment be conducted and there are entries to support the fact that these were in fact undertaken. However, as was noted within the chronology there is no evidence to suggest this resulted in a meaningful increase in the risk assessment around Vihad's welfare or that matters were escalated appropriately.
5.31	For reference the author examined the NICE guidelines regarding mental capacity, which provide a clear pathway of assessment. There is clear guidance that this should be an on-going process, not purely confined to the initial assessment of a client / patient.
5.32	In addition, safeguarding policies for adults at risk are available to all practitioners through their own agency and through the Reading Safeguarding Adults Board policies and procedures.
5.33	There does not appear to have been a safeguarding plan documented within the information supplied as part of this review. Having identified that Vihad's behaviour was increasing in risk there does not appear to be a formalised plan as to how those risks are to be mitigated.
5.34	**Cultures**
5.35	During the practitioner learning event several RBC staff stated that the continual change to team structures was unsettling and impacted upon their ability to provide a quality service.
5.36	When discussing the changes, RBC staff accepted that there was always a need to provide the best service possible with limited resources, however they felt that in the past senior leaders had not been honest with them about what was driving the necessity to re-structure Adult Social Care teams and departments. They had been informed that the motivation for the re-structuring was the need for

	service improvements, however they felt that it was actually budgetary considerations that were driving the changes, and that service improvement was a secondary factor.
5.37	This apparent lack of clarity and honesty led one staff member to state that there appeared to be some 'murky decision making' round the issue of the RBC re-structures. There was a perception that changes were enforced upon the RBC Adult Social Care teams with little or no consultation with staff.
5.38	RBC staff felt that the continual re-structuring had eroded the knowledge and skills from their teams and had made them less effective. They felt that they were continually being asked to 'do more with less' and that their workloads had increased as a result. Because of this the quality of care and support they were able to give to clients / patients had reduced and as a result many of them felt demoralised.
5.39	Within the timeframe of this review there was also the factor of the Covid restrictions. Vihad moved to the Reading area right at the start of the Covid breakout, when the initial restrictions were at their most severe. Consequently, professional teams were forced to adopt new working conditions. These necessary working restrictions undoubtedly impacted upon the service provided.
5.40	**Does our safeguarding system support practitioners to consider cases holistically?**
5.41	Systems and processes were in place for supervision and management oversight, however if staff working with Vihad did not recognise the holistic concerns around his risky behaviour then they may not necessarily escalate matters or recognise the need for supervision.
5.42	The system of supervision and support is so important to provide reassurance to staff and to ensure that action is taken which is in the best interest of the patient.
5.43	A high turnover of staff can result in teams becoming less experienced. A consequence of this is that some members of staff may lack the knowledge, experience and confidence to escalate matters in the correct manner when faced with an increase in risk to the patient / client. There are instances recorded within the chronology whereby a needs or risk assessment has been conducted and yet there is no plan documented to shown how those risks are to be mitigated.
5.44	Easy access to information and assessment tools is vital as part of the ongoing support given to staff within all agencies working with adults at risk. This helps them maintain their professional knowledge and understanding of complex safeguarding issues.
5.45	However, the questions that arise from this are; how many of the staff involved with Vihad know where to find this information? If staffing levels are very low, do they have time to access and learn the information?
5.46	Since the death of Vihad the RBC Adult Social Care have ensured that supervisors are more readily contactable. Regular weekly and monthly supervision meetings are held which was commented upon

	by staff at the learning event as being one of the positive things to come out of the Covid restrictions.
5.47	Since this time the accessibility of information in RBC has improved, and safeguarding and risk management policies are readily available on the internal intranet.
6	**Conclusions**
6.1	There were several good learning points highlighted within the chronologies. These included attempts by social workers and occupational therapy teams to engage with Vihad to help support him and raise his awareness around the risks of wandering. The appointment of an advocate was a positive step, although the extent of the contact they had with the family is not known.
6.2	Within RBC there is a Multi-Agency Risk Panel which is led at a senior level. This provides staff with an opportunity to raise any concerns they may have, particularly if they feel that there is an issue for which they need guidance and support. There are no records within the files that indicate that Vihad's case was suitable to be dealt with by the high-risk panel.
6.3	There is clearly a need to maintain good communication between different services and agencies. Within the Practitioner Learning Event, it was apparent that a number of staff present were frustrated with their inability to obtain further information from out of area agencies, who had been Vihad's previous care provider. They stated that this had become an ongoing issue which they had been unable to resolve, and which hampered their attempts to provide the comprehensive holistic care they wanted to deliver to Vihad.
6.4	The length of the delay to obtaining the information (circa three years) seems inexplicable and should have been escalated to a more senior level to be resolved. Staff were not in possession of all the facts relating to Vihad's history and consequently were hampered at the outset regarding his mental condition and unable to complete full and comprehensive risk assessments.
6.5	Whilst the remit of this review was not intended to include any input from the out of area agencies, the author feels that the lack of information supplied to services in Reading undoubtedly impacted upon the service provided.
6.6	In addition, Vihad had the misfortune to move to a new area right at the outset of the covid pandemic. Professionals and managers were reassuring during conversations with the author about the limited impact the pandemic had to services and stated that they tried as much as they could to continue with 'business as usual'. Having heard about the adaptations that were required to operate during the pandemic (e.g. telephone consultations rather than personal visits) the conclusion of this report is that those factors undoubtedly impacted upon service delivery.
6.7	During the period under review there did not appear to be a cohesive approach to care planning within the community setting. There is no indication with the records reviewed of any one agency taking the

	lead in terms of co-ordinating the care given to Vihad. There does not appear to be a clear decision-making pathway or an individual or agency who took a grip of the situation. If there had been it would undoubtedly have been a great assistance to professionals who were trying to co-ordinate the care and support for Vihad.
6.8	The author has been made aware that a system called Connected Care was used by BHFT and RBC during the period under review. This enables access to joined-up care records providing a view of a patient's health and care history, current and past medications and a summary of previous events and episodes of care, as well as discharge summaries and clinic letters. However, there was no mention of this system within the information supplied to the author, or during the practitioner learning event, which suggested that it was not widely accessed.
6.9	There are several limitations with the system (information may not be live), however if it had been appropriately utilised at the time of Vihad's death it may have assisted professionals with their risk assessments and subsequent decision making.
6.10	Within the scope of this review, it has not been possible to ascertain why there was a delay in out of area agencies supplying vital information to the Reading authorities. The SAB may conclude that they want to pass this report onto the out of area safeguarding adults board for their information.
7	**Recommendations**
7.1	**Reading Borough Council should review the current structure of its adult social care community teams to establish if they are correctly staffed and resourced to meet the growing demands placed upon the service.** Low staffing levels adversely impact upon the care and support that professionals were able to provide to Vihad. RBC Adult Social Care services were '*understaffed'* during the period reviewed and this situation still appears to continue today. Poor staffing levels appear to have contributed to the staff who cared for Vihad taking a task orientated approach to his care and as a result they failed to recognise the wider context of his risky behaviour. It is recognised that recruitment and retention of staff is a national issue and that RBC is working to establish integrated community teams, which are aimed to improve staffing levels and service delivery.
7.2	**The importance of Risk Assessments when dealing with vulnerable patients should be emphasised to staff as a priority. The escalation policies and the availability of online toolkits (safeguarding, non-engagement) and other resources to assist the risk management process should also be highlighted.** This will help inform staff and assist them when completing their risk assessments regarding this type of behaviour. This should also highlight the interface for ongoing MCA assessment of patients, particularly in relation to decisions that will be time and decision specific, if it is suspected that there may be some form of impairment.

	The SAB should ensure that all toolkits are easily accessible, relevant and kept up to date.
7.3	**West of Berkshire Safeguarding Adults Board, through the development of their prevention strategy, should promote the importance of holding multi-agency meetings to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to vulnerable adults.** Referral pathways to High-Risk panels should be shared with all the agencies involved and should include all contact details to use when raising a safeguarding alert. Where risk is considered to be unmanageable, agencies should consider escalation options with Safeguarding leads. Measures should be put in place to ensure that cases where self-neglect is suspected are referred to social care prior to the discharge of a person from hospital. The author acknowledges that there is an safeguarding escalation policy and guidance for multi agency working in place and is available on the SAB website, but would recommend reviewing/relaunch and test impact.
7.4	**Berkshire Safeguarding Adults Board to commission a multiagency table top review for key agencies to probe Thames Valley Police's processes around the MASH, MIST and information sharing in relation to adults**. This will include (but not be limited to) areas around initial responses, information sharing, strategy meetings/discussions and support of vulnerable victims/witnesses of abuse or neglect. Enhanced partnership working will ensure a more holistic view is taken to complex safeguarding concerns and this approach will result in better outcomes. This would re-enforce to staff that they are able to obtain up to date and current information from police in situations where vulnerable patients / clients have come into contact or been dealt with by police. Police often hold important information about individuals that would be beneficial to other professionals when undertaking risk assessments. The re-emphasis of this function would greatly improve information sharing between the different partners. The table top exercise would highlight potential gaps for partners for TVP to then improve on, and update the board.
7.6	**Ensure that carers needs in relation to Severe Multiple Disadvantage are recognised as part of the assessment and whole family process utilising a multidisciplinary approach to support people within this group and prevent high risk behaviours. Improve data recording to determine the impact of this area on carers and inform future service and support planning.** If risk factors are shown as being elevated in any of the sections of the carers assessment, then the form should be used to allow the assessor to justify their evaluation and explain how they intend to mitigate / manage the risks identified.

Safeguarding Case Review Multi Agency Action Plan Vihad SAR							
BRAG STATUS KEY		**Blue**	**Red**		**Amber**		**Green**
		Action Embedded	Action not being implemented or serious delays/concerns identified or Action being implemented but with possible delays/concerns		Action being implemented and on track for completion within timescales		Action Completed
Dates discussed		Endorsed by SAB 13/2/25.					
No	**Recommendations**	**ACTION REQUIRED**	**BY WHEN**	**LEAD Agencies OFFICER(S)**	**OUTCOME TO BE ACHIEVED**	**BRAG STATUS**	**ACTIONS COMPLETED WITH EVIDENCE**
1	**Reading Borough Council should review the current structure of its adult social care community teams to establish if they are correctly staffed and resourced to meet the growing demands placed upon the service.** Low staffing levels adversely impact upon the care and support that professionals were able to provide to Vihad. RBC Adult Social Care services were '*understaffed*' during the period reviewed and this situation still appears to continue today. Poor staffing levels appear to have contributed to the staff who cared for Vihad taking a task	RBC DASS to present to the SAB the outcome of its Adult Social Care restructure including a structure chart detailing vacancies and lines of governance. The presentation will include a statement from the DASS as to whether the staffing levels can adequately meet the demand of adult social care implemented since Vihad.	March 2025	DASS Reading Borough Council	To provide assurance to the SAB that the staffing issues identified by this SAR have been addressed.		

	orientated approach to his care and as a result they failed to recognise the wider context of his risky behaviour. It is recognised that recruitment and retention of staff is a national issue and that RBC is working to establish integrated community teams, which are aimed to improve staffing levels and service delivery.						
2	**The importance of Risk Assessments when dealing with vulnerable patients should be emphasised to staff as a priority. The escalation policies and the availability of online toolkits (safeguarding, non-engagement) and other resources to assist the risk management process should also be highlighted.** This will help inform staff and assist them when completing their risk assessments regarding this type of behaviour. This should also highlight the interface for ongoing MCA assessment of patients, particularly in relation to decisions that will be time and decision specific, if it is suspected that there may be some	• Analysis of the training offer across the partnership and the impact BHFT's new approach to Risk Management. • Partnership survey to identify the gaps in the system which negatively impacts on the effectiveness of Risk Management. • Audit on Risk Management practice across statutory partners.	September 2025	SAB	Embed a good understanding of appropriate and effective risk management practice within our partnership.		

	form of impairment. The SAB should ensure that all toolkits are easily accessible, relevant and kept up to date.						
3	**West of Berkshire Safeguarding Adults Board, through the development of their prevention strategy, should promote the importance of holding multi-agency meetings to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to vulnerable adults.** Referral pathways to High-Risk panels should be shared with all the agencies involved and should include all contact details to use when raising a safeguarding alert. Where risk is considered to be unmanageable, agencies should consider escalation options with Safeguarding leads. Measures should be put in place to ensure that cases where self-neglect is suspected are referred to social care prior to the discharge of a person from hospital.	Review, relaunch, schedule regular reviews and test effectiveness of: SAB's Escalation process: Resolving-Professional-Disagreements-in-cases-that-meet-the-statutory-criteria-for-Safeguarding-Adults-V.2.1.pdf Pathways for Multi-agency Planning – including high risk panels updated to ensure clear links to all panels.	June 2025	Task and Finish Group	With the engagement of all SAB Partners to produce up to date effective processes for escalation and multi-agency working by building on the tools already available and ensuring that there is knowledge of these toolkits within the partnership.		

4	**Berkshire Safeguarding Adults Board to commission a multiagency table top review for key agencies to probe Thames Valley Police's processes around the MASH, MIST and information sharing in relation to adults**. This will include (but not be limited to) areas around initial responses, information sharing, strategy meetings/discussions and support of vulnerable victims/witnesses of abuse or neglect. Enhanced partnership working will ensure a more holistic view is taken to complex safeguarding concerns and this approach will result in better outcomes. This would re-enforce to staff that they are able to obtain up to date and current information from police in situations where vulnerable patients / clients have come into contact or been dealt with by police. Police often hold important information about individuals that would be beneficial to other professionals when undertaking risk assessments. The re-emphasis of this function would greatly improve information sharing	SAB to agree plan for review, progress will be monitored by the SAB.	March 2025 (start date)	West of Berkshire Safeguarding Adults Partnership Board	The review to identify solutions to improve multi-agency safeguarding practice.		

	between the different partners. The table top exercise would highlight potential gaps for partners for TVP to then improve on, and update the board.						
6	**Ensure that carers needs in relation to Severe Multiple Disadvantage are recognised as part of the assessment and whole family process utilising a multidisciplinary approach to support people within this group and prevent high risk behaviours. Improve data recording to determine the impact of this area on carers and inform future service and support planning.** If risk factors are shown as being elevated in any of the sections of the carers assessment, then the form should be used to allow the assessor to justify their evaluation and explain how they intend to mitigate / manage the risks identified.	Post publication of the SAR the SAB will analysis a sample of care act assessments to test if carers needs are adequately addressed across the partnership. SAB's S42 audit tool will look at the consideration of carers needs within safeguarding enquiries. Data on carers assessments to be captured on the SAB's Dashboard.	Dec 2025	Scrutiny and Impact Subgroup	Assurance that learning from SAR has been embedded and opportunities for further improvement are identified.		