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safeguarding adults

Prevention

Welcome to:

How Safeguarding Adults Reviews Can Help Prevent Further Abuse

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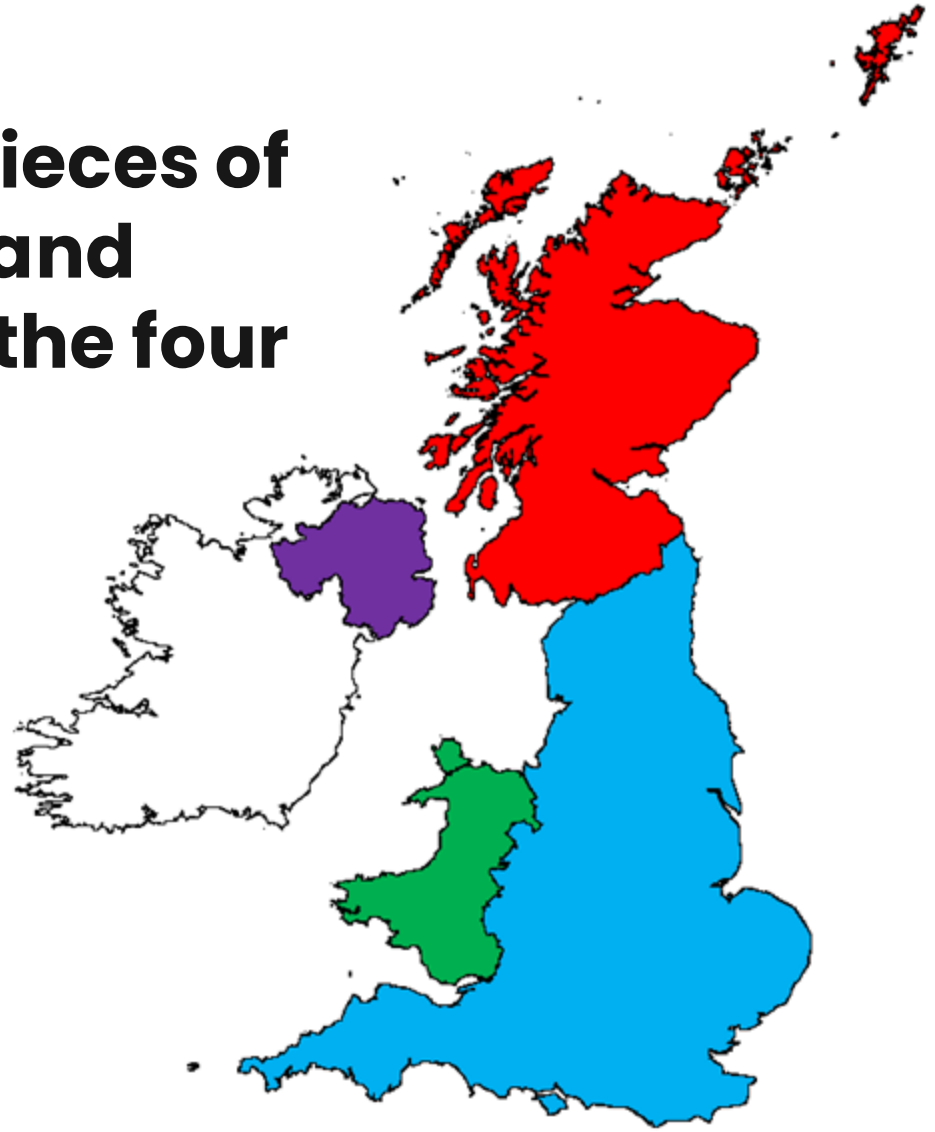
Four Different Nations

There are different pieces of relevant legislation and practices in each of the four home nations :

England
Wales
Scotland
Northern Ireland



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England

Safeguarding Adults Reviews (SARs) were introduced in section 44 of the Care Act 2014 and are conducted by Local Safeguarding Adults Partnership Boards (LSAPBs). Previously these reviews were called Serious Case Reviews (SCRs).

Wales

Adult Practice Reviews (APRs) are conducted in Wales, and Safeguarding Adults Boards were established under section 134 of the Social Services and Wellbeing (Wales) Act 2014.

Scotland

Significant Case Reviews (SCRs) are held in Scotland and Adult Protection Committees (APCs) were introduced by Section 42 of the Adult Support and Protection (Scotland) Act 2007.

Northern Ireland

Adult Serious Case Reviews (SCRs) are held. However, no specific legislation covers adult safeguarding, there is a need to interpret the 2015 policy 'Adult safeguarding prevention and protection in partnership', although the Safeguarding Board Act (Northern Ireland) 2011 set up the Safeguarding Board for Northern Ireland (SBNI).

Six Key Principles

The Care Act 2014 highlights these six key principles :

Empowerment : Support / encouragement to make decisions.

Prevention : Better to take action before harm occurs.

Proportionality : Least intrusive responses appropriate to risk.

Protection : More protection for adults at greater risk.

Partnership : Working together to prevent, detect and report.

Accountability : Transparency in safeguarding.

The Purpose of the SAR

The overall intended purpose of SARs is to **learn** and **improve**, to :

- Understand **why** an adult came to harm
- Identify contributory **factors** to the harm of an adult
- Agree appropriate **actions** to prevent **future** deaths or serious harm occurring again.
- Look at examples **of good practice** and agree how this information could be used to improve safeguarding practice.

Common Misconceptions

SARs are **not** meant to :

- Be confused with public inquiries.
- Apportion blame or fault.
- Rely on hindsight.
- Betray confidentiality.
- Be feared.
- Be ignored.

The Purpose of the SAR

- It can be extremely difficult to keep a focus on learning rather than apportioning blame in cases where severe abuse or neglect has occurred.
- This can occur however, particularly where there is media ‘involvement’ and a case attracts ‘public interest’.
- If ‘human error’ has been identified as one potential factor in a particular situation this can lead to a lack of consideration or understanding of wider causes and learning opportunities.
- This may be worsened by cognitive biases where groups or individuals are stereotyped, or where situations are used to reinforce other ‘agendas’

Media Portrayal

House of Horrors revealed. Have policymakers learned nothing ?

‘A care system that just doesn’t care’. Major failings identified at Hospital.

Social Workers were warned on 12 occasions about neglected veteran.

Dying man’s pleas for help not taken seriously by cash-strapped council.

GP failed to act quickly enough to save woman who died alone in agony.

Desperate family who begged for help seen as ‘troublemakers’ by hospital.

‘They should have known what he was going to do’ says victim’s sister.

Homeless man killed by asylum seeker failed by system meant to protect him.

Crisis of confidence in NHS – MP shares her fury about care review findings.

Charity bosses took no action to protect vulnerable women and children.

Safeguarding Adults Boards – Formation

- Every local authority across England must form a Local Safeguarding Adults Partnership Board (LSAPB).
- Three core representatives :
  - the local authority
  - integrated care boards
  - the police

Local Safeguarding Adults Partnership Boards – Remit

- To help **oversee** the protection of adults who meet the following three conditions :
  - Have care and support needs (whether local authority is meeting any of those needs or not).
  - Is experiencing, or is at risk of abuse, or neglect.
  - As a result of those needs is unable to protect themselves against the abuse and neglect, or the risk of it.

- As part of these roles, they may, at times, be required to conduct a SAR.

When is a SAR required ?

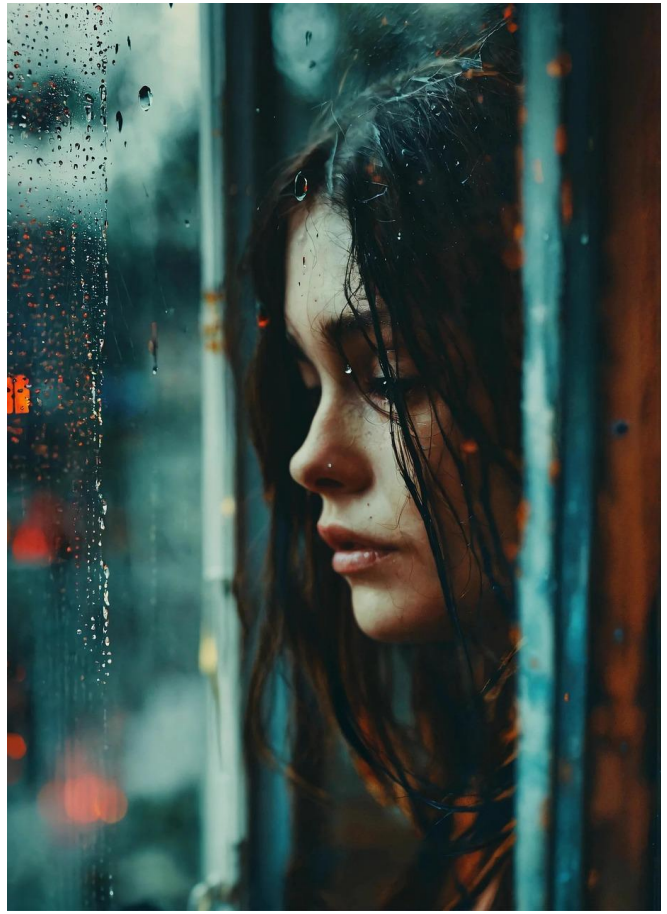
- An adult has died – it is suspected the death occurred from abuse or neglect (whether the LSAPB was aware of this or not).
- An adult is still alive but has experienced serious abuse or neglect.
- Reasonable concerns about how a LSAPB, or other people involved in the LSAPB worked together (to safeguard an adult).
- Where there are concerns that organisations did not work effectively together to safeguard an adult and abuse or neglect was avoidable.
- Where good practice is identified - lessons can be learned and applied to improve the effectiveness of safeguarding practice.

‘Serious Abuse or Neglect’ ?

For example, where an adult :

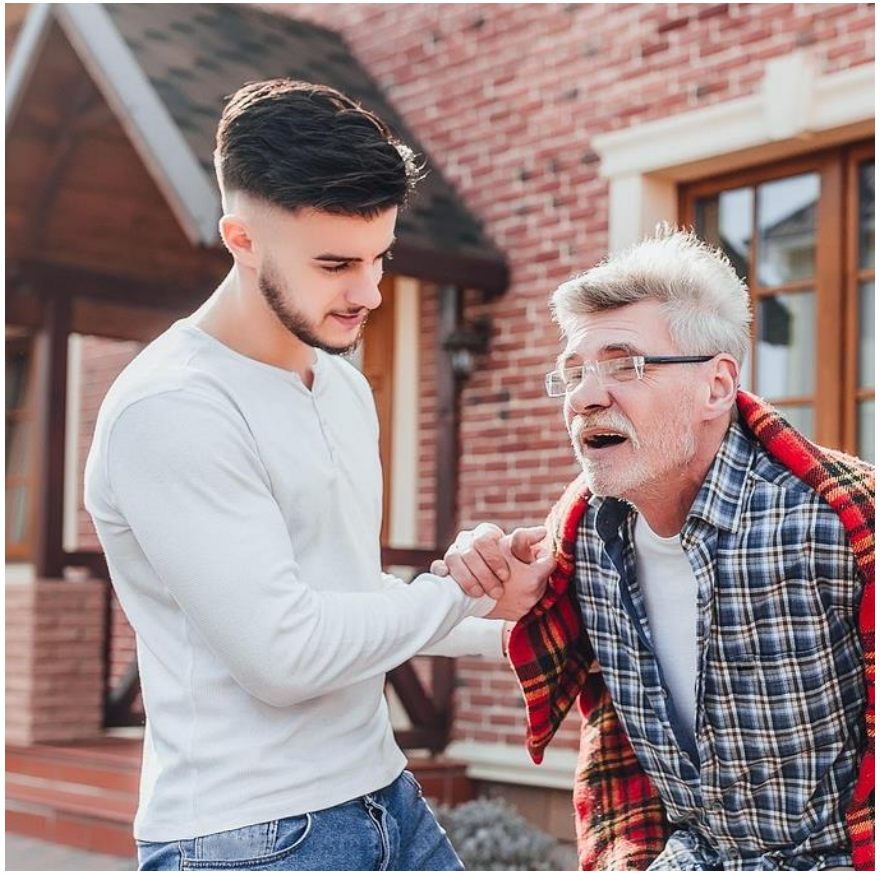
- might have died if it wasn’t for an intervention to stop the continuation of the abuse.
- has suffered permanent harm, due to the abuse or neglect.
- has reduced capacity, due to the abuse or neglect.
- is now experiencing a reduced quality of life, because of the physical and psychological impact of the abuse or neglect.
- The purpose is to identify learning that can drive change that will prevent harm occurring in future similar circumstances.

Serious Abuse or Neglect



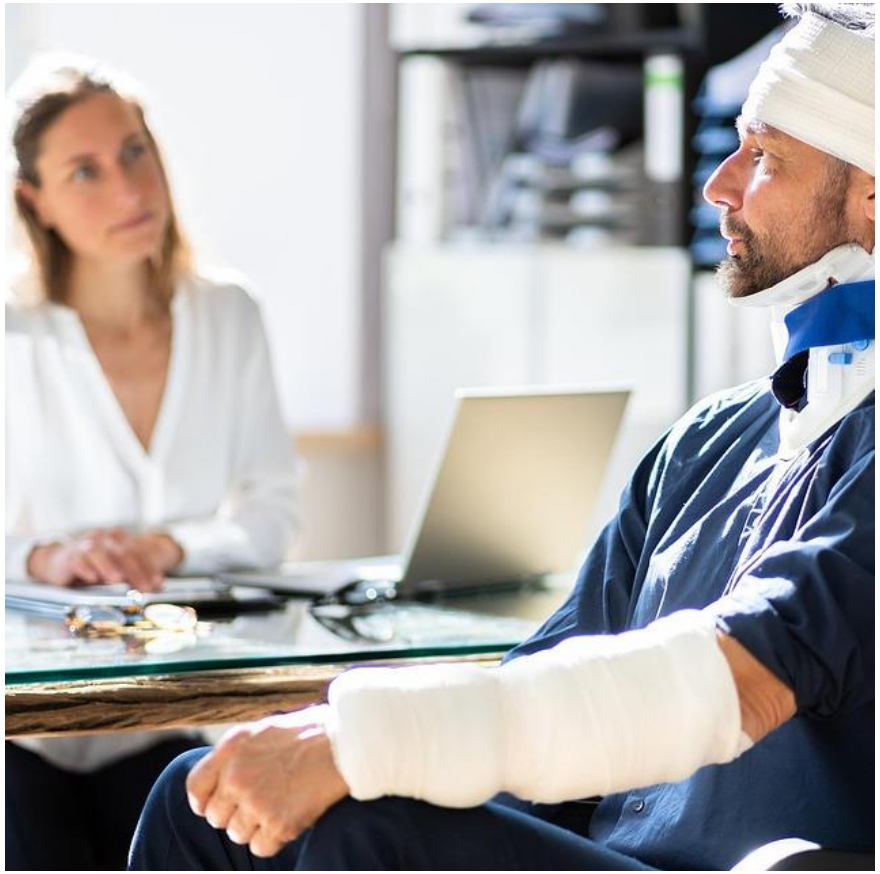
- Anna was trafficked to the UK as a victim of modern slavery and forced to engage in sex work. She was also introduced to heroin and her addiction was used to control her.
- She attended A&E on twelve different occasions in February but refused treatment and would not give her name.
- Her life was saved by a stranger who found her collapsed in the street.

Serious Abuse or Neglect



- After years of self-neglect within his own home, Ben who has Alzheimers is now unable to walk.
- He has lost nearly all of his vision due to diabetic retinopathy.
- He now requires regular dialysis as a consequence of severe kidney damage and has had to have his right foot amputated.

Serious Abuse or Neglect



- Carl who has a learning disability was targeted on numerous occasions whilst in a care home which left him with many physical injuries and concussion.
- Most injuries have healed, however the permanent damage to his frontal cortex caused by the assaults is irreversible.
- He now has impaired executive functioning and significant issues in terms of his mental capacity to make more complex decisions.

Sharing Information Internally :

- ❑ Safeguarding (Protection & Wellbeing)
- ❑ Risk
- ❑ Priorities
- ❑ Timescales and Reviews
- ❑ Lessons learned
- ❑ Near misses and ‘Successes’
- ❑ Who to contact
- ❑ Reporting mechanisms
- ❑ Policy & Procedure
- ❑ Changes
- ❑ Internal Audit

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Sharing Information with others :

- ❑ Safeguarding Concerns (Protection & Wellbeing)
- ❑ Risk
- ❑ Clarity of ‘Ownership’
- ❑ Who to contact
- Reporting Mechanisms
- Policy & Procedure
- Whistleblowing
- ❑ Expectations
- ❑ Roles and Responsibilities

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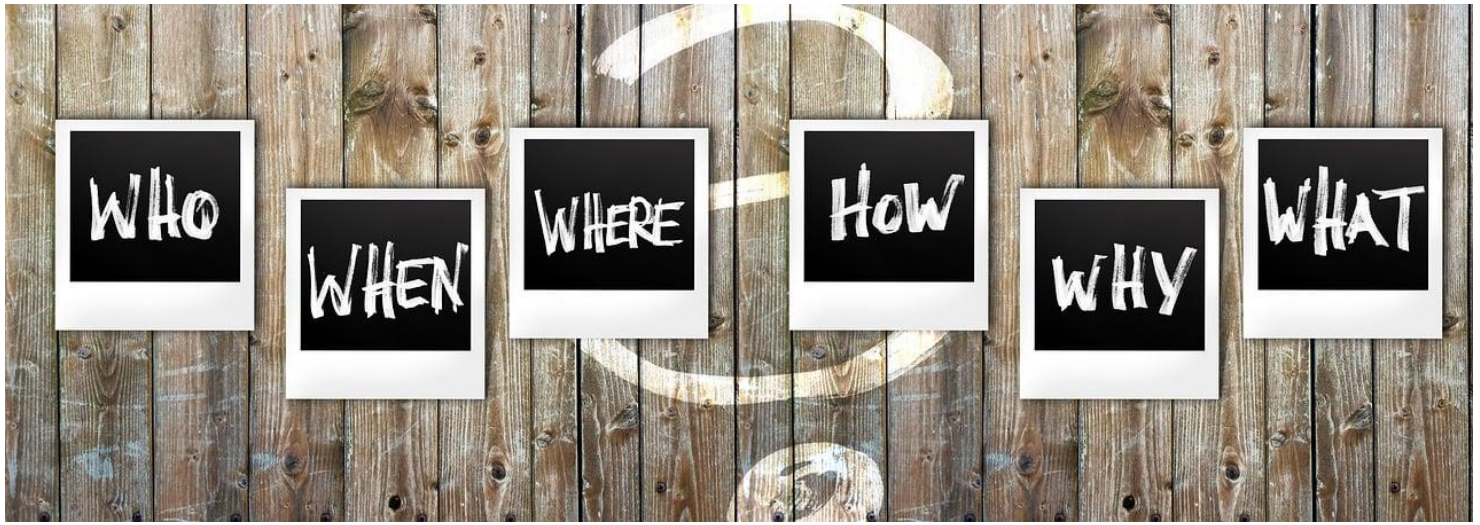
Information Sharing:

- Safeguarding Concerns (Protection & Wellbeing)
- Risk
- Ownership
- Best Practice
- SARs
- Media
- Networking
- Training
- External Audit



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Most Common Themes

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Most frequently mentioned good and poor practice themes

Most frequently mentioned good practice themes	No. of mentions	Most frequently mentioned poor practice themes	No. of mentions
Responding to health	56	Mental capacity	138
Personalisation	53	Risk assessment	134
Continuity	37	Safeguarding	115
Care/support	36	Working with carers	111
Safeguarding	32	Care/support	110
Mental capacity	32	Responding to health	99

Key Findings

In terms of SAB governance, a few reports noted an absence of guidance; examples included lack of policies on self-neglect, escalation, risk and mental capacity.

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National Analysis of Safeguarding Adults Reviews

The analysis showed:

- **Self-neglect** to be the most prevalent type of abuse (featuring in 45 per cent of reviews)
- **Neglect/omission** (37 per cent)
- **Physical abuse** (19 per cent)
- **Organisational abuse** (14 per cent).

This differs from the pattern of safeguarding enquiry activity, in which neglect/omission features most frequently, followed by physical abuse, financial/material abuse and psychological abuse.

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What is a MARM?

[Northamptonshire Safeguarding Adults Board - Adult Risk Management (ARM)]

What is ARM?

The Adult Risk Management (ARM) is a process where agencies come together to support adults who are finding themselves in high-risk situations. Risks might include self-neglect or refusing to engage with services, and if not addressed the behaviour could lead to serious harm or death.

The ARM process is person-centred and is designed to support the individual and to improve their wellbeing by reducing risk taking behaviour.

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Who might be involved in an ARM?

Relevant agencies will work together to support the person at risk, such as Adult Social Care, Police, Fire & Rescue Service, Housing Provider, Health colleagues, Voluntary and Community Services and Probation.

How does the ARM process work?

An ARM meeting is arranged with professionals who will work with the individual to create a Risk Enablement Plan and provide them with the necessary support to reduce the level of risk to help keep them safe.

If the person engages in the ARM process, the Risk Enablement Plan will be agreed with them and where appropriate, their family/friend/carer or an advocate.

The plan will help identify any risks they are experiencing and how they can manage or reduce them. The plan may be changed over time as the risk reduces or changes. When the risk of serious harm has reduced or been removed, the ARM may no longer be required. However, the ARM process can re-start if the risk increases again.

The MARM framework aims to:

- Ensure timely sharing of information
- Encourage collaborative working
- Promote the safety and security of adults who do not meet safeguarding thresholds, who cannot access services, or who refuse support
- Enable adults to retain control over their lives and to make choices and decisions
- Support early intervention/prevention
- Provide guidance for partners to call and manage multi-agency meetings, which can be called by any of the partner agencies and not just social services.

Examples of people who may require a response under the risk framework include:

- Adults who are at risk of exploitation and are victimised because of vulnerability, lifestyle or specific needs
- Adults who are not receiving support but are making repeated demands on local services
- Adult survivors of child sexual exploitation who are at risk of further exploitation
- Adults who have capacity to refuse support around issues which may put them at risk. This may include self-neglect, hoarding or exploitation

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Assessing Risk

The risk assessment process has four distinctive and **sequential**

stages, and social care practitioners should go through each of them

with the individual.

- Understanding the person's circumstances
- Identifying risks
- Assessing impact and likelihood of risks
- Managing risks – risk enablement and planning

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Assessing Risk

- Identify risks in the life-context of the individual and their circumstances (and therefore impact on quality of life and individual wellbeing).
- Identify risk perspectives from all the people involved.
- Identify weighting of risks (to establish high and low risk concerns, impact on emotional, social and psychological wellbeing).
- Identify current and past strategies for managing risks.

Summary

- Utilise the ARM process where necessary
- Consider and update your knowledge on the Local Authority Policy and Procedure for ARM
- Learn lessons from serious incidents
- Share best practice
- Audit Safeguarding Referrals
- Look for common themes in your own organisations safeguarding cases
- Training for all staff
- Update policy and procedure

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