



# Current Safeguarding Messages February 2021 Workshop

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# Aims and Learning Outcomes

- This one hour Microsoft Teams workshop will focus upon the findings and research from the latest National and Local Safeguarding Adult Reviews
- Aimed at front line practitioners from statutory and non statutory safeguarding agency's. Exploring how we can put the 'learning' back into front line practice to ensure the safety of the adult at risk, their carers and families that we work with



# Latest National Research on Safeguarding Adult Reviews

# What is a Safeguarding Adult Review (SAR)?

- A Safeguarding Adults Review (SAR) is a Multi-Agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is to promote *effective learning and improvement*, not to apportion blame
- The purpose of a SAR is to learn the lessons about how professionals and organisations work together, and to consider how the learning can be used to improve practice for others in the future

# When is a SAR undertaken and by whom?

The Care Act 2014 statutory guidance says that the Safeguarding Adult Board **must** arrange a review involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

1. there is reasonable cause for concern about the SAB, *partner agencies or other persons with relevant functions worked together to safeguard the adult; and*
2. **Either**
  - a) The adult has died, and the SAB knows or suspects that the death resulted from serious abuse or neglect; OR
  - b) The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect

# When is a SAR undertaken and by whom?

The Care Act 2014 statutory guidance says that the Safeguarding Adult Board **may** also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

# National Analysis of SARs

An analysis of SARs completed nationally between April 2017 and March 2019 was undertaken

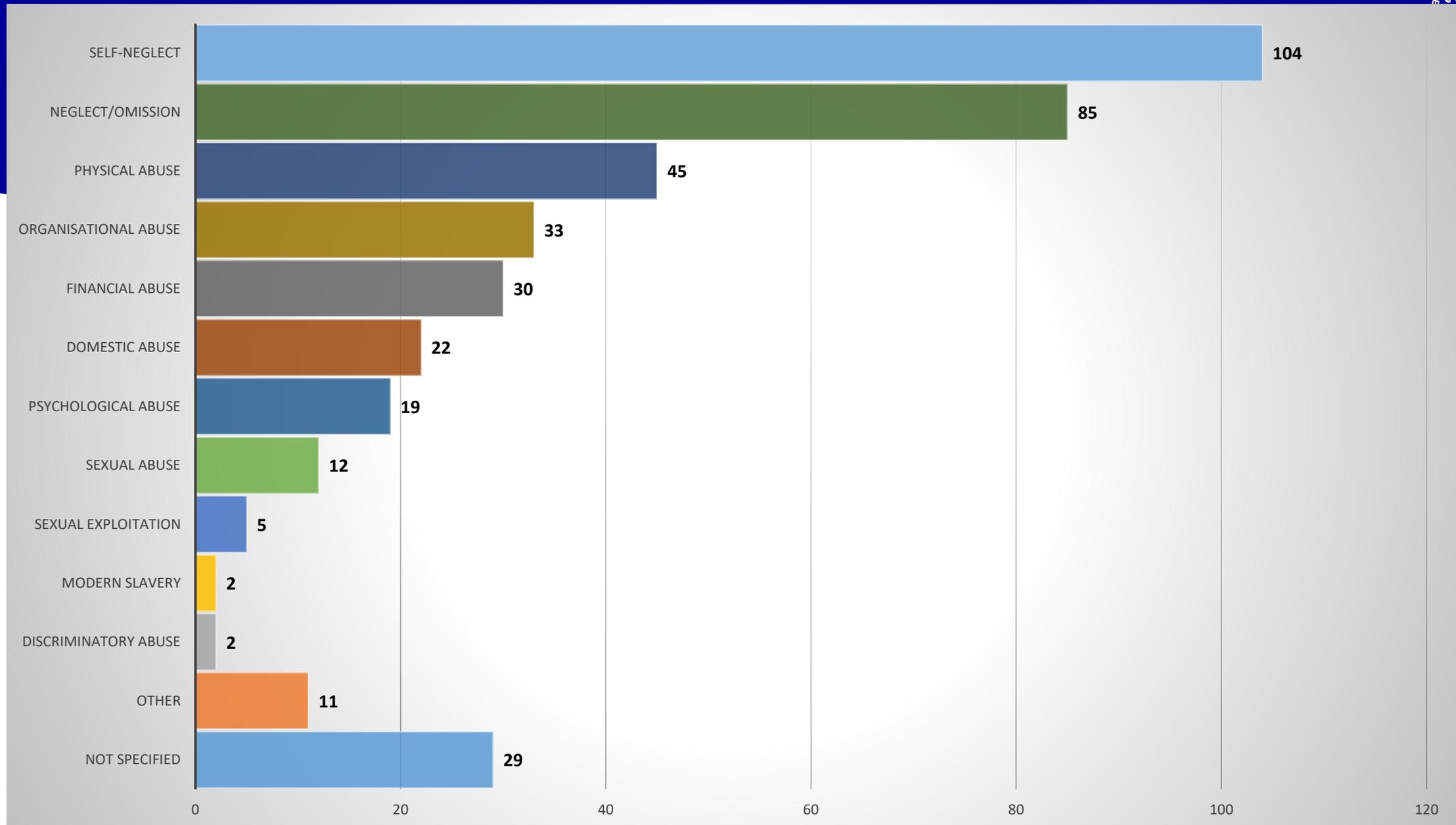
- ▶ A total of **231** SARs from **103** Safeguarding Adult Boards
- ▶ There were 263 people whose experiences were reviewed in the SARs, 81 per cent of whom had died

[Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association](#)

Gender of individuals featured In SARs										
Gender	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	All regions
Male	7	9	33	8	17	18	19	12	6	<b>129</b>
Female	10	4	28	6	23	13	10	5	10	<b>109</b>
Other / Transgender / Unknown <sup>93</sup>	1	1	7	4	5	1	2	2	2	<b>25</b>
<b>Total</b>	<b>18</b>	<b>14</b>	<b>68</b>	<b>18</b>	<b>45</b>	<b>32</b>	<b>31</b>	<b>19</b>	<b>18</b>	<b>263</b>

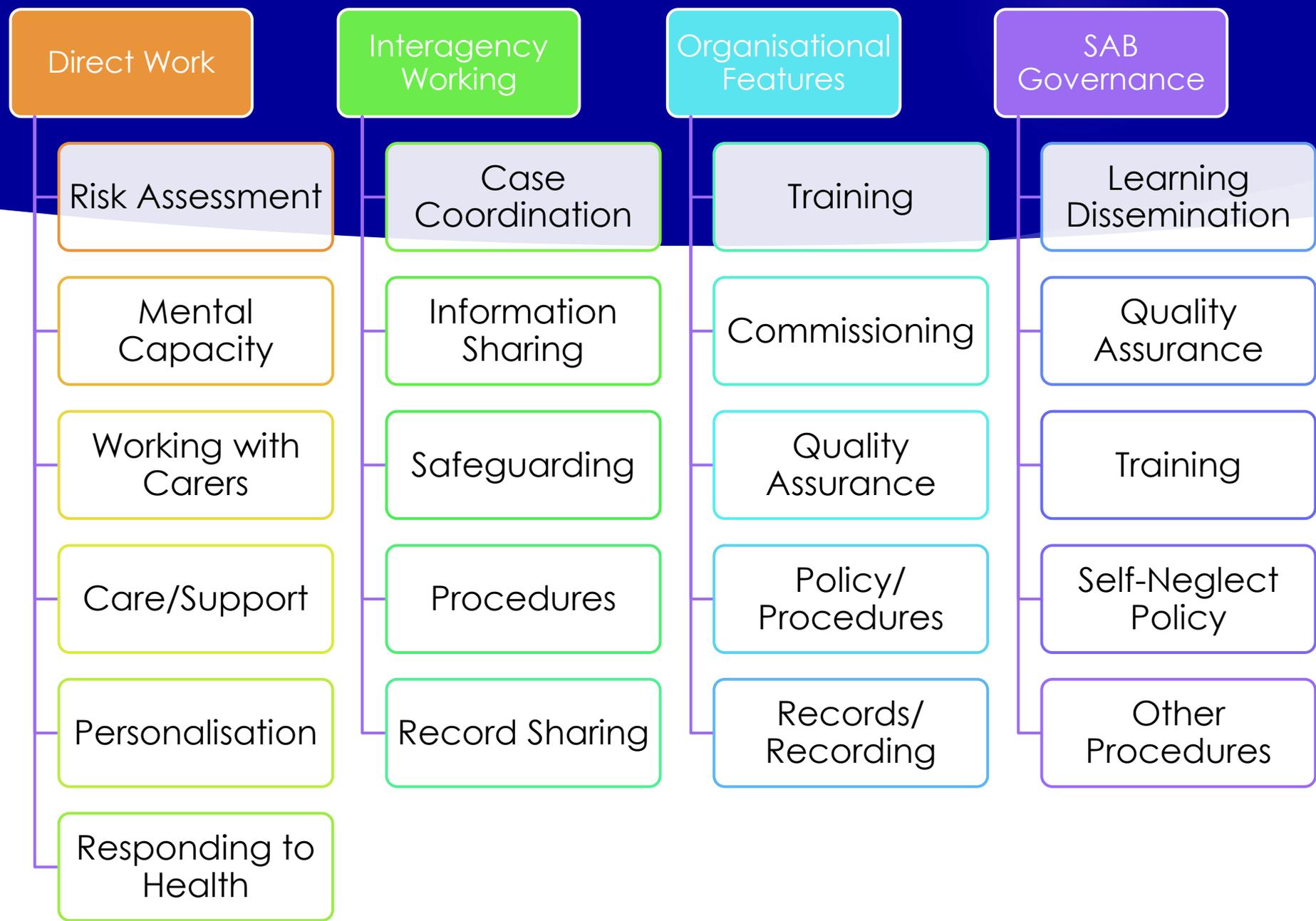
Age of individuals in SARs compared with age of people in section 42 enquiries				
Age	Total s42	Percentage in s42 enquiries	Total SAR	Percentage in SARs
0-17	0	0.0	1	0.5
18-64	1128	3.5	120	61.2
65-74	2270	7.0	34	17.3
75-84	7031	21.7	16	8.2
85+	21973	67.8	25	12.8

There were slightly more men than women. The average age was 55. Comparison with Section 42 data showed that the people featured in SARs were more likely to be younger and male, whereas those for whom Section 42 enquiries took place were older and female.



- ▶ ‘What emerges from detailed reading of the SARs is the complex interplay between physical comorbidities and between physical and mental ill-health, and the complex medical conditions which practitioners were called upon to manage. Such complexity illustrates the necessity of bringing together a bespoke team around the person’
- ▶ ‘What also emerges from a detailed reading of the reviews is the significance of the impact of a life event, such as loss of a parent. That impact may well be hidden from view, at least initially, and highlights both the importance of time to establish a trustworthy relationship and skill in sensitively exploring emotional distress’

# Recommendation Themes across 4 domains





# Latest Local Safeguarding Adult Reviews

**Alan**

# About Alan

- ▶ The background to Alan was discussed during the workshop

# Themes Identified

- ▶ There was a lack of understanding about The Office of the Public Guardian and Power of Attorney.
- ▶ There was a lack of understanding of Coercion and Control in family relationships, and how the adult's mental capacity should be considered in this situation
- ▶ There was inadequate information sharing
- ▶ Policy and procedures weren't always followed
- ▶ It was hard to identify the issues; neglect, financial abuse, coercion and control
- ▶ There were challenges in dealing with the family/carers who were manipulative/aggressive/difficult

# Key Learning

There needs to be:

- ▶ better use of multi-agency meetings to share information and make effective decisions to ensure that robust protection is in place for adults at risk. These meetings should include care providers who often have a great deal of information about a case.
- ▶ a process to ensure that before a person is discharged from hospital all safeguarding concerns are addressed and appropriate referrals made, particularly if the discharge is to be during a weekend
- ▶ there should be better information sharing and each agency should be clear what their responsibilities are.
- ▶ there needs to be better knowledge of Power of Attorney rules/processes so professionals can be more confident to identify, challenge and report any potential misuse of LPA,
- ▶ Professionals need better understanding to be able to identify domestic abuse offences and what support may be available for victims of coercive control.
- ▶ Where coercive control is suspected, timely and full records must be kept, so that a pattern of behaviour can be demonstrated.
- ▶ There needs to be better understanding of how concerns of a coercive or controlling relationship can be discussed with the OPG without the Attorney being involved in a way that could increase a risk to the adult who may be in a controlling relationship.
- ▶ When faced with repeatedly aggressive and manipulative persons, professionals should be supported, and robust action taken to protect them so they can do their work safely.



# Latest Local Safeguarding Adult Reviews

**Peter**

# About Peter

- ▶ Peter was born in Poland, he was a computer engineer and had been married, but had lost contact with his wife.
- ▶ At some point, while in Poland, he acquired a brain injury
- ▶ He had no recourse to public funds
- ▶ He was homeless
- ▶ He was support by a variety of agencies
- ▶ He was alcohol dependant, and had physical and mental health needs
- ▶ He had a number of hospital presentations - 25
- ▶ Peter died after falling into the River Cam in December 2018. At the time of his death Peter was 45 years of age. The cause of death was cardiac arrest.

# The Referral

- ▶ A number of agencies worked extensively to support and work with Peter, this work intensified shortly before Peter's death, as the risk of him being unable to sustain his lifestyle and the harm it was causing his health was recognised.
- ▶ In February 2019 a SAR referral was made by his the GP. The referral was made on the basis that Peter had died, was in need of care and support services and that there was learning that could be achieved from the circumstances of Peter's death.

Period of review 1<sup>st</sup> January 2018 to 24<sup>th</sup> December 2018

# Themes

There was a clear pattern of repeating behaviour; Peter was unable to keep up his accommodation because of his alcohol use, despite good support being offered, so he ended up living on the streets. When his health or safety reached a critical level he would then end up in hospital, mostly because members of the public called an ambulance after seeing him either incapacitated or suffer a fall and injury

- ▶ Mental capacity
- ▶ Best interest
- ▶ What to do when individuals don't want to engage
- ▶ Diagnosing of mental health problems
- ▶ Use of different legislation and Safeguarding procedures
- ▶ How to effectively work together when dealing with individuals who do not want the help
- ▶ How to ensure that one agency co-ordinates/leads when engaging with the individual

# Key Learning

There needs to be:

- ▶ greater awareness of the long-term effect of alcohol misuse on mental capacity and the recognition of Alcohol Related Brain Damage.
- ▶ greater understanding of the duty of care under the Care Act 2014 and what is available for those persons who have no recourse to public funding.
- ▶ continued training and understanding of the Multi Agency Risk Management Guidance (MARM).
- ▶ a review of what services are available locally for street drinking people, particularly those who are resistant to change. We need to look at what good practice is recognised nationally. A multi-agency, holistic and whole system-based approach is needed - any work in this area should include input from a service user group.
- ▶ The Street Aid Scheme needs promoting and education is needed on the risks of direct street donations to the homeless. (Peter lacked motivation to stop drinking, and he received a lot of financial contributions which funded for his drinking) This work should include the views of those with lived experience.
- ▶ The Homeless Hospital Discharge Protocol needs to be reviewed and promoted to ensure consistent application.
- ▶ Work is needed between the SAB and health providers of accident and emergency services to establish whether a marker can be added to frequent vulnerable homeless hospital attenders, with a link to a lead professional.

Finally – the review recognised that a number of organisations, and individuals, worked very hard to support Peter but often Peter did not, or could not accept the support available due to his alcohol dependency.

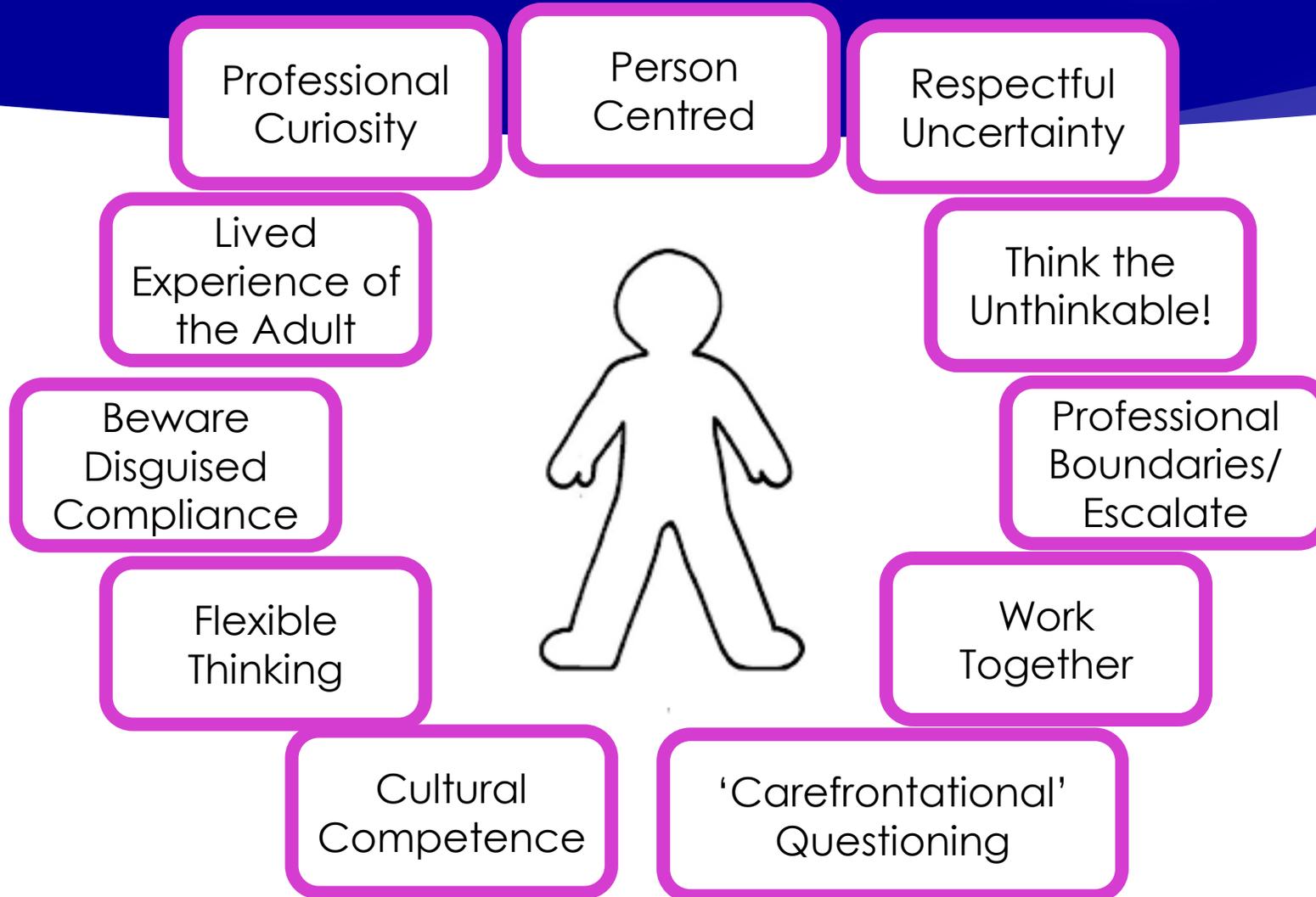
## Cambridgeshire Street Aid Scheme

- ▶ Cambridge Street Aid helps people on the streets to turn a corner. We do this by raising a fund from which people who are, or have been, on the streets can apply for a grant to help them get off, and stay off, the streets.
- ▶ <http://cambscf.org.uk/cambridge-street-aid.html>

## Safer off the Streets Peterborough

- ▶ All the partners in Safer off the Streets believe that everyone has the right to a home, to have hope and to feel part of a community, that's why charities and organisations across the city have joined up to create a network or support to help people who are sleeping rough, but also to look at ways to prevent and support people so they don't end up on the streets in the first place.
- ▶ <https://www.saferoffthestreets.co.uk/>

# Pre-requisite Tools for Practice





# SAR Audit Activity

# Background

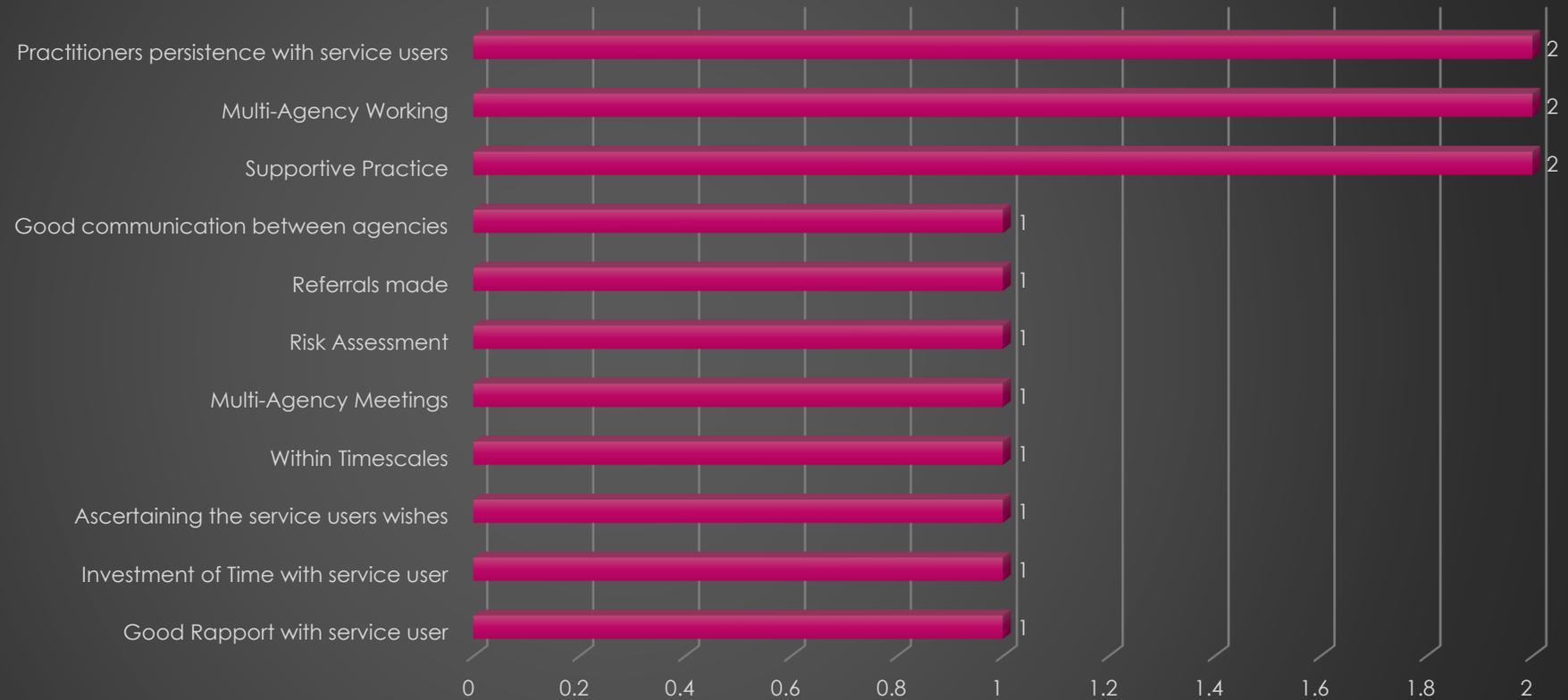
- ▶ The initial Thematic Report (January 2020) looked at all SARs undertaken from 2011 – 2018 across Peterborough and Cambridgeshire. A request from the SAR subgroup was for a smaller audit of SARs to be undertaken from after the Care Act 2014's implementation 2015 until 2019. Specifically at a time when reports may have been written differently to include both good and poor areas of professional practice to learn from
- ▶ **Thematic Review** was undertaken of the Professional Themes found within Safeguarding Adult Reviews (SARs) and SAR Action Plans from 2015 - 2019
- ▶ In total both boards undertook 3 Safeguarding Adult Reviews and a Safeguarding Adult (SA) Briefing during the period 2015 to 2019

# Good Practice

## Good Areas of Professional Practice

- ▶ Within three of the reports there was a small section, ranging from a paragraph to a page that focused on 'good practice'. Even though in some of the reports the terms of reference included the requirement for good practice to be highlighted there was very little mention of it.
- ▶ This omission could be due to the fact that there were few illustrations of positive practice identified within the cases. However, it is or more likely that the analysis and style of writing adopted by the author has a predominant focus on 'poor practice', that both SARS and Serious Case Reviews (Children's reviews) have historically tended to follow.

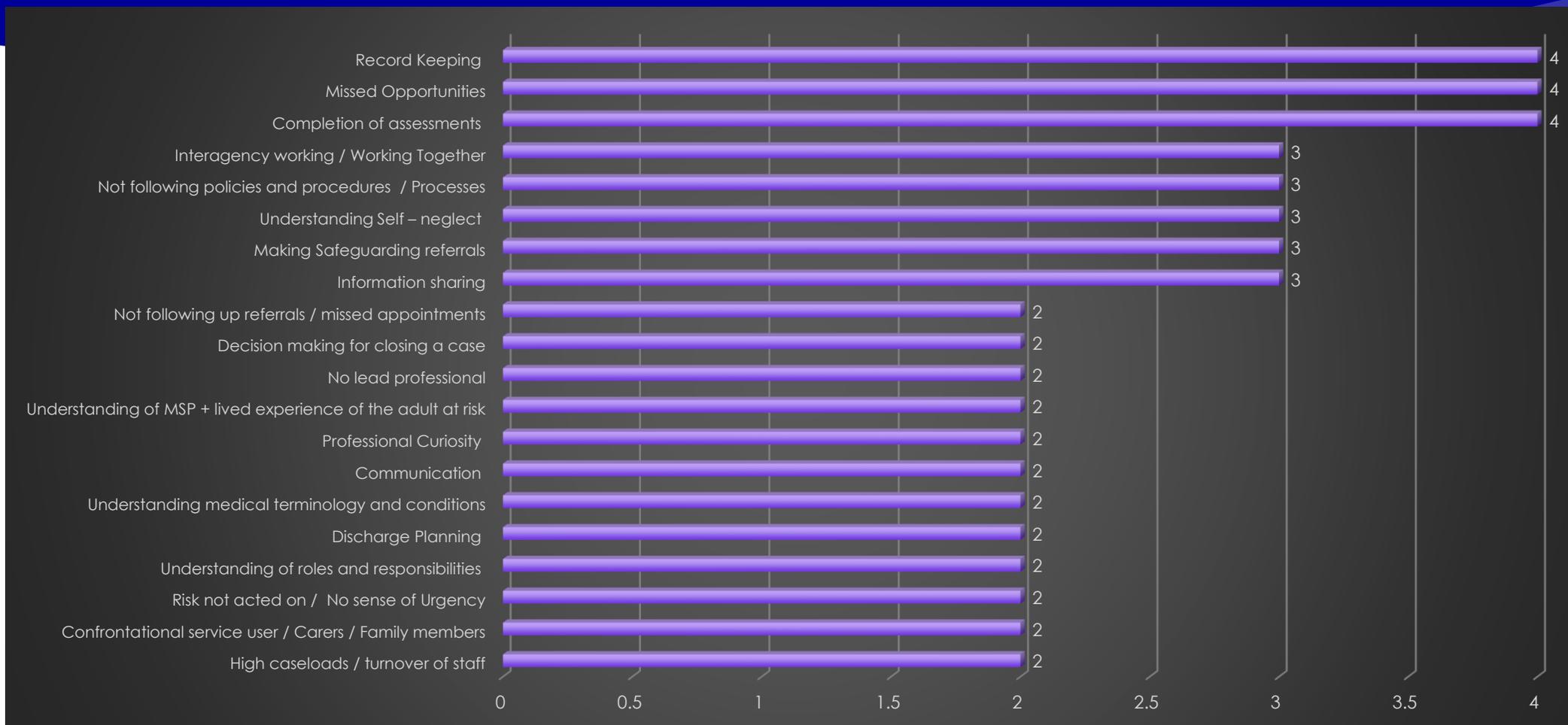
# Good Practice



# Areas for Improvement

- ▶ As with the thematic review of SARs in January 2020, professional's **recording** and assessments featured in every review (100%) of this sample. The phrase '**missed opportunities**' was also recorded in 100 % of these cases. Missed opportunities are individual to each case and were often situations that the report authors felt could and should have been acted upon by professionals.
- ▶ A similar finding to the thematic review report in January was that in 75% of this sample failed to **share information** and to **make safeguarding referrals**, did not follow **policies and procedures** nor **work together** to safeguard the adult at risk.
- ▶ A different feature, as compared to the initial thematic review report, was the practitioners understanding of **self-neglect**. This anomaly is due to the small sample size and that the majority of cases selected had adults at risk that experienced self-neglect. For these cases professionals failed to identify self-neglect and to use the risk assessment tools available for assessments and to support referrals.
- ▶ The professional theme of practitioners ascertaining the **lived experience of the adult**, finding out what life is like for the adult at risk featured within 50% of SARs, which is higher than the findings within the thematic review (2020). The disparity is possibly due to this being a smaller more select sample it is important to note that it is '**good practice**' that professionals actively seek the lived experience of the adult at risk in order to inform their assessments, planning and the support that can be offered to safeguard them

# Areas For Improvement



# ‘SO WHAT’ has happened since the SARs? (in this sample)

- ▶ Task and finish set up to focus on some of the findings within the SARs and these included groups on; Discharge and Planning and Pressure Ulcers.
- ▶ **Multi-Agency Risk Management** Tool (MARM) was developed and launched within workshops during 2019
- ▶ Multi-agency policies and procedures have reviewed and developed situated on the safeguarding adult partnership board’s website
  - ▶ Escalation policy (Resolving Professional Differences)
  - ▶ Practice guidance on Pressure Ulcers
  - ▶ Protocol for working with people with hoarding behaviours
  - ▶ Risk management guidance
  - ▶ Policy and procedures to support those people who self-neglect
  - ▶ Mental Capacity Act guidance

## ‘SO WHAT’ continued ....

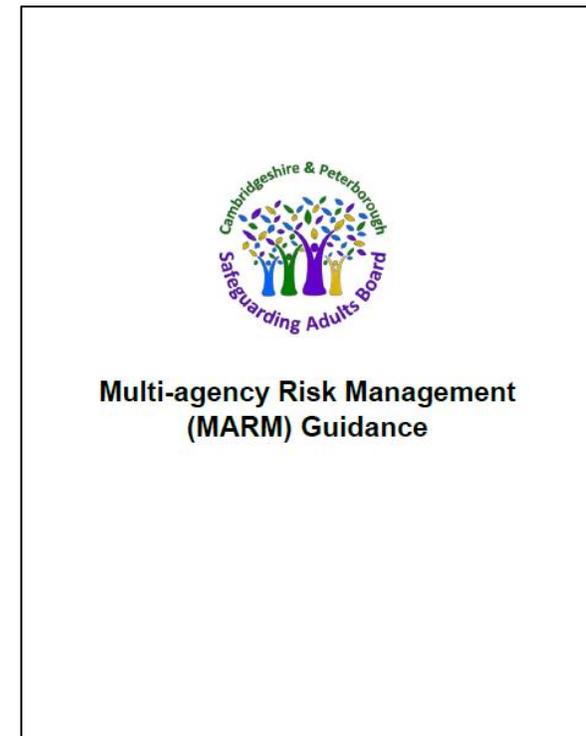
- ▶ Within the action plans were a number of actions undertaken by single agencies as a result of the SAR and recommendations
- ▶ Since the reviews, the safeguarding partnership board has integrated a multi-agency **training programme** including :Self-neglect and Hoarding / Mental Capacity Act /Having complex conversations (being professionally curious) renamed ‘Strategies for affecting positive change’ /Working Together /Understanding roles and responsibilities/ Parental mental health
- ▶ Termly Workshops / Virtual Workshops / SWAYs/ Briefings
- ▶ ‘**lived experience of the adult**’ took place during 2019 . Practitioner **guidance** on the lived experience of the adult was launched during August 2019 within the latest virtual learning lessons workshops.

# Multi-Agency Risk Management

The Multi-Agency Risk Management Guidance document sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed.

This guidance must only be used where the adult:

- ▶ has the mental capacity to understand the risks posed to them,
- ▶ they continue to place themselves at risk of serious harm or death, and
- ▶ refuse or are unable to engage with necessary care and support services





# Training

# Virtual Briefings and Training



The screenshot shows a web browser displaying the website for the Cambridgeshire & Peterborough Safeguarding Partnership Board. The URL in the address bar is <https://safeguardingcambspeterborough.org.uk/home/covid-19/e-learning...>. The page header includes the organization's logo and name, along with navigation links for the Safeguarding Children Partnership Board, Safeguarding Adults Partnership Board, and Multi-Agency Safeguarding Training. A red button labeled "Reporting a concern" is visible. The main content area is titled "E-Learning during Covid-19" and includes a breadcrumb trail: Home » Home » COVID-19 Information » E-Learning during Covid-19. The text states: "Safeguarding is everyone's responsibility and this has **not** changed in the response to the Coronavirus pandemic. The [Community Services Prioritisation Plan](#), [The COVID 2020 Act](#), [COVID 19 Changes to the Care Act 2014](#) and the variety of [COVID 19 Guidance](#) are all **indicating that safeguarding children and adults is as critical during COVID as it is statutory at other times.**" Below this, it says: "Given all the increasing risks of abuse we need to be even more vigilance at this time. This can feel daunting to ensure you are keeping people safe and meeting your safeguarding obligations under the added pressures of COVID-19." A final note states: "Please note that due to the Coronavirus all face-to-face training provided by Cambridgeshire and Peterborough Safeguarding Adults and Children Partnership Board has been cancelled." A "Translate" button is located at the bottom right of the page.

User-Led resources on a variety of topics, including:

- ▶ Safeguarding Adults
- ▶ Safeguarding Children
- ▶ Online Abuse
- ▶ Domestic Abuse

# (Virtual) Training Currently on Offer

## Safeguarding Children

- Current Children's Safeguarding Messages: **February 2021 Workshop**
- Graded Care Profile
- Working with Child Sexual Abuse
- An Introduction to Child Criminal Exploitation
- Introduction to Child Neglect
- The Sexual Assault Referral Centre and Supporting Victims of Child Sexual Abuse
- Fabricated & Induced Illness (FII)
- Sexually Harmful Behaviour (SHB)

## Safeguarding Children and Adults

- An Introduction to Domestic Abuse

## Safeguarding Adults

- Current Adult's Safeguarding Messages: **February 2021 Workshop**
- Hoarding & Safeguarding Adults at Risk
- Self-Neglect & Safeguarding Adults at Risk
- Making Safeguarding Personal



# Slides for Professionals



**Adult Safeguarding  
Partnership  
Tool Box**

MAY 2019

www.safeguardingcambspeterborough.org.uk



**Basic Safeguarding  
Adults at Risk Training  
Slides For Professionals**

APRIL 2019

www.safeguardingcambspeterborough.org.uk

<https://safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/>

# Professional Briefings



**Safeguarding Adults Partnership Board Practitioner Briefing**  
**Safeguarding Adult Review - Arthur**

**What is a safeguarding adult review (SAR)?**

- The Care Act 2014 statutory guidance says that a Safeguarding Adult Board must arrange a SAR when the following criteria is met:
  - When an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
  - If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAR was undertaken on a male who we shall call Arthur, to respect his anonymity. The SAR was initiated whilst Arthur was alive and it was reported that he neglected his own health and wellbeing and appeared to have hoarding behaviours. The referral, for a SAR, concluded that Arthur was a "vulnerable adult" with limited mobility, who had suffered significant harm due to potential neglect to his wounds.

In the case of Arthur all agencies were required to provide Independent Management Reviews (IMRs) and a chronology of their involvement with Arthur. In addition, a practitioner's event log place which explored key episodes and events within the timeframe being reviewed by the SAR enabling professionals to talk through their experiences in a safe and learning environment.

**Changes since the SAR for Arthur**

- During early 2019 Multi-Agency Risk Management (MARM) Guidance was developed and launched within workshops across the region. 137 professionals attended the workshops. The **Multi Agency Risk Management Guidance** sets out a co-ordinated, multi-agency approach designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed. It seeks to provide frontline professionals with a framework to facilitate effective working with adults who are at risk; where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions.
- Workers are encouraged to have regular meetings or 'huddles' regarding cases where there are safeguarding concerns to look at risks and how to work effectively together with the adult at risk.
- Self-Neglect and Hoarding multi-agency training has been developed and designed and is available through the Safeguarding Boards Training Brochure. Lived Experience of the Adult at Risk workshops were cascaded across the region earlier this year. 71 professionals from a variety of agencies attended Arthur's case study was used as an exercise for ascertaining what the safeguarding issues were, what the roles of professionals for ascertaining what the safeguarding issues were, what the roles of responsibilities of professionals should be and how agencies could work together to

**Safeguarding Adults Partnership Board Practitioner Briefing**  
**Briefing Number 2: Safeguarding Adult Practitioner Themes and Lessons**



The Cambridgeshire and Peterborough Safeguarding Adult Board (CPSAB) has undertaken a number of Safeguarding Adult Reviews (SARs) and a recent multi-agency audit. From the audit and the SARs reoccurring practitioner themes when working with adults at risk and their families were found. These themes have also been identified within national SARs as lessons for agencies to learn and to put into practice:

**Voice of the Adult at Risk:** Ensuring that the adult's voice is not just listened to but is heard. It is a phrase used to describe the real involvement and experiences of the adult at risk, not just what they tell us but 'What is life like for them?' - 'What do they understand / want to learn and to put into practice?'

**Professional Curiosity:** is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. In other words **ask questions** about 'What is life like for the adult at risk living at home / in a care setting?' 'What is it like for the family?' etc.

**Respectful Uncertainty:** Meaning that Professionals must remain **open** to the explanations, justifications or excuses they may hear. In other words professionals should not take what then ask the professionals who do (i.e. medical professionals).

**Cultural Competence:** is a term used to describe a set of skills, values, behaviours and principles that enable professionals to work effectively with service users who have one or more of the protected characteristics, as defined by the Equality Act 2010. Illustrations of these include disability; ethnicity or race; gender; gender identity; religion and belief; sexual identity/orientation and mental health.

Professionals need to be culturally competent and **should not make assumptions** about an adult at risk nor their family and as part of informed practice should be confident to ask about what their life experiences are in order to meet their needs and to provide the best service.

**Think The Unthinkable:** is a phrase that has been used in Children's Serious Case Reviews where professionals did not think that serious harm could ever be inflicted on a child by their parents. Professionals sometimes need to think about the worst case scenario and that family members might be harming children / adults at risk.

For working with an adult at risk think about the negatives and the risks, within their environment, as well as the protective factors... have a balanced approach to thinking about what might be happening in terms of safeguarding and potential abuse.

**Safeguarding Adults Partnership Board Practitioner Briefing**  
**Briefing Number 1: Self-Assessment Audit Tool**



**Self-Assessment Audit Tool - What is it?**

In line with the statutory responsibilities under the Care Act 2014, in order to assure the safeguarding adult board that agencies are effectively safeguarding adults at risk an agency self-assessment audit tool was developed for agencies to complete.

During 2017 the self-assessment audit tool was developed and in 2018 was piloted with the three statutory partners of the board which included: Peterborough city council local authority, Cambridgeshire county council local authority, Cambridgeshire constabulary and the clinical commissioning group.

The remaining agencies, who make up the membership of the adults quality effectiveness group (QEG) and others were asked to complete and submit the self-assessment audit tool by the end of December 2018. Alongside this, practitioners of those agencies undertaking the self-assessment audit tool, were given the opportunity to complete an anonymous survey (Survey Monkey) to gather their views and thoughts about some of those questions contained within the self-assessment audit tool. In total 406 professionals completed the survey.

- What did we find out?**
- Good areas of practice** identified within the self-assessment audit tool:
- Escalation policy process was mentioned as part of multi-agency working
  - There were illustrations of where policies had made a difference to practice and the environment for working with an adult at risk.
  - Reminder cards given to staff about safeguarding
  - In some instances there was evidence recorded that service users were asked what they want to happen to them
  - Some agencies actively audited cases to examine practice
  - Safeguarding for some agencies, was reportedly noted as being in every job description
  - Some agencies evidenced that they displayed safeguarding posters with contacts written on and that they included links to the SAB website
  - Some agencies evidenced that they were assessed as adults at risk were asked to sign consent forms for sharing information, if there is a safeguarding concern

**Areas to improve on**

Both the self-assessment audit tool and the survey suggest that professionals know where to find and how to access their **policies and procedures** regarding safeguarding adults at risk. The survey responses showed that 86% of professionals know how to access their policies, although 14% (47 people) indicated that they did not. It was not clear from the evidence given from the self-assessment audit tools whether policies and procedures are up to date.

The self-assessment audit tool showed that staff knew about policies and procedures relating to **allegations made against staff**. However, there was no evidence given to show that professionals had accessed the policies nor if there had been any referrals / reported concerns within the agency. The survey supported agencies, in that only 6% of respondents (19 people) did not know what to do if they had a safeguarding concern about a staff member.

Most agencies reported that they had a clear **Whistleblowing Policy** in place. However there was no evidence as to whether the policies had been used by staff and although 87% of survey respondents indicated that there was a clear whistleblowing policy within their agency only 76% felt confident to use it.

<https://safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/>

# 7 Minute Briefings

7 MINUTE BRIEFING SAFEGUARDING ADULT REVIEW ON PETER

**1** Peter was a 46 year old man who was born in Poland and came to the UK. He was unable to find employment since he arrived and had no recourse to public funds (RRPF). Whilst visiting Poland he sustained a serious head injury. In the UK Peter was homeless and spent a long period of time living on the streets. He was alcohol dependent, and regularly admitted to hospital. Several statutory and charitable agencies were involved in trying to support Peter and deemed him to have mental capacity when he was sober. Peter often declined the support offered. Peter's health deteriorated and the risk to his wellbeing and safety increased. Tragically after being discharged from hospital Peter fell into a river and later died of a cardiac arrest.

**2** **KEY LEARNING POINTS**  
There were a number of organisations, and individuals working within them, who worked very hard to support Peter but he often did not engage with the support available or was unable to due to his alcohol dependency and inability to abstain from alcohol.

**3** ACC Peter did alcohol use limited due status and limited money. He was not a resident a sec 1. Profesion understood care under and what it individual 2. Profesion aware of it Management consider its and support adults at it engage wit

**4** M Peter's this profes for profes assess his 1. Profesion or long term reasons on mental ca 2. When a assesser need to be Related 2 mental he how this individuals

**7** **INFORMATION**  
Adult Safeguarding Partnership Board Website <http://www.safeguardingcambspeterborough.org.uk>  
Multi-Agency Risk Management Guidance (MARMG) <http://www.safeguardingcambspeterborough.org.uk/marmg>  
Alcohol Related Brain Damage / Report and Professionals <http://www.safeguardingcambspeterborough.org.uk/alcohol-related-brain-damage>  
Safeguarding Adult Reviews <http://www.safeguardingcambspeterborough.org.uk/safeguarding-adult-reviews>

7 MINUTE BRIEFING SAFEGUARDING ADULT REVIEW ON ALAN

**1** **BACKGROUND**  
Alan was 52 years of age and his wife passed away in 2013. He had many health conditions and later in life was diagnosed with dementia. Alan's son Barry was granted Lasting Power of Attorney (LPA). Alan had concerns and the care company raised safeguarding concerns in relation to the care being afforded to Alan by his son and his partner, Cain.

**2** **AGENCY RESPONSE TO CONCERNS**  
1. Strategy discussions were held through not all relevant agencies were present. This meant a lack of **shared information** with no **coherent and coordinated** action plan. The history of the case was not reviewed. 2. Alan was discharged from hospital and the safeguarding team was not consulted. This meant that there was no possibility of any support with Alan and Barry to help prevent his son with Alan and Barry to help prevent his discharges. 3. The RSPCA gave a warning regarding the conditions that the pigs were left in. Agencies did not follow this up or highlight it as a **concerning contributory factor** to the case as to what was happening within the case as to what was happening within the home where Alan lived. 4. The Office of the Public Guardian (OPG) and the police were made aware of potential financial abuse. However, neither agency **communicated** with each other resulting in no investigation.

**3** **COERCION & CONTROL**  
Agencies need to be aware of and able to identify the elements of coercion and control within relationships and family contexts.  
Agencies should accurately **record** incidents in a **clear** manner to evidence the elements of potential coercive control. To support people with social care needs who are experiencing coercive control agencies should **work together** to ensure that the person's **wishes and choices** are put at the centre of any civil or criminal proceedings.

**4** **MENTAL CAPACITY**  
Alan was recorded as having mental capacity by agencies but not by the Office of the Public Guardian (OPG) who did not share their assessment with other professionals.  
On one occasion carers were asked to tell Alan that he could ask Barry and Cain to leave their care of him and to leave his address. However, Alan was both unlikely and probably unable to make such a request, due to the apparent control that Barry was able to exert on their relationship.

**5** **CHALLENGING FAMILY**  
It Barry and Cain were challenged by professionals or agencies did something that they disagreed with this resulted in agencies being **threatened** with complaints and emails. Some practitioners felt intimidated by Barry who reportedly threatened to sue the agencies. However, beyond these experiences agencies and staff continued to work with Barry and Cain with a view to continuing to care for and to support Alan.  
Professionals working with complex and difficult cases should be offered **supervision and supportive Management oversight**.

**6** **LASTING POWER OF ATTORNEY (LPA)**  
Agencies were concerned about how Barry handled his father's financial matters. Professionals felt unable to inform the OPG of their concerns as this may have been deemed to be the person with LPA and potentially resulted in increased risk to Alan from Barry. Professionals should be **aware of what the lasting power of attorney means** and of the **procedures and processes** involved with the OPG when supporting an adult at risk.

**7** **INFORMATION**  
Adult Safeguarding Partnership Board Website <http://www.safeguardingcambspeterborough.org.uk>  
Pills L (2016) Supporting people with social care needs who are experiencing coercive control - CH, MIRA and Women's Aid. <http://www.safeguardingcambspeterborough.org.uk/pills-l-2016>  
Mental capacity and coercion - what does the law say? (bad) <http://www.safeguardingcambspeterborough.org.uk/mental-capacity-and-coercion-what-does-the-law-say>  
Safeguarding Adult Reviews <http://www.safeguardingcambspeterborough.org.uk/safeguarding-adult-reviews>  
Office of the Public Guardian and Lasting Powers of Attorney <http://www.gov.uk/government/organisations/office-of-the-public-guardian>

Resources for Practitioners |  
Cambridgeshire and Peterborough  
Safeguarding Partnership Board  
([safeguardingcambspeterborough.org.uk](http://safeguardingcambspeterborough.org.uk))

Bottom of the page – also what is a SAR 7 minute briefing



<http://www.safeguardingcambspeterborough.org.uk>