Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - Paul

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Paul could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here – www.safegaurdingadultsinbexley.com

2. What happened?

Paul had a history of traumatic events that led to him eventually taking his own life. Paul was known to a wide-range of agencies, including mental health & domestic abuse services. Paul's had three children, one of whom had died, which impacted him greatly. There was concern regarding why Children's Services were not involved when a minor was in the home and severe domestic abuse was occurring.

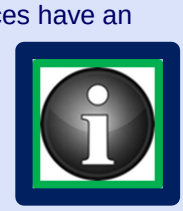
Bexley Safeguarding Adults Board involved key agencies across the partnership so that a Safeguarding Adults Review would seek to learn lessons as to how Paul took his own life whilst services were involved with him and his family.

3. Recommendations 1 - 7:

1. Familial domestic abuse examples to be explored within safeguarding training to ensure that all agencies can recognise familial abuse. **2.** Full history of traumatic events impacting upon a persons' mental health should form part of the assessment. **3.** Trauma informed approaches should be used & follow up care and support arranged. **4.** Mental Health Services to recognise the importance of the Local Authority role in providing advice, Guidance & oversight to safeguarding interventions. **5**.The development of a suicide risk assessment process/training for emergency services to be recognised within crisis planning. **6**. The safety & wellbeing of each party should have been considered. If plans in place were not maintaining safety & wellbeing of all parties further advice & guidance should be sought and/or a defensible rationale provided. **7.** All assessment processes to consider the accessibility of services in relation to literacy/trauma informed approaches.

4. Recommendations 8 - 13:

8. If audits suggest that letters are routinely sent to those who are displaying signs of trauma, unable to read or incapable of accessing the service for some other reason then, an equality impact assessment covering accessibility to services should be conducted as a multi-agency event. **9.** Capacity assessment recording to be shared as examples of good practice across all agencies. Although Bexley are working hard on capacity across the partnership, some examples of proportionate assessment where a full report is not required would be helpful for everyday use. **10**. Panel members and Board members to reflect upon who would be expected to conduct such complex capacity assessments (Understand the impact of executive functioning on a person's ability to make a decision). **11**. To share good practice examples in a manner that is accessible to all practitioners. (See recommendations about safeguarding, information sharing and Local Authority overview of outcomes). **12.** The ability of people to access these services to be shared across all agencies as good practice examples. **13**. Mental Health Services have an array of useful resources that may not always be known to other agencies. Multi agency safeguarding responses with a lead agency identified & oversight, guidance provided by the Local Authority in safeguarding situations.



5. Recommendations 14-21:

14. Oversight does not require the Local Authority to chair or lead enquiry processes, rather to be reassured that steps have been taken to maintain safety and wellbeing as defined by the individuals themselves or provide a defensible and lawful rationale. **15.** The Care and Support Statutory guidance identify. The safeguarding of carers (Family members providing care and support) to be identified in all safeguarding training. Safeguarding considers the whole family & wellbeing principles are applied. **16.** Training should provide examples in practice. At each stage the Local Authority should be providing oversight and guidance. SAB to consider what proportionate responses are expected. **17.** The potential impact of coercive and controlling behaviours affecting a person's ability to make autonomous decisions should be explored in all safeguarding interventions that involve domestic abuse, including familial domestic abuse. **18.** Training and briefing regarding decision making to be provided in the most accessible format across all agencies. **19.** Support to be provided to Adult Social Care practitioners to ensure that they can recognise that strengths-based approaches will not limit access to services. **20.** For the SAB annual report to identify the impact that the change of process has had in creating improved preventative measures and strength-based approaches. **21.** The review of referral pathways including adult safeguarding to include an audit of improved and more consistent decision making and identification of the person leading the safeguarding enquiry. **22.** To ensure that all mental health & ASC staff recognise the importance of up to date care and support planning that supports family care providers, but also holds them accountable for meeting needs or reporting concerns. For domestic abuse services and ASC to monitor recognition/response of familial domestic abuse/risk assessment and management.

6. Recommendations 23 – 24:

23. SAB to understand the S.75 agreement as a critical issue particularly regarding clarity and oversight around health & social care safeguarding concerns as it lacks at the moment coherency across the agencies.

24. For the SAB to support partners to understand 'Think Family Approach' so that measures in place are effective and robust to give the LA oversight it requires.