Lambeth Safeguarding Adult Partnership Board

Annual Report

April 2014 – March 2015

Content

Introduction

This is the 6th Annual Report of the London Borough of Lambeth's Safeguarding Adults Partnership Board (LSAPB). It is pleasing to note that the Board has progressed from strength to strength both in terms of its membership and its achievements.

This year's report is written at a time when the Care Act 2014 has just recently come into force and this has significant implications for Adult Social Care and all Board partners. It puts the LSAPB on a statutory footing and places statutory duties on the Board and its partners in the way it must deliver on its Safeguarding Adults work. Thus, as safeguarding adults at risk becomes further embedded in policy and practice, we anticipate a far greater profile for adult safeguarding.

Safeguarding of adults at risk remains at the centre of the Board's strategic work-plan. At a time when the way in which public services are delivered are under review and there are expectations on public services to make savings, it remains crucial to ensure that safeguarding adults remains a consistent core aspect of the work undertaken by all partner agencies and individuals working in adult health and social services and the wider community.

This report publishes a summary of the outcomes and recommendations of one Safeguarding Adult's Review (serious case review) within Lambeth; the clear message running through the findings is the importance of using the Mental Capacity Act 2005 in complex cases and the need to have clear routes for case co-ordination and escalation in the management of chronic conditions in people with profound and multiple disabilities. Learning identified from this review is being embedded in practice through the action plans developed by the Board's Serious Case Review Sub-Group. This group has ensured that the plans are implemented operationally and strategically by all partners.

Gill Vickers

Director of Adult Social Care, London Borough of Lambeth and Acting Chair, Lambeth Safeguarding Adults Partnership Board

SECTION ONE

What is meant by Safeguarding Adults?

The Care Act 2014 introduced statutory duties for local authorities to protect (safeguard) residents in their area, from abuse and neglect.

Section 42 of the Care Act says:

Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

has needs for care and support (whether or not the authority is meeting any of those needs),

is experiencing, or is at risk of, abuse or neglect, and

as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Then:

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Local Authorities now have a statutory duty to protect adults at risk from abuse & neglect

Who is considered an Adult at risk?

Anyone who is 18 years and older who needs care and support. They may be ill, frail or have a disability and are unable to protect themselves from significant harm.

What is abuse or neglect?

Abuse is mistreating or neglecting someone so that it has a negative impact on their quality of life. It is seen as the violation of an individual's human and/or civil rights by any other person or persons. The types of abuse include; physical, sexual, psychological, financial and material, neglect and acts of omission, discriminatory and organisational.

Many aspects of abusive behaviour may constitute a criminal offence and all suspected abuse must be investigated.

Where can it occur?

Abuse of adults can happen anywhere; at home, in a health care or support setting, in hospital, in the workplace or in public places.

CASE EXAMPLE:

Sarah had been dependent on her brother for some time due to her learning difficulties. She had two children, one of whom also had a Learning Disability. Sarah's brother managed her finances and carried out the shopping for the household. Sarah disclosed one day that her brother had assaulted one of her children. He also refused to give Sarah her bank card and she was not sure how her money was being spent. He was verbally abusive toward the whole family. Sarah disclosed he had mental health problems.

Adult Social Care raised a safeguarding concern and alerted Children Social Care (CSC). A safeguarding plan was co-ordinated with Police. Sarah did not want to lay a charge against her brother however mental health services agreed to work with Sarah's brother to address his violent behaviour. Steps were taken to put alternative support arrangements in place for both Sarah and her children to ensure their safety and wellbeing.

What is Making Safeguarding Personal?

Making Safeguarding Personal (MSP) is a personalised approach that enables safeguarding to be done *with*, and not *to* people. This is an initiative led by the Local Government Association to make sure that our safeguarding processes are people centred and address all the concerns of the customers involved.

Lambeth have recognised that safeguarding practice needs to focus on achieving meaningful outcomes and improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.

We are moving toward a process that supports conversations with people, to achieve what they want, when they are experiencing, or at risk of experiencing abuse or neglect.

What does this look like in Lambeth?

There are now key Social Workers in teams who are nominated to focus on only safeguarding adults work. This means they are freed up from other work to focus on doing safeguarding adults only. This is to help ensure that we are doing person-centred and outcomes focused safeguarding. The role is on a 3-6 month rotational basis so that all social workers get an opportunity to develop these specialist skills.

What's different and what does this mean for service users?

We are making sure that people being safeguarded are better informed about what Safeguarding adults is, the process that will be followed and how they will be involved.

We do this by explaining this to them at the start of the process and by giving them an explanatory letter which puts this in writing. If they have any difficulty understanding information or with communication, we arrange an advocate to ensure their views and wishes are heard.

We ask people what they want from the safeguarding process at the beginning. The types of questions we ask include:

- What things would help you to feel safer or are most important to you?
- What would you like NOT to happen?
- Do you consent for an investigation to take place?
- How would you like us to keep you informed about what happens next?

We check at the end of the Safeguarding process if we've actually made a difference. We ask questions like:

- Do you feel safer now?
- Do you feel more able to protect yourself in the future?
- Did we keep you updated in the way you asked?

How will we know we are improving?

We are being assessed on how we get on, by an external body called 'Research in Practice for Adults'.

SECTION TWO

How we tell Lambeth residents about Safeguarding Adults:

Lambeth Council's website has information about what Safeguarding Adults is about and how to report a safeguarding adults concern.

The LSAPB's Annual report is also published here so all residents can access information about Safeguarding Adults in their community.

The Community Reference Group is a sub-group of the Board. Representatives from various community groups such as Action against Elderly Abuse and Healthwatch, attend. These members distribute information in the community and this includes information about safeguarding including how and where to get the right support.

Information leaflets are displayed in the Lambeth town hall for the public to access information about services including Safeguarding Adult services.

All LSAPB's board partners have a duty to provide information and advice under the Care Act. They have recognised the need for improved mechanisms of communication to Lambeth residents about Safeguarding Adults including better information leaflets and information on their respective websites.

The LSAPB's Annual Report is published on Lambeth's Council's website so residents can access information about safeguarding adults in their community.

How can Lambeth residents report Safeguarding Adult concerns?

In an emergency – you should always call the Police or Emergency Services on: **999**

Lambeth Adult Social Care have a central referral point for where safeguarding adults concerns can be reported. In Adult Social Care these go to our Initial Contact Service which is open Monday to Friday 9am to 5pm and can be reached via 020 7926 5555 or at adultsocialcare@lambeth.gov.uk.

There is also an Emergency Duty Team which can take referrals after hours by calling: 020 7926 1000

Information about raising concerns about a child can also be found on Lambeth Council's website.

All Board Partners have Safeguarding Adults' Policy and Procedures in place which detail and inform how professionals must respond to concerns of abuse or neglect.

In Kings College and St. Thomas' Hospitals, safeguarding concerns can also go via their own Safeguarding Adults Teams. Where there is an allegation that the hospital itself has caused harm, they would complete an internal investigation which is shared with the local authority as the lead agency.

What we do to protect 'adults at risk':

When a Safeguarding adult concern is raised, someone, such as a social worker, nurse or someone the persons trusts, will talk to the adult at risk, about their situation, and find out what the adult at risk thinks should be done to keep them safe and properly cared for.

The health or social care professional will contact the people the adult at risk would like to have involved to build up a picture of what has happened.

In these situations the process of gathering information about the situation is called a 'Safeguarding Adults Enquiry'

The health or social care professional will agree with the adult at risk who needs to be involved. Depending on the situation, this might be the Police, GP or other professionals, to help keep the adult at risk safe.

The aim of our safeguarding work is to enable the person to live their life fully and safe from harm. We try our best to accommodate the person's needs and wishes. We aim to avoid it being a complicated or intimidating process.

The new protocol seeks to improve better identification by children practitioners, of adults with additional needs and better identification by adult practitioners, of children who may be affected by adults with additional needs.

How we are improving joint working between adults and child protection:

A revised protocol has recently been implemented in Lambeth to support health and social care professionals who come across families where parents or others in a household have care and support needs which may have a negative impact on the child(ren), or affect the adults or parents' ability to care for the child(ren).

It highlights the responsibility of those working to safeguard adults at risk also needing to be aware of their responsibilities to safeguard and promote the welfare of children and young people. There will be occasions when, those working with adults at risk identify risks to children and young people, and similarly those working with children and young people, identify adults at risks. On these occasions, safeguarding adults and safeguarding children's procedures will need to operate side by side.

The new protocol seeks to improve better identification by practitioners working with Children, of adults with additional needs and better identification by practitioners working with Adults, of children who may be affected by adults with additional needs.

Examples of safeguarding adults' cases in Lambeth:

Case example one:

Lambeth's Trading Standards were alerted to concerns about a rogue trader operating in both Lambeth and a neighbouring borough. Information was obtained about this trader and it was discovered that he was preying on elderly female Lambeth residents. The details of his victims revealed that both were elderly females and considered as meeting the safeguarding adults' criteria for 'adults at risk'. These cases were presented at Lambeth's Vulnerable Victims panel and safeguarding adults' procedures were initiated.

A social worker working with Trading Standards conducted home visits and carried out needs assessments to offer support where needed. The police assisted with the arrest of the rogue trader and protective measures for the victims and Trading Standards collated the evidence for the prosecution.

In total it was discovered that one of the victims over a period of over six years, had given this rogue trader a total of £26,375 for alleged home repairs. The other victim, over a period of three years, had given this same rogue trader £21,610 for alleged gardening work.

A social worker working with Trading Standards conducted home visits and carried out needs assessments to offer support where needed.

The rogue trader pleaded guilty to six offences including:

•3 offences of fraud contrary to section 1 & section 2 of the Fraud Act 2006

•3 offences of engaging in a commercial practice contrary to Regulation 10 & 6 (1)(a) of the Consumer Protection from Unfair Trading Regulations 2008

Case example two:

Following an increase in the number of safeguarding concerns, complaints from family members and following an inadequate CQC inspection report of one of the care homes in the borough, Lambeth Adult Social Care and Integrated Commissioning agreed that a formal suspension should be placed on the home. This meant that no new residents would be placed there until the home could show considerable improvements in the standard of care it was providing.

Residents placed within the home were reviewed by Social Workers to ensure that they could remain there and that their care and support needs could continue to be met. Lambeth's Local Healthwatch also started visiting the home to meet with service users and family members to gather both information about the concerns they were encountering, but to hear from them how they wanted to see things improve.

This has resulted in transparent and robust monitoring of how the home is demonstrating its improvements and providing assurances about their standards of care.

SECTION THREE

The Lambeth Safeguarding Adults Partnership Board (LSAPB)

Who are we and what do we do?

Lambeth's Safeguarding Adults Board is a statutory multi agency board with key responsibility for agreeing how each relevant organisation in Lambeth, will work together to safeguard and promote the welfare of Adults in Lambeth.

It meets quarterly to coordinate the strategic approach and to review the effectiveness of what is being done to keep adults safe and how partners are working together to respond to concerns about abuse and neglect.

What has changed recently?

On 1st April 2015 the LSAPB became a statutory Safeguarding Adults Board for purposes of section 43 of the Care Act 2014.

The Care Act makes some requirements of a safeguarding adult's board which include:

- It must publish each year a strategic plan. In preparing this plan, it must consult the local Healthwatch and involve the local community
- It must publish each year an annual report detailing what it has done during the year
- It must conduct Safeguarding Adults Reviews (previously known as Serious case reviews)

The Care Act clearly sets out that safeguarding adults boards are independent bodies that are on a par with, and will hold to account, other Boards and partnerships rather than being in a hierarchical relationship with them.

What does this mean for the LSAPB?

The LSAPB was already in operation and had clear strategic objectives prior to the Care Act. It published an annual report and carried out serious case reviews (now known as safeguarding adult reviews).

However, over the course of the next year, the LSAPB will need to ensure that all Board partners have identified and implemented the necessary changes to ensure their compliance with the Care Act.

The LSAPB will also need to be clear how it intends to consult Healthwatch and the Community on its' strategic plan, as this is now a requirement within the Care Act.

Lambeth's Safeguarding Adults Partnership Board became a statutory Board on the 1st April 2015 in accordance with The Care Act

What the Board achieved in 2014/2015:

- The Board has ensured that safeguarding work has a clear outcome based focus: expectations about reporting requirements have been put in place to give it assurance from all partners about outcomes
- The Board has developed revised reporting arrangements include producing a themed report at each quarter, which will allow for scrutiny in particular areas
- All partners commission safe and cost effective services (Board's reporting requirements include assurance indicators from commissioners)
- The council and partners have engaged people who use services in the design of its services
- The Board receives regular monitoring information in regard to age, disability, sex and race and therefore delivery accords with the six local government equality strands
- The Board and its constituent organisations have robust and effective service delivery that makes safeguarding everybody's business
- The Board oversaw preparations for the Care Act 2014, introducing a policy and procedure compatible with the Act
- The Board agreed a local Information Sharing Agreement for safeguarding adults, which is compatible with the Care Act 2014.

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What impact has this had?

- Revised reporting arrangements have improved the mechanisms for getting assurances on outcomes. This has led to the identification of a number of gaps that need to be addressed by each individual board member and by the Board itself
- Services are held accountable through performance measures, including quality measures, towards achieving the outcomes for people in the strategy
- A commitment has been made to implementing Making Safeguarding Personal by LB Lambeth Adult Social Care
- Hidden Voices established practitioner and service user forums with a focus on developing ways of measuring user outcomes.
- A letter was produced by service users and the Hidden Voices project (within Healthwatch who seek to engage with residents and understand how the safeguarding process can be improved). This letter is now given to residents by front line teams to provide residents with information on Safeguarding and what to expect from a safeguarding enquiry at the start of the process.

The Board's Strategic Work Plan for 2015/2016:

Our strategic priorities for the coming year will focus on prioritising the following areas:

1) Outcomes for, and experiences of, people who use services

- The council and its partners will demonstrate improved safeguarding outcomes alongside wider community safety improvements
- The Board or its constituent agencies will achieve high levels of expressed positive experiences from people who have used safeguarding services
- The council and partners will fully engage people who use services in the design of its services
- The Board to receive regular monitoring information in regard to age, disability, sex and race
- Commitment made to implementing Making Safeguarding Personal by LB Lambeth Adult Social Care

2) Working together

- There is multi-agency commitment to safeguarding

To achieve high levels of expressed positive experiences from people who have used safeguarding services

3) Leadership, strategy and commissioning

- There is recognised and active leadership by the council on Adult Safeguarding
- There is joint and co-ordinated leadership with and by other key partners
- The Board and its constituent members have a clear vision, priorities, strategies and plans for Adult Safeguarding
- The council and its partners have developed mechanisms for people who are organising their own support and services to manage risks and benefits

4) Service delivery, performance and resource management

- Domestic violence, hate crime, anti-social behaviour and community cohesion work includes 'vulnerable adults'

How will the Board achieve this?

- All safeguarding work in Lambeth will be carried out in MSP compliant ways by end of March 2016

- MSP implementation will create a reliable data source for measuring safeguarding outcomes, allowing the Board to monitor this so that it either receives the assurance it needs or can identify and address problem areas

- Implementation of MSP will include:
  - Routine information provision in all safeguarding enquiries about Hidden Voices
  - Work between ASC, SLaM and Hidden Voices to support people with experience of safeguarding enquiries to be engaged in service design
  - Board Community Reference Group to be a vehicle for engagement between the Board and people who have experienced safeguarding adults enquiries
  - Partner agencies to consider how they will engage with MSP and make use of information from service users about outcomes

- Development of the Multi Agency Safeguarding Hub (MASH) for safeguarding adults will include incorporating community safety issues within its remit, supporting effective multi-agency responses.

- The reporting to the Board will be revised to report on the 9 'protected' characteristics

- Hidden Voices will be a source of information to the Board about people's experiences.

- London Borough of Lambeth will be able to demonstrate their leadership through having safeguarding adults' arrangements corporately and not just within adult social care, and by having effective arrangements for the relationship of LSAPB, LSCB, the Health and Wellbeing Board, and the Safer Lambeth Partnership.

- By March 2016 the Board will have reviewed the effectiveness of leadership across partner agencies by measuring
  - Attendance by partners at meetings of LSAPB and its sub-groups
  - Number of agenda items at PADeC and LSAPB proposed by each partner agency

- The Board will have met Care Act expectations as all members will have completed a Care Act audit and identified actions to ensure compliance

- Safeguarding adults' policy and procedures will be revised to better support risk management and positive risk taking for those directing their own services.

- Systems will be improved to allow for better identification of safeguarding concerns that relate to self-directed support, which will enable better analysis and intelligence about this area.

- Mechanisms will be put in place, which support social care and health

staff to enable people to manage risks
in ways that are meaningful to them.

Lambeth Safeguarding Adults Partnership Board (LSAPB) members 2014-15

Name	Role and organisation	Period of membership (2014-15)
Adela Kacsprzak	Assistant Chief Officer, National Probation Service	Mar 2015 - Mar 2015
Aisling Duffy	Chief Executive, Certitude	Apr 2014 - Mar 2015
Ann Baxter	Independent Chair	Apr 2014 - Mar 2015
Ann Corbett	Programme Director, Community Safety, LB Lambeth	Apr 2014 - Mar 2015
Ann Hamlet	Head of Safeguarding Adults, Kings College Hospital NHS Foundation Trust	Apr 2014 - Mar 2015
Bruce Grain	Station Manager, Fire Service	Apr 2014 - Mar 2015
Catherine Pearson	Chief Executive, Healthwatch Lambeth	Apr 2014 - Mar 2015
Clement Guerin	Head of Quality and Safeguarding Adults, LB Lambeth	Apr 2014 - Mar 2015
Cllr Daphne Marchant	Liberal Democrat Spokesperson for Adult and Care Services, LB Lambeth	Apr 2014 - May 2014
Cllr Jackie Meldrum	Cabinet Member for Social Care, LB Lambeth	Apr 2014 - Mar 2015
Cllr Jane Pickard	Deputy Cabinet Member Older People, LB Lambeth	Apr 2014 - May 2014
Cllr Jim Dickson	Cabinet Member for Health & Wellbeing, LB Lambeth	Apr 2014 - Mar 2015
Cllr Shirley Cosgrave	Clapham Common Conservative Ward Councillor, LB Lambeth	Apr 2014 - May 2014
Deborah Parker	Deputy Chief Nurse, Guys and St Thomas NHS Foundation Trust	Apr 2014 - Aug 2014
Dominic Stanton	Interim Divisional Director, LB Lambeth	Apr 2014 - Jun 2014
Fiona Connolly	Assistant Director, Adult Social Care, LB Lambeth	Jun 2014 – Mar 2015
Gill Vickers	Director of Adult Social Care, LB Lambeth	Jun 2014 - Mar 2015
Graham Norton	Ambulance Operations Manager, London Ambulance Service	Apr 2014 - Mar 2015
Helen Charlesworth-May	Strategic Director Commissioning, LB Lambeth	Apr 2014 - Mar 2015

Janna Kay	Quality and Safeguarding Adults Manager, LB Lambeth	Sep 2014 - Mar 2015
Kaied Ghiyatha	LSCB Business Manager, LB Lambeth	Mar 2015 - Mar 2015
Lenny Kinnear	Chief Executive, Age UK Lambeth	Apr 2014 - Mar 2015
Lisa Humphreys	Interim Delivery Director, Children's Social Care, LB Lambeth	Sep 2014 - Mar 2015
Lucy Canning	Service Director, Psychosis Clinical Academic Group, South London and Maudsley NHS Foundation Trust	Apr 2014 - Mar 2015
Mala Karasu	Safeguarding Adults Trust Lead, Guys and St Thomas NHS Foundation Trust	Apr 2014 - Mar 2015
Mandy Green	Associate Director, Commissioning, LB Lambeth	Apr 2014 - Mar 2015
Maria Millwood	Director of Integrated Commissioning, LB Lambeth and Lambeth Clinical Commissioning Group	Apr 2014 - Mar 2015
Martin J Huxley	Detective Superintendent, Lambeth Metropolitan Police Service	Apr 2014 - Jul 2014
Martin Owens	Head of Reducing Reoffending, HMP Brixton	Dec 2014 - Mar 2015
Melodie-Ann Dalrymple	Senior Probation Officer - London Probation Trust / London CRC Probation	Apr 2014 - Mar 2015
Moira McGrath	Director Integrated Commissioning (Older Adults) / CCG Safeguarding Lead, LB Lambeth and Lambeth CCG	May 2014 - Mar 2015
Paula Townsend	Deputy Director of Nursing, Kings College Hospital NHS Foundation Trust	Jun 2014 - Mar 2015
Sean Oxley	Detective Superintendent, Lambeth Metropolitan Police Service	Jul 2014 - Mar 2015
Sue Foster	Strategic Director, Delivery, LB Lambeth	May 2014 - Mar 2015

SECTION 4

One Safeguarding Adult Review (Serious Case Review)

Overview:

This case concerns a young woman, Miss B, who died at the age of 26, from pneumonia exacerbated by very low weight and concerns about her nutritional status. She had pressure sores that would have been painful and distressing. The Panel's inquiries sought to establish what had occurred, what could have been done differently and what lessons can now be learned about the way that health care is offered to, and coordinated on behalf of, people with profound and multiple disabilities. It sought to clarify the point at which decisions should be taken formally in the best interests of someone who cannot make, or influence, the decisions being taken about their health care, even when this is contentious in relation to family carers. Decisions not to access or follow orthodox, evidence-based, medical advice, which seemed to have been the situation in this person's case, may need to be challenged in order to ensure that they are treated on an equitable basis to other citizens.

Miss B's parents had become aware of her impairments in infancy at a time that coincided with her routine vaccinations. They came to believe that she was disabled as a result of these immunisations when her presentation, and particularly a condition known as microcephaly, is not consistent with this view. They later refused to allow Miss B to have tests that might have clarified her condition and the Panel felt that investing time in carefully exploring the basis of Miss B's condition would have provided a firmer basis for evidence- based interventions as she grew older.

Some of these issues have been shared with the Safeguarding Children's Board to inform their work with disabled children across the Borough. But Miss B's parents used this false sense that their daughter had been damaged by the medical profession, to justify not following some of the advice they were given, for example when she was a child they did not want her to take medication for her epilepsy, and when she was an adult, already very emaciated and unwell, they did not pick up a repeat prescription for dietary supplements that had been prescribed.

Pharmacists might have been able to help with monitoring this aspect of Miss B's care. While neither of these decisions *caused* Miss B's death, they may have damaged her quality of life and her dying. It may be that some of this difficulty in the relationships between professionals and family carers rested on cultural misunderstandings, or it might have been that her family did not respond well to formal letters, but preferred phone conversations or face- to- face consultations. They certainly sought out help at times but were not necessarily consistent in following through. Health care professionals tried to keep the parents "onside" but placation was not a safe option for Miss B and they should have been supported to challenge their views of what was the best treatment, without in any way removing support or failing to respect the on-going care that Miss B's family continued to provide.

The professional network around Miss B noted her loss of mobility and her low BMI and monitored her weight over some time but did not use their observations to change gear in the level of care they were giving or the urgency with which they were dealing with her symptoms. They did not have clear reference points against which to evaluate her deteriorating condition. They used neither standard measures nor carefully calibrated

personalised indicators to say when Miss B's weight had dropped to dangerous levels, instead there was a view that her low weight was "normal for her" and somehow an inevitable part of her condition instead of a consequence of malnutrition and difficulties in feeding her.

Although many individuals did raise concerns, there was no agreed route through which they could escalate their concerns. The Panel agreed that improved case coordination, especially for people with complex health care needs, was a priority and that a forum should be set up to act as a focus for enhanced risk management for those with the most difficult presentations.

Closer working relationships between specialist learning disability health professionals and those working in mainstream primary and secondary care were indicated. An application for Continuing Health Care funding had been set in motion on but Miss B was deemed ineligible for NHS care despite her extremely low weight and her need for on-going health care intervention. She might otherwise have been assigned a case coordinator who could have acted as a clinical lead and focus for health care interventions but as this route was closed off the coordination role remained with social care staff.

The whole network lacked a focus and it is clear that the records and instruments, such as Health Action Plans and care plans, were not being used proactively to manage Miss B's care or to guide decision-making. Nor were assumptions challenged within an integrated multi-disciplinary forum where health professionals across different specialisms could pool their knowledge of her presentation and the likely trajectory of her condition.

Since the events described in this report, a complex case forum has been convened in Lambeth and should in future act as the focus for this level of integrated and detailed planning.

Although many individuals did raise concerns, there was no agreed route through which they could escalate their concerns.

GP's in particular may need additional support to provide primary care to people with rare syndromes and complex presentations. They also need additional training and support to make decisions within the framework set out in the 2005 Mental Capacity Act, especially when there is conflict with family carers and/or when managing chronic conditions as opposed to single one-off medical treatment decisions.

In this case a formal application to the Court of Protection might have provided a route through which a consensus between the network of health and social care professionals and Miss B's family carers could have been forged.

A graduated approach to shared decision-making, - one that makes clear the imperative to work in the best interests of the adult-at-risk, was proposed as an alternative to allowing the situation to reach a point where treatment could no longer be effective.

Police investigated Miss B's death but the CPS decided that there were insufficient grounds to think that it had been caused by neglect. The Coroner's Inquest accepted the pathologist's cause of death that Miss B had died of natural causes. The Coroner felt satisfied that there were no contributory factors and she stated she had the benefit of the Police report to support this. Miss B's low body weight was accepted as not unusual given her condition. The Coroner did however highlight a theme of discontinuity between professionals and she was concerned about the possibility of this reoccurring. She expressed concern that despite there being two distinct bodies involved i.e. Local authority and SLAM, there had been no sufficient links and it was evident that there

were times when professionals were not clear about who was doing what.

Neglect is a complicated concept, implying an agreed sense of what *should* have happened as well as evidence that someone had *deliberately* not provided an acceptable level of care. Improved guidance for posthumous investigations and on sharing of information after a vulnerable adult's death might have facilitated this process.

The Panel concurred that no one person or agency had let Miss B down, but that collectively the services had not worked consistently enough to guarantee her safety, or to assure her well-being. The Panel could not say retrospectively, that her death was preventable, although an independent expert suggested that she might have lived longer had she been given timely nutritional assistance for example by continuing her calorific supplements or having a PEG fitted. The Panel were particularly concerned that Miss B received no pain relief or palliative care.

A safeguarding intervention was initiated in the year before Miss B died but the protections put in place were not followed through over time. After her death a detailed investigation *was* carried out but it was difficult for this to find solutions to what we have come to see as system-wide problems.

In contrast, this SCR has prioritised the task of translating lessons from Miss B's particular case into workable recommendations for change and service development in Lambeth that will be of benefit to other people with intellectual disabilities and complex health problems. The Safeguarding Adults Board for Lambeth will have oversight of detailed action plans and will monitor their implementation until safe good-enough practice is embedded in the systems and culture of the organisations concerned and in their multi-agency partnerships.

Recommendations and Learning:

- Sharing of information, risk management, routes for escalation and *case-coordination*
- Training needs of GP's, district nurses, Community Learning Disability Team, day centre staff and medical specialists focused on *clinical care*
- Management of the diagnosis and *management of chronic conditions* in people with profound and multiple disabilities with parents and family members, including managing transition from children's to adult services
- Using the *Mental Capacity Act 2005 in complex cases*
- *Commissioning* of health care services on behalf of people with intellectual disabilities from both mainstream and specialist clinical teams
- Management of a coherent and robust *infrastructure* for case management, safeguarding and the supervision of staff
- Implications for *housing agencies*
- Lessons with *implications for pan-London and national bodies*

Plans & Further Action:

An Improvement Plan for addressing the issues identified was produced, including timescales for completion, against which the SAPB has been able to measure progress.

Agenda item 11 – TABLED

SECTION 5: **Safeguarding Adults in Lambeth 2014- 15**

5.1 The number of safeguarding adults concerns

Chart 1: Safeguarding adults concerns

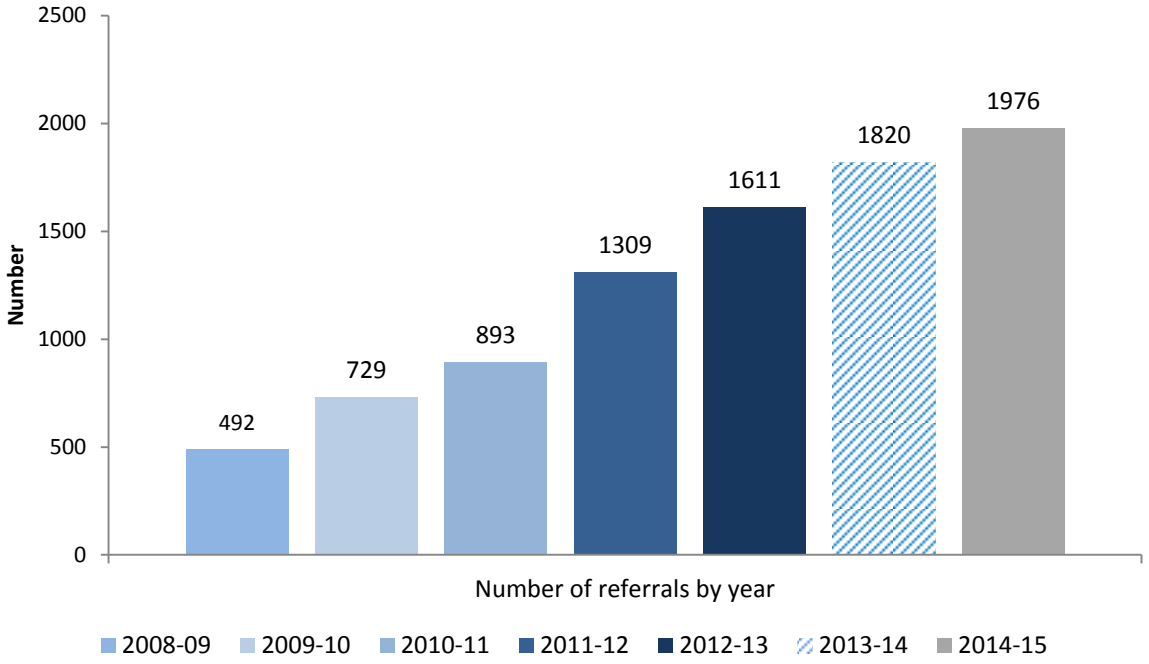


Chart 1 shows how many safeguarding adults concerns were received each year by London Borough of Lambeth Adult Social Care and South London and Maudsley NHS Foundation Trust, as these are the two organisations which coordinate the responses to safeguarding adults concerns in Lambeth.

In 2014-15 the pattern of an increase each year continued. This reflects increased awareness of adult abuse, of the need to report abuse in Lambeth and improvements in the systems in place to ensure all services report concerns about possible abuse or neglect.

It is likely that 2015-16 will see a further increase. As well as the ongoing trend of increasing awareness, the coming in to force of the Care Act 2014 on 1st April 2015 broadens the range of issues that will be seen as a safeguarding concern.

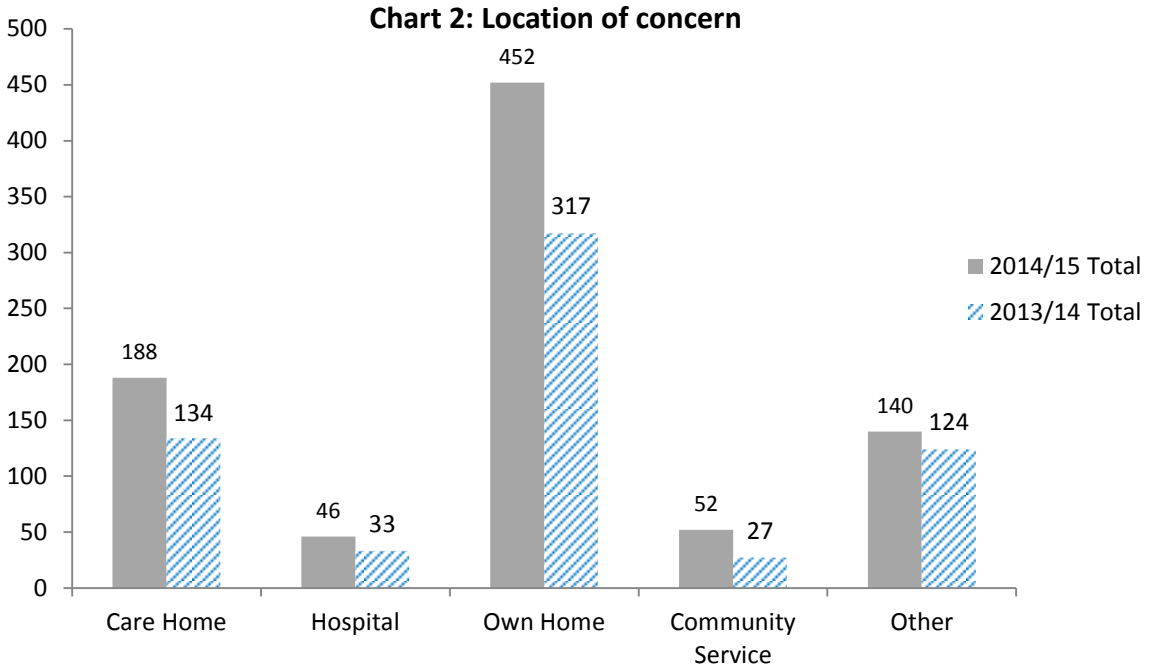
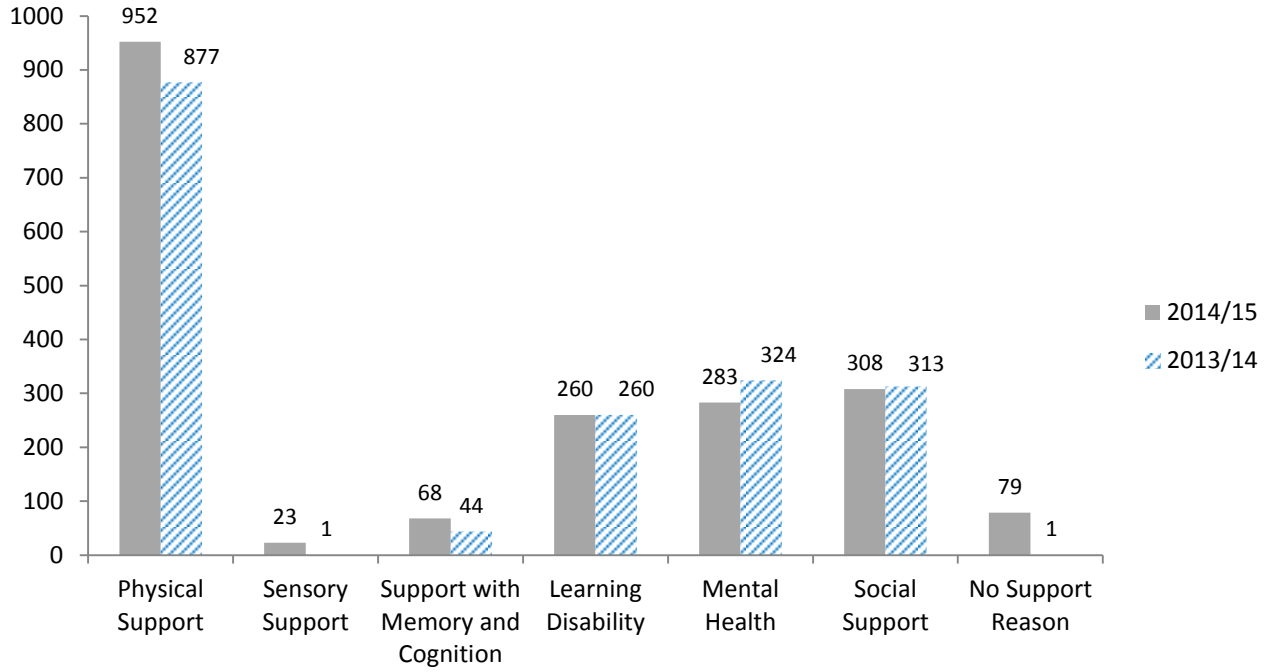


Chart 2 shows where the issue that gave rise to the concern about abuse or neglect took place. The most common location of where safeguarding concerns occurred was within individuals' own homes, which is in line with what we have seen for the past five years.

In 2014-15 Lambeth Safeguarding Adults Partnership Board has started to collect information to identify which safeguarding concerns relate to some key issues that the Board has identified, such as medication mismanagement and prevention and care of pressure wounds. By understanding where these issues occur, the Board can plan targeted action to address them.

Chart 3: Safeguarding referrals - by service user group

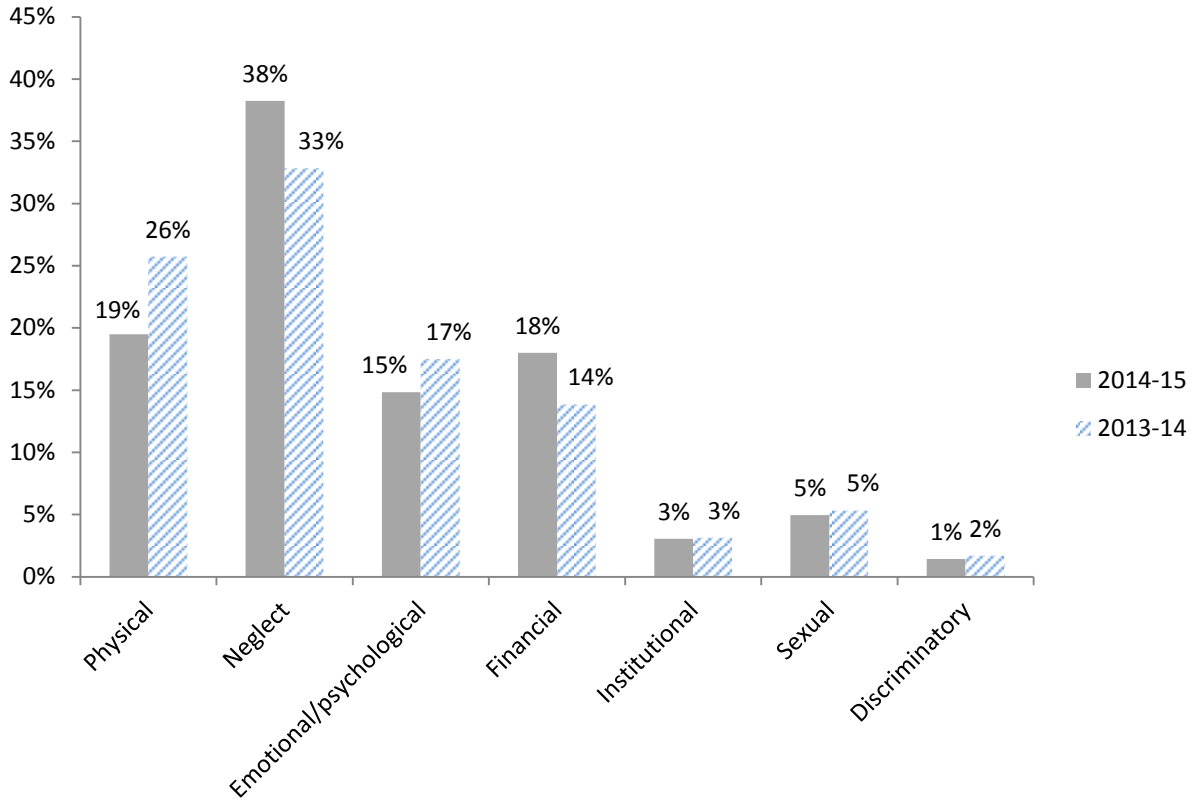


The proportion of safeguarding enquiries by service user group broadly mirrors the pattern of people using adult social care services. Most people using adult social care services in Lambeth do so in connection with their physical health needs, and it is within this group that we see the most safeguarding adults concerns.

The number of safeguarding concerns relating to people with mental health needs is lower than might be expected. In 2015-16 the Board will be looking in to this to get assurance that concerns about abuse or neglect of people with mental health needs are recognised and responded to as they should be.

The proportion of safeguarding adults concerns relating to people with substance misuse needs was higher than might be expected. We have seen this pattern consistently, and it is related to the particularly chaotic lives some of these people are living.

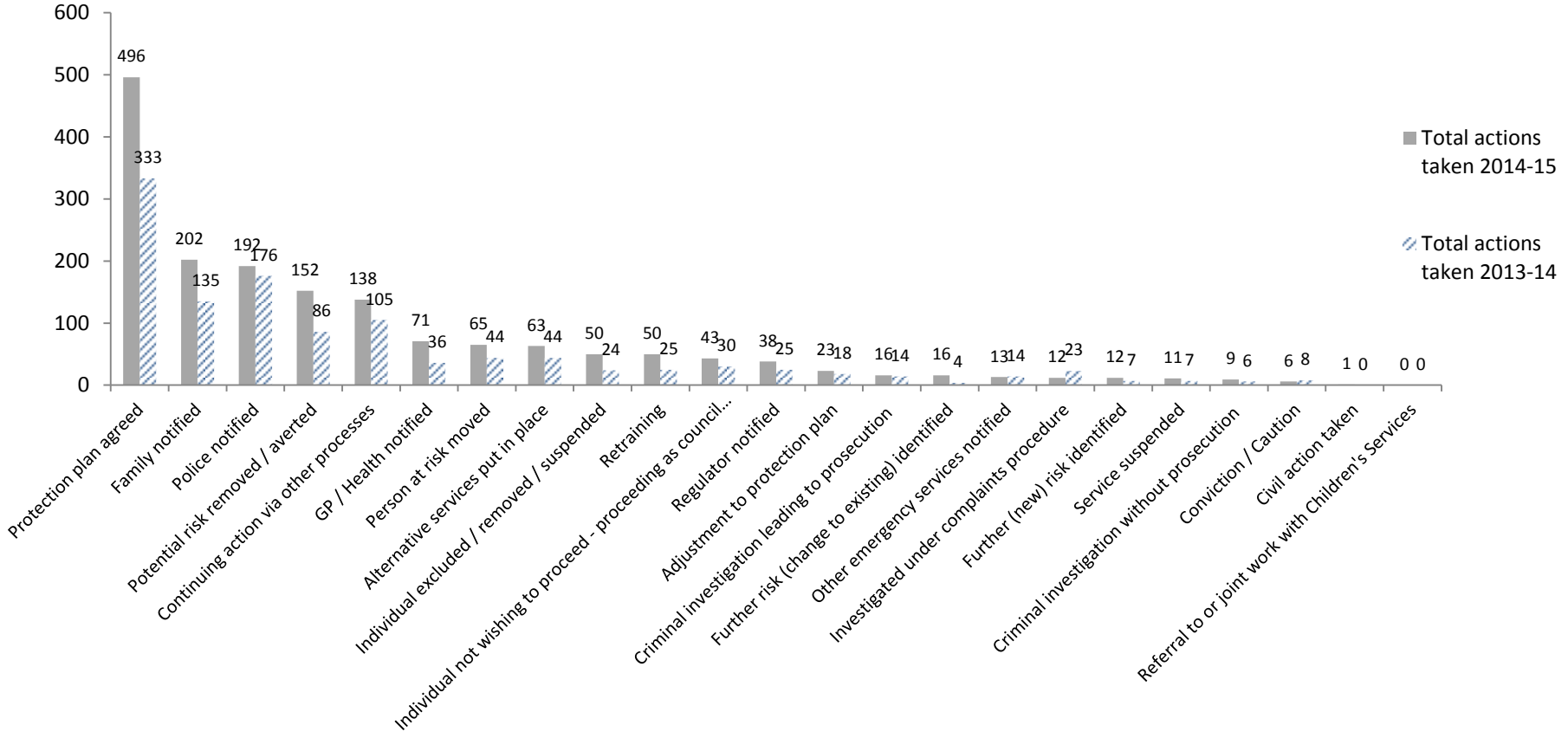
Chart 4: Issues of concern



The most common issues were neglect (38% of all concerns), physical abuse (19%) and financial abuse (18%). This is similar to the national picture. The proportions of institutional abuse, sexual abuse and discriminatory abuse are similar in 2014-15 to those in 2013-2014.

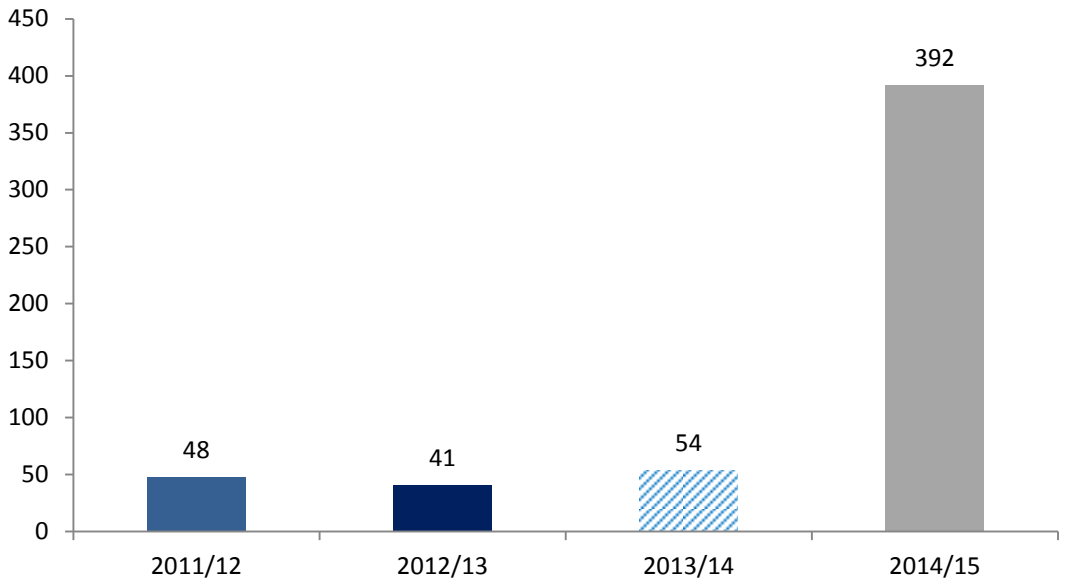
The proportion of concerns relating to neglect increased. Some of this is because the piloting of electronic call monitoring with some home care services improved the ability to spot issues such as missed visits.

Chart 5: Types of actions taken following safeguarding adults enquiries



The types of actions taken are broadly similar to those in previous years. There has been recognition nationally and locally that simply counting the actions taken does not tell us much about the impact that the work has had, and whether people are any safer at the end. The Board has been working on improving this and in 2015-16 it will be routinely receiving information about the outcomes that safeguarding adults work has achieved.

Chart 6:DoLS authorisation requests received



Lambeth Safeguarding Adults Partnership Board has oversight of use of the Mental Capacity Act 2005 (MCA), including its Deprivation of Liberty Safeguards (DoLS).

The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. They do this by helping to make sure that decisions made on their behalf are done so in their best interests, and also by empowering them to make their own decisions wherever possible.

Following a decision by the Supreme Court in March 2014, use of DoLS increased dramatically across England and Wales, and Lambeth has been no exception. As has happened elsewhere, this has put severe pressure on the Lambeth Council's ability to complete the assessments required for the DoLS process in a timely manner, despite committing additional resources to this work.

We anticipate that the numbers will increase again in 2015/16, perhaps doubling again.

The Government has asked the Law Commission to review this area of law, but any changes resulting from that will be some years away so this is likely to remain a challenging area of work.