Safeguarding Adults in Lambeth

Lambeth Safeguarding Adults Board: SAR Subgroup Briefing

Across Lambeth, there are a number of different review methods being used by partner organisations and other statutory bodies to identify key learning points. The Safeguarding Adults Review (SAR) Subgroup wants to ensure that this important multi-agency learning is shared as widely as possible, so that it can support us in practice and help us to prevent future abuse and neglect of adults at risk.

Learning from Safeguarding Adults Review - 'Mr E'

Mr. E was a white man aged 62, who struggled with alcohol and drug addiction and issues of anxiety and depression. He had been known to the Substance Misuse Services and offered information and support to access services. However Mr E's refused to engage or made explicit statements that he had no intention to stop. He was considered to have the mental capacity to make this decision. On the 17th March 2017, Mr E died in a fire at his house.
The review found that a considerable amount of work had been done by the agencies involved and there was no link between Mr. E's death and a lack of action by agencies.

The review made a number of recommendations, which Lambeth Safeguarding Adults Board is taking forward. These included improving communication pathways by having an escalation procedure and the development of a multi-agency self-neglect policy which would set out how agencies can raise persons of concern, and facilitate a multiagency approach, where the threshold for a safeguarding enquiry is not met.

Learning from Domestic Homicide Review - 'Sofia'

The Safer Lambeth Partnership has recently published a Domestic Homicide Review (DHR) relating to 'Sofia'. Sofia was murdered by her former partner while she walked her children home from school. Sofia lived and worked in Lambeth.

There were a number of lessons learnt, two of which were particularly relevant across organisations. Firstly, there was important learning about the '*necessity to understand and identify **financial and economic abuse**, including how it operates in the context of an abusive relationship underpinned by coercive control*'. Secondly there was learning about '*being able to assess domestic abuse in a **family context** in order to safeguard children and the non-abusive parent, as well as to hold the perpetrator to account*'. In the case of Sofia, it was found services could have done more to consider the family context.

In addition to the learning, the DHR outlined 27 separate recommendations. One of the recommendations was in relation to each organisation in the review promoting a '*workplace policy to support employees who may be victims of violence, abuse or stalking*'. It is acknowledged that an organisational workplace policy can be an effective measure to help support victims of domestic abuse who are employees.

Read the full DHR report here.

Update from Lambeth LeDeR Project

The Learning Disabilities Mortality Review (LeDeR) Programme is a national programme of reviews aimed at making improvements, both nationally and locally, to the lives of people with learning disabilities.

Through the reviews undertaken so far in Lambeth, it was evident that a number of people died whilst in hospital. This correlates with national statistics which indicate that people with a learning disability are more likely to die in a hospital setting. This learning emphasised the need for local services to continue to promote good quality end of life care planning for people with a LD.

There were both good and not so good examples of application of the Mental Capacity Act. Again, this correlating with nationally emerging themes.

In the reviews, there were examples of extremely good care, which evidenced a person centred approach. For example, care home staff visited their resident in hospital throughout the persons illness, and were present when the person died. Additionally the reviews demonstrated good multi agency working, particularly between GP services and community providers

Ensuring effective communication between hospitals and care homes: 'Red bag scheme'

A safeguarding adults concern was recently raised after a lady who was resident in a care home, suffered a stroke and went to hospital. When she was discharged back to the care home, the hospital did not provide information about her changed needs, and as a result the care home did not update the care plan to capture and change how to care for her differently.

Did you know there is an established system in place, known as the Red Bag scheme, which enables better communication to/from hospital, and which can be used for all types of information that needs to be 'handed over' to the receiving care team?

The 'red bag' accompanies the person when they are transferring *to and from hospital.* It is used only when a person is going between care homes and hospitals. Information placed into this bag includes essential details about the patient such as their communication abilities, list of medications and medical history. It can also include relevant personal artefacts, such as dentures. When the hospital discharges someone back to the care home, the hospital should place discharge medicines and written discharge summaries into the red bag so that the receiving care-team has the relevant updates they need to amend the care plan. Find out more and *share this knowledge in your team!*

Referring cases to the Safeguarding Adults Review Subgroup

Under the Care Act 2014, the Board is responsible for the coordination of Safeguarding Adults Reviews (SARs). These reviews are commissioned where there has been an incident of serious harm or death involving an adult at risk, and there is concern that partner agencies could have worked together more effectively to protect the adult. A multi-agency process, SARs aim to identify where agencies or individuals might have been able to act differently and this learning is implemented to try and prevent serious harm or death from happening again.

If you know of a case which you think might meet the criteria for a SAR, please contact the SAR Subgroup (LSABAdmin@lambeth.gov.uk).
Remember any confidential information must be sent securely.