

# Lambeth Safeguarding Adults Board 2019-20

# Contents

• <b>Introduction</b>	
• Foreword from Independent Chair of the LSAB .....	1
• What is safeguarding adults?.....	3
• How to raise an adult safeguarding concern .....	3
• About the Board .....	4
• The local picture .....	4
• <b>Safeguarding Activity</b>	
• What does the local data show us? .....	5
• Key themes from the data .....	6
• Key findings from awareness survey .....	7
• <b>Our Priorities And Targets In 2019-20</b>	
• What did we say we would do? .....	8
• <b>Achievements In 2019-20</b>	
• Tools for practice .....	9
• Communication and involvement .....	10
• Opportunities for learning .....	11
• Achievements of partner organisations .....	12
• <b>Reviewing Our Progress</b>	
• What are we continuing to work on? .....	16
• <b>Safeguarding Adults Reviews</b>	
• What is a Safeguarding Adults Review? .....	17
• SAR Martin .....	18
• SAR Yi .....	20
• <b>Moving Forward</b>	
• What's next? .....	21
• <b>Appendices</b>	
• Board Members 2019/20 .....	22
• Glossary/List of acronyms .....	23

# A note from the Chair

I am proud to be introducing my fifth Annual Report as the Independent Chair of the Lambeth Safeguarding Adults Board (SAB). This report, giving information on the work carried out in the year leading up to the end of March 2020, is brought to you as part of our duty under the Care Act 2014 which requires each Safeguarding Adults Board (SAB) to publish an annual report.



Our strategy this year can be described simply as ensuring that all partners to the Board focus on ***Representation, Awareness and Prevention.***

Representation is important requiring that each of us take account of Lambeth's diverse communities in everything we do. Awareness is crucial so that every citizen is clear about what constitutes abuse, neglect, or harm for those people with care and support needs and importantly that people know where to report incidences of abuse. Prevention is key to everything we do to ensure that those with care and support needs who are vulnerable, are supported so that they can protect themselves, are able to determine how they can best be protected and indeed are protected when necessary.

We always intend our Annual Report to be clear and readable – there are set requirements for that which we must publish within it and you will see that we have included information on what the Board has delivered this year.

This report sets out :

- how the Board has achieved its objectives, set out at the start of the year and how we implemented our strategy
- how each of our partners has implemented the strategy and worked to deliver effective safeguarding services
- the findings of 'Safeguarding Adults Reviews' – these are reviews which have been concluded between April 2019 and March 2020 and where an adult has died or where there have been serious issues and concerns; and where it was identified that there could be learning and improvements made by organisations to ensure that similar issues do not recur.

## INTRODUCTION

The Board and its partners must demonstrate how they ensure that people with care and support needs are protected from abuse and neglect. We do this by scrutiny of performance data and information and occasionally we focus on specific services. We usually receive a “personal safeguarding story’ at each meeting with a focus on how services have been effective, but also in terms of whether we need to do more to ‘make safeguarding personal’.

Challenging times remain for our citizens and for partners in the public sector and those voluntary sector agencies which support people in Lambeth. The impact of Covid-19 at the end of this year is well known and this, coupled with the ongoing impact of financial austerity throughout the year, has presented extreme challenges within the borough. These challenges have led organisations to restructure the way they organise their services, though it is impressive that despite these additional pressures, all partners to the Board have continued to work effectively together and to respond when being held to account by the SAB. Partners have shown continuous commitment to our three key strategic areas.

Finally, I would like to thank those partners and organisations who have supported the continued work of the Board’s subgroups. The effective work of the three subgroups reflected in this annual report is a massive commitment by those involved and I welcome the passion and drive shown which continues to deliver improving services. Importantly our engagement with Lambeth’s communities through the Community Reference subgroup of the Board continues to evidence increasing awareness of safeguarding issues. All of this would not be possible without the hard work and professionalism of the Board’s Support Officer, Ceri Gordon and Safeguarding Adults Lead, Janna Kay, to whom I am extremely grateful for their ensuring the smooth running of the SAB.

I hope that you find the annual report informative and helpful



Siân Walker,  
Independent Chair of the Lambeth Safeguarding Adults Board

# What is safeguarding adults?

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves.

**It is something that everyone needs to know about.**

The [LSAB website](#) has lots of information about Safeguarding Adults which will help you to better understand what safeguarding adults means and what you can do to prevent abuse from happening, and support adults who may be experiencing abuse or neglect.



# How to raise an adult safeguarding concern

If you are concerned about a person who is over the age of 18 years of age, they have care and support needs, and you feel they are being abused or at risk of abuse from another person, you should seek help for them.

If you need to raise an adult safeguarding concern, [report it using the online form](#) - this is the quickest and most secure way to report concerns. The person telling us about the possible abuse or neglect can remain anonymous.

**In an emergency dial 999.** If the person is not in danger now dial 101.

If you're not sure what to do, or need some advice, there are people who can help. You can talk to your GP or nurse, a social worker, a police officer or your key worker. They will help you to respond to your concerns.



[To find out more about what happens when you raise an adult safeguarding concern, see our quick and easy guide.](#)

## INTRODUCTION

### About Us

The Lambeth Safeguarding Adults Board is a statutory board that co-ordinates safeguarding adults work in Lambeth. The Board has an Independent Chair and is a multi-agency partnership that includes a range of organisations.

We want to ensure that all residents and people who work with adults at risk in Lambeth know about safeguarding adults and know how to respond should they come across a concern. We do this by promoting and maintaining cohesive partnership working to safeguard adults at risk from harm.

The Board is not responsible for delivery of services, though those who plan and make decisions about services locally have representation at the Board and give the Board regular assurance on how services are delivered.

### The local picture

Nearly a third of a million people live in the London borough of Lambeth; it is one of the most densely populated local authorities in England and Wales. Lambeth has several distinctive neighbourhoods including Waterloo, Brixton, Clapham, Streatham and Norwood.

The borough is ethnically diverse and around 150 different languages are spoken by families in the borough . 55% of the population belong to a White ethnic group, with the remaining 45% to Black, Asian and Minority Ethnic group. Black people make up a third of the population (30%). We are also home to a strong Portuguese community.

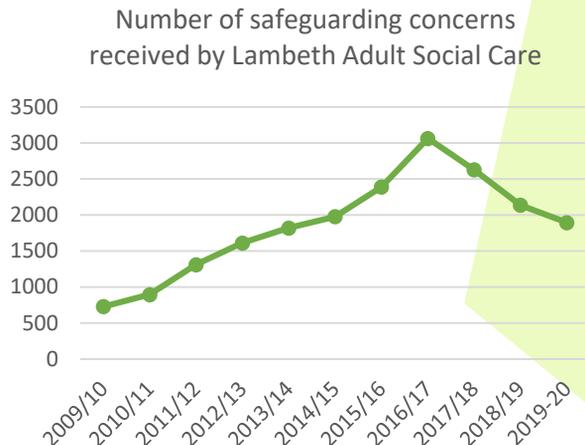
Lambeth also has a 'high turnover': 40,000 people leave the borough, and over 40,000 others move to the borough every year. This, coupled with high levels of deprivation, presents a challenging picture for local services seeking to support those most in need.



## What does the local data show us?

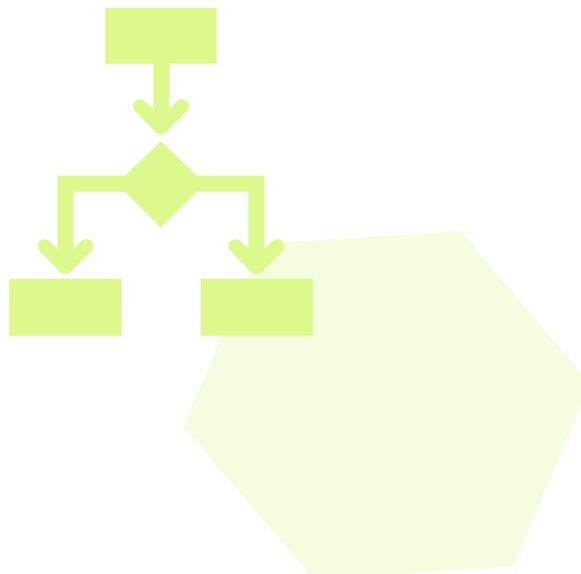
Lambeth has a high volume of adult safeguarding concerns being reported each year, and almost half of these proceed to a Section 42 enquiry.

In 2019-20 Lambeth Adult Social Care received an average of 157 adult safeguarding concerns each month, with an average of 72 of these moving to safeguarding enquiries (Section 42).



Lambeth has previously seen year on year increases in the volume of adult safeguarding referrals being received, peaking in 2016/17.

The reversal of this trend from 2017/18 onwards is a result of a practice changes in the borough. For instance, we now have a new way of recording referrals for other types of support that are initially reported as a safeguarding concern. This does not mean that we are not responding to these concerns, but means that they are being directed to more appropriate pathways e.g. to receive an assessment of needs



## Key themes from our data



Abuse and neglect of adults at risk is most likely to happen at home. 57% of concerns received in 2019-20 took place in the person's own home. These cases will include incidences of domestic abuse and concerns relating to services provided in the home.



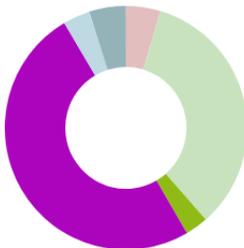
42% of concerns received in Lambeth in 2019-20 related to neglect and acts of omission. Other common categories of abuse include financial abuse (22%) and physical abuse (20%)



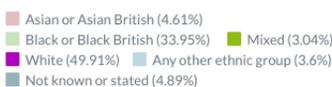
Approaches to adult safeguarding should be person led. In Lambeth, people were asked about what they wanted to happen as part of the safeguarding enquiry in 84% of cases.



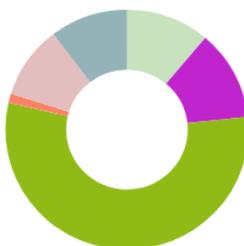
Perpetrators of adult abuse and neglect are most likely to be a person known to the adult at risk, with 47% of concerns in 2019-20



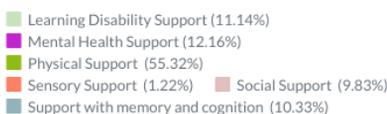
Data relating to ethnicity is generally reflective of the [Lambeth population](#) (see page 3), and 55% of safeguarding adults concerns in 2019/20 concerned individuals 65 years or older which is a reflection of the adult social care service user group.



Whilst these figures are in line with what we might expect, there is still more to do in terms of reaching out to different Lambeth communities and helping them to understand adult safeguarding. We also want to think more about how we work with younger adults at risk.



We also consider data relating to primary support need. This shows that 55% of safeguarding concerns received in 2019/20 related to individuals whose primary support was in relation to physical health. We want to ensure that adult safeguarding is also accessible to those with mental health support needs and learning disabilities, and that they are able to make their voice heard. This will be part of the work of the Community Reference Group over the next three years.



## Key findings from awareness survey

The Community Reference Group led an awareness survey to find out more about what people understood about adult safeguarding in Lambeth. This was a repeat of the survey undertaken in 2017/18, and in 2019/20 we had a stronger focus on gathering feedback from service users and residents (rather than professionals). We have used this feedback to develop our future plans.

We found that:

- 22% said that they did not know or were unsure what adult abuse is. This is an increase from the 2017/18 survey where only 11% responded this way (we think this is a reflection of more professionals taking the 2017/18 survey).
- As with our 2017/18 survey, the lowest recognised possible form of abuse was mate crime (28% of respondents). This was followed by restraint (48%) and organisational abuse (51%).
  - The Community Reference Group has already done some work to create awareness raising material in relation to [mate crime](#) and [appropriate use of restraint](#). There will be a continued focus on these areas in 2019/20



“I didn't know there was a Lambeth Safeguarding Board. I think you need to raise your profile by actively engaging with residents”

“[I would like to know] how to take action that will make a difference”

“I think [the LSAB] are doing well, I already have three different leaflets from Lambeth on what to do. It might help to describe how to spot that abuse has happened, because often people are afraid or embarrassed to talk about it”



Each year, the Board must publish its strategic plan outlining how it will meet its main objectives.

In order to give clear direction the Lambeth Safeguarding Adults Board produced an [overarching plan for the three years](#) from 2017-18 to 2019-20 which focused on **three key priorities** to guide our work plan for each year.

This was then used to develop a focused plan for 2019-20, which focused on measuring our progress.

1

## Representation

We want to ensure that the Lambeth Safeguarding Adults Board is representative of the communities it serves.

In 2019-20, the Board set out to increase engagement with service users, with a report detailing service user feedback on how Making Safeguarding Personal is achieved.

2

## Awareness

We want to make sure that Lambeth residents and people working with those with care and support needs can recognise and act when there are concerns about the risk of abuse and neglect.

Our strategic plan for 2019-20 included a focus on multi-agency training, professional supervision and raising awareness.

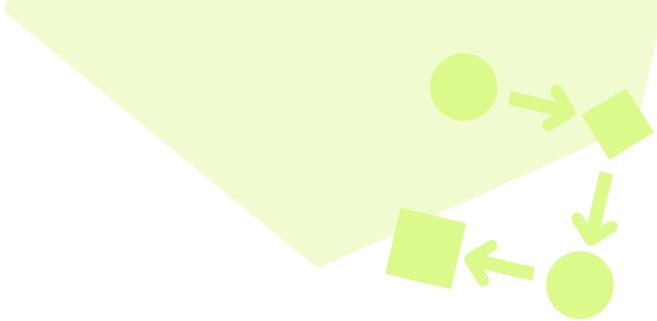
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## Prevention

We want to have assurance that we do all we should when we respond to a risk of abuse and neglect, and apply any lessons learned to prevent something similar happening again.

As well as receiving regular assurance from Board Members, we set a target to develop a multi-agency framework for responding to high-risk cases.

## Tools for practice



### Supervision framework

Effective professional supervision is essential to support practitioners responding to safeguarding concerns and undertaking safeguarding enquiries. This [framework](#) aims to provide specific guidance on supervision in the context of adult safeguarding.

The Board developed the framework following review of Safeguarding Adults at Risk Audit Tool which found many partners were struggling in this area.

### Managing allegations against staff

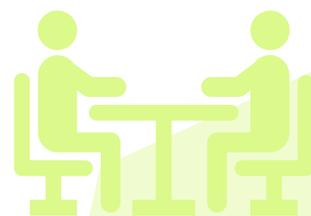
A lot of progress has been made in the development of a framework to support partner organisations in creating a policy and procedure that reflects the needs of their organisation and their service users when responding to allegations against a person in a position of trust. We are now working on final amendments and hope to make this tool available for partners in 2020 (*subject to delays caused by COVID-19 pandemic*).

### Decision Making

The Board has developed a [new tool](#) to assist practitioners in assessing the seriousness and level of risk associated with a safeguarding adults concern, to support them when making referrals. The tool also gives an overview of how the law is applied by the local authority (Section 42(1) and (2)) and clarifies what response referrers can expect.

### Collaborating with Department of Work and Pensions

As part of our strategic plan for 2019-20, the Board wanted to improve understanding of adult safeguarding in financial services. This has included work with the Department of Work and Pensions to improve their policies for responding to adult safeguarding concerns; this work will continue in 2020/21.



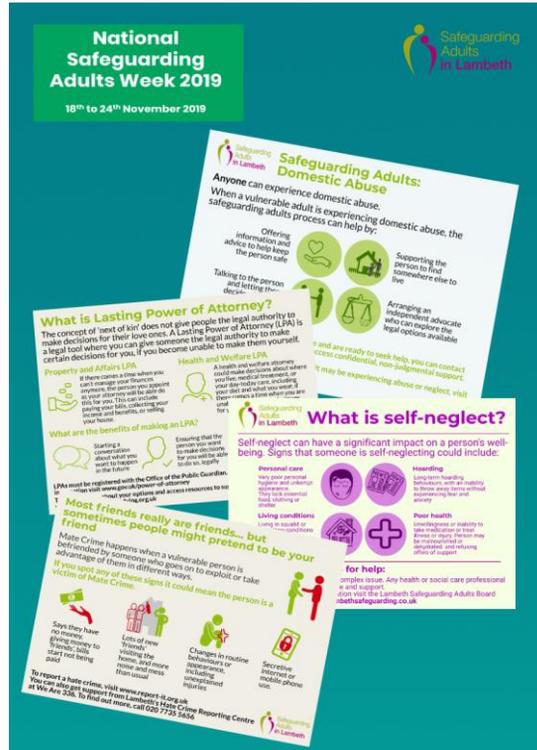
# Communication and involvement

## Raising awareness

Board Members took part in National Safeguarding Adults Week by promoting [new digital awareness content](#) that set out to raise awareness of the different types of abuse and how to seek help. Our Chair also hosted the first in a series of Q&A sessions in the community and with Adult Social Care staff.

## Feedback from service users

Healthwatch Lambeth presented a report to the Board which set out the findings from service users' feedback on their experiences of the adult safeguarding process. This found that there were a number of examples of good practice, with people feeling safer at the end of safeguarding enquiries. This feedback also highlighted areas for improvement which will be taken forward by Lambeth Adult Social Care.



## Engagement

Led by the Community Reference Group, the Board has started to make new connections with different communities in Lambeth by sharing information and inviting them to be part of our subgroups and take part in events. This remains an ongoing piece of work.

## Opportunities for learning

### Responding to Self-Neglect

The Board hosted an event for local voluntary and community groups which explored the way in which they can support individuals who may be self-neglecting. The event also recognised the important role these groups play in supporting statutory services, and invited participants to make a [pledge](#) about what they would do to protect adults at risk.



### Recognising modern slavery

An event led by ‘Stop by the Traffik’ guided participants from Lambeth’s voluntary and community sector on how to spot the signs that someone is a victim of modern slavery, and helped them to think about the possible barriers to victims seeking support.



It is a subject that I knew absolutely nothing about and I have found this invaluable, especially understanding that modern slavery can be absolutely anywhere and anyone. I didn't know much about who to contact and hadn't thought about all the signs. I will share with my peers.

### SAR Yi Learning Event

In December 2019, Lambeth hosted a learning event which aimed to equip professionals in safeguarding with knowledge of those experiencing multi-exclusion homelessness, by providing them with an update on the findings and recommendations from a cross-borough Safeguarding Adults Review. The event was attended by a wide range of professionals from multiple-boroughs (see page 20 for more information about what happened to Yi).

## Achievements of partner organisations

### Age UK Lambeth

Since 2018 Age UK Lambeth has made a commitment to ensure all staff & Volunteers working with people have access to the most appropriate level of Safeguarding training to enable them to carry out their roles. All frontline staff are offered a higher level of safeguarding training.

We are proud to be involved in the Safeguarding Adults Board in Lambeth and we are represented at a strategic level by the Deputy Chief Executive Officer, Kim Connell. Our Community Development Manager, Tom Stannard, is an active member of the Community Reference Group.

### Metropolitan Police Service

The last 12 months has been a period of significant change and transition for the Metropolitan Police Service with the move from 32 borough based policing units to 12 larger Basic Command Units (BCU). Central South BCU now serves both Lambeth and Southwark boroughs from a policing perspective.

This change saw the creation of a new Safeguarding strand which brought together officers who investigate domestic abuse, rape, serious sexual assault, child abuse, missing persons and other associated areas in one department. This has both increased resilience and the opportunity to manage the challenges of safeguarding issues in a much more holistic manner.

The amalgamation and transition has progressed as planned providing a platform to build on in terms of Adult Safeguarding. Particularly key to this was the development of a new Mental Health team who will look to work in partnership with a real emphasis on longer term problem solving and prevention.

### Lambeth Adult Social Care

The local authority is responsible for the public law (Care Act 2014) decision as to whether a statutory S42 adult safeguarding enquiry should be undertaken and in leading such enquiries. We are confident that all Adult Social Care staff can recognise and act on concerns about abuse and neglect of adults at risk. Despite the high numbers of adult safeguarding concerns (over 2000 per annum) received, quality assurance audits show some excellent work happening in relation to safeguarding plans and advocacy.

The recent Healthwatch Lambeth survey (with feedback from service users who had been through an adult safeguarding process), showed that actions agreed at the start were carried out and that most people reported feeling safer as a result of the safeguarding process. We see this as a significant achievement in relation to our commitment to making safeguarding personal.

Adult Social Care has worked hard to maintain good working relationships with all partners so that effective multi-agency working can be enabled. Where this is not happening, agencies have felt able to escalate concerns, so that any issues which are interfering with this, can be addressed. An example of this is where both Housing and Fire Services colleagues expressed concerns about not knowing when someone may be vulnerable or have support needs; therefore hindering them from delivering effective safeguarding responses. This has seen the development of an Information Sharing Protocol to support how and when this information can be shared.

## ACHIEVEMENTS IN 2019-20

### Lambeth Clinical Commissioning Group (CCG)

During 2019-20 Lambeth CCG has continued to fulfil its statutory obligations to safeguard adults who are experiencing, or are at risk of, abuse or neglect. The CCG has remained an integral partner of the Lambeth Safeguarding Adults Board (LSAB) and associated subgroups, contributing significantly to the LSAB work plan throughout the year.

Key highlights included the support provided by the CCG to primary care colleagues through the development of two bespoke adult safeguarding resources which are available to all GP Practices in Lambeth; these being the Template GP Practice Adult Safeguarding Policy and Procedures, and the GP Practice Adult Safeguarding Competency Guide. These resources will promote effective adult safeguarding work in our local Practices. The CCG has provided formal supervision to individual Practice GP Adult Safeguarding Leads through a supervision forum.

The CCG was also instrumental in organising and delivering two successful multi-agency training events on the Mental Capacity Act and Domestic Abuse. These events were attended by a wide range of health and social care professionals as well as third sector organisations. Each event had over 100 participants and received excellent feedback.

### Kings College Hospital NHS Foundation Trust (KCH)

2019/20 has been another busy year for the Kings Safeguarding Adults Service. There has been an increase in DoLS applications and learning disability notifications for patient admissions continue to rise each quarter. There has been a focus on service development; including the provision of services for people with a Learning Disability service and also alignment with the Child Safeguarding service as part of the 'Think Family' ethos.

The Mental Capacity Act continues to be a focus. MCA 'big talks' have been held, giving staff the opportunity to hear from guest speakers on new judgements on the MCA and DoLS. KCH hosted the Lambeth Together MCA awareness day which focussed on Best Interests and Advanced decisions.

The service has continued to engage with the local Safeguarding Adults Boards and actively participates in the sub-groups of these boards contributing to the wider safeguarding agenda.

KCH is committed to ensuring its workforce is sufficiently skilled in safeguarding training. Over the last year training compliance figures have seen a quarter on quarter improvement for adult safeguarding training and it has been acknowledged by the 'Prevent' Regional Lead that the Trust has made one of the best improvements nationally for its 'Prevent' training compliance. However the CQC noted that the Trust is not compliant with the 85% target for Prevent, Safeguarding Adults Level2 and MCA across all staff groups and the service will be taking steps to address these gaps.

The CQC inspection has highlighted the risk to the Trust in terms of not receiving timely outcomes for Section 42 safeguarding enquiries from the Local Authorities. The Safeguarding service are taking steps to address these concerns.

## ACHIEVEMENTS IN 2019-20

### Guys' & St Thomas' Hospital NHS Foundation Trust

The Trust continued to see high numbers of safeguarding adults referrals from right across the organisation for patients with a variety of vulnerabilities. Many of these patients have very complex needs and require advice and support from a number of professionals and often external agencies. As a result the Trust has focused on preventative safeguarding interventions to ensure that the most vulnerable patients get the right support at the right time delivered by skilled staff. The Trust has invested in a Director of Nursing for vulnerable patients to strengthen the leadership for the vulnerability agenda including safeguarding adults. This post is supported by two Leads from the Medical Director's Office to provide medical leadership for safeguarding adults.

Recognising the complexities presented by patients, each directorate now has an appropriately trained vulnerable adult lead who will be the person whom staff contact for advice and support in the first instance. Many of the directorates also have complex cases or vulnerable adults panels that regularly review these patients and work towards achieving best outcomes for very vulnerable patients and their carers. The vulnerable adult leads attended their first workshop on 4<sup>th</sup> February 2020 where they gained knowledge on specialist team working within the Trust and the support they can provide. This included adult and children safeguarding teams, the learning disability team and the palliative care service. The attendees also had the opportunity to work through case scenarios involving patients with very complex care needs.

Carer support is high on the Trust agenda and carer feedback is sought at different levels that is used to improve on the services that we provide. The Trust runs a Carer Network event that provides information and training for carers on different aspects of the caring role. The event is held 4 times a year and well attended and evaluated. Bespoke training days for carers of people with dementia are being planned

The Trust provides a variety of training for staff and has achieved target compliance of 85% for safeguarding adults and 'Prevent' training. Update sessions are provided as bespoke sessions at the clinical areas to meet the needs of staff. Modern Slavery training is now provided to targeted groups of staff for e.g. A&E staff as cases involving human trafficking and modern slavery are on the increase.

The Trust has worked very closely with the LSAB through sub-group and Board membership in progressing and achieving its strategic priorities. It has participated in the safeguarding adults awareness survey which commenced in November 2019. It is working with LSAB and partners looking at developing a clear process for collaborative working with regards to safeguarding people with complex safeguarding needs as a key priority.

Investment has also been made in the form of a third Clinical Nurse Specialist for supporting patients with dementia and their carers. This has enabled the strengthening of the support provided to patients and carers within the Trust Memory service and their aftercare through appropriate referrals and information.

## ACHIEVEMENTS IN 2019-20

### HMP Brixton

Adult Safeguarding continued to be the priority aim at HMP Brixton in 2019/ 2020 and there were many successes. In July 2019 the Independent Prison Inspectorate found safeguarding outcomes dramatically improved to “reasonably good” from 2017 when the prison was “fundamentally unsafe”. Verbal feedback at the time stated that improvement was unprecedented in prisons and the most significant improvement inspected.

HMP Brixton continues to work with some of the most damaged and difficult local people and in partnership continues to offer intensive drug services, widespread innovative employment and educational opportunities and bespoke interventions for those particularly vulnerable to self-harm and violence including a local Man’s Club and every man having a regular session with an appointed keyworker.

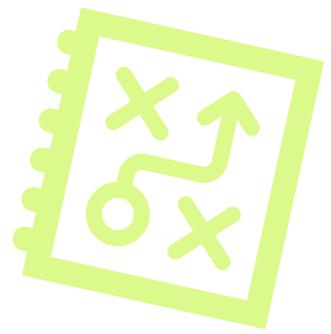
In February 2020 the Safeguarding and Segregation Team won a national award within the Ministry of Justice for their commitment and achievements in promoting innovation, learning and openness to drive up safety.

### London Community Rehabilitation Company

The London CRC works with service users to ensure they complete their probation period, and have the right support to make positive life changes and break the cycle of reoffending. London CRC works closely with partner agencies across the statutory and voluntary sectors to safeguard vulnerable adults and to meet the needs of our service users who present with a wide range of needs.

Areas of good practice in adult safeguarding in the last year include:

1. Engagement with multi-agency partnerships, which involves sharing information and working collaboratively to safeguard victims and service users alike. For example, through the MARAC (domestic abuse); IOM (prolific offenders); Channel (Prevent); and gangs forums.
2. Promoting staff learning and development, for example through embedding the CRC’s new risk assessment system; London CRC public protection boards (previous focus on modern slavery, future focus on female offenders and mental ill health); and master class events (e.g. counter-extremism).
3. London CRC provides a variety of services and interventions to help service users understand their behaviours, develop a prosocial identity and make positive changes. For example, we deliver the restorative justice Making Amends programme and work with partners to ensure service users are supported in their recovery from drug and alcohol misuse, and to improve their emotional wellbeing.



# What are we continuing to work on

## Representation

We have made a start on our work to make adult safeguarding representative of all Lambeth communities. Nonetheless, we still want to do more to engage with these communities and involve them in our work.

This extends to Board level. We will continue to think carefully about how we ensure we develop a Board membership that is representative of Lambeth.

## Prevention

In an initiative led by Bromley SAB, Lambeth collaborated with other local SABs to create a new multi-agency communications pathway for escalating concerns about people with complex needs which may not meet the Section 42 threshold. Once this pathway is agreed, work needs to be done to embed this in practice.

The Mental Capacity Act subgroup are developing a new, simple and easy to use audit tool to complement the Board's guidance and charter document. These will be brought together to create an accessible toolkit for professionals.

## Awareness

We set ourselves a target to engage more with financial services. We have laid the groundwork for this, including local engagement with [Cifas](#), work with the Department of Work and Pension and making initial contact with local banking institutions. We will continue to follow up on these areas of work in order to strengthen relationships and improve awareness.

The Board has agreed an approach to local multi-agency training. The Performance and Quality Subgroup will take this forward and develop a sustainable model of training which utilises local expertise. We have plans in place for another series of masterclasses organised in collaboration with Lambeth Together and the Lambeth Safeguarding Children Partnership. Originally scheduled for March 2020, these were postponed to September 2020 as a result of the COVID-19 outbreak. This will include supporting organisations with the implementation of the Safeguarding Adults Supervision framework through training for safeguarding leads. The Board will also consider whether similar work is needed to help smaller organisations make sense of the allegations against persons in positions of trust framework, once this is agreed.

Alongside the Safeguarding Adults Review (SAR) subgroup, there is also work to develop learning tools to help better disseminate learning from SARs and measure impact on practice.

# What is a Safeguarding Adults Review?

Under the Care Act 2014, the LSAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These are independent reviews commissioned where there has been an incident of serious harm or death involving an adult at risk.

SARs set out to establish what may have gone wrong and to identify where agencies or individuals could have acted differently. SARs also recognise the complexity of safeguarding work and will identify the areas of good practice too.

Key recommendations are made at the end of a SAR and this will often include the learning needed to prevent future incidents of serious harm or death from happening again.

In 2019/20 we concluded two SARs, led by independent reviewers which examined what happened in the cases of Martin and Yi.

The below summarise what happened in these cases and what we have done in response to recommendations. The full reports for both SARs are available on our website.



## What happened to Martin?

Martin was a 51-year-old gay man who lived alone. Martin had family who he connected with on and off, dependent on how he was coping with his alcohol addiction – something he had struggled with for many years. His body was found at his address on the 16th March 2018, having last been seen alive on the 12th March. Martin was seen by three agencies on the 12th March; the Metropolitan Police, the London Ambulance Service (LAS) and a General Practitioner (GP), all of whom tried to convince him to go to hospital. He had clearly been unwell and was found to be lying on a soiled bed with no signs of food in the house. His neighbours had reported their concerns when they noted the smell and had not seen him for some time.

All three agencies were extremely concerned about Martin's self-neglect and the impact it was having on his wellbeing. Martin refused to go to hospital, and he was assessed as having capacity to make this decision. An adult safeguarding concern was raised following the referrals from Police and LAS to Lambeth Adult Social Care (ASC). The GP spoke with ASC on the same day that he saw Martin however ASC did not rate the response as urgent, as was told that Martin could walk and had said he would visit his GP.

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## What we did following the review

The Safeguarding Adults Review was concluded in July 2019 and made a number of recommendations. These have been used to formulate an action plan that the Board and partners are implementing. Key areas of work include:

### Responding to Self-Neglect

It was recommended that local policy and procedure be updated in order to examine how risk to adults who are self-neglecting is understood and assessed, and how concerns are communicated. This is currently being drafted, and we hope to finalise this in 2020.

### Communication Systems

There were a number of recommendations which considered how agencies and teams communicate with one another, and a recommendation to explore how GP practices engage with patients as a preventative safeguarding response. These are being considered at subgroup level and GP Safeguarding Forum.

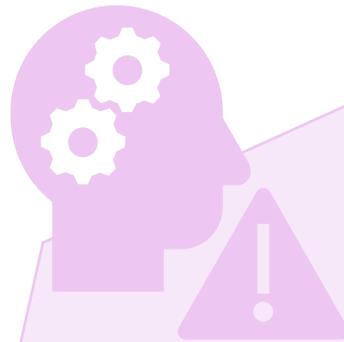
### Executive Capacity

The review noted that assessing someone's mental capacity to make certain decisions, can be complicated in cases where people self-neglect. This is often because a person may present as able to understand, retain and communicate their decision articulately. The review highlighted that a mental capacity assessment in these contexts, should consider whether a person can convert their decisions into meaningful action. If they cannot, this may indicate that they are not able to use and weigh information to make decisions, and as such, likely lack capacity. This links to work to develop LSAB self-neglect guidance.

To read the full report, [visit our website.](#)

### Vital Interests

The review recommended that a mechanism for coordinating urgent multi-agency conversations be developed when there is a risk to 'vital interests', with scope for creative multi-agency solutions. This links to work to develop framework for responding to complex cases. The MCA Subgroup are currently working to agree definition of vital interests and to consider how this can link into guidance documents.



## What happened to Yi?

Yi was a man who owned a property in Newham and had been living and working in London for several years. It is understood that by 2006 he had abandoned his home and had long periods of rough sleeping, often moving between different London boroughs. He had a diagnosis of schizophrenia and a brain injury, but his needs appeared to have been misunderstood due to his often aggressive presentation and alcohol abuse. In July 2017, he was admitted to hospital and later placed by LB Lambeth into a nursing home.

A Safeguarding Adults Review was undertaken by Newham, Islington, City and Hackney & Lambeth's Safeguarding Adults Boards to understand the barriers that prevented professionals from understanding and protecting Yi. Lambeth agreed to join the review process to benefit from the learning although were not at fault as had responded appropriately when Yi came into the borough

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## What we did following the review

The Safeguarding Adults Review was concluded in August 2019. The report highlighted a number of strategic recommendations to help systems respond to cases where people 'ping-pong' between services. In Lambeth, this has led to some of the following actions:

### Local homelessness strategy

The recommendations from this SAR have informed Lambeth's local homelessness prevention strategy.

### Eviction and abandonment protocol

A protocol regarding evictions was developed in consultation with Commissioners and Providers. All providers across the Housing Vulnerable Adults' Pathway and Young Person's Pathway are expected to adhere to this.

### Removing barriers for effective communication

It was recommended that local policy and procedure be updated in order to examine how risk to adults who are self-neglecting is understood and assessed, and how concerns are communicated. This is currently being drafted, and we hope to finalise this in 2020.

To read the full report, [visit our website](#).

## What's next?

At our Development Day in February 2020, we created a new [three year strategic plan](#) which will guide the Board's work up to 2022-23.

This plan has been built around three key priorities; Working Together, Making Safeguarding Personal and Prevention & early action.

Our more focused aims have been developed using feedback from our recent awareness survey, learning from Safeguarding Adults Reviews and by reviewing outcomes from our previous strategic plan. We have also taken the time to review our aims in the context of the coronavirus (COVID-19) pandemic. We will be:

- Identifying areas for collaboration and joint working with our strategic partners and building relationships with external bodies, including in areas of transitional safeguarding.
- Continuing to expand our network and increasing engagement with local residents and service users, with specific focus on experiences of the safeguarding adults process and Making Safeguarding Personal.
- Focus on wider dissemination of key learning from Safeguarding Adults Reviews. This will also include more robust plans to measure the impact of this work, and will incorporate learning from other review processes – including those which look at impact of coronavirus on adult safeguarding.
- Promoting new tools and learning opportunities which promote best practice and support frontline professionals.
- Seeking to improve representation of black, Asian and ethnic minority voices at the Board.

## MEMBERSHIP OF THE LAMBETH SAFEGUARDING ADULTS BOARD

The Board is made up of senior members from a range of organisations.  
Full Board Members during 2019/20 were:

Name	Title	Organisation
Adela Kacsprzak	Head of Service: Lambeth & Wandsworth Cluster	National Probation Service
Catherine Pearson	Chief Executive	Healthwatch Lambeth
Ciara McKay	Director of Nursing, Adult Services and Adult Safeguarding	Guys and St Thomas' NHS Foundation Trust
Darren Levy	Director of Housing	Lambeth Council Housing
CLlr Ed Davies	Lead Councillor for Adults and Health	London Borough of Lambeth
Fiona Connolly	Executive Director	Lambeth Adult Social Care
Hirila Rose	Head of Service, Safeguarding	Certitude
Iain Keating	Detective Superintendent Safeguarding	Central South BCU, Metropolitan Police Service
Jo Haworth	Deputy Chief Nurse	Kings College Hospital NHS Foundation Trust
John Lavelle	Service Director, Lambeth	South London and Maudsley NHS Foundation Trust
Kevin Marshall-Clarke	Head of Safety and Residence	HMPS Brixton
Kim Connell	Deputy Chief Inspector and Safeguarding Lead	Age UK Lambeth
Liz Clegg	Acting Director Integrated Commissioning	London Borough of Lambeth/Lambeth Clinical Commissioning Group (CCG)
Norm Perry	Borough Commander, Lambeth	London Fire Brigade
Richard Outram	Director of Adult Social Care	Lambeth Adult Social Care
Ruth Hutt	Director of Public Health	London Borough of Lambeth
Sian Walker	Independent Chair	
Sophie Bartle	Contracts and Partnerships Manager	London Community Rehabilitation Company
Teresa Foster	Detective Chief Inspector	Metropolitan Police Service, Lambeth

### Advisory Board Members:

Name	Title	Organisation
Barbara Joyce	Welfare Specialist	Office of the Public Guardian
David Rowley	Lead Safeguarding Nurse	Lambeth Clinical Commissioning Group
Janna Kay	Adult Safeguarding Lead	Lambeth Adult Social Care
Mala Karasu	Head of Safeguarding Adults	Guys and St Thomas' Hospital NHS Foundation Trust

## GLOSSARY/LIST OF ACRONYMS

**Channel** – [Channel](#) is part of the Prevent strategy (see below) and focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism, using a multi-agency approach.

**DoLS** – The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. To find out more visit our [website](#).

**IOM** – [Integrated Offender Management](#) allows local and partner agencies to co-ordinate the management of offenders.

**Lambeth Together** - [Lambeth Together](#) is a local initiative to put in place a new health and social care system for Lambeth which will make services better and easier to access for everyone who lives or works in the borough.

**LeDeR** – The [Learning Disabilities Review Programme](#) is a national programme which aims to support improvements in the quality of health and social care service delivery for people with learning disabilities, and to help reduce premature mortality and health inequalities for people with learning disabilities.

**LPS** - The Mental Capacity (Amendment) Bill (May 2019) replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. For more information about these changes [see here](#).

**MARAC** – a Multi-Agency Risk Assessment Conference is a meeting where information is shared on the highest risk domestic abuse cases . To find out more, see [SafeLives introduction to the work of the MARAC](#).

**MCA** – The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. For more information, visit our [website](#).

**MSP** – Making Safeguarding Personal is an initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

**Prevent** - [Prevent](#) is part of the government’s counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. The Home Office works with local authorities and a wide range of government departments, and community organisations to deliver the Prevent Strategy.

**SAR** – Safeguarding Adults Review. These are independent reviews commissioned where there has been an incident of serious harm or death involving an adult at risk. For more info, see page 16.

# Lambeth Safeguarding Adults Board



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