

Protecting
adults from
abuse and
neglect



ANNUAL REPORT 2020/21

Lambeth Safeguarding Adults Board

WHAT DOES “SAFEGUARDING ADULTS” MEAN?



The Care Act 2014 says that local authorities, like Lambeth Council, must protect the people that live or spend time in their area from abuse and neglect.

WHAT DOES ABUSE AND NEGLECT MEAN?



Abuse is hurting someone or treating them badly, like hitting them or calling them names.

Some of the types of abuse are: Physical, Sexual, Psychological, and financial.



Neglect is when someone who needs help is not being cared for properly by the people who are supposed to be looking after them.

WHO IS AN ADULT AT RISK?



Anyone 18 years and older who needs care and support.

They may be ill, frail or have a disability.

They can't protect themselves from harm.

WHERE DOES ABUSE AND NEGLECT HAPPEN?

Abuse can happen anywhere.

It could be:



- In a hospital
- In a care home
- In a person's own home
- Or out in the community



WHO CAN YOU TALK TO IF YOU HAVE CONCERNS?



If there is an emergency you should always call 999

If it is not an emergency, you can:

- Call Adult Social Care on 020 7926 5555.
- Email Adult Social Care adultsocialcare@lambeth.gov.uk
- Call 101 to report non-emergency crime to the police.



You can also speak to:

- Your GP or Nurse
- A voluntary or community organisation
- RESPOND by calling 080 8808 700
- We Are Hourglass 0808 808 8141 (for older person's at risk)

WHAT HAPPENS ONCE A SAFEGUARDING CONCERN IS RAISED?



First, a social worker or another professional who knows the person well will talk to them to try and understand what has happened, and where they need help.

They might also talk to other people, such as the person's friends or family.



If a crime has been committed, the police may investigate what has happened.



Those working on the enquiry will make sure that no one else is at risk of harm.

They will do their best to reach a good outcome for everyone involved.

WHAT IS THE LAMBETH SAFEGUARDING ADULTS BOARD?



The Lambeth Safeguarding Adults Board brings together professionals who work with adults at risk so that they can work together to support and protect them.

The Board has members from Fire Services, Police, Hospitals and Voluntary organisations who work together to protect people from harm.



In 2020/21 the Board was led by Siân Walker, our independent chair.



Anu Singh took over as our new independent chair April 2021 and will help us to achieve our new aims.

WHAT HAS BEEN HAPPENING IN LAMBETH IN THE LAST YEAR?

The report outlines how many times we have been told about abuse or bad treatment and shows that:



- The number of safeguarding adults concerns has gone up.



- Most safeguarding concerns happen in people's own homes.



- We saw a lot more safeguarding concerns about self-neglect. This is when someone might come to harm because they do not look after themselves. This might be not eating or taking their medication or looking after their personal hygiene.

WHAT DO WE KNOW ABOUT THE PEOPLE WHO HAVE EXPERIENCED ABUSE OR NEGLECT?



- Most safeguarding concerns involve a person who is aged 65 and over.



- There are more safeguarding concerns for women than for men.



- There are more safeguarding concerns for people with physical disabilities compared to those with mental health conditions or learning disabilities.



- Safeguarding concerns for people from different ethnicities are generally in line with the wider population. We still want to do more to reach out to different Lambeth communities to improve responses

WHAT DID THE BOARD SAY THEY WOULD DO?



- The Board had an action plan that described what they wanted to achieve in this year.
- These actions focused on three areas:



- **Making Safeguarding Personal**
This is about making sure people have choice and control during safeguarding enquiries.



- It is also about making the Board more representative of the communities in Lambeth.



- **Working Together.** This is about making sure professionals work together with the community and the people they support.



- **Prevention and early action.** This is about supported people to feel safe and taking steps to stop abuse and neglect from occurring.

WHAT HAS THE BOARD DONE IN THE LAST YEAR?



- Members of the Board have worked together to improve the way that we work with adults at risk of abuse and neglect.



- We spoke to people about what adult safeguarding means to them and created a report based on what they told us.



- We hosted a series of online classes for professionals which looked at complicated areas of adult safeguarding.



- We took part in National Safeguarding Adults Week in November 2020, where we aimed to raise awareness through online events.



- We took part in a national data project to keep an eye on what impact Covid-19 has had on adult safeguarding in Lambeth.



- We regularly updated our website so that people could access important information about responses to Covid-19. This included a guide for volunteers and information about using the Mental Capacity Act.



- You can also find out about what we did this year by watching our short video!

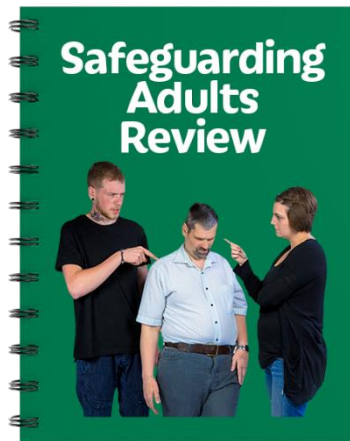


Click on the blue link below to watch the video.

[What we did in 202-21 video](#)

SAFEGUARDING ADULTS REVIEWS

WHAT IS A SAFEGUARDING ADULTS REVIEW?



A Safeguarding Adults Review takes place when an adult at risk passes away or comes to serious harm, and it is felt that professionals around them should have done more to protect them.

We didn't complete any Safeguarding Adults Reviews in this last year. Instead, we took the opportunity to look back at the Safeguarding Adults Reviews we completed in previous years.

WHAT HAPPENED TO MARTIN?



Martin lived in Lambeth. A number of different services were called to his home where they found that Martin was very unwell.

The home Martin was living in was dirty and there was no food in the house. Although professionals were worried,

Martin said that he did not want go to hospital. Sadly, Martin was so unwell that he later passed away.

WHAT DID THE REVIEW FIND?



The review found that whilst Martin said he would be able to go to his GP and get some food, no one checked to make sure he would be able to do this on his own, or to explore other options with him. This is called ‘executive functioning’ and links to how we assess a person’s mental capacity.



This also links to how we respond when a person says that they do not want help or support, but we are worried about their immediate safety - this is sometimes referred to as a person’s ‘vital interests’. The review found that in these situations, it is important that we do not simply walk away.

WHAT DID THE BOARD DO ABOUT THIS?

The Board came up with an action plan to make sure that we are able to learn lessons from Martin's case and make any needed changes.

As part of this:



- The Board created new guidance to help those who support people who are self-neglecting.



- We also created a new video to help people better understand executive functioning and how to respond.



Click on the blue links below to watch the video.

[Responding to self-neglect-
animated video](#)

WHAT HAPPENED TO MR E?



Mr E lived in Lambeth and had a history of anxiety and depression, as well as substance misuse.

In March 2017, Mr E died in a fire at his house. The London Fire Brigade believed this was caused by an unextinguished cigarette. Mr E may have been unable to react due to substance misuse.

WHAT DID THE REVIEW FIND?



The review found that the professionals working with Mr E did a lot to encourage him to accept support and that there was nothing professionals could have done to prevent Mr E's death.

The review did however make some suggestions about how services could improve to help people like Mr E in the future.

WHAT DID THE BOARD DO ABOUT THIS?

The Board came up with an action plan to make sure that we can learn lessons from Mr E's case and make any needed changes.

As part of this:



- The Board has worked on a new tool that helps professionals come together to talk about their concerns and share the risk. This is called the Complex Case Framework.



- The Board has written a letter to NHS England so that they can think about how GP's work with vulnerable people

WHAT DOES THE BOARD PLAN TO DO NEXT YEAR?

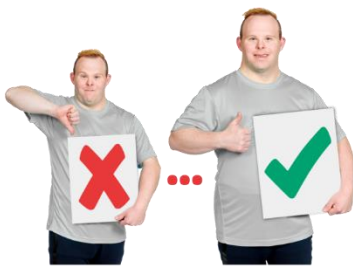


The Board has created a new action plan that it will work on for the next year.

There are lots of things we want to do. This includes:



Closer working with the voluntary and community sector



Doing more to ensure that the lessons we learn from Safeguarding Adults Reviews lead to change



Doing more to hear about people's experiences of adult safeguarding processes