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BARNSLEY SAFEGUARDING ADULTS BOARD

Learning Outcomes:

By the end of the session, you will be able to:

- Understand and apply the criteria under s.42 of the Care Act
- Understand the role of different agencies in safeguarding adults
- Understand and use the tools created by Barnsley Safeguarding Adults Board (BSAB)
- Understand the importance of Mental Capacity in Adult Safeguarding

Quick Quiz……

- What piece of legislation underpins adult safeguarding?
- The Care Act
- What section of the Care Act establishes a duty to conducting enquiries where there are concerns that an adult has been abused or neglected?
- S.42
- Which organisation is the "lead agency" for adult safeguarding?
- The local authority
- What is the name of the multi-agency body, in each local area, that is responsible for ensuring there is good collaborative working around adult safeguarding?
- Safeguarding Adults Board
- At what age are people considered "adults" for the purpose of s.42 of the Care Act?
- 18
- What criteria is used to identify "adults" that we have a duty to under s.42 of the care act?
- They have care and support needs
- What is the name given to the principles of giving people choices around any safeguarding action and allowing people to define their own outcomes?
- Making Safeguarding Personal
- What does the acronym Pipot stand for?
- Persons in Positions of Trust

Introduction

Why is Safeguarding Important?

- Protects people's rights to live in safety, free from abuse and neglect
- Promote wellbeing and prevent abuse and neglect from happening
- Ensuring safety and wellbeing for anyone subjected to abuse or neglect
- Take action against those responsible for abuse or neglect taking place
- Learning lessons and making changes to prevent similar abuse or neglect happening to others

Safeguarding is everyone's business

Legal Context and Making Safeguarding Personal

- **Care Act 2014** – Statutory duty to safeguard adults, based on 6 core principles
- **Prevention** – give adults skills to prevent harm and/or organise care and support to prevent harm
- **Empowerment** – provide information, access to resources etc to equip adult to keep themselves safe
- **Protection** – when required by the adult or when they are unable to make this decision for themselves
- **Proportionality** – adults choices must be respected when possible and if action is taken it must be proportionate to the risks
- **Partnership** – working with the adult and relevant agencies to deliver their outcomes
- **Accountable** – to the adult and the wider community

Multi-agency working

- Safeguarding adults requires organisations to work closely together, in partnership, to support and safeguard adults at risk of abuse and neglect.
- Strong partnerships are those whose work is based on an agreed policy and strategy, with common definitions and a good understanding of each others' roles and responsibilities

- **Duty to Cooperate (s.6 [generally] and s.7 [in specific cases])**

Roles and Responsibilities

Everybody

- Be able to recognise the signs of abuse and neglect.
- Take action to prevent adults at risk being abused and neglected.
- Take action to protect adults at risk from being abused and neglected, if you suspect it.
- Raise appropriate safeguarding concerns with the Local Authority if you are concerned about abuse and neglect.
- Where possible and appropriate, get the consent of the adult to raise the safeguarding concern and ask them what outcome they want.

Local Authority and Safeguarding Adults Boards

- Record safeguarding concerns where Sec 42(1) criteria for decision making is met.
- To initiate appropriate safeguarding enquiries in relation to Sec 42(2)
- Retain overall responsibility for safeguarding enquiries(Sec 42(2))
- Make available safeguarding training and development opportunities for staff
- Manage incidents of safeguarding in relation to People in Positions of Trust (PiPOT)
- Produce a Partnership Annual Report

Statutory Criteria for Decision Making (Three-point test)

Definition of adult at risk of abuse: (Sec 42(1) of the Care Act)
There criteria
A person aged 18 years or over

Where there is reasonable cause to suspect that an adult:

- Has needs for care and support (whether or not the Local authority is meeting any of those needs) and;
- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse or neglect.

Where safeguarding concerns do not meet the criteria?

Paragraph 14.44 The Care Act Statutory Guidance states:

Local authorities may choose to undertake safeguarding enquiries for people where there is not a sec 42 enquiry duty, if the local authority believes it is proportionate to do so, and will enable the local authority to promote the persons wellbeing and support a preventative agenda

(Also: The Care Act Sec 1- Promoting wellbeing)

Decision Support Guidance

- Barnsley Safeguarding Adults Board's decision support guidance
- Support in the identification and decision making when something meets the criteria for s.42 of the Care Act
- Highlights key points to consider and communicate when raising safeguarding concerns or risk assessments

- How dependent/independent is the person?
- What is the relationship/power dynamic between the person at risk of harm and the potential source of abuse?
- How frequently is the possible abuse/neglect occurring?
  - Has this happened before?
- What is the impact of the possible abuse/neglect?
  - What does this mean for the life of the person at risk/other people?
  - How high is the risk of the possible abuse/neglect to the person's wellbeing?
- What does the adult at risk of harm want?
- Are other people at risk of harm (including children)?
- Is the potential source of harm in a position of trust?
- Are you aware of any plans to manage the risk/harm?

Consent?

Where possible, the adult should be consulted and obtaining consent is best practice. However, the individual or professional, may still be able to raise a concern, where consent has not been gained if:

- In serious situations, to prevent serious harm occurring. For example, in cases of self-neglect where the adult is at serious risk of harm- referral without consent to inform multi agency risk assessment and support
- The adult lacks capacity to consent - best interest decision (MCA)
- The adult is under coercive control
- It is in the public interest- there are risks to other 'adults at risk' –
  - the concern is about organisational or systematic abuse, or
  - relates to an employee or volunteer (adults at risk of children)
  - Abuse has occurred on property owned or managed by an organisation providing care

How do I raise a concern?

For Children

- If someone is in danger call 999.
- If it is not urgent, call 01226 772 423.
- If it is out of working hours, call 01226 787 789.

For Adults

- If someone is in danger call 999.
- If it is not urgent, call 01226 773 300
- If it is out of working hours, call 01226 787 789
- Email - adultsocialservices@barnsley.gov.uk

What happens after I submit the concern

- Front door workers send to the relevant social care team
- Social worker allocated
- Additional information sought, if needed
- Manager decision
- Feedback provided
- Option to challenge if you disagree with decision

Mental Capacity and Safeguarding

Unwise Decision/Have Capacity

- Someone understanding information vs Someone using information (Executive Functioning)
- Someone seeming to understand, and being articulate in expressing their refusal/decision – does not mean that they can "*weigh up*" the information
- "Presumption of capacity" – is not an reason not to consider someone's capacity (and assess it) if they are making "unwise decisions". Particularly, where there are high risks.
- What is documented?
- Manchester Thematic Review of Family Carers – Family Carers – Refusal of Support

Did not attend/was not brought

- DNA is where someone is not dependent on others to get them to appointments. Otherwise, was not brought.
- BSAB "Was not brough policy" – often missed in safeguarding adults.
- How is this documented?
- How is it followed up?
- How do they/you engage with other agencies about your concerns?
- Lola – SAR – Barnsley
- Adult O – SAR – missed appointments with multiple healthcare professionals since being a child.

Background

- O died at 24 years old as a result of sepsis and bronchopneumonia in October 2020. She had had sepsis on multiple occasions.
- O had complex health needs from birth. These included, cerebral palsy, scoliosis, blindness, epilepsy, quadriplegia and a profound learning disability.
- O was cared for by her mum throughout her life. O's mum had refused support from services on multiple occasions. The SAR described O and her mum's loving relationship and that O's mum had "advocated" for her through her life.
- Mum had a "fear" of health environments found that those environments and professionals caused her anxiety e.g. she was frightened of visiting the dentist.
- There were consistent themes where O would not be brought to medical appointments throughout her life.
- As a child, O attended a special educational school and that setting promoted access to health services and an environment when professionals could visit and see her. This was lost when O was an adult.
- O left school at 19. There was no formal transition process that took place. These was confusion about why this was.

Timeline (1)

- 2005 – noted by Children's Social Care that O's mum had *"anxiety regarding seeing health professionals, and that she needed some support to take Adult O to the dentist, because she was too frightened."*
- 2009 -
  - noted that O was not being taken to Consultant Paediatrician appointments.
  - Concerns raised about O's dental hygiene and non-attendance at appointments.
  - School noted that O's weight was more stable during term time (when she had school meals) than when at home. She would lose weight during holidays.
- 2011 – a school worker contact CSC because of O's weight loss, poor personal care and I missing dental appointments.
- 2012 –
  - Social Worker from Children's Services discussed O's missed appointments at Supervision because she was concerned about missed dental appointments.
  - O was discharged from dental hospital because of numerous missed appointments.

Timeline (2)

- 2013 – O had a pressure sore on her hip due to her wheelchair not being appropriately fitted. A new mould was made and the sore healed.
- 2014 (O was 15/16)
  - School was concerned that O’s mum was not taking O to health appointments. Safeguarding advice was sought, but view that it didn’t meet the safeguarding threshold.
  - Consultant Paediatrian wrote to O’s family as O was not brought to their clinic. They also wrote to the GP to ask why this might be.
- 2015 – O was not brought to a school dietic appointment. No cancellation or reason for this was given.
- 2016 (O was 17/18)
  - Consultant Paediatrician wrote to the LD Matron and GP to request starting transition to adult services. This was not responded to. The Consultant wrote again to say that the transition would be complex. No evidence that this was responded to.
  - O had a pressure sure due to her sleep system rubbing.

Timeline (3)

- 2017 (O is now an adult)
  - O was admitted to hospital with a chest infection and sepsis. O's mum had contacted GP as O had cold like symptoms and was short of breath. O was in hospital for 8 days.
  - LD Matron documented that the school nurse told them that O's mum had a phobia of hospitals.
- 2018 –
  - O's mum declined a carers assessment offered by ASC.
  - O was referred to a day centre for 2 days a week (at the request by O's mum). However, O's mum subsequently declined this as she believed it was too expensive. ASC stopped involvement at that time.
  - O was not taken to a Paediatric epilepsy clinic. O was referred back to her GP and referred to an adult clinic.
  - O did not attend her other Consultant Paediatric clinics and was referred back to her GP.
  - O got a chest infection and was admitted to hospital. There were signs of sepsis. O had pneumonia high sodium and a kidney injury. Concern she had been dehydrated for a while.
  - GP met with O and mum after discharge to advise on how to recognise when O was unwell.

Timeline (4)

- 2019 –
  - O was not brought to the adult epilepsy clinic, and discharged back to GP. It was later rearranged to August 2019, but O was not brought to that appointment.
  - GP identified that O's epilepsy medication had not been collected for over a year. Also, O had not been brought to her learning disability health checks. Recognised that O was not on the GP's learning disability register, and was added. A medication review was conducted.
  - O's mum cancelled a dietician's home visit, as O was not well. Subsequent appointments were made, but were cancelled as O or her mum was not well.
  - Continence service identified a strong smell in O's urine. Advised O's mum to increase fluid intake and take a urine sample to GP. This was communicated to GP. Urine sample was not taken and no follow up from GP.
  - GP saw O at home as O became unwell. Anti-biotics prescribed for a chest infection. Advice given on what to do if deterioration.

Timeline (5)

- 2020-
  - O had first learning disability health check in August 2020.
  - Dieticians try to contact O's mum on several occasions to arrange a home visit. No response to calls or letters. Contact made with GP surgery.
  - Administrator at GP surgery informed Dietician that O had been in September 2020. No further action taken.
  - In October O's mum contact GP as O was unwell.
    - Sepsis pathway was triggered and ambulance took O to hospital.
    - GP had SG concern as 3rd sepsis incident in 3 years. Also, necrotic pressure sore on heal.
    - O died as a result of sepsis and bronchopneumonia.

Analysis (1)

- ASC said that O didn't have a transition plan as she didn't have social care needs.
- Lack of Legal Literacy – MCA and Safeguarding (Working Together and Care Act)
- No multi-agency response to concerns.
  - Some good practice in sharing concerns/issues. However, no joined up action.
- Repeated incidents of "was not brought". Across multiple organisations and disciplines (Epilepsy, Dental, Dieticians, Paediatrician).
- Were the concerns of other professionals appropriately considered and followed up?
- Was information about O's mum's anxieties around health professionals fully understood?
  - Was the impact of these anxieties understood?
  - There were no reasonable adjustments made as a result of them.
  - Were the reasons for O's refusal of services understood.
  - This was not true. It was because O's mum declined support.

Analysis (2)

- O accessed no adult services despite needing them.
  - Services reflected that this was because these had been declined when she was a child.
  - Where was the consideration of her best interest as an adult?
- Decisions about O's care were unlikely to have been compliant with the Mental Capacity Act (MCA)
  - Capacity was considered when she was 16 +
  - Likely to have been assumptions of capacity(?)
  - No advanced care planning and likely deprived of liberty in community
  - Were O's best interest's considered?
    - If so, did these take into account her not being brought to appointments?
    - Did these take into account the challenges that O's mum had in taking her to appointments?
    - Did this take into account O's refusal of support as a carer?
    - Was O's best interest considered when the offer of day services were made?
    - Was the refusal of carers support and day services considered to be "red flags", particularly when considered in relation to a history of not being brought to health appointments?

Points for Discussion

- Do we know about people in need of services, where support was declined as child, but they may now be adults?
  - Are decisions made about them accessing services made in their best interest?
- When we raise concerns or engage with other agencies, is information about the history of the individual's care and engagement with the family provided?
- Do we share information about the broader needs of the family and carers shared?
  - Is advice, support and reasonable adjustments made for them around these?
- Where we have raised concerns, but receive no response, do we follow this up?
- Do we raise our own safeguarding concerns where we are worried, or do we feel dependent on agreement from other agencies or practitioners?
- What happens when someone is discharged/leaves a service?
  - What is the reason for them leaving/discharge?

Resources

- Barnsley Safeguarding Adults Board Tools and Resources
- Organisational Abuse
- Decision Support Guidance for Raising a Safeguarding Concern
- Link to online form
- Any questions, please email Jonathandouglass@barnsley.gov.uk