

1 Background

Following the deaths of two vulnerable men who were living with the combined effects of multiple disadvantage and serious incidents involving two others, Islington Safeguarding Adults Board (ISAB) commissioned a Safeguarding Adults Thematic Review. The Safeguarding Adults Review (SAR) subgroup agreed on a SAR in Rapid Time methodology. This review considers the experiences of the four individuals, each considered by most agencies involved with them to have lived with the combined effects of multiple disadvantage. The review placed a particular emphasis on understanding the interface between responses to anti-social behaviour and the management of concerns about the safety, wellbeing and risk experienced by the four individuals. A total of eight recommendations were made within this review.

Learning Points

2 **Lack of strategic oversight and leadership**

Are current operational and strategic safeguarding practices in respect of how they meet the needs of adults living with multiple disadvantage being reviewed?

Are relevant strategic boards working collaboratively to explore the most appropriate partnership, governance and implementation arrangements for adults living with multiple disadvantage?

3 **Inconsistent agency coordination**

Are you aware of the [multiagency panels](#) and their criterion available to frontline staff and key partners?

Does your front-line staff have adequate training and practice development opportunities around convening and chairing effective multi agency professional meetings?

Are you able to identify a named lead professional or agency who will act as the main point of contact and lead on sharing information and convene multiagency discussions?

4 **Invisibility of Trauma-Informed Care**

Is there adequate training available around trauma informed practice for teams working with multiple disadvantage who self-neglect and are brought to the attention of police and anti-social behaviour teams? Is ISAB assured about partners responses to the behaviour and risks surrounding adults living with complex trauma?

Are staff aware of the [Camden and Islington Trauma-Informed network](#)?

5 **Strengthen person-centred approaches**

Is staff aware of [Making Safeguarding Personal](#) and relevant guidance? Are resources shared widely within your agencies?

Are you able to provide ISAB assurance about how staff is supported to involve adult in discussions about safeguarding concerns about them. How is this recorded and justified where it is deemed not appropriate?

Are there development opportunities to learn about recording person-centred discussions and actions in case notes?

6 **Risk escalation and normalization issues**

Have your staff had training around risk normalization for those working with adults who live with the stigma of drug and alcohol dependency, self-neglect and experiences of rough sleeping?

Have you as a partnership identified a multiagency risk escalation approach for working with adults with multiple disadvantage?

7 **Protected characteristics not being considered in care planning and risk management practice**

Are you robustly recording and documenting protected characteristics for the adults you support?

How are discussions about protected characteristics informing care planning and risk assessment?

Are there mechanisms in place providing frailty-related support?

8 **Active input from mental health teams**

Is there an 'advice mechanism' from specialist clinicians for front line practitioners supporting adults with multiple disadvantages?

Is this support available to all key partners including GP's?

9 **Approaches to self-neglect and non-engagement to be coordinated and visible**

Has your agencies self-neglect policy and procedures been recently reviewed to reflect risks and challenges?

Is information around this included in the safeguarding training delivered?

Is there a feedback loop between agencies to assist communication?