Statement of the Independent Chair

Swindon Safeguarding Adults Board (SSAB) is today publishing a Safeguarding Adults Review (SAR) following the death of Honor, a 90-year old widow living with her son, in January 2017. Concerns were raised over a period of time, predominantly by her daughter, about Honor's welfare but did not result in protective action being taken due to Honor's denial of any problems and an assessment that she had mental capacity to make her own decisions. The cause of death is recorded as bronchial pneumonia and malnutrition (with a likelihood this was caused by neglect).

The Board and all those involved offer our sincere apologies and condolences to Honor's family on the circumstances surrounding her tragic death.

Purpose of a SAR

With the implementation of the Care Act 2014 there is a statutory requirement to undertake SARs when certain criteria are met. In this instance, it was commissioned because:

- there was reasonable cause for concern about how SSAB members or other agencies providing services, worked together to safeguard an adult and
- an adult died, and SSAB knew or suspected that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

A SAR is a multi-agency review process that seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

Findings and Lessons Learned

All partner agencies involved in this case engaged positively in the process of the SAR and in developing the action plan in response to the findings in the report. The main lessons learned by the Board and its member agencies include:

1. The need to improve *social work practice* in respect of:
    - risk assessments
    - making appropriate safeguarding decisions that require the balancing of mental capacity and the impact of domestic abuse on a victim's ability to self-determine
    - recognition of the impact of coercive control and domestic abuse on older people
    - using multi-agency discussions to share information prior to making key safeguarding decisions and risk evaluations
    - ensuring practitioners are aware of best practice and put this into operation

2. Detecting when cases are going wrong by:
    - improving the oversight and supervision of practice
    - having effective quality assurance processes in place

3. Improving the connection between the Safeguarding and Domestic Abuse Boards to:
    - support practitioners' understanding of the links between them
    - ensure agencies are sighted on the potential for generational abuse

Each partner organisation concerned, particularly Adult Social Care, has considered the findings and agreed its own actions to improve practice. Examples of their progress include:

Local Authority - Adult Social Care

The Local Authority fully endorses the findings of the report and accepts the need to improve social work and safeguarding practice. A separate and detailed action plan has been agreed and is being implemented. Progress against the action plan is monitored monthly by the Director of Adult Social Services. The following improvements have been made:

- A new dedicated manager for the Safeguarding Team has been appointed on an interim basis whilst a permanent appointment is made
- Specialist safeguarding supervision has been implemented for the safeguarding team and social work team
- Managers have monthly supervision and oversight of all allocated safeguarding cases to ensure a timely conclusion of investigations
- Enquiry Managers will have access to a regular 'weekly' supervision session led by a senior member of the Safeguarding Team to ensure adequate support and advice is available on a weekly basis to ensure effective, responsive decision making
- All Team Managers hold a "Learning and Development Record" of their teams learning to ensure that everyone is fully participating in regular learning opportunities
- The ADASS guidance on safeguarding and domestic abuse has been made available to all social care teams
- A new threshold document has been adopted and published on the safeguarding website
- The Director has highlighted the main lessons from the case in all staff briefings and all teams have been requested to discuss the case and action plan in team meetings in May 2018
- Staff training on domestic abuse and coercion and mental capacity and safeguarding is taking place in May 2018 for all social care and occupational therapy staff
- A decision-making tool is being developed by the Head of Social Work that will support consistent decision making in relation to our initial response times. Each safeguarding concern/referral that progresses to a Safeguarding Enquiry will be allocated a risk rating (Red/Amber/Green) by the Adult Safeguarding Management team at the point of screening. Each rating will have an associated maximum response time. Response time performance will be monitored monthly and reported to the Director of Adult Social Services

Clinical Commissioning Group (CCG)

Having raised this case initially for this review due to the concerns expressed by Honor's GP, the CCG takes very seriously its commitment to safeguarding adults and to ensure health professionals and health organisations learn the lessons from such cases.

In the work the CCG undertakes it does so ensuring safeguarding is of the highest priority and that it complies with the Care Act 2014 duties. Through its commissioning functions it has a responsibility to ensure all the services it commissions also have arrangements in place to make certain they also comply with this and other legislation relating to the welfare of adults within Swindon.

The CCG have been involved throughout this review to ensure it can take the learning back into all its functions as a commissioner to drive improvements in practice across health. In response to this review the CCG will ensure all the recommendations that apply to health professionals and health organisations are implemented without delay. The CCG has set out how it will achieve this in its action plan that aligns with the LSAB action plan to address all the findings of this review

Wiltshire Police

Head of Public Protection Detective Superintendent Deb Smith, said: "Wiltshire Police are fully committed to exploring the issues in more depth, and are dedicated to the delivery of a multi-agency action plan. We always ensure that findings from such reviews are embedded and used to improve how we work with agencies to safeguard and protect vulnerable adults"

Monitoring of progress

The SSAB and individual organisation's action plans will be subject to regular monitoring and challenge and the use of audit activity to continually monitor progress against areas for improvement. The Board remains committed to ensuring that the findings are fully addressed so the same issues are not repeated in future

Diana Fulbrook, Swindon SAB Independent Chair
May 2018

Swindon SAB, 3rd Floor, Wat Tyler West, Beckhampton Street, Swindon SN1 2JG
Tel: 01793 463559
Email: LSAB@swindon.gov.uk
Website: www.swindon.gov.uk/lsab