**Wiltshire Council**

**Health and Wellbeing Board**

**21 March 2019**

---

**Subject: Wiltshire Safeguarding Adults Board (WSAB) – update to members of the Health and Wellbeing Board**

---

**Executive Summary**

The Chair of the WSAB is attending the Health and Wellbeing Board on 21 March to provide members with an update on:

- Two Safeguarding Adults Reviews the Board has undertaken
- The learning from those reviews that will help us more effectively safeguard vulnerable adults in the future
- Development of the Board's three-year strategy for 2019-2021

The primary statutory duty of the Board is to carry out a Safeguarding Adults Review (SAR) when:

"an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133)"

The purpose of a SAR is not to hold any individual or organisation to account, but to allow local organisations to learn lessons from the past.

In 2018/2019, the Board completed two reviews allowing us to re-examine how effectively our multi-agency system works to safeguard adults.

These reviews are now available to read at www.wiltshiresab.org.uk - this report:

- Summarises the circumstances that prompted these statutory reviews and key changes that have already and are being made.
- Sets out the wider learning points from these reviews, two other reviews that have already been published and a review that will be published later this year.
- Details how our next three-year strategy will help us ensure that learning from these reviews will help to improve how adults in Wiltshire are safeguarded.

**Proposal(s)**

It is recommended that the Board:

i) Notes the outcome of the 2018 Safeguarding Adults Reviews relating to Adult C and Adult D.

ii) Ensures that this learning has an impact on the work of its member agencies.

iii) Asks the WSAB to provide it with reassurance that changes have been and will be made as a result of these reviews.

iv) Commits the necessary partnership resources to ensure that action plan can be delivered effectively.

v) Acknowledges the aims of the WSAB's strategic plan for 2019-2021 and continues to support the work of the Board to safeguard vulnerable adults in Wiltshire.

**Reason for Proposal**

The Wiltshire Safeguarding Adults Board is accountable to the Health and Wellbeing Board for its work as a partnership to protect all adults in its area who have needs for care and support and who are experiencing, or at risk of, abuse or neglect against which they are unable to protect themselves because of their needs. The WSAB's work is directly related to improving health and wellbeing outcomes for vulnerable adults across the county.

**Wiltshire Council**

**Health and Wellbeing Board**

**21 March 2019**

---

**Subject: Safeguarding Adults in Wiltshire – Learning from local experience**

---

## Purpose of Report

1. To report to the Health and Wellbeing Board:
   - The outcome of two Safeguarding Adults Review (SAR) completed and published by the Wiltshire Safeguarding Adults Board (WSAB) in late 2018 and early 2019

2. Safeguarding Adults Board **must** arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133).

   SABs **must** also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support (s.14.134).

   The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

3. The purpose of such a review is not to reinvestigate or to apportion blame, it is:
   - To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
   - To review the effectiveness of procedures (both multi-agency and those of individual organisations).
   - To inform and improve local inter-agency practice.

## 4. Safeguarding Adults Review – Adult C

### Background

Adult C was diagnosed with paranoid schizophrenia in 1989 and was resident in a local mental health hospital. However, supported by health and social care services, he was able to move out of the hospital to live independently.

At the time of his death Adult C was known to mental health services at the NHS and Local Authority and the Court of Protection Team at The Local Authority. Adult C was difficult for professionals to engage in his treatment. He did not accept his diagnosis or comply with medication and because of this he was managed using a Community Treatment Order under the Mental Health Act. This ensured Adult C received his monthly anti-psychotic

medication injection and reduced the risk he may have posed to himself or others. Those arrangements continued until he died.

In September 2017, there were increasing concerns about Adult C. There had been reports that Adult C's behaviour was changing, and the police had been involved. There were also concerns about Adult C's physical health and finally a neighbour informed the Housing Association that they were concerned for Adult C as they had not seen him that day. This led to a plan to recall Adult C to hospital for further assessment under the terms of the Community Treatment Order. It was necessary to arrange a bed for admission. This took a week.

When Adult C was recalled to the mental health hospital, it was recognised that his physical health was of grave concern. Adult C was admitted to hospital after a physical examination revealed he was emaciated and starved, and he died eight days later as a result of community-acquired pneumonia and paranoid schizophrenia.

After the death of Adult C, his family found that payments to his personal account had been stopped and there were only a few pounds in the account. Adult C had not received regular physical health assessments and sufficient assessment of his capacity to make decisions in his own best interest are not clearly evidenced. Professionals had worked with Adult C over a number of years, however, the complexity of the case, Adult C's reluctance to engage and a failure to work effectively across agencies posed an increased risk to Adult C's health.

**Multi-agency recommendations**

Since Adult C's death there have been significant changes in the way agencies work. In addition to those changes the recommendations in this report also call for:

- Measures to ensure improved communication and multi-agency approaches to care planning where adults at risk are unwilling to engage.
- Better recognition of self-neglect and use of mental capacity assessments where someone who needs physical health care is reluctant to engage.
- More effective engagement with families who are undertaking a caring role of those adults at risk who have long-term complex needs.

Agencies in Wiltshire have worked with, and Adult C's family have spoken to, the author of the report to ensure that we can learn from experience and protect others from harm.

**5. Safeguarding Adults Review – Adult D**

Adult D was 40 years old. He was of no fixed abode but is understood to have been living with a relative in Somerset. We know that Adult D had presented to a Hospital Emergency Department in the South of England in early 2017, reporting symptoms of alcohol withdrawal. He was advised to continue drinking on discharge, to avoid withdrawal, until he could access support.

A few days later whilst travelling through Wiltshire, Adult D was asked to leave a train when it stopped at a local station after he was found to be heavily intoxicated and unable to produce a ticket.

In the early hours of the following morning, police were called to a nearby block of flats where Adult D had gained access to a communal area. Officers had difficulty communicating with Adult D, who appeared to speak little English. On finding Adult D to be heavily intoxicated, officers called an ambulance and paramedics attended. Physical checks were not carried out by the paramedics and Adult D was not taken to hospital. Adult D was left with police officers who then took Adult D to a local public toilet block, in which they believed he had indicated he was content to shelter overnight. Adult D was found, deceased, the following morning in the toilet block.

A Coroner's Inquest found that Adult D's death was caused by acute alcohol intoxication and hypothermia.

**Key multi-agency recommendation**

- Alcohol-dependent adults are particularly vulnerable and are frequently seen by emergency services, however in the event that Adult D had been taken to a hospital, there is no certainty he would have been admitted and, if he had been taken to a police station, no medical assistance would have been immediately available. Resource limitations may make the creation of a specialist resource to support adults in this situation untenable, therefore the system needs to mitigate risk by agreeing a multi-agency protocol and using existing powers and resources to ensure that adults at risk are protected, to ensure we prevent the same thing happening again**. A multi-agency protocol should be established to support professionals who are called to attend adults at risk who are highly intoxicated and who pose a risk to themselves and, potentially, to others.** This will support professionals to make the right decisions to protect adults from risk.

## 6. Broader learning from statutory reviews

Over the last three years WSAB has carried out four Reviews. A fifth review is due to be published in Spring 2019. Whilst it should be noted that these Reviews represent only a fraction of the many cases where vulnerable people are supported by services, the cumulative learning from these reviews demonstrates challenges related to:

- Application of the Mental Capacity Act (2005)
- Identification and support for those who are self-neglecting
- Effective application of safeguarding procedures and effective risk assessment in complex cases
- Communication between agencies
- Safeguarding those who are moving between health and care settings
- Ensuring the voice and wishes of vulnerable adults and their families is central to safeguarding activity
- Engaging with those adults who are at high risk of harm but are reluctant to seek support

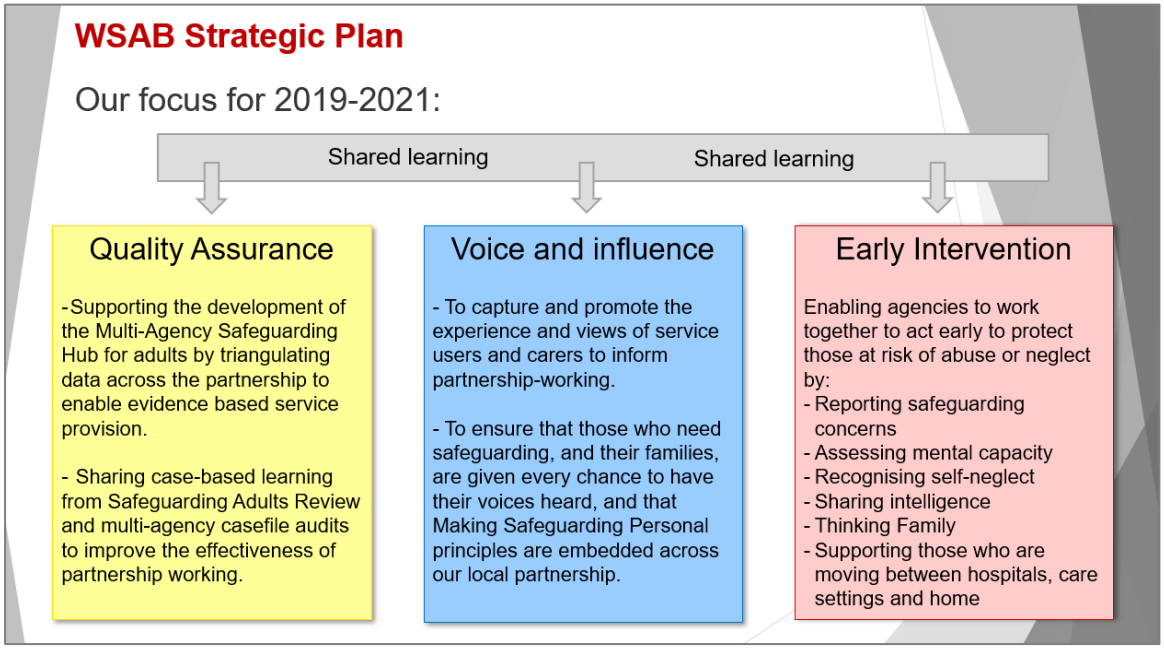
These challenges are not unique to Wiltshire and reflect some broader national challenges that relate to the complexity of safeguarding those with complex care and support needs to retain the degree of independence they want.

## 7. WSAB Three-Year Strategy

Under statutory guidance, the Board must publish a strategic plan. We are now in the process of developing our next three-year plan and we have used data from across our partnership to inform that plan. Our aim is to inform and enable intelligent safeguarding,

that not just responds to need but anticipates demand to allow us to work preventatively to protect vulnerable adults from harm.

We are currently consulting on our draft plan and a final copy will be signed off by the Board in late March and sent to the Chair of the Health and Wellbeing Board. Our focus for the next three years is described below and is underpinned by an action plan. This approach has been designed to allow us to do more to safeguard adults at risk in Wiltshire based on what we know about our county's care and support needs.




**Presenter name:** **Richard Crompton**
**Title:** **Independent Chair**
**Organisation:** **Wiltshire Safeguarding Adults Board**

---

Report Authors: Emily Kavanagh
Wiltshire Board Manager
01225 716693