Walsall Safeguarding Partnership
Learning from Case Reviews

Right for Children, Families and Adults

August 2023

As a Safeguarding Partnership we have a duty of care towards children and adults with care and support needs, to explore how practice can be improved through changes to the system established though learning gained from multi-agency reviews.

In this edition we focus on the learning from our Walsall Safeguarding Adult Reviews.

Referral Consideration

Once a referral for a SAR is submitted the three statutory partners will meet to confirm the referral meets criteria.

Following agreement, scoping information will be gathered and a partnership meeting convened to identify further details about the case and establish initial learning.

Sometimes all learning can be identified at this point and the case may be completed in rapid time.

Alternatively, there may be a need to progress to a traditional SAR.

Safeguarding Adult Reviews

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, or the adult is still alive, and the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked together more effectively to protect the adult.

SAR Referral Process

To make a referral for consideration of a SAR, please download the referral form found on the West Midlands Regional Adult Safeguarding Information Hub and send by email to the Safeguarding Business Unit: safeguardingbusinessunit@walsall.gov.uk

Contents in this edition:

Coming up next time:

SAR11 & SAR12
In Rapid Time

SAFEGUARDING ADULT REVIEWS

What Happened? SAR7

MS was alcohol dependent and suffered from regular falls, confusion, hallucinations, had reduced mobility and was incontinent. MS died in hospital of multiple organ failure, the underlying cause being alcohol liver disease.

MS lived with a partner in a hostel, and was known to have stress, anxiety and depression caused, or made worse, be the death of her relatives. Practitioners described MS as having a very forceful personality, and that MS "knew what she wanted".

Good Practice:

- Proactive support by tuberculosis nurses.
- Additional referrals/tests made by GP to eliminate other potential physical causes of blackouts.
- GP practice proactive and heavily involved in MS care.
- GP provided information and time to register with new practice when moved out of area.

Learning Identified:

- Missed opportunities for interventions.
- Insufficient consideration given to protect an adult from abuse.
- Ownership of case leadership and instigating joined up working.
- Mental capacity assessments to be made available,
- Ensure provision of accommodations for people with tuberculosis.
- Recognition of those who self-neglect.
- Family involvement and Think Family Approach

What can you do now?

⇒ Read the full **SAR7** Overview Report HERE
⇒ Revisit the webinar on...Trauma Informed Practice
⇒ Revisit the webinar on...Self-Neglect
⇒ Read again...Self-Neglect 7 min briefing
⇒ Read again...Regional Policies & Procedures

What Happened? SAR8

GS was a private person who struggled to form relationships but enjoyed a level of social contact once he was familiar and could trust someone.

GS had a long-term diagnosis of paranoid schizophrenia, experiencing distressing auditory hallucinations and feeling suspicious and mistrustful of people. He had a number of health issues including Chronic Obstructive Pulmonary Disease (COPD), Hyponatremia (low sodium levels), iron deficient anaemia and angina pectoris. He was significantly hearing impaired, to the degree that this impeded communication with him.

Good Practice:

- The discharge to assess pathway in Walsall is reported to be well-established and works well.
- Social Care Facilitator and the Health Care Practitioner worked well together.
- Dedicated support by agencies involved in care.
- Piloting of Multi Agency Safeguarding Tracker (MAST) information sharing system to enable identification of agencies involved.
- Development of shared heath and social care basic record sharing system.

Learning Identified:

- Consideration given to involving care providers in reviews of care and support plans.
- Support plans to include how to support a person's emotional, mental health and communication needs.
- Risks to self-neglect to be understood by all agencies.
- Shared assessments and contingency plans are at heart of multi-agency working.
- Practitioners must have a shared and common understanding of the indicators of self-neglect across all aspects of a person's life.
- How physical and mental health needs are understood together with impact on engagement.
- Mental Capacity Assessment determines the steps taken to address urgent needs of a person refusing treatment.
- Advocacy can play a useful role in ensuring person centred care for people who are fearful of interactions.
- Person centred care is supported by consistency in supporters as well as skilful and knowledgeable support.

What can you do now?

⇒ Read the full **SAR8** Overview Report HERE
⇒ Revisit the webinar on...Self-Neglect
⇒ Read again...Self-Neglect 7 min briefing
⇒ Familiarise yourself with the 7 minute briefings on information sharing and professional curiosity
⇒ Attend the eLearning Course Understanding the Mental Capacity Act

Click on the words / links below to view a catalogue of WSP:

Training Courses—eLearning—Webinars—7 Minute Briefings