SAFEGUARDING ADULT REVIEW LEARNING BRIEFING

Adult R

May 2024

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

A Safeguarding Adult Review (SAR) is a multi-agency process which seeks to determine what relevant agencies and individuals involved with an individual could have done differently to have prevented harm or a death from taking place.

The Care Act 2014 states that a Safeguarding Adults Board* must commission a SAR when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or more effectively to protect the adult
- an adult in its area has not died, but the adult has experienced significant abuse or neglect, whether known or suspected.

SAFEGUARDING ADULT REVIEW

This SAR was commissioned by the Bristol Safeguarding Adults Board (BSAB) in August 2018. The BSAB became part of the Keeping Bristol Safe Partnership in 2019.

Why was a SAR commissioned?

Adult R (pseudonym) was a victim of multiple incidents of abuse and exploitation within the community. Adult R is alive and was involved in the review process, living free from abuse outside of Bristol. The full SAR report has not been published to protect the person's identity. Agencies, such as the GP and Adult R's drug worker, engaged with each other to safeguard Adult R. This highlights the understanding of the importance of agency cross-working.

The focus of this review looked at the following safeguarding themes: cuckooing, systemic responses to repeated patterns of victimisation, how agencies recognise and support protective factors, and how systems can help adults with care and support needs to protect themselves from risk and exploitation.

SAR process

The review period was May 2017 to July 2018. The initial lead reviewer could not complete the review, so a second reviewer was appointed in February 2019. The COVID-19 pandemic further slowed down the review process.

BACKGROUND INFORMATION

Adult R had a difficult and challenging childhood, and they attended an education provision referred to as a "special school". They were subjected to abuse over time and were traumatised by these events. When combined with their potential learning disability and poor education, this resulted in illiteracy.

In adulthood, Adult R experienced extreme episodes of exploitation including serious and violating assaults, presenting to their GP with PTSD.

When cooperating with the police, Adult R suffered repercussions and harm, leaving them feeling unprotected by the police and no longer wishing to support any further investigations.

Due to Adult R's experiences, they were known to self-harm, self-neglect, misuse drugs and alcohol, and presented as extremely anxious. Services stated that Adult R had fluctuating capacity because of these factors.

KEY FINDINGS

Finding 1

The case identified the **lack of a dual care pathway** which limited a holistic approach to support. This highlights the **need for a stronger Multi-Agency Safeguarding Hub**.

Finding 2

Professionals' understanding of executive **mental capacity and how to assess this was not robust**. This impacted professionals' ability to respond.

Finding 3

There was a **lack of multi-agency safeguarding coordination** around a complex individual who had developed a poor trust of services but was considered high risk.

Finding 4

The case shows a **lack of use of escalation policies within agencies**, where there is disagreement on how to assess the level of risk posed to an individual.

Finding 5

Within the focus period of the review, the main provisions of the Care Act 2014 were not fully executed. This indicates **a lack of knowledge around the legislation**.

Finding 6

Without a cuckooing strategy in place, a coordinated community safety response for complex and high-risk cases such as that presented by the person in this case **may be limited and inconsistent across the city**.

RECOMMENDATIONS

1. **Recommendation for a dual diagnosis care pathway** for drug support services and mental health services which would provide a more **holistic treatment** for service users.
2. Service professionals to receive more **training with a focus on mental capacity**.
3. The provision of resources for workforce to **develop confidence in engaging with complex cases**.
4. More **awareness of the escalation policy** across the partnership workforce.
5. Review practices to develop a more **person-centred approach**.
6. To develop a **defined multi-agency strategy** in Bristol for themes such as cuckooing, drug-dealing, and other criminal activities.

GOOD PRACTICE

RAPPORT BUILDING

The SAR shows a **strong rapport** with several agencies that were involved with Adult R. The GP built a trusting relationship with Adult R, as well as the several Police Community Officers who had **provided support within the person's original home**.

IDENTIFICATION OF VULNERABILITY

A **multi-agency decision** by Bristol City Council Housing and Landlord Services to relocate the person to a new address highlights **a good understanding of vulnerability**. This decision removed Adult R from the increased risk within their community.

INDICATORS OF AGENCY CROSS-WORKING

Agencies, such as the GP and Adult R's drug worker involved within the case **engaged with each other to safeguard**. This highlights the understanding of the **importance of agency cross-working.**

DETAILED RECORD-KEEPING

Whilst working with Adult R, the GP **held detailed accounts of events** which indicates **understanding of the safeguarding adults protocol**, as well as the need to **escalate concerns** to Bristol City Council Adult Social Care.

SUPPORT

Bristol Support Services

- Bristol Hate Crime and Discrimination services: BHCS-leaflet-07-003.pdf (wellaware.org.uk)
- Safeguarding Adults: Safeguarding adults 2014 (wellaware.org.uk)
- Victim Support: Victim-Support-easy-read-guide.pdf (wellaware.org.uk)
- Checking someone is safe to work with you: Victim-Support-easy-read-guide.pdf

National Support Services

- Mental Capacity Act: Mental Capacity Act 2005: An easy read guide (local.gov.uk)
- Getting ready to talk about your health: 3-Qs-Leaflet-1-Getting-ready-for-a-talk-about-your-health-2022-FINAL-2.pdf (library.nhs.uk)
- Understanding Cuckooing: Cuckooing – this is when someone who you think is your friend uses your home to sell or hide drugs. – Learning Disability Devon

SEND US FEEDBACK

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www.bristolsafeguarding.org/contact-us

Guidance for Professionals

- NICE dual diagnosis: 1 (nice.org.uk)
- SCIE- understanding mental capacity assessments: Assessing capacity - SCIE
- CQC safeguarding service users: Regulation 13: Safeguarding service users from abuse and improper treatment - Care Quality Commission (cqc.org.uk)