

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm.

Adult RR

Adult RR was 52 years of age at the time of his death in 2020, having died in his home from a pre-existing medical condition. He had been living in supported accommodation, commissioned by the local authority and supplied by a private care provider. Adult RR had a learning disability, Asperger syndrome, and autistic spectrum disorder.

Themes that emerged from the Safeguarding Adult Review in to Adult RR;

- ◆ Absence of multi-agency information sharing and planning
- ◆ Managing escalating risk; monitoring and enforcement of improvement plans
- ◆ Role of Police and CQC in prosecution of care providers
- ◆ Not working to principles of Making Safeguarding Personal

Agencies Involved; Buckinghamshire Adult Social Care/Commissioning Team, Community Learning Disability Team, Hospital Learning disability Team, CCG.

Examples of Good Practice

When developing an approach to work with someone showing signs of self-neglect, it is important to try to understand the individual and what may be driving their behaviour. Here are some general pointers for an effective approach:

Multi-agency: Work with partners to ensure the right approach for each individual

Person centred: Respect the views and the perspective of the individual, listen to them and work towards the outcomes they want

Acceptance: Good risk management may be the best achievable outcome, it may not be possible to change the person's lifestyle or behaviour

Analytical: It may be possible to identify underlying causes that help to address the issue

Non-judgemental: It isn't helpful for practitioners to make judgements about cleanliness or lifestyle; everyone is different

Empathy: It is difficult to empathise with behaviours we cannot understand, but it is helpful to try

Patience and time: Short interventions are unlikely to be successful, practitioners should be enabled to take a long-term approach

Trust: Try to build trust and agree small steps

Reassurance: The person may fear losing control, it is important to allay such fears

Bargaining: Making agreements to achieve progress can be helpful but it is important that this approach remains respectful

Exploring alternatives: Fear of change may be an issue so explaining that there are alternative ways forward may encourage the person to engage

Always go back: Regular, encouraging engagement and gentle persistence may help with progress and risk management

Recommendations

Adult Social Care should develop performance measures to monitor the use of formal strategy discussions following a safeguarding referral, including the quality of the subsequent multi-agency planning

The Learning Disability Team should develop new policy, to consider formally requesting a strategy discussion whenever a safeguarding referral is submitted

To support the developing culture of partnership working in Buckinghamshire, the Safeguarding Board should develop a programme of multi-agency training events. This should focus on developing relationships and an understanding of agencies roles in safeguarding investigations. It would be useful for this to include the process for requesting strategy discussions and the partnership's escalation policy

The Local Authority should commission a review of the improvement plan agreed with the care provider. This should be done in the context of Adult RR's case and with regard to wider practice

It is recommended that specialist police staff who participate in strategy discussions, are provided enhanced training in relation to offences specific to the care of vulnerable people. This should include how consideration of such offences may contribute to a wider multi-agency safeguarding plan

"The review has identified key learning from Adult RR's case and this report outlines the themes which have the greatest potential to deliver improvements. The Safeguarding Adults Board should now consider whether this learning has already been identified following Adult RR's death and how any improvements are being implemented. It is clear that partnership working is already improving in Buckinghamshire and how the safeguarding partnership embed this culture should be the focus of future activity."

[CQC Standards - 13 Fundamental Standards \(HOW TO FOLLOW?\) | QCS](#)

[Who we are | Care Quality Commission \(cqc.org.uk\)](#)

Who are we and what do we do?

[About the BSAB - Buckinghamshire Safeguarding Adults Board \(buckssafeguarding.org.uk\)](#)

Link to the Adult RR report;

[Safeguarding Adult Reviews - Buckinghamshire Safeguarding Adults Board \(buckssafeguarding.org.uk\)](#)