

# TSAB Newsletter

## May 2021



## Summary of the Work of the Board

The Board last met virtually on 22 April 2021. The minutes of [previous meetings](#) can be accessed via our website.

## Overview on Safeguarding Adult Reviews (SAR) and Learning Lessons Reviews (LLR)

The Care Act 2014 states that a Safeguarding Adult Board (SAB) 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, and there is a concern that partner agencies could have worked together more effectively to protect the adult. The aim of the process is to learn lessons and make improvements, not to apportion blame to individuals or organisations. Learning Lessons Reviews (LLR) follow a similar process to SAR's but are non-statutory.

## NEW - LLR Learning Briefing

The [Overview Report](#) from the recent LLR has now been published and contains some valuable learning points for all organisations to consider.

A [Learning Briefing](#) has been developed in line with the recognised seven minute technique, to ensure the learning is manageable and memorable. Managers are encouraged to disseminate this two page briefing as appropriate to support continued learning and development.

## Professional Challenge and Curiosity

Following on from the Josh Safeguarding Adults Review, TSAB would like to remind professionals that a [Learning Briefing](#) has been developed in relation to Professional Challenge and Professional Curiosity.

## Safeguarding Adults Concern Form

If you need to report a Safeguarding Concern, please ensure that you are using the most up to date [Concern Form](#) which can be found via our website. We recommend that you access the form via our website each time you use it, as opposed to saving a copy to your desktop to ensure that you are using the correct version of the form. Please share this as a reminder with your colleagues

## Training Update

Our training programme for 2021– 22 is now underway.

To see what is currently available and to book, please visit our [website](#)

Available to book now:

- **Making Safeguarding Personal Webinar - 2 half day sessions**
- **Safeguarding and Self-Neglect Webinar - 3 half day sessions**
- **Legal Literacy Webinars (including a new module on Aftercare under the S.117 Mental Health Act) - 6 individual - 2 hour Sessions**
- **Modern Slavery Webinar hosted by Hope for Justice - 2 dates available**
- **Safeguarding Adults Training for Managers of Services - Full Day Course**

**LEARNING BRIEFING** | Learning Lessons Review  
Adult D

**1 Background**  
Adult D was in his early sixties, had a long-term partner and two children from a previous marriage. Adult D had ongoing physical health problems which led to a decline in his mental health resulting in admissions to and between hospitals where he sadly died of natural causes. This Learning Lessons Review looks at how services worked together to support Adult D and specifically considers how services responded to the following key issues: self-neglect, application of the Mental Health Act, communicating an unconfirmed diagnosis of a terminal illness, safeguarding, housing, and transfers between hospitals. Adult D's partner was consulted throughout the review which highlighted learning around support for carers. The review also highlighted good practice including: good communication and strong multi-agency and partnership working.

**2 Theme 1: Assessment, Care and Review**  
Adult D and his family were informed that he had a terminal illness which later proved to be an incorrect diagnosis; this had a significant impact on Adult D's physical and mental health. Careful consultation and planning should take place before giving this information to patients and their families, particularly when a diagnosis has not yet been confirmed.

Adult D was transferred to a Primary Care hospital which was not registered for detaining patients under the Mental Health Act. There must be recognition that, in order to legally detain a patient using the Mental Health Act, the hospital must be specifically registered to do so.

Adult D was supported at 3 different hospitals and by 3 different social work teams as his physical health, mental health needs and location changed. Although there was good multi-disciplinary working across these services and teams, the review identified that stronger working practice would include arranging regular multi-disciplinary meetings to draw in workers from all relevant agencies, and family/ carer/ advocacy representatives to provide a forum for communication and challenge.

**3 Theme 2: Mental Capacity Act**  
Mental capacity assessments could have been strengthened in the case of Adult D. He frequently declined food and medicines and appeared to understand that he may die because of these decisions. Practitioners worked on the basis of presuming capacity and when faced with a number of unwise decisions did not consider carrying out formal mental capacity assessments to determine decisional and executive capacity. This approach may have determined that Adult D had fluctuating capacity and considered how Adult D's health conditions may have also impacted upon his decision making.

Adult D's partner was a strong advocate and able to challenge professionals and act on Adult D's behalf. However, she felt that she was not well supported as a carer and it would have helped her if she had been signposted to carer support services as set out by the Care Act 2014.

When practitioners have ongoing concerns about mental capacity and unwise decisions being made they should seek early support from their managers to ensure they have access to legal advice at a time when they may be struggling to understand their role in preserving life when someone is self-neglecting.

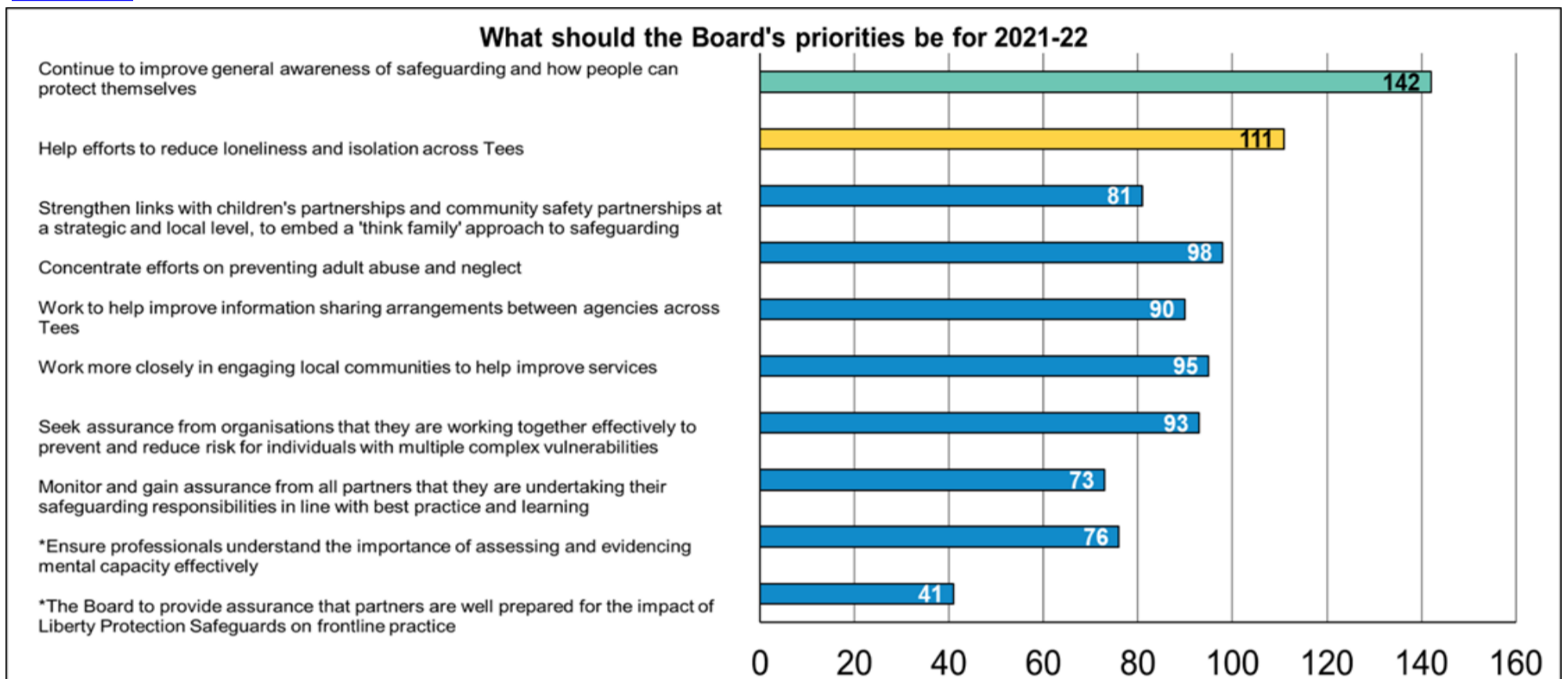
**4 Theme 3: Discharge Planning and Housing**  
Prior to Adult D's discharge from the Mental Health hospital several housing options were explored, including residential care, supported living and rehabilitation services; none of these were a viable option which resulted in his discharge to B&B accommodation. This solution was in place for a matter of days prior to his return to hospital. There was no 'step down' provision for mental health patients prior to discharge into the community which may have better met Adult D's needs.

Involvement of Housing Colleagues in multi-disciplinary team meetings from an early stage could improve discharge planning options.



## Annual Survey Results 2020-21

The Board's Annual Survey 2020-21 was completed by **255** members of the general public and professionals. Thank you to those who completed it. The feedback from each survey has been collated to provide an overall view, illustrated below, however it should be noted that there were some differences between the responses from professionals and the general public. The results will help the Board to develop the Strategic Plan for 2021-22. Further detailed analysis is published as part of the [Annual Communication and Engagement Report](#)



## Introducing Nick Hunt, Corruption Prevention Officer at Cleveland Police.

Safeguarding teams are being introduced to Nick Hunt, Corruption Prevention Officer for Cleveland Police. Nick's new role will focus on prevention by raising awareness of corruption in its various guises to increase reporting, alongside preventing corruption and breaches of the standards of professional behaviour.

His aim is to work alongside colleagues in counter corruption to raise awareness of his role, which includes a focus on police officers abusing their position for sexual gain and sexual harassment. Nick hopes to work with agencies to highlight the tell-tale signs, and develop confidence in reporting concerns. Historically not all information or concerns have been reported to the police however, victims regularly confide in other professionals due to their belief the police won't believe them or take them seriously.

Nick says: "I've always been passionate about tackling corruption. Even in these extremely challenging times, the vast majority of our officers, staff and partners operate with the upmost honesty and integrity. Unfortunately, at times, a minority act in a way that fundamentally betrays the trust communities place in us. Corrupt practices have a corrosive nature which can quickly undermine our legitimacy."

"I am always available to discuss anyone's concerns, however small, and can guarantee you that your concerns will be taken seriously and investigated. Together we are stronger and can prevent this unacceptable behaviour".

"We have lots of fantastic officers and staff working for Cleveland Police, but there are people who use the cover of the police service to carry out misconduct or criminal activity. These people must be caught and dealt with."

If you would like to discuss anything with Nick, he can be contacted via:

Email – [prevent.corruption@cleveland.pnn.police.uk](mailto:prevent.corruption@cleveland.pnn.police.uk)

Tel: - 01642 306929



## Dates for the Diary

- Mental Health Awareness Week—10-16 May
- Dementia Action Week—17-23 May
- Carers Week—7-13 June
- World Elder Abuse Day –15 June
- Learning Disability Week - 21- 27 June
- TSAB Spotlight on 'Support Services' campaign—5-9 July



## National Safeguarding Adults Week

National Safeguarding Adults Week is taking place from Monday 15th November to Friday 21st November.

Some of the themes announced include adult grooming, safer cultures and mental health. TSAB will begin planning local activity and communications over the following months, if you would like to be involved or have any ideas for activity or promotion please let us know.



## Children's Partnerships Information

The Local Safeguarding Children's Partnerships newsletters can be accessed here;

[Hartlepool & Stockton-On-Tees Safeguarding Children Partnership Newsletter](#)

[South Tees Safeguarding Children Partnership Newsletter](#)

## Social Media and Website

We aim to share key messages from official sources via our social media channels as well as other communications.

During March, TSAB ran a successful Spotlight on 'Self-Neglect' campaign. The resources can be found within our [January 2021 Newsletter](#) or on our Twitter and Facebook channels.



@TeeswideSAB



@TeeswideSAB



[www.tsab.org.uk](http://www.tsab.org.uk)

## Find Support in Your Area

The Board's website also sets out relevant [support services](#) by type of abuse and by each individual Borough across Tees. If you think someone with care and support needs is neglecting themselves you can contact your [Local Authority](#) or for hoarding matters your Environmental Health Office for advice.

This list is not intended to be a definitive source of Information for all Service Providers.

## Your Comments

If you have any suggestions for the Newsletters:



[tsab.businessunit@stockton.gov.uk](mailto:tsab.businessunit@stockton.gov.uk)



01642 527263

