Birmingham Safeguarding Adults Board

A Serious Case Review in Respect of A2

Executive Summary

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Birmingham Safeguarding Adults Board
executive summary of a serious case review in respect of A2 who died 2012

This Executive Summary provides a brief summary of the main findings, conclusions and recommendations of the Serious Case Review (SCR) following the death of A2 in 2012.

1. Background

1.1 A2 was well known to agencies including: GP surgeries; Birmingham and Solihull Mental Health Foundation Trust (BSMHFT); Birmingham City Council Adults and Communities Directorate (BCC A&C); Sandwell & West Birmingham Hospitals NHS Trust (S&WB NHS Trust); West Midlands Police (WMP); Birmingham Community Healthcare NHS Trust (BCHC NHS Trust) (who had only peripheral involvement, providing chiropody in 2006/2007 and involvement on A2's admission to hospital on 31st October 2011. Therefore not all of the findings apply to this organisation). A2 had a number of long term health conditions, including diabetes and a diagnosis of paraphrenia. Shortly before his death he was also diagnosed with dementia.

1.2 The above agencies were challenged by A2's reluctance to engage with them in connection with health and social care needs.

1.3 The period analysed by the SCR panel is July 2007 to March 2012.

1.4 A2 died in April 2012, in an inpatient palliative care unit for people in the final stages of illness. The cause of death was recorded as dementia, peripheral arterial disease and type 2 diabetes. Since an admission to hospital on 1st November 2011, an end of life pathway had been pursued, keeping A2 comfortable. He was cared for in a nursing home prior to the admission to the palliative care unit and was in receipt of continuing health care funding.

2. Purpose of Serious Case Review

2.1 The Birmingham Safeguarding Adults Board (BSAB) Safeguarding Adults Policy, Procedure gives details of the purpose of convening a serious case review. Broadly this is to establish whether there are lessons to be learned from the circumstances of the case in particular about the way in which local professionals and agencies work together to safeguard vulnerable adults.

2.2 Individual Management Reports (IMRs) deal in detail with the actions required within each agency. The Birmingham Safeguarding Adults Board will provide a scrutiny role in relation to single agency action plans but those individual actions/recommendations will only be included in the recommendations of this SCR:

- Where they have significant implications across agencies or for the case as a whole
- Where they underline highly pertinent matters which may have received limited attention in the IMR recommendations - and the BSAB needs to be alert to them

2.3 The Terms of Reference of this Serious Case Review are:

1. To establish and analyse the chronology of events in relation to A2 in the period July 2007 to Feb 2012
2. To examine the information known to agencies about A2 between July 2007 and Feb 2012

3. To examine the care and treatment provided by all those agencies involved in his care and in supporting his wellbeing including where relevant: multiagency decision making in response to his needs and the agencies understanding of the legal basis for those decisions with particular reference to the Mental Capacity Act and Mental Health Act (including the interface between these two pieces of legislation) and, in particular, staff understanding of their responsibilities in this legal context.

4. To examine the adequacy of the communication and collaboration between all agencies involved in supporting the care and wellbeing of A2 between July 2007 and Feb 2012

5. To examine the relevant policies and protocols in operation at the time of involvement with A2 including whether practice was in accordance with the local safeguarding adults policy and procedure

6. To establish whether there are lessons to be learned from this case about the way in which local professionals and agencies carried out their responsibilities to care for A2 and to safeguard his wellbeing as a vulnerable adult.

7. To prepare an independent overview report based on the findings and conclusions of the SCR panel and to make recommendations that can be implemented and acted upon by the Birmingham Safeguarding Adults Board member agencies so that any necessary improvements in practice come about.

8. To ensure that conclusions are evidenced.

3. A2 and his family

A2 was a 78 year old man. He had close contact with his daughter and a son. It is likely that his daughter was (at least at times) living in his house with him although this is never confirmed in records. There were two other sons who were resident at a home in Erdington specialising in care of individuals with learning disabilities. Little is known of them but they did visit A2 regularly when he was resident in a care home between 2004 and 2007.

Within the records there are recurrent themes which give some insight into the relationship between A2 and the professionals involved. Records include information that he was difficult to engage; failed to turn up for appointments; failed to order repeat prescriptions or to take prescribed medication. At one point we learn that he had a negative experience with statutory agencies when they were involved in the care of his wife. His distrust of the police is cited. These are isolated comments in the records which are not pursued with A2.

We learn from a recorded conversation with the care home manager that A2 was not readily accepting of the loss of his leg in 2000 and that there was a long standing dispute and claim in this respect. He periodically met with 'someone' who was looking into his grievances. He is described on occasions within the records as: rude; aggressive in nature; eccentric.

In October 2007, whilst A2 was living in a care home, a doctor from BSMHFT describes him: "as being suspicious and paranoid initially, but once a rapport was established A2 admitted to having a diagnosis of diabetes and prostate cancer, but denied having any current or historical psychiatric illness. A2 informed Dr 1 that he believed in witchcraft and that he did not want to talk about his beliefs. He admitted to using fruit to ward off bad people and influences. He was also said to burn fruit on his cooker as a form of witchcraft (reported by staff). [A2's family] stated that this behaviour by A2 was longstanding and not a recent development."

The police IMR identifies the need for caution in attributing some of A2's comments as indicative of mental health problems when some of these comments may be more indicative of commonly held beliefs in Caribbean cultures.

A2: health issues. A2 was diabetic and non compliant with treatment/ medication. He had a right below knee amputation in 2000. In 2004 he moved into a care home from hospital. He moved around the home by self propelled wheelchair and spent most of his time in his flat within the complex. A2 also had a diagnosis of prostate cancer and was reported by a home care team to have had 3 strokes and a heart attack.
A2 had a history of mental health problems and a diagnosis of Paraphrenia — a form of psychosis which is associated with onset in later life, characterised by the presence of delusions (BSMHFT IMR). He did not recognise himself as having a psychiatric disorder. He sometimes denied physical conditions (such as the prostate cancer) but at other times acknowledged these. His family at one point advised that he was more in favour of herbal medicine than conventional medicine.

4. Summary of case outline

In November 2004 A2 was discharged from hospital to a care home in Balsall Heath, Birmingham. In November **2007** the placement was reviewed and A2 chose to move back to independent living with the support of his family.

In **2008** A2 and his family requested support via a Direct Payment. There were delays in setting up the Direct Payment. A review of this arrangement was not undertaken until June 2009 despite concerns expressed by a care agency in July 2008.

Despite a range of recorded health issues, significant concerns and failed appointments there is no record of any health professional seeing A2 during the 9 month period between April 2008 and January 2009.

In the first half of **2009** there is no record of any agency having direct contact with A2 until on 22 June 2009 BCC A & C completed a first review of home support. This review should have taken place 28 days into the service. The review record states "A2 is happy with the care provided by his family" and that "There were no concerns about the direct payment". There is no record of any exploration of the fact that the family now appeared to be providing the care and that they were doing so under a direct payment arrangement (even though earlier the family had been advised that this was not permissible). There is no clear record of a *holistic* needs assessment, despite his complex needs, nor of a carers' assessment. There was no further contact until a safeguarding referral made to BCC in April 2010.

In **2010** there are records of **three safeguarding episodes**. The **first, on 2 April 2010,** relates to allegations of financial abuse by A2's family. It was recommended that a review of the direct payment take place because of lack of compliance with submission of quarterly returns.

The **second safeguarding episode** was reported on **10 May 2010** by a social worker to the police. "SW1 reports to Police that A2 has alleged that [family members] are stealing from him."

The Police IMR gives information from the police log as follows: "the house is in an absolute state unfit for humans. A2's bedroom had a strong smell of urine and there were mouse droppings in all rooms and mice were seen in A2's room. The substantial amount of litter on the floor meant that A2 was effectively unable to move independently in his wheelchair. The kitchen was described as unfit for the preparation of food with mouse droppings in the cupboards. The fridge freezer had no food in it. " They report that A2 seems unaware of how bad the living conditions are. Formal referral is made to BCC Social Care. No further Police action was taken. There is no record demonstrating that the safeguarding adults procedure was followed.

A social worker carried out a home visit on 8 June (a month later). A2 and family were not at home. A note was left. Finance section stopped the direct payment at this time due to non compliance. There are then failed phone calls and a further visit to A2 and his family. On 19 August the senior social worker recommended closure of the case.

The **third safeguarding episode** was referred to adult social care by OPAS (Older Peoples' Access Service) on **8 November 2010.** This concerned allegations of: financial abuse, neglect and verbal abuse by a family member who it is recorded, lives with A2 and is his main carer.
Visits to A2 by the social worker and the CPN elicit inconsistent accounts from A2 as to whether his money is being taken by his family. Concerns about A2's living conditions persist. There are a range of concerns evident from the records of: BCC; the police; the GP and a referral for a mental health assessment of A2.

In **January 2011** concerns which emerged following the safeguarding referral in November 2010 persisted. More failed health appointments in respect of

diabetes are logged by Health agencies. There is no proactive involvement recorded of BCC with A2 until a joint home visit with a CPN on 15 June 2011. Other than some small improvement in the home conditions, the situation remained very much the same and A2 persisted in declining all offers of support. As a result of A2's unwillingness to engage in treatment he was again discharged from the mental health service back to the care of the GP with an expectation on the part of the CPN that BCC would follow up on continuing concerns about the home conditions. However on 28 July BCC A&C also closed A2's case because he refused assistance.

On **31 October 2011** following a visit to A2 the GP advised BCC of concerns regarding his health and wellbeing and possible "elder abuse". This led to BCC reopening the case on 1 November 2011. A2 was admitted to hospital and the record of the social worker and rapid response team who visited on that day and initiated the hospital admission summarises the concerns:
"1) A2 appears dehydrated.
2) He is a diabetic-but has not been on any medication. He has had no routine checks for his diabetes.
3) It appears he has not been eating properly.
4) The family [member] arrived when we were at the house. He did not appear to understand why his dad needed to go into hospital. He said that family [member] was the prime carer.
5) A2 may have pressure sores as he has been lying in bed. The family [member] stated his dad was doubly incontinent.
6) A2 has pressure sores on his leg which were dry. Possibly grade 4."

It was concluded that he was not fit for surgery and he was referred to the RAID team (a BSMHFT commissioned mental health team on site at the hospital). A diagnosis of vascular dementia was recorded; a capacity test was undertaken by BCC and a referral to IMCA service made. It was agreed that in A2's best interests he be discharged to a nursing home. The move took place on 28 December. A2 died on 12 April 2012.

5. Key issues: summary of analysis

There were positive elements of practice and evidence of good intentions to support A2. These are evidenced in the full report. The following themes are recurrent and significant and form the basis of recommendations to improve practice. They are analysed in detail in the full report. Cross cutting themes of communication and collaboration across agencies; adequacy of policy and procedures (and, in particular adherence to these) and recording were areas of concern within these themes.

- **Assessment, monitoring and review processes and, in particular, practice in identifying, assessing and managing risk**

A2 was an individual with multiple health needs (both physical and psychiatric) and about whom there were concerns in respect of lifestyle; decision making; living conditions; financial abuse; possible neglect/self neglect. There was a need to clearly identify *and record* A2's support needs and the level and nature of his vulnerability so that this could inform actions. However it is clear that assessment, monitoring and review processes were flawed. This was evident

within and across agencies including in respect of Community Care assessment; Direct Payments process; Care Programme Approach assessment; keeping track of deterioration in physical health issues; safeguarding processes.

Action/ timescales bore no relation to the level of implied risk/concern and that level of concern had often not been clearly quantified or analysed. Indeed on occasions, despite significant risk, agencies withdrew often because of A2's lack of engagement. There was little evidence of agencies coming together to gain a holistic picture of A2's needs. The Birmingham Safeguarding Adults Board safeguarding adults procedures are very clear that risk management is central to effective safeguarding of adults at risk. The importance of risk identification, assessment and management are indicated at every stage of the safeguarding process. There is no evidence that this guidance was followed.

Recording is an essential part of best practice and is particularly important in the context of risk management. There were failings across agencies in respect of recording. There are repeated acknowledgements in IMRs of missing or inadequate records. These failings are dealt with in the action plans of individual agencies.

There was little evidence of a person centred approach or of any real engagement with carers. There was no carers' assessment undertaken. Records give no indication that professionals had any sense of what motivated A2 or what drove his decision making. His decision making capacity was not rigorously assessed until November 2011, following his admission to hospital. This lack of insight into A2's history and reasons for making decisions/taking or failing to take actions is striking and represents a failure to engage in a person centred way in the assessment of need and risk.

Formal review of assessments was rare. Even when carried out, the quality and depth of review was poor. Practice failed to adhere to policies and guidance regarding the review of either his community care assessment or the Direct Payment.

- **Working with individuals who are difficult to engage**

Challenges to professional involvement by individuals who use services may not be indicative of an informed choice to reject support and treatment but may constitute an alert that something is wrong which requires assessment and intervention. Organisations were challenged with regular instances of "did not attend". Procedures to deal with this must not be based on generalised assumptions but must respond to personal circumstances, level of risk, and any issues in relation to mental capacity where there are indicators (as there were in this case) that these are a relevant and a necessary consideration. Furthermore valuable information was not recorded, making the recognition of risk and questions about A2's wellbeing difficult to identify.

Whilst recognising the significant challenge faced by professionals there needed to be a greater emphasis on exploiting the opportunities which presented for working positively with A2 and working to understand and

minimise the resistance. This needed in part to include exploration of A2's reasons for declining support; services; medication and treatment as well as supporting his understanding of what the likely outcomes of refusing treatment and services might be. This required professionals to be clear themselves about what the key issues and risks were. They were not. It required that professionals question A2's capacity to make decisions (and where appropriate undertake formal mental capacity assessments). Advocacy may have offered a way of engaging more effectively with A2/his family in these areas.

• **Safeguarding adults process and practice**

The process and rationale for working with safeguarding concerns is clearly set out in the multiagency safeguarding adults procedures[1]. This framework for proceeding had the potential to benefit A2 in: identifying problematic issues/risks (across agency and discipline boundaries); in providing a framework for keeping track of the impact of interventions in these areas of risk; in providing prompts to consider relevant issues such as mental capacity. However, at no point was the process adequately followed.

It is significant that allegations of financial abuse (a tangible act of abuse) were always the trigger for referral into the safeguarding adults process (with the exception of the concerns following A2's admission to hospital in November 2011). In fact, the concerns around neglect and possibly self neglect should have indicated an alert/referral but a cumulative pattern which might have indicated significant harm was not being identified and responded to in the context of safeguarding adults. It was the case that the two sets of issues progressed largely in parallel. By operating within the prescribed process *all* of the concerns can be identified and actions put in place to address them.

The case of A2 sheds some light on significant lessons for working effectively in cases of financial abuse:

- The importance of partnership working and with a broader range of organisations/departments/disciplines than is often the case with other forms of abuse
- The importance of recognising the links between financial abuse and other forms of abuse (in this case neglect). The need to look at the wider implications and risks associated with the alleged financial abuse
- Addressing the challenge of achieving a unified response where there are a range of aspects to the abuse (types of abuse) and avoiding the temptation for agencies to work separately on separate aspects of the same presenting situation. All of the information needs to be assessed holistically
- The need for an awareness of the range of offences that might be represented in financial abuse situations and the potential remedies (for example in the case of A2, section 44 of the Mental Capacity Act and the Fraud Act, 2006 may have been relevant)
- A need to understand potential methods of assessing/investigating financial abuse and who has the skills to undertake these

[1] Safeguarding Adults Policy, Procedure (June 2009) and Good Practice Guide (November 2010) published by Birmingham Safeguarding Adults Board

- A clear understanding of the available guidance on capacity and financial abuse and on autonomy and choice in this context (what are the possible responses/outcomes where individuals both with and without capacity decline to pursue a complaint or to provide information/evidence?)
- The need to understand the relationship between service user and carer(s) and the significance of the motive for "caring"

• The legal basis for decision making and the possibilities for legal action in the context of the presenting needs and risks

There is evidence that the range of legal options/ the implications of legislation were insufficiently explored. Where legal options are discussed in records there is a lack of clarity as to the rationale for such considerations.

It is important that staff are aware of the complex legal framework and that their awareness is kept up to date. Legal options may not, in the end, have made a difference to the decisions and outcomes. Nevertheless these are essential considerations. Where there is doubt about legal issues, expert legal advice must always be sought by staff. Organisations must be clear with staff about where and how advice can be accessed. There is no record of any legal advice being sought in any organisation despite obvious lack of clarity on some legal issues. Legal options that might potentially have had a role to play in supporting the situation or in supporting judgements relating to the concerns that existed are set out in the full report.

Practice in the context of the Mental Capacity Act (MCA) presented significant issues including: the failure to adequately assess A2's capacity; the failure to work consistently within the principles of the MCA; lack of awareness of the Section 44 offence relating to wilful abuse or neglect of an adult who lacks capacity; the issue of possible coercion of A2 and the necessary assessment of decision making capacity/best interests in this context; the need for understanding of the interface between the Mental Capacity Act and the Mental Health Act.

• Supporting front line practice: organisational issues, culture and supervision

Front line workers should not be left exposed to managing high levels of risk alone and without the authority and support to manage them effectively. It is important that the themes in this report are seen as organisational issues and not simply as individual failings.

A culture that encourages appropriate challenge needs to be supported. There were few examples of such constructive challenge either within or across organisations. Clarity in terms of escalation processes, whistle blowing policies as well as opportunities for peer support can assist. Organisations should provide opportunities for debate and promote evidence based practice.

The importance of managerial supervision of staff was underlined in this review. This includes the importance of management oversight particularly in

safeguarding cases. This needs to include supervision of: records and standards of documentation; of application of procedures; of implementation of training. The culture and processes of multidisciplinary meetings and consistency of approach across teams also feature within the lessons underlined by this case in the context of supervision. Some improvements in leadership and monitoring of practice against the expectations of organisations have already been made. These actions need to be sustained and must go hand in hand with an emphasis on the role of supervision in the support and development of staff.

6 Conclusions

6.1 A2 was an adult at risk whose health and social care needs were diverse and cut across agency boundaries. He moved out of a care home into his own independent accommodation. This move required his needs to be assessed due to challenges presented to independent living in part by his lack of mobility (he was confined to a wheelchair) and also because of a range of health needs. These would require that continuity of care was assured in the context of a move to a different geographical area. A2 was reluctant to engage with professionals despite considerable health needs as well as care needs and safeguarding issues which he alternately acknowledged and denied. His frequent failure to turn up for appointments and declining of support meant that agencies were challenged in their attempts to support him.

6.2 From the beginning of the period when he was living in the community there were indications that A2 had health problems which were of a serious nature (diabetes and associated issues; high blood pressure; prostate cancer) and these required vigilance and treatment. However, A2 constantly missed appointments and failed to follow through treatment plans or take advantage of repeat prescriptions. In fact he had no medication for his diabetes between 2008 and his admission to hospital in November 2011.

6.3 A2 also suffered from mental ill health with a diagnosis of paraphrenia and it was at times unclear as to whether he understood the implications of his failure to engage with either health or social care professionals. In November 2011 he was also diagnosed with dementia.

6.4 Safeguarding concerns were referred to Birmingham City Council Adults and Communities Department on three occasions during 2010, on each occasion in respect of reported financial abuse by his family. On admission to hospital in November 2011 the GP referred A2 to Adult Social Care again due to safeguarding concerns, following a home visit, about A2's wellbeing. There were concerns that he was not being looked after properly by his son and daughter.

6.5 This serious case review has highlighted inadequacies in the assessment and management of A2's various needs and of the risks inherent in his situation. Despite the above complex circumstances and range of needs, practice was on the whole reactive. The situation merited a robust, disciplined and proactive approach involving a recorded holistic assessment of the needs and risks, which was shared and discussed across disciplines and agencies,

with associated strategies for monitoring, managing and reviewing the known risks.

6.6 Such an approach required professionals to attempt to engage with A2 and his family to elicit a clearer picture of how things were for each of them and what their needs, wishes, beliefs, priorities, motivations were (person centred assessment with A2; carers assessments with his son and daughter). It required that professionals share with A2 and his family what they knew of the concerns and risks to try to ensure that any decisions made by A2 and his family were informed. However, remarkably little is known about A2 or his family and still less about how they functioned as a family unit.

6.7 Professionals did not therefore understand the basis upon which A2 declined to work with professionals or to facilitate their attending to his needs. Neither did they question his ability to make those judgements about declining health and social care support. It was not until the very end of the period reviewed that a formal assessment of A2's capacity was carried out or an Independent Mental Capacity Advocate engaged to ensure that decisions were made in his best interests. Yet, there were a series of decisions made by A2 that were problematic and presented serious risk to his health and wellbeing.

6.8 Failings in relation to practice in the context of the Mental Capacity Act were prominent across most agencies. Those failings included: understanding and putting into practice the five core principles of the Act; formalising and documenting assessments; understanding of the concept of "best interests" and the need for formal assessment of this with A2 at the centre; the interface between the Mental Capacity Act and the Mental Health Act; the relationship between coercion and capacity.

6.9 Policies and guidance were not followed including policy and procedures in relation to: safeguarding adults, risk assessment and risk management, direct payments, the Mental Capacity Act and the Code of Practice; refusal of services/failed appointments (DNA policies); recording; supervision. The adequacy of these policies and procedures requires attention alongside ensuring that staff are familiar with them and working with them.

6.10 Practice in safeguarding adults from abuse was notable for the absence of records which might have demonstrated that the BSAB policy and procedures had been followed. There was little evidence to suggest that even the basic framework of these procedures was followed let alone the guidance and principles set out for staff. In some agencies the basic policy, procedures and training are not in place. This needs to be addressed. In others, training and management oversight are already in place and perhaps actions need to concentrate on more innovative approaches which integrate learning and support into everyday practice and experience. This might include innovative approaches to learning, supervision and practice itself.

6.11 The specialist area of financial abuse is particularly challenging and requires that professionals across agencies use the available research,

guidance and law to inform practice so that in future they can learn from some of the lessons illustrated in the case of A2.

6.12 Practice needed to be underpinned by legislation. The principles of the Mental Capacity Act and of the Human Rights Act were central in this case. The circumstances should have triggered consideration of a range of legal alternatives associated with the risks inherent in A2's situation. Professionals need to be aware of and/or have easy access to advice on those alternatives. Few were considered in this case.

6.13 A2 had presented with mental health issues as well as mental capacity issues. The importance of a holistic assessment informing discussion of the relative role of the two pieces of associated legislation was indicated. The Mental Health Act and the Mental Capacity Act had a potential role in relation to his mental and physical health needs as well as the safeguarding issues which presented. This was never analysed and until the end of A2's life neither piece of legislation impacted upon the risks he faced.

6.14 In part inaction and failure to consider options had to do with a lack of clarity about who should take responsibility for areas such as assessment of A2's capacity or even the decision to make that assessment. There were issues about ownership of decisions and there was a need for challenge across agencies and disciplines. Successful challenge requires robust evidencing of views and decisions and the above demonstrates that this was not achieved by those involved with A2.

6.15 Organisational culture features in the reasons for challenge being absent or unsuccessful. Organisations must nurture a culture which values team work; peer support; mutual respect; constructive debate; reflective practice; evidence based practice. Supervision has to balance managerial oversight with support and opportunities for development. Staff confidence is an issue which needs to be addressed.

6.16 The agencies involved in this Serious Case Review are committed to ensuring that the issues represented here are addressed. They have identified actions within their own agency which will help to ensure that single agency shortcomings are addressed. The recommendations in section 7 below will form the basis of a BSAB action plan designed in the main to address multiagency failings. A recent BSAB Serious Case Review into the death of A1 recommends actions with some degree of overlap with the issues raised by the case of A2. Where this is the case this is highlighted (*) so that prioritising of actions can bear this in mind.

7 Recommendations

*Those recommendations marked * also feature in a recent Birmingham SCR into the case of A1*

7.1 Empowering and including people who use services and their families/carers

Member agencies to the safeguarding adults' board will ensure that person-centred principles are embedded in all relevant policies, procedures and guidance.

***7.2 Carers' assessments**

Relevant agencies will ensure that Carers' assessments (in line with the relevant legislation) are offered to all identified informal carers involved in providing support to individuals who use services and that there is a process to consider/review where such offers are refused.

***7.3 Service Users who are reluctant to engage with professionals**

The SCR into the case of A1 required the BSAB to commission guidance / checklists for staff in situations of significant risk where treatment is refused. In the light of learning from the case of A2 this guidance should be strengthened to include the issues reflected in the case of A2.

7.4 In the handover from the PCT to Clinical Commissioning Groups (CCGs) the BSAB, the PCT and the CCGs will work together to support measures to ensure that as CCGs emerge safeguarding adults is built into commissioning and governance processes

7.5 Identification, assessment and management of risk

Guidance outlining a joint approach to identification, assessment and management of risk will be developed and agreed across all partner agencies to the BSAB.

Training in risk assessment and risk management will be reviewed in the light of this SCR across agencies.

***7.6 Safeguarding Adults process and practice**

Across agencies there was a failure to follow the process set out in the BSAB safeguarding adults policy and procedures or to apply relevant guidance and principles. Single agencies will be required to provide assurances to the BSAB that the relevant necessary actions highlighted in IMR reports are being addressed. These relate to adequacy of policy, training and management oversight.

7.7 Improving practice in relation to financial abuse

Intervention in respect of financial abuse requires that professionals across agencies use the available research, guidance and law to inform practice so that in future they can learn from the lessons illustrated in the case of A2. The BSAB will draw up specific practical guidance in relation to safeguarding adults from financial abuse.

7.8 The BSAB will establish links with the Crown Prosecution Service

***7.9 Improving practice in relation to the Mental Capacity Act**

Failings in relation to practice in the context of the Mental Capacity Act were prominent across most agencies. The SCR in respect of A1 has already undertaken to consider training requirements and the effectiveness of training in respect of the MCA.

In the light of the learning from the case of A2 the BSAB will build on this, underlining the importance of facilitating learning in respect of the MCA by making available practical case study based resources for learning and development.

The BSAB will consider development of a local tool for the assessment of capacity.

7.10 Working understanding of the range of relevant legislation

All agencies must ensure, through training and supervision, that staff are aware of the complex legal framework and that their awareness is kept up to date. The relevant learning in this SCR will be disseminated to support this. Organisations must be clear with staff about where and how legal advice can be accessed.

7.11 Challenge and organisational culture

Organisations must nurture a culture which encourages and values constructive challenge and debate.
Managers and staff at all levels must be encouraged to seek clarity, to challenge decisions and to escalate issues of concerns within a well defined process. Whistle blowing procedures should be prominent in organisations.

7.12 Supervision

All agencies will review their policy and approach to supervision of staff involved in complex cases to ensure a focus on supporting effective assessment and management of risk and on ensuring that learning from training is transferred into practice. Supervision should include a balance facilitating management oversight and challenge, staff support and identification of staff development needs.

7.13 Progress on single agency action plans will be monitored by and reported to the BSAB via the SCR subgroup to the Board

References

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12 What Price Dignity? Keynote address by Lord Justice Munby to the LAG Community Care Conference: Protecting Liberties, 14 July 2010