

# SAFEGUARDING ADULTS CONFERENCE



**BREAKOUT SESSION:  
Interagency  
Involvement & Cross  
Borough Working on  
Safeguarding Cases**

**Derek Oliver**

**Assistant Director of Adult Social Services  
Richmond & Wandsworth Councils**

# **WORKSHOP FACILITATORS**

**Lynn Wild (Head of Safeguarding & Professional Standards)**

**Richmond & Wandsworth Councils**

**Ally Smith (Safeguarding Adults Board Co-ordinator)**

**Richmond & Wandsworth Councils**

**Sarah Loades (Adult Safeguarding Lead Nurse)**

**Richmond & Kingston CCG**

**Marino Latour (Safeguarding Lead Nurse)**

**Wandsworth & Merton CCG**

**Virindar Basi (Safeguarding Manager)**

**Richmond & Wandsworth Councils**



# **THE TASK**

**What we are  
here to do**



# WHAT WE WILL COVER

**01** LOOKED AT A CASE STUDY

**02**

**ISSUES IMPACTING ON CROSS BOROUGH WORKING**

**03**

**HOW WE IMPROVE CROSS BOROUGH & INTERAGENCY WORKING**

**04**

**COMPONENTS OF A CHECKLIST/PRACTICE IMPROVEMENT**

# **- THE CONTEXT -**

**A Reminder of our working  
requirements**

# INTRODUCTORY REMINDER

Safeguarding adults is about people working together to protect but ensure wellbeing, wishes and beliefs are respected.

Sharing the right information, at the right time, with the right people, is fundamental to good safeguarding adults practice.

Effective multi-agency working is challenging in day-to-day work. It is time-consuming and can lead to conflict. However, putting together different parts of the jigsaw is essential.

Working with people who lack capacity and where families/carers are assertive, requires diligence and the ability to assert professional expertise.

To support and protect adults who are at risk of abuse or neglect requires a genuine desire to know and understand the circumstances around that person and what they have experienced.

Working across local authority boundaries is an emerging challenge to effective safeguarding in a number of areas and is emerging in SARS.

# INTRODUCTORY REMINDER

Safeguarding adults is about people working together to protect but ensure wellbeing, wishes and beliefs are respected

Sharing the right information, at the right time, with the right people, is fundamental to good safeguarding adults practice

Effective multi-agency working is challenging in day-to-day work. It is time-consuming and can lead to conflict. However, putting together different parts of the jigsaw is essential.

Working with people who lack capacity and where families/carers are assertive, requires diligence and the ability to assert professional expertise.

To support and protect adults who are at risk of abuse or neglect requires a genuine desire to know and understand the circumstances around that person and what they have experienced.

Working across local authority boundaries is an emerging challenge to effective safeguarding in a number of areas and is emerging in SARS e.

# EXERCISE

**Developing better  
interagency working  
and cross local  
authority working**



# GROUP DISCUSSION Process

- Small facilitated groups
- Follow a real case study through 3 stages
- Use this to learn, pose questions & share ideas
- Capture discussions as actions
- Work towards building a checklist and prompts

# GROUP DISCUSSION Process

- Small facilitated groups
- Follow a real case study through 3 stages
- Use this to learn, pose questions & share ideas
- Capture discussions as actions
- Work towards building a checklist and prompts



# CASE STUDY: PART 1

- An elderly lady, Julie, is referred to Local Authority (LA1) by the London Ambulance Service (LAS).
- Concerns relate to self neglect, based on her appearance & confusion.
- She is reported to own a property in LA3, but currently living with her son, John, in LA1.
- Her son Peter states he has Lasting Power of Attorney (LPA) for his mother.
- He refuses social services support for his mother.
- He assures professionals that he will privately arrange some home support for his mother.

- Doctors have concerns:
  - about Julie's Atrial Fibrillation
  - her high blood pressure
  - and are undertaking tests.
- Peter discharges his mother against medical advice and moves her into his property in LA2.
- LA1 closes the case.

# GROUP DISCUSSION PART 1

- How should this situation have been handled?
- What was missed/did not happen?
- Is there anything else that should have been done?
- Develop a list of actions/ prompts that could form part of checklist

# GROUP DISCUSSION PART 1

- How should this situation have been handled?
- What was missed/did not happen?
- Is there anything else that should have be done?
- Develop a list of actions/ prompts that could form part of checklist



# CASE STUDY: PART 2

- 2 weeks later, Peter brings Julie to A & E at another hospital.
- She appears unkempt, is confused and her blood pressure is high.
- She is admitted to hospital for further tests.
- She is found to be very dehydrated, unsteady on her feet & appears to be self-neglecting.
- She is reported as living with her youngest son, John, in LA1.
- The hospital make a safeguarding referral to LA1 with concerns of neglect/self-neglect.

- The Safeguarding Adults Manager (SAM) contacts John
- John advises that his brother Peter has LPA & contact/arrangements should be discussed with Peter.
- A week after admission Julie is much better
- Doctors remain concerned about her medically and also about her possible self neglect.
- Before formal discharge is planned, Peter discharges Julie against medical advice.
- He states that he plans to privately arrange home care for his mother and that she will be living with him in LA2.
- LA1 closes the safeguarding enquiry.

# GROUP DISCUSSION PART 2

- Does Local Authority 2 have all the information they need to support Julie?
- How well is Julie involved in decisions about her health and care?
- What actions might the Local Authority 2 have taken to obtain a full picture?
- What checks should health professionals have made?
- What actions might have been taken to better support and safeguard Julie and ensure she is actively involved in decisions about her health and care?
- Continue your list of actions/ prompts that could form part of checklist

# GROUP DISCUSSION PART 2

- Does Local Authority 2 have all the information they need to support Julie?
- How well is Julie involved in decisions about her health and care?
- What actions might the Local Authority 2 have taken to obtain a full picture?
- What checks should health professionals have made?
- What actions might have been taken to better support and safeguard Julie and ensure she is actively involved in decisions about her health and care?
- Continue your list of actions/ prompts that could form part of checklist



# CASE STUDY: PART 3

- A month later, LAS bring Julie to hospital and notify LA3 of a safeguarding concern about self-neglect.
- Julie is admitted into hospital and found to be acutely confused, dehydrated, hypertensive and her mobility is poor.
- Her son Peter, advises that she has had a few falls at home.
- She may have also fallen out of bed but he does not know details as he found her on the floor.
- The hospital are undertaking a number of tests and they are concerned she may have a fractured neck of femur.

- Peter discharges Julie with an undertaking he will take her to a private clinic for x-rays & will arrange care workers at home.
- He discharges his mother against medical advice.
- LA1 passes the safeguarding concern to LA3 (Julie's ordinary residence).
- LA3 are able to obtain information on all 3 instances from the other 2 local authorities.
- They also check to find Peter does not have an LPA for his mother.

- LA3 undertake a Mental Capacity Assessment to determine Julie's capacity to make decisions about her care and support needs. They find she lacks capacity.
- They arrange for home carers to support Julie at home, however, Peter denies the workers access.
- The SAM notifies the police with concerns of coercion, control and also neglect. The police commence enquiries.
- While LA3 are arranging the safeguarding meeting to review the protective arrangements and agree how best to support Julie, they find out that Peter has taken his mother to Jamaica to live.
- Julie dies one week later in the care home.

# GROUP DISCUSSION

## PART 3

- What are the learning points?
- What worked well/ less well in this situation?
- What prevented professionals from better protecting Julie?
- What systems would help support Julie and to ensure she was actively involved?
- What could have/should have happened?
- Finalise your list of actions/ prompts that could form part of checklist

# GROUP DISCUSSION

## PART 3

- What are the learning points?
- What worked well/ less well in this situation?
- What prevented professionals from better protecting Julie?
- What systems would help support Julie and to ensure she was actively involved?
- What could have/should have happened?
- Finalise your list of actions/ prompts that could form part of checklist

# Summary

- 1
- 2
- 3



# GROUP DISCUSSION

## Summing up

- What hinders effective interagency co-operation in safeguarding cases?
- What systems would help to make cross agency and boundary co-operation more effective?
- Finalise your list
- List a set of **3 tips and hints** to support practitioners to work more effectively on safeguarding across boundaries.  
(Remember to think about how we will ensure that we make a difference for people with care and support needs.)





Q<sub>10</sub>

U<sub>1</sub>

E<sub>1</sub>

S<sub>1</sub>

T<sub>1</sub>

I<sub>1</sub>

O<sub>1</sub>

N<sub>1</sub>

S<sub>1</sub>

H<sub>4</sub>

R<sub>1</sub>

S<sub>1</sub>

A<sub>1</sub>

E<sub>1</sub>

L<sub>1</sub>

G<sub>2</sub>

C<sub>3</sub>

L<sub>1</sub>

L<sub>1</sub>

Remember to hand  
in your sheets



**Thank  
You**