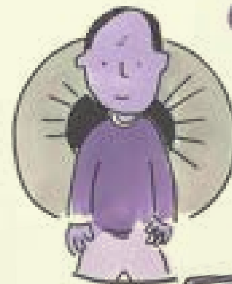
BRENT Safeguarding Adults

Safeguarding **Adults** in Brent



INVOLVE OTHERS

Enabling....

TO DO LIST

don't just be task focused

I HAVE RIGHTS

PREPARATION PLANNING AFTERCARE SUPPORT

I can take risks

KEEP OUT

break through the barriers

SPECTRUM

LEARNING DISABILITY

HI, HOW ARE YOU? REALLY

make every contact count

Make sure you look at the bigger picture

WE ARE ALL PART of a DIVERSE SYSTEM

WE ARE BETTER TOGETHER

ANNUAL REPORT

2020-21

CONTENTS

1. Introduction by the Independent Chair of Brent Safeguarding Adults Board
2. Welcome to Brent
3. What is Adult Safeguarding?
4. Principles of Adult Safeguarding
5. How to Report Abuse in Brent
6. Case Studies
7. Safeguarding Activity in Brent with a report from the Head of Adult Safeguarding
8. Structure of the Safeguarding Adults Board and Its Sub-Groups
9. Events
10. Board Activity
11. The Safeguarding Adults Board Strategic Plan 2019-2021
12 Partner Organisations
13. Safeguarding Adult Reviews
14. Brent Safeguarding Adults Board Budget, Income and Expenditure 2020-2021
15 The Coming 12 Months

WE ARE ALL PART of a DIVERSE SYSTEM

1 INTRODUCTION BY THE INDEPENDENT CHAIR OF BRENT SAFEGUARDING ADULTS BOARD

Welcome to the Brent Safeguarding Adults Board (SAB) annual report. The annual report is one of the statutory responsibilities of the SAB within the Care Act 2014. This report covers the period April 2020 – April 2021.

Given the pandemic and the impact on services, this year's annual report is a streamlined shortened version in order to reduce demands on stretched resources. Nonetheless, the SAB has kept a focus throughout the pandemic on how services have responded to a situation that is unique in everyone's experience. In line with its statutory mandate, the SAB has sought and obtained assurance regarding how services have worked effectively together to respond to the pandemic and to safeguard people from abuse and neglect. In particular, the SAB has monitored the response by the local authority, the Clinical Commissioning Group and its partners to the needs of residents and staff in care homes. It continues to discuss with all of the statutory and non-statutory partners of the SAB, how to ensure that lessons are learned from the response to the pandemic locally and nationally.

Safeguarding duties were not eased by the Coronavirus Act 2020. Accordingly, the SAB has continued with work arising from its strategic business plan. It has routinely evaluated the data on the number of adult safeguarding concerns received and the outcomes of the response to them. Learning and development sessions have taken place virtually. Our flagship event, our annual Safeguarding Adults Board Conference, had to be postponed until the summer of 2021 and so is outside of the scope of this annual report and will be reported on next year. However, multi-agency, multidisciplinary webinars have been held on topics including self-neglect, making safeguarding personal, and mental capacity assessments.

One of the statutory responsibilities of the SAB required by the Care Act 2014 is to commission Safeguarding Adult Reviews where the criteria are met. During 2020/2021, the Board finalised and published the SARs on Adult D and Adult E. The SAB is now monitoring the implementation of the recommendations from these two reviews in order to ensure that necessary service improvements are embedded and maintained. The SAB has continued overseeing the SARs on Adult F and Adult G, details of which will be reported in full in the next annual report.

I would like to record my appreciation for the work of all SAB partners. All have worked incredibly hard over the course of the pandemic when services came under great strain. Despite operational pressures, adult safeguarding remained a focus for all agencies and all partners contributed to the work of the board.

I expect that this will also be the last annual report of my tenure since I am stepping down in my role as Independent Chair of Brent SAB at the end of 2021. I would like to thank all of the partners of the Brent Safeguarding Adults Board for their hard work and level of engagement during my time as Independent Chair.

I hope you enjoy reading this year's annual report.

PROFESSOR MICHAEL PRESTON-SHOOT
INDEPENDENT CHAIR

2 WELCOME TO BRENT

Population: 327,800 people live in Brent.

Brent is one of the most diverse areas in London. Almost two thirds of the population are from Black, Asian and minority ethnic groups, the third highest in London after Newham and Redbridge. Around 16% of residents are White British. Brent is one of the most linguistically diverse areas in the country with around 150 different languages used.

Compared with other areas, Brent residents are more likely to have a religion: 82% had a religion compared with 71% across London and 68% nationally – the fourth highest rate in England.

Around a third of households in Brent live below the poverty line, once housing costs are taken into account.

3 WHAT IS ADULT SAFEGUARDING?

The Care Act 2014 gave adult safeguarding in Safeguarding Adults Boards (SABs) and laid out what the duties were of SABs, namely: to publish an annual report and strategic plan, to commission Safeguarding Adult Reviews, and to hold partner agencies accountable for how they work together to protect adults from abuse and neglect. The Act requires partner agencies and services to work together to protect adults at risk of abuse and neglect.

TYPES OF ABUSE

Physical abuse, Domestic abuse, Sexual abuse, Psychological or Emotional abuse, Financial or Material abuse, Modern slavery, Discriminatory abuse, Organisational or Institutional abuse, Neglect and acts of omission and Self-Neglect.

ENQUIRIES

Under Section 42 of the Care Act, the Local Authority has a responsibility to undertake an Enquiry where a case meets the criteria specified in section 42(1). The Act specifies that local authorities have a duty to undertake an Enquiry where there is a concern that an adult with care and support needs is unable to protect themselves when experiencing or at risk of abuse or neglect. If the criteria are met, then the local authority must conduct an Enquiry and decide on any action under section 42(2).

REVIEWS

Where the strict criteria are met, Section 44 of the Care Act states that Safeguarding Adults Boards must arrange a Safeguarding Adult Review. A Safeguarding Adult Review is completed by a suitably qualified person, independent of the local authority and its partners. The purpose of a Safeguarding Adult Review is to gather all the facts about the case and for the independent author to make recommendations, in order that the local authority and its partners can learn lessons and improve future practice to achieve better outcomes for adults at risk in future. Further information regarding the current status of Brent's Safeguarding Adult Reviews can be found later in the annual report.

MAKING SAFEGUARDING PERSONAL

Capacity to make decisions is one of the key differences between safeguarding adults and safeguarding children. An adult has autonomy to make decisions about the way they wish to live their life. Any Enquiry should include an attempt to gain the views of the adult at risk as to what they would like to happen, providing any necessary support such as an advocate. This is called 'Making Safeguarding Personal'. If the adult at risk has the capacity to make a decision, their wishes must be respected. However, this view must be balanced with an assessment of the risks and an agreement reached as to how these risks will be monitored and managed.

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If a person needs protective measures to be put in place to keep them safe, and is assessed as having lost capacity to make decisions about that particular area, either the Local Authority or the Court of Protection, depending on the circumstances, can authorise a DOLS. This gives the service or individual who provides care to a person legal authority to restrict their liberty in a specified way in order to keep them safe. There are strict criteria as to what is appropriate when putting such measures in place. This area currently sits within safeguarding adults in the Local Authority. The DOLS legislation is due to be replaced by the implementation of Liberty Protection Safeguards. At the time of writing the annual report the expectation remains that the change will occur in April 2022.

4 PRINCIPLES OF ADULT SAFEGUARDING

Empowerment: People being supported and encouraged to make their own decisions and informed consent.

Prevention: It is better to take action before harm occurs.

Proportionality: The least intrusive response appropriate to the risk presented.

Protection: Support and representation for those in greatest need.

Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability: Accountability and transparency in safeguarding practice.

WE ARE BETTER TOGETHER

5 HOW TO REPORT ABUSE IN BRENT

The Safeguarding Adults Board is a strategic board. The Board is not responsible for progressing operational safeguarding concerns. This is carried out by Adult Social Care within Brent Council. The mandate of the Board is to seek assurance that adult safeguarding is effectively managed by all services within the Borough.

If you wish to raise a safeguarding concern there is a safeguarding form – please refer to webpage **www.brent.gov.uk/services-for-residents/adult-social-care/preventing-and-reporting-abuse** where you can download a form and email it to **safeguardingadults@brent.gov.uk**

If you have any trouble completing the form please contact the Duty Team at **safeguardingadults@brent.gov.uk** and they will help you.

Alternatively, you can contact the safeguarding adult team on **020 8937 4098 or 020 8937 4099** from 9am-5pm, Monday to Friday.

6 CASE STUDIES

Adult A lived with her adult son, who had both physical and mental health needs. Concerns were raised of domestic abuse, including the son taking her money and shouting abuse at her, which made Adult A fearful for her safety. Adult A was supported to talk about the life she wanted to live, which meant not being in fear. She also wanted her son to be supported to move out and get the help he needed, so that in time they could have a healthier relationship. Police were involved, along with an advocate, so that protective orders could be put in place and we could work at the right pace with both the mother and son.

Adult B is an inpatient at a Learning Disability Service. An anonymous safeguarding concern was raised concerning staff using inappropriate force during a restraint at the service. A multi-disciplinary safeguarding meeting was arranged and a protection plan was put in place. The staff member concerned was moved to non-clinical duties. The adult at risk was provided with advocacy support to assist her in going through the Enquiry process. The multi-agency liaison involved notifying the local authority, health commissioners and the Police as well as internal departments. Evidence was gathered and all parties interviewed. The matter was passed to Police colleagues to ascertain whether or not a crime had taken place. Although the evidence gathered proved that no crime had taken place and the force used was reasonable in that it was required to protect the adult at risk and others, other practice areas had been identified during the Enquiry and an action plan identified to improve some of the systems at the service. An allegation protocol was also devised and shared in order to use the learning from this concern to assist in managing any future concerns.

.

WE ALL HAVE A ROLE TO PLAY...

7 SAFEGUARDING ACTIVITY IN BRENT

BRENT LOCAL AUTHORITY SAFEGUARDING TOTALS FOR 2020-2021				
Safeguarding Concerns	Section 42 Safeguarding Enquiries	Other Safeguarding Enquiries	Total Enquiries	Conversion rate % Enquiries/ Concerns
1925	655	8	840	350%

CONVERSION RATE CHANGES IN BRENT FROM PREVIOUS YEARS:

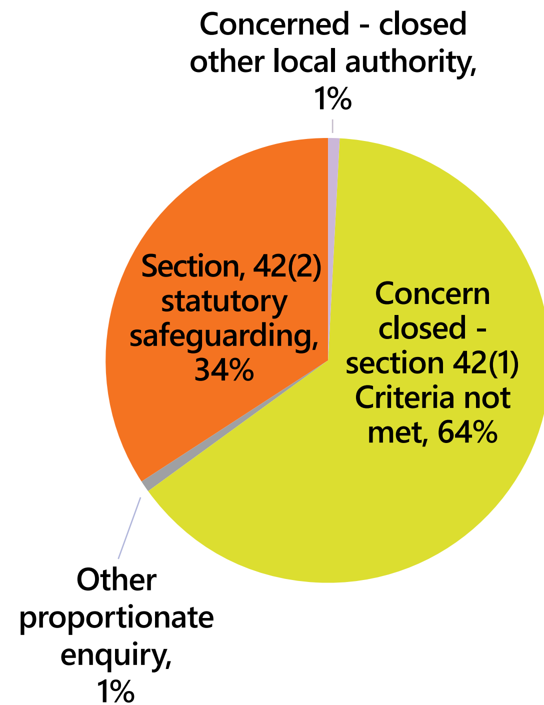
2019/20 1,411 concerns received, 60% meeting S42(2)

2018/19 1,493 concerns received, 72% meeting S42(2)

2017/18 1,675 concerns received, 42% meeting S42(2)

2016/17 1,712 concerns received, 37% meeting S42(2)

OUTCOME OF CONCERN 20/21



REPORT FROM THE HEAD OF ADULT SAFEGUARDING, BRENT COUNCIL

During 2020/21 the Safeguarding Adults Team (SAT) worked hard to embed a framework that helps to provide consistency in how we respond to concerns of abuse. This framework focused on what we term S42(1) and guides our decision making, with our focus very much on 'making safeguarding personal', meaning we aim to understand the outcomes the individual wants to achieve. This helped the SAT to then undertake our statutory duty when we needed to take further action, which is what we term S42(2). Importantly, we recognised the need for additional capacity to the team members who took the initial reports of abuse, meaning more time and space to help people recover and increase their resilience to abuse. As a result, the SAT could support more people at the stage of S42(1) around their immediate safety and the outcomes they wanted to achieve. The adult social care department also moved to a new model where different teams took a lead for the safeguarding enquiry, so those who know the resident best or may have been working with them already, can support the resident through the actions needed to keep them safe. There has been evidence from case oversight during the transition of this new model that all parts of adult social care have the skills and knowledge to work sensitively, with personalised focus, and with good legal literacy, the practice involved to safeguard adults at risk.

Overall, the data this year from previous shows a significant increase of reports of abuse, which started in August 2020 and has continued to date. It is positive that more people are recognising abuse and neglect and ensuring it becomes 'everyone's business'.

TYPE OF ABUSE FOR CONCERNS RAISED		
Abuse Type	Number	Percentage
Neglect / Acts of Omission	553	27%
Psychological / Emotional Abuse	415	20%
Physical	313	20%
Financial / Material	260	15%
Self-neglect/Hoarding	222	15%
Domestic abuse	69	8%
Sexual Abuse	61	3%
Self-harm	60	3%
Organisational	15	2%
Sexual Exploitation	13	1%
Cuckooing	12	1%
Pressure ulcer	10	<1%
Modern Slavery	7	<1%
Mate crime	6	<1%
Radicalisation	5	<1%
Hate Crime	4	<1%
Discriminatory	3	<1%
Female Genital Mutilation	2	<1%
Forced Marriage	2	<1%
Honour based violence	1	<1%

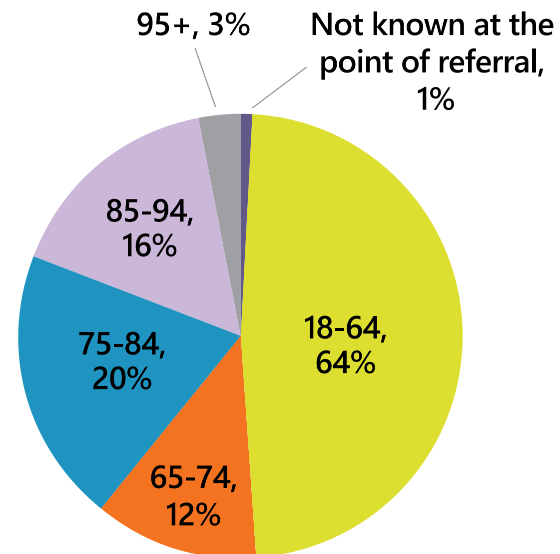
As with previous years; Neglect and Acts of Omission continue to be the number one category of abuse.

Psychological and Emotional Abuse has seen a rise in the number of concerns as has Self-Neglect and Hoarding.

Two new categories of abuse have been added to the data collected namely 'Cuckooing' (whereby a person's own home is taken over by those wishing to exploit them) and 'Pressure ulcers' (these are often a result in the deterioration of skin integrity and a person becoming bed bound).

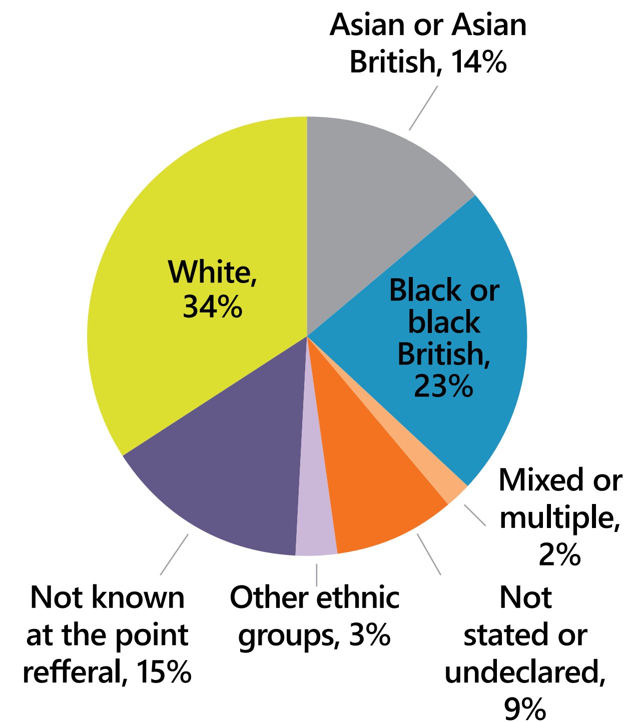
As per previous years, there are slightly more female (53%) than male adults at risk where abuse was reported. The most common age group in relation to concerns raised was adults aged 18-64 followed by adults aged 75-84.

AGE



In terms of a breakdown in the ethnicity of people who are referred to the Adult Safeguarding Team as an Adult At Risk, the majority of people were recorded as being White (34%) with Black or Black British (23%) and Asian or Asian British (14%). This differs from the demographics of Brent according to the Census. The next annual report will detail the work of the Brent SAB in addressing this disparity.

ETHNICITY



LOCATION OF ABUSE FOR CONCERNS RAISED		
Abuse Type	**Number**	**Percentage**
Own Home	1241	64%
Care Home (Residential)	155	8%
Care Home (Nursing)	115	6%
Other	106	4%
Hospital – Mental Health	79	6%
In the Community (excluding community services)	80	4%
Hospital - Acute	57	3%
In a Community service	49	2%
Hospital - Community	32	2%
Extra Care or Sheltered Accomodation	11	2%

As with previous years, the most common location for abuse to take place is in a person's own home. 64% of Concerns reported to the Safeguarding Adults Team took place in the person's own home. The total combined locations outside of a person's own home totalled 36%.

MAKING SAFEGUARDING PERSONAL

In our commitment to make safeguarding personal, we ask individuals, or their representatives if unable to communicate or contribute, about the extent to which their desired outcomes were met and if they felt safer. As these are not mandatory, not everyone responds and we may also exclude those who have died.

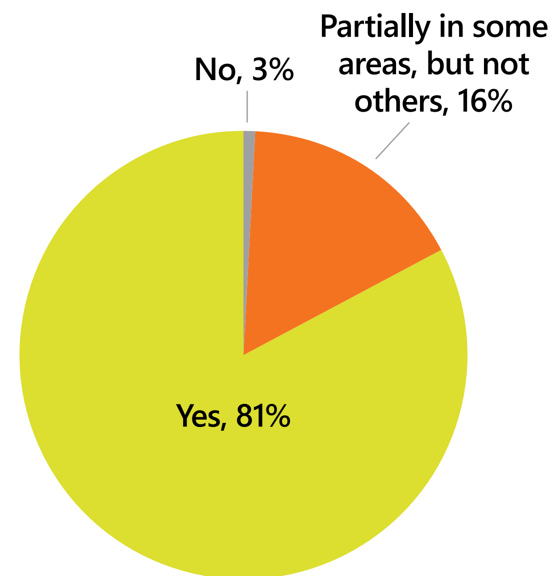
For those able to respond, 72% felt their desired outcome were met. The remainder was partially met (22%) and not met (6%).

This was similar when we asked individuals if they felt safer, with 81% stating yes.

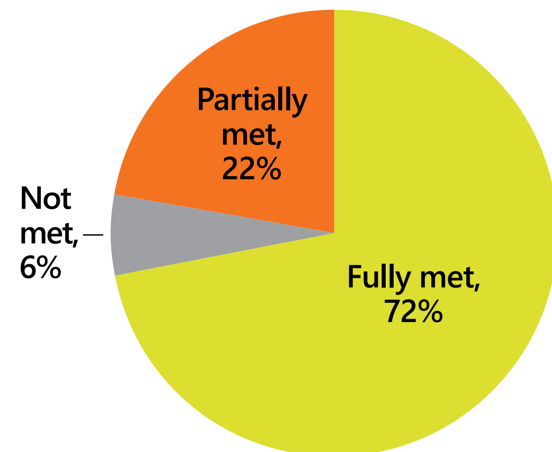
ADVOCACY

One of the duties of the Safeguarding Adult Team is to consider whether or not a person subject to an Enquiry requires support from an advocate. The diagram below gives a breakdown of who has required an advocate and who the advocate was.

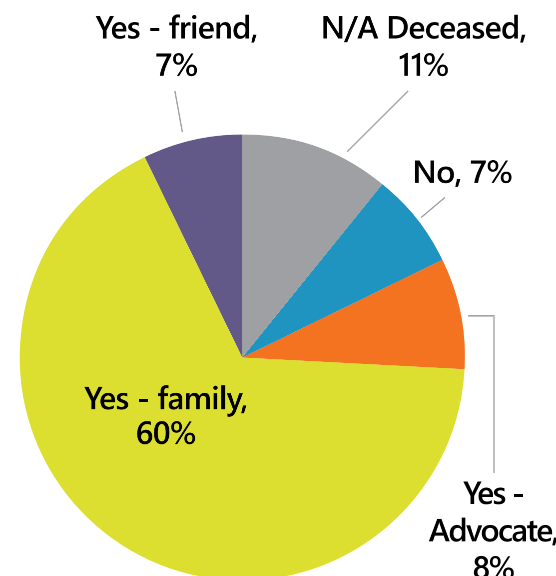
FEELING SAFER



DESIRED OUTCOMES MET



SUPPORTED BY ADVOCATE FAMILY OR FRIEND



8 STRUCTURE OF THE SAB AND ITS SUB-GROUPS

SAFEGUARDING ADULTS BOARD (SAB)

The Board is a partnership made up of statutory and non-statutory partners. The statutory partners are; The Police, Clinical Commissioning Group and the Local Authority (Brent Council). Non-statutory partners can be anyone invited by the SAB to become a partner. The Safeguarding Adults Board meets on a quarterly basis. There are three sub-groups that assist the SAB in carrying out its duties. These sub-groups meet when required other than the Executive Sub-Group which meets twice-yearly. Each sub-group has different aims and objectives linked to the Safeguarding Adults Strategic Plan.

CASE REVIEW SUB-GROUP

The Case Review sub-group is a multi-agency and multi-disciplinary group. It considers referrals for Safeguarding Adult Reviews (SAR). Where the criteria are met, it commissions and manages mandatory Safeguarding Adult Reviews. In addition, the Case Review Sub-Group commissions and oversees discretionary Safeguarding Adult Reviews for cases that fall outside of the mandatory criteria for a SAR but where there is still learning for practitioners and their agencies. The Sub-Group aims to ensure that lessons learned are shared and acted upon, and impact is assessed.

PROVIDER CONCERNS SUB-GROUP

The Provider Concerns sub-group members share knowledge and intelligence about local care services and engage key stakeholders, identify collective concerns or issues, and agree an appropriate multiagency response. Partners ensure a robust multi-agency approach to all quality concerns that are raised.

THE EXECUTIVE

The Executive has been reformed and now meets bi-annually. The Executive is a meeting of senior leaders from the statutory partners of the SAB. The focus of the meeting is on governance.

9 EVENTS

The Brent safeguarding adults board continued to offer an annual programme of multi-agency learning and development. Due to the pandemic, face to face sessions could not go ahead. Therefore the SAB offer moved online and was offered as a virtual programme.

The learning activities were open to all professionals who work or volunteer with adults at risk in Brent.

Learning and development within the SAB is overseen by the part time learning and development coordinator and the board is kept regularly updated of training offered as well as attendance and popularity of sessions.

The annual programme comprises a range of learning activities and opportunities including;

- annual conference
- lunch and learn sessions
- learning dissemination events
- awareness raising events
- joint learning events/sessions with other strategic partnerships including Brent Safeguarding Children's Forum

The learning topics offered are chosen in response to learning needs identified by practitioners and managers, the objectives in the strategic plan as well as feedback from evaluations.

SAB MULTI-AGENCY TRAINING PROGRAMME SUMMARY 2020/21

- 7 learning topics delivered
- 15 occurrences
- 260 training places accessed

TOPICS INCLUDED

- Making safeguarding personal – Patrick Hopkinson
- Working with complex dependent drinkers – Mike Ward
- Case Law update – Alex Ruck Keene-39 Essex Chambers
- Working with adults who self-neglect – Professor Michel Preston-Shoot
- Transitional safeguarding – Dr Adi Cooper and Dr Christine Cocker
- Financial abuse – Professor Keith Brown
- Domestic abuse- Advance charity
- Learning dissemination Adult D - Professor Michel Preston-Shoot

The transition to virtual sessions has seen a rise in bookings, a 61% increase in total places booked.

10 BOARD ACTIVITY

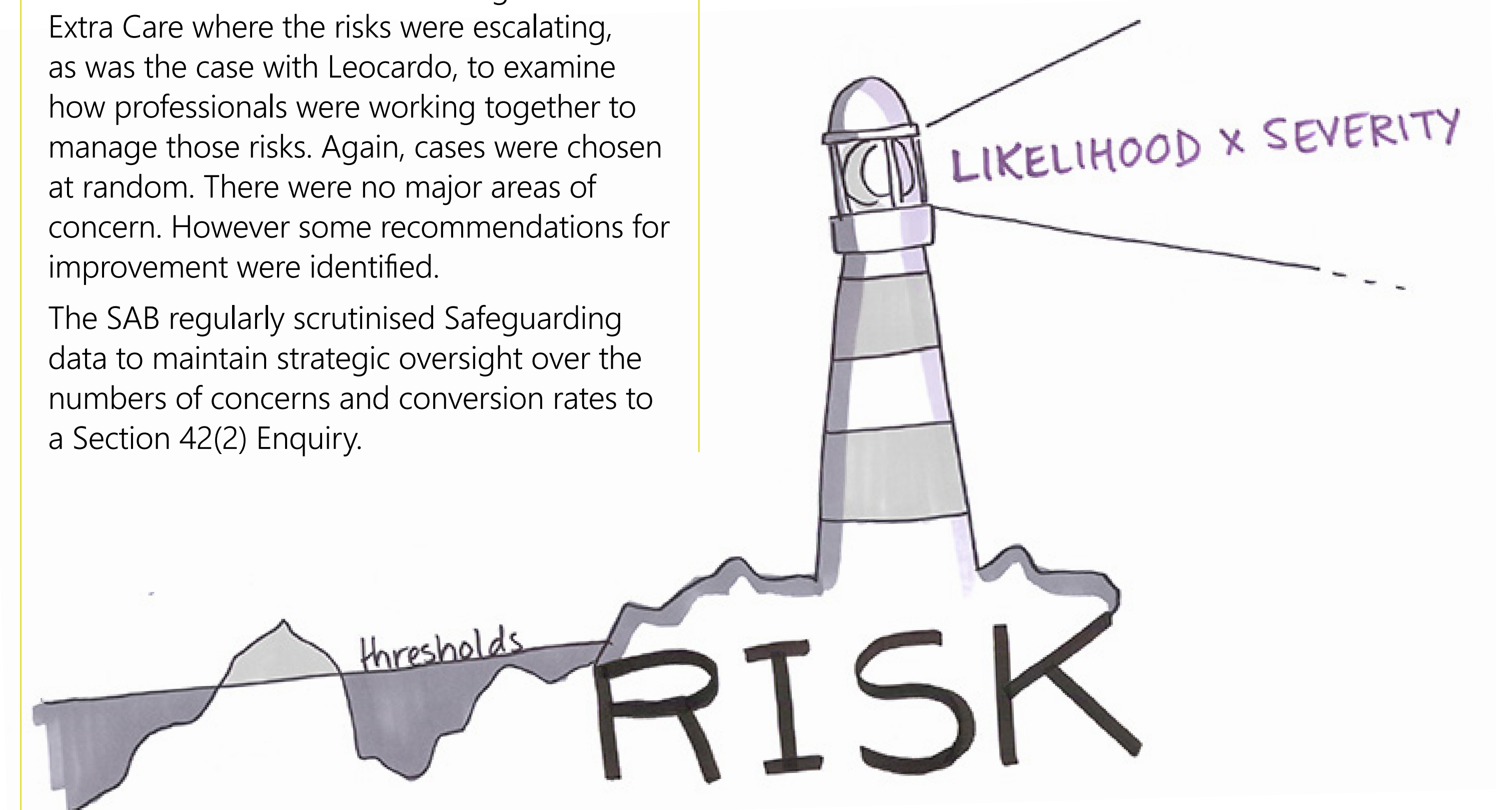
Over the period 2020 – 2021, The Safeguarding Adults Board (SAB) has focussed on ensuring that safeguarding systems have continued to work effectively during the pandemic. Agencies have been held to account at SAB meetings on safeguarding adults related activity and partners have had the opportunity to challenge each other in relation to strategic oversight of services.

Due to increases in the level of fraud as a general trend in the United Kingdom the SAB had one meeting that part-focussed on financial abuse and commissioned multi agency learning and development sessions aimed at increasing awareness.

The SAB has also been monitoring the NHS Learning Disability Mortality Review and local actions that have arisen from reviews of people with learning disability in Brent.

Following the completion of the SAR on Leocardo (Adult E), the SAB commissioned an independent audit in relation to Extra Care placements. The first audit focused on the appropriateness of the initial placement, with cases chosen at random out of the most recent placements into Extra Care. A second audit focussed on auditing cases in Extra Care where the risks were escalating, as was the case with Leocardo, to examine how professionals were working together to manage those risks. Again, cases were chosen at random. There were no major areas of concern. However some recommendations for improvement were identified.

The SAB regularly scrutinised Safeguarding data to maintain strategic oversight over the numbers of concerns and conversion rates to a Section 42(2) Enquiry.



11 THE SAFEGUARDING ADULTS BOARD STRATEGIC PLAN 2019-2021

During late 2019, the Safeguarding Adults Board held a 'Board Development Day' event. Presentations to Board members were made by operational agencies who provide a service to adults at risk of abuse and neglect in Brent. The purpose of the presentations was to give services the chance to tell the SAB what they felt the Board should focus on strategically over the next 2 years. Feedback from the ADASS Peer Review was also incorporated into the day's discussions as well as using information obtained by the audits commissioned by the SAB. Following the presentations, Board members came together for group discussion to identify themes. At the following SAB meeting the Strategic Plan was agreed and later published on the Safeguarding Adults Board website;

PRIORITY 1 – SELF NEGLECT

The Care Act 2014 statutory guidance (DH, 2020) defines self-neglect as:

"A wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding." The Brent SAB aims to ensure strategic development of working with people who self-neglect. In order to work towards achieving this priority Brent SAB have:

- Monitored self-neglect data at the SAB and asked agencies to account for their response.
- Developed multi-agency self-neglect policies and procedures which are published on the Independent Safeguarding Adults Board Website (www.brentsafeguardingpartnerships.uk)
- Undertaken multi-agency learning dissemination events in relation to Adult D throughout 2020 and 2021 and Developed a 7 minute briefing in relation to Adult D.
- Organised multi-agency learning and development sessions examining different aspects of self-neglect (both undertaken and planned for 2021) facilitated by:
  - Michael Preston-Shoot
  - Suzy Braye
  - Susan Harrison
  - Heather Mattuozo
  - Mike Ward
  - (planned) On completion of the Adult F SAR, learning events will be facilitated by the Independent author Patrick Hopkinson.

PRIORITY 2 – LEGAL LITERACY

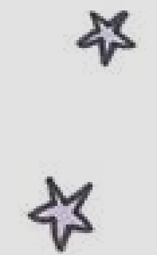
Legal Literacy is knowledge and awareness of the legal options open to practitioners in order to safeguard adults at risk from abuse and neglect. The Brent SAB aims to empower practitioners in Brent with knowledge as to the options open to them and develop systems in order that this informs decision-making. In order to work towards achieving this priority Brent SAB have:

- Commissioned multi-agency learning and development sessions by legal experts Alex Ruck-Keene and Tim Spencer-Lane.
- Publication of the Adult E SAR, development of the 7-minute briefing and learning dissemination events that highlighted areas around legal literacy that required development.
- Extra care audits presented to the SAB.
- Work planned for 2021 aimed at highlighting learning from case law.
- Multi-agency audit planned for 2021 developed regionally entitled "The Safeguarding Adults Partnership Audit Tool".

PRIORITY 3 – INFORMATION DISSEMINATION

Some of the feedback at the Development Day was that information sometimes did not always reach those who need it most. In order to work towards achieving this priority Brent SAB have:

- Organised professionals conferences in 2019, 2020 and 2021 to ensure practitioners who work in Brent can come together for multi-agency learning and development.
- A planned community conference for the summer of 2021 raising awareness in relation to Financial Abuse and Domestic Abuse to reach smaller organisations and the general public.
- Launch of the Safeguarding Adults Board Website as a vehicle to disseminate learning and information and promote the independence of the SAB in Brent (www.brentsafeguardingpartnerships.uk)
- Attendance at community roadshows as arranged by Brent CVS to promote Brent SAB and raise awareness in relation to Adult Safeguarding.



12 PARTNER ORGANISATIONS

13 SAFEGUARDING ADULT REVIEWS

Adult E

Adult E was published at the end of the reporting period of this annual report. A seven-minute learning briefing was developed to ensure that lessons are learned. A copy of this briefing is included within this annual report on the next page.

Adult F

A reviewer was selected but due to the pandemic work has proceeded slowly due to pressures on services. The aim is for completion late 2021. The themes of this review are self-neglect, mental capacity and making safeguarding personal.

Adult G

A reviewer was selected but due to the pandemic work has proceeded slowly due to pressures on services. The aim is for completion late 2021. The themes of this review will be; commissioning and oversight, pressure ulcer care, safeguarding and cross-borough working and transitions between services that provide care.

Background and What Happened.

Leocardo was a black male who moved to the United Kingdom from Trinidad in 1961 and made his home in Brent. He had a long career spanning 40 years working for London Underground and had two daughters. He was diagnosed with Lewy Body dementia in 2012. His daughters held Lasting Power of Attorney for Finance and Health and Welfare. Leocardo became increasingly at risk in his own home. An agreement was reached that he would move to alternative accommodation. The accommodation he moved to is known as 'Extra Care Housing'. This model of care involves individual rental apartments, each with their own tenancy, with a registered domiciliary care agency located on site to provide care. Unfortunately, after moving into the placement, Leocardo went missing on a number of occasions and was found and returned by Police. Unfortunately, he left the placement for the final time in August 2017. His body was found in October 2017 by a farmer tending to his field on the outskirts of London. The case met the criteria for a Safeguarding Adults Review.

Learning point: Effective Case Management

Working with people where the risk posed to them is escalating is a challenge and requires professionals to balance care vs control. There was learning in relation to how Leocardo's case was managed:

- The importance of separating key information from supplementary information and using key information to form a sound risk assessment.
- Using new information to update the risk assessment when necessary.
- Clear handovers and cover arranged where there are staffing changes / extended leave.
- Effective management oversight overseeing any staffing changes.

Learning point: Legal Literacy

A clear understanding by all partners on what legislation to use and when. For example use of community DoLS.

Learning point: Clear Recording

In Leocardo's electronic file, the case records were extensive, frequent and detailed. This meant that key information became difficult to locate due to the number of contacts and information sent between the agencies involved. Key information therefore became lost in the volume of contact. There is a responsibility on all agencies where there are concerns to record these concerns clearly and concisely so that the information can be used to take action and reduce the risks posed. There should also be clear announcement and recording of important meetings such as 'Best Interest Meetings'.

Learning point: Application Mental Capacity Act (MCA) and working with family members who hold Power of Attorney.

A person who holds a registered Power of Attorney can make a decision on the person's behalf where it is proven that they lack capacity to make that decision at that time. Where a decision is made on behalf of a person, the MCA states that this should be in the person's best interest and be the least restrictive option. The Coroner's ruling at the Inquest expressed concern that in Leocardo's case professionals were too focussed on the least restrictive option rather than Leocardo's safety, which should have been the primary concern. It is important to remember that the local authority retains overall responsibility for a person's welfare when they lack capacity and are placed. This is the case even if family members hold Lasting Power of Attorney and are making decisions. Therefore, agencies must have a clear focus on the risks posed and the person's safety. If professionals feel that risks posed have become too great, they must be prepared to challenge the views of family members who hold Lasting Power of Attorney and take the case to the Court of Protection in the event of a dispute.

Learning point: Multi-Agency Working

In Leocardo's case the agencies did not work together effectively, each taking action in isolation. Measures to manage risks (GPS trackers and door sensors) were not succeeding in managing the risks posed. What needed to take place was a multi-agency risk management meeting where concerns were discussed and a plan of action agreed across the different agencies involved. Each agency should be clear as to their role and responsibility to keep a person safe.

Learning point: Escalation systems

Where concerns are raised but there is a concern regarding how an agency is responding to those concerns, there should be a clear escalation system in place. In Leocardo's case, information suggesting risks were escalating was not responded to adequately. Some of the information had been sent to workers who had left or individuals who were on extended leave. A clear system would ensure key information is not lost and is acted upon.

14 BRENT SAFEGUARDING ADULTS BOARD BUDGET, INCOME AND EXPENDITURE 2020-2021

INCOME 19/20	AMOUNT
Clinical Commissioning Group	£25000
Brent Council	*£37400
MOPAC	£5000
LFB	£500
Total	**£67900**

ITEM	EXPENDITURE 20/21 (ROUNDED COST)
SAB Learning and Development virtual offer	£9,300
SAR Adult E completion costs	£4000
Independent Chair Fee's	£16500
Learning and Development Platform	£2000
Annual Report Costs	£1000
Printing costs	£100
Total	**£32900 (£35000 move into reserves)**

*In addition to the above sum, Brent Council pay for staffing costs to support the functioning of The SAB namely;

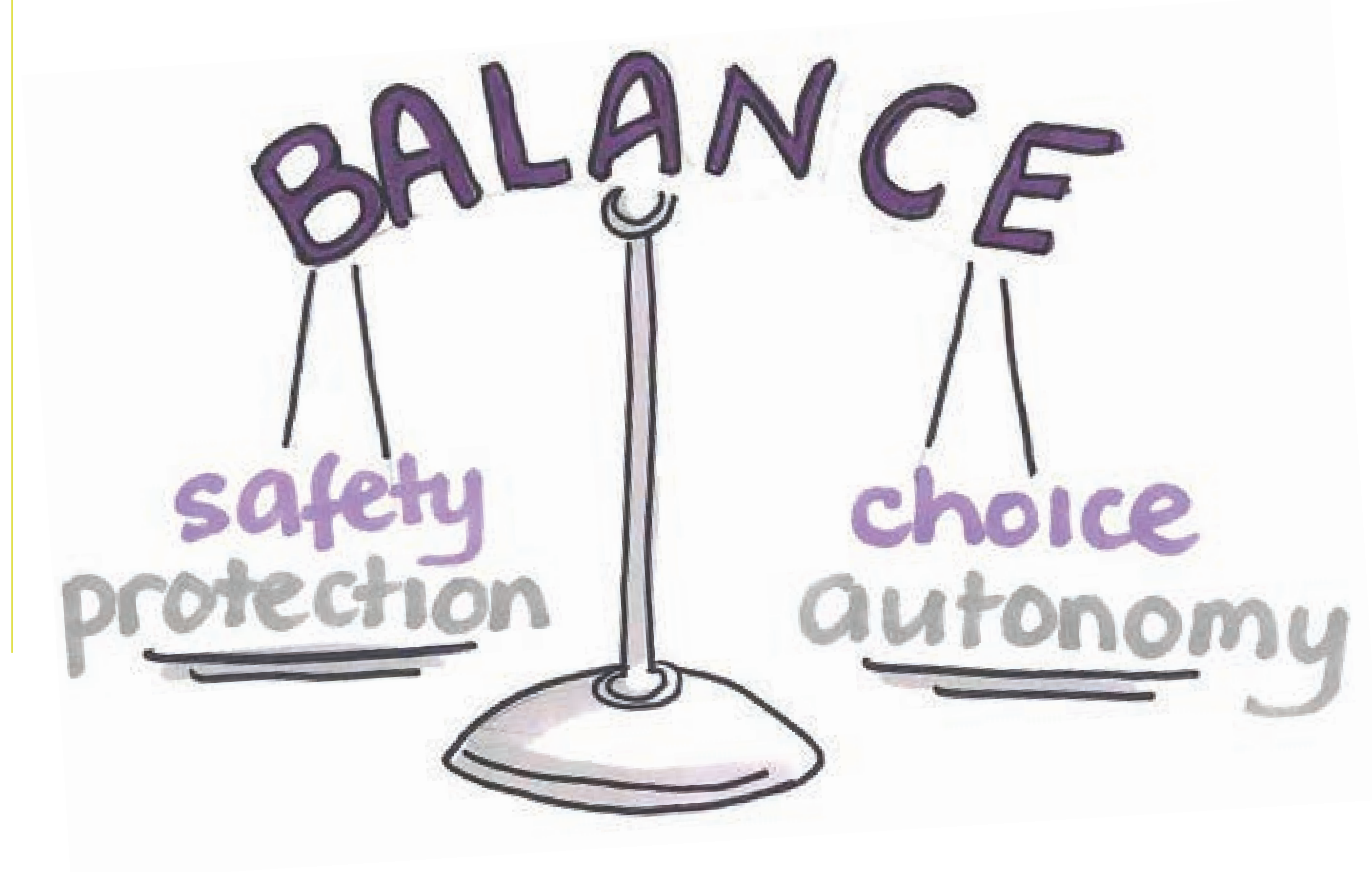
- 1 full time Strategic Partnerships Manager (portion of time)
- 1 full time Strategic Partnerships Lead
- 1 part time Strategic Partnerships Learning and Development Coordinator

15 THE COMING 12 MONTHS

The Safeguarding Adults Board postponed its annual conference this year due to the pandemic and will be reported on in the next annual report.

Currently Adult F and Adult G are in their final stages of completion. The SAB is also considering new referrals and in the early stages of panning work for two Discretionary Safeguarding Adult Reviews. The Case Review Group will also continue to consider new referrals.

At the end of 2021, Brent Safeguarding Adults Board will be recruiting a new Independent Chair of the Safeguarding Adults Board. It will also run an event to refresh its strategic plan. All up to date information will be published on the independent safeguarding website. This will also be reported on in next year's annual report.



Graphic images were used with permission
from the artist;
Cara Holland
Head Visualiser
www.graphicchange.com
+44 (0) 7730 683703

8907BDU1021