SSASPB Newsletter

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Stop adult abuse

Edition: 1 2021

Date: June 21

In this edition

1. Introduction by the Independent Chair

I take the opportunity through this newsletter to acknowledge and recognise the enormous contributions that partner organisations have together made during the current COVID pandemic to protect and prevent the abuse and neglect of adults with care and support needs in Stoke-on-Trent and Staffordshire. There are many superb examples of where individuals and organisations have been alert to the increased risks to the most vulnerable people in our local areas and found ways of working to provide protection and support. On behalf of the SSASPB I thank you.

The Safeguarding Adults Board has been working hard to raise awareness of how to spot the signs of abuse and neglect - and what to do when it may be occurring. This newsletter builds on that awareness raising by highlighting key messages and suggesting practical actions.

A key role for the Safeguarding Adults Board is to initiate a Safeguarding Adults Review when an adult dies as a result of abuse and neglect and there is concern that partner agencies could have worked together more effectively to protect the adult. This newsletter provides an overview of the SAR process, the criteria to be considered, and how to initiate a referral.

Further information about safeguarding adults can be found on the SSASPB website that has recently been refreshed taking account of feedback to help make it an even more user friendly source of guidance. The website can be reached through this link.

If you have any suggestions as to what you would find helpful in future SSASPB newsletters, or have any comments on this newsletter please email them to SSASPB.admin@staffordshire.gov.uk

John Wood

Independent Chair, SSASPB

2. What is Adult Safeguarding and how to make a good referral

The Board aims to improve the awareness of what Adult Safeguarding is and how to raise a safeguarding concern. Ruth Martin, Safeguarding Team Leader and acting Principal Social Worker for Staffordshire County Council, worked with Staffordshire Police to produce a short video on what is Adult Safeguarding, signs to look out for and how and when to raise a safeguarding concern. This is a very succinct video which we would like to share to encourage good quality referrals. A link to the video can be found below:

What is Adult Safeguarding? - YouTube

If you think that an adult with care and support needs is being abused or neglected:

If the adult lives in Stoke-on-Trent:
Telephone: 0800 561 0015 at any time
Minicom: 01782 236037

If the adult lives in Staffordshire:
Telephone: 0345 604 2719
Monday to Thursday 8:30am to 5pm, Fridays 8:30am to 4:30pm, excluding Bank Holidays
0345 604 2886 at any other time

3. Safeguarding Adult Reviews (SARs)

What is a Safeguarding Adults Review

A Safeguarding Adults Review (SAR) is a process through which SSASPB partner agencies work together to identify the lessons that can be learned from reviewing the circumstances and partner interaction when an adult has died or been seriously injured; and abuse or neglect has been suspected. As a result of a detailed review, recommendations are made to change or improve practice and services. The aim of the process is to learn lessons and make improvements, not to apportion blame to individual people or organisations. It is more about promoting effective learning and improvement to prevent future deaths or serious harm occurring again. It relies on a spirit of openness to learning about what went well, as well as what could be improved. The process is based on national guidelines and has been agreed by all agencies who are members of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board. Further information can be found in the Care Act 2014 Care and Support Statutory Guidance, (Chapter 14 para 14.133) and the SSASPB SAR protocol can be found on the SSASPB website.

3. Safeguarding Adult Reviews (SARs) continued...

How do I make a SAR referral?

The SAR referral form is on the SSASPB website. This must be completed very carefully, and all answers responded to with the detail requested. It must then be forwarded to the Board member of the organisation making the referral for approval. The amount of detail requested is needed so that decisions may be taken as quickly as possible to allow any lessons to learn to identified and acted upon promptly. It is particularly important that the detail of the neglect that has resulted in abuse or neglect is included in the referral. This helps to inform the decision making as to whether the criteria for the SAR is met and also helps to inform the learning to be gained.

Anybody who doesn't work for a Board partner organisation and wishing to make a SAR referral can contact the Board by emailing SSASPB.admin@staffordshire.gov.uk.

What are the top three lessons to learn from SARs in Stoke-on-Trent and Staffordshire?

- Practitioners should expect their decisions to be challenged and, in turn, challenge others - whether they are part of their own or another organisation. Challenge is healthy and will be encouraged. If agreement cannot be reached, the Board has an Escalation Policy explaining how to escalate professional disagreement.
- Complex cases which involve the engagement of many organisations benefit from the appointment of a 'lead professional' to assist with clear focus and multi-agency planning. This person may be from any organisation connected with the adult about whom there are concerns and will usually be the one who is best placed to achieve the engagement of the adult.
- Practitioners should always fully document the reasons for their decisions. These must be recorded in clear language and acronyms explained on first use. This is really important as often cases get passed on between teams owing to a number of reasons including promotions, sickness and career changes. The receiving practitioner must have the best available information available to them to continue to support the adult to be safe.

Case Study: Steven Hoskin 2006 (Cornwall)

Steven Hoskin was an adult with a learning disability and lived in St. Austell, Cornwall. In 2006 he was brutally murdered by a 29-year-old man and a 16-yr old girl; a 21-year-old man was charged with manslaughter. They forced him to climb over a barrier on a railway viaduct and then stamped on his hands until he fell to his death.

3. Safeguarding Adult Reviews (SARs) continued...

The following video reflects on to what extent lessons have been learned following the Serious Case Review (Now called Safeguarding Adult Reviews) into the circumstances leading up to the death of Steven. One of the contributors, Professor Michael Preston-Shoot, challenges partners connected to adult safeguarding saying that there is more to learn from that review. He identifies several key learning points which are to be acted on at operational, supervision and strategic levels. Please take 12 minutes to look at this video and share it widely within your organisation.

Have we learned from Steven Hoskin's murder? (2020) | Safeguarding adults | SCIE

4. SSASPB partner: Rockspur

Board partner Rockspur

Introduction by Nick Morris Deputy Manager & Registered Manager Supported Living Service.

Rockspur are a User Led, Not For Profit, Community Interest Company providing Day Opportunities and Supported Living to adults with care and support needs. We operate 7 days a week throughout South Staffordshire & Cannock Chase Districts as well as Wolverhampton. We are proud Members of the Prevention and Engagement Sub Group of the SSASPB with the aim of promoting excellent practices and education within our learning disability community relating to Adult Safeguarding. We are currently working with the SSASPB to review the Annual Report to make this more accessible to adults with care and support needs.

The Board has asked Rockspur to produce an accessible version of the 2020/2021 SSASPB Annual Report. This will be led by the adults that Rockspur provide services for and is an exciting new venture for the Board. Those involved have been given freedom to produce a version that will be of most use to adults with care and support needs and as soon as it is ready for distribution it will be sent out electronically through the Board membership and placed on the SSASPB website. This is likely to be in late October 2021.

We plan to have further co-production projects in the future and seek support from them by way of a reference group , this will include requesting input to discussions on future Board Strategic Priorities.

5. Sepsis Awareness

The need to improve the awareness of Sepsis was a lesson learned from a SAR in 2020. Therefore we have included a section about it in this newsletter'

What is Sepsis?

Sepsis sometimes confused with septicaemia or blood poisoning – is the immune system's overreaction to an infection or injury. Simply put the immune system starts attacking its own organs and tissues. We don't as yet understand why this happens but if not treated immediately, sepsis can result in organ failure, amputation and death. However with early diagnosis it can be treated, often relatively easily with antibiotics.

Many people think sepsis is a rare condition. It isn't the figures are truly shocking: it affects 248,000 people every year in the UK and it kills 48,000 which is more than breast, bowel and prostate cancer combined. It is believed that thousands of lives could be saved through raising public awareness of the symptoms, educating professionals to help them spot it quicker and empowering people to just ask "could it be Sepsis?".

Slurred speech or confusion

Extreme shivering or muscle pains

Passing no urine in 24 hours

Severe breathlessness

I feel like I might die

Skin that's a funny colour

Our aim is to avoid the 10,000 potentially preventable deaths

What is it

- Where the body over responds to *infection* causing organs to start failing
- Most commonly associated with bacterial infection of lungs or urinary tract

Why does it matter

- It can be fatal, estimated 50,000 lives lost per year in UK to sepsis
- Up to 10,000 of these deaths *may* be preventable

Who does it affect

- Anyone - but risk factors include....
- Under 1s, over 75s, frail, lower immune system due to illness or medication, some pregnant ladies, IV drug users, those with catheters.

For more information on recognising sepsis symptoms please read the NHS Sepsis leaflet