Isle of Wight Safeguarding Adults Board

Isle of Wight
Safeguarding Adults Board

About the Board

- The Isle of Wight Safeguarding Adults Board (IOWSAB) is a multi-agency partnership, coordinated by the local authority, which gives strategic leadership for adult safeguarding across the Isle of Wight.
- Statutory requirement under the Care Act 2014 with three statutory partners:
  - Isle of Wight Council
  - Hampshire & Isle of Wight Integrated Care Board
  - Hampshire & Isle of Wight Constabulary

Core Functions

Strategic Planning

Develop and publish a strategic plan outlining how objectives will be met.

Annual Reporting

Publish an annual report evaluating the effectiveness of safeguarding work.

Safeguarding Adults Reviews (SARs)

Commission reviews where an adult with care and support needs has died or been seriously harmed due to abuse or neglect

IWSAB vs LA Safeguarding Team

IWSAB	LA Safeguarding Team
Strategic oversight	Day to day case management
Multi-agency coordination	LA-led interventions, advice & guidance
Commission SAR's	Receive safeguarding concerns and conduct enquiries (s.42)
Focus on system learning	Focus on individual outcomes
Independent Chair / Scrutineer	Managed within the Council

Board Structure

Executive Group

IOW Safeguarding Adults Board

Workforce Development Subgroup

Safeguarding Adult Review Subgroup

Quality, Assurance and Performance Subgroup

Independent Scrutineer

Regional & National Networks

Isle of Wight Safeguarding Adults Board

Isle of Wight Health & Care Partnership	Isle of Wight Community Safety Partnership	Isle of Wight Domestic Abuse Partnership Board	Isle of Wight Childrens Safeguarding Partnership
National Safeguarding Adults Chairs Network	Adult Social Care Stakeholder Board	National Safeguarding Adults Board Managers Network	SE Regional Board Managers Network
4LSAB Housing Subgroup	4LSAB Policy Subgroup	4LSAB Health Subgroup	4LSAB Fire Safety Development Group

SAR Subgroup

- The law requires local SABs to arrange a SAR when an adult in its area dies or is harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk.
- The purpose of a SAR is not to hold any individual or organisation to account as there are other processes available for that purpose; they are about learning lessons for the future. SARs ensure that SABs get the full picture of what happened, so that all organisations involved can improve as a result.

SAR Themes

- Hoarding
- Alcohol / Drug use
- Mental ill health
- Diabetes management
- Carer stress
- Controlling and coercive behaviour
- ‘Unseen’ individuals

'Ms L' LEARNING BRIEFING
MAY 2024

Isle of Wight Safeguarding Adults Board

OVERVIEW

In December 2021, a Safeguarding Adult Review was jointly commissioned by the Isle of Wight Safeguarding Adults Board and Southampton Safeguarding Adults Board to review professional involvement received by an adult who suffered severe abuse and neglect whilst living in Southampton and subsequently moved to the Isle of Wight.
The individual (named Ms L to preserve anonymity) had medical conditions which made both communication and physical movement extremely challenging. Whilst having mental capacity to make her own decisions, Ms L was reliant on family members and carers to meet daily care and support needs and to aid communication. Over several years, Ms L was subject to coercive control, abuse, and neglect by those in a position of financial power and attending to her care needs.
The review was conducted by an independent lead reviewer to consider how agencies work together to safeguard adults in and across both areas.

SUMMARY OF THE CASE

Ms L has Cerebral Palsy and requires intensive assistance to meet her daily living and communication needs. Ms L has mental capacity however is reliant upon a communication board to share her views. Family members and carers were often used as advocates during home visits and assessments.
Ms L lived in Southampton with the support of a live in carer and attended a day centre twice a week. Between November 2015 and February 2020, nine separate safeguarding concerns were raised, consisting of neglect, financial, physical, and psychological abuse. When concerns were raised, most of these resulted in some action being taken through informal social care visits, which did not include clarifying Ms L's safety or attempting to speak to her without her family and live in carer being present.
In August 2019, the carer informed social workers that she was intending to move to the Isle of Wight, at this time, Ms L was seen and seemed keen to move with her, however the suitability of the move and proposed property was never established, either prior to, or after the move, and Ms L was never spoken to alone regarding this.
Concerns were expressed about Ms L's welfare and in particular claims that the live in carer and a family member were in a relationship, but these were not investigated adequately during the subsequent planning for her transfer of care to the Isle of Wight. Records of assessments were shared, however there was no sharing of information about the nine safeguarding concerns raised.
Shortly before Ms L moved to the Isle of Wight in March 2020, she was seen by a Practice Nurse at her GP surgery, who noted pressure ulcers and advised care to be arranged. However, due to the move and a delay in registering with a new GP, this was not known to local health services and therefore was not followed up.
Further concerns were raised regarding Ms L's physical condition and the neglected home environment and through July and August 2020, four additional safeguarding concerns were

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'Glen' LEARNING BRIEFING
October 2024

Isle of Wight Safeguarding Adults Board

SUMMARY OF THE CASE

Following his discharge from the Navy, Glen had been unable to maintain accommodation and had been homeless for approx. 20 years. It's not known when Glen came to the Island, but it is believed he spent his time between the UK mainland, the Isle of Wight and Crete. Glen had some obvious health conditions but had limited contact with Island Health Professionals.

Glen had intermittent contact with the Islands Local Authority Homelessness Team and had several offers of temporary accommodation which he declined. Concerns were raised about his declining mental and physical health in June 2023, but Glen declined support and treatment on many occasions.

On the 5th January 2024, Glen was found deceased, lying in a field with no shelter or sleeping bag, he was 72 years old.

LEARNING IDENTIFIED / QUESTIONS FOR PRACTITIONERS:

- → Practitioners to consider what and how actions and interactions are recorded and to be mindful of how these could be interpreted in the future.
- → Practitioners to seek supervision and consider escalation if the intervention requested is not considered.
- → Practitioners to consider the impact of adverse weather warnings and agency specific actions when working with homeless individuals.

LINKS FOR BEST PRACTICE AND FURTHER TRAINING

- 4LSAB Guidance on Adult Safeguarding Roles and Responsibilities
- 4LSAB Housing Practitioner briefing on Homelessness
- 4LSAB One Minute Guide to Professional Curiosity
- 4LSAB Guidance on Responding to Self-Neglect
- 4LSAB Multi-Agency Escalation Protocol

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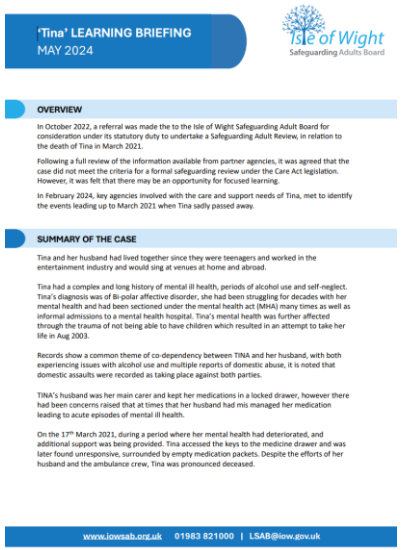

'Tina' LEARNING BRIEFING
MAY 2024

Isle of Wight Safeguarding Adults Board

OVERVIEW

In October 2022, a referral was made the to the Isle of Wight Safeguarding Adult Board for consideration under its statutory duty to undertake a Safeguarding Adult Review, in relation to the death of Tina in March 2021.

Following a full review of the information available from partner agencies, it was agreed that the case did not meet the criteria for a formal safeguarding review under the Care Act legislation. However, it was felt that there may be an opportunity for focused learning.

In February 2024, key agencies involved with the care and support needs of Tina, met to identify the events leading up to March 2021 when Tina sadly passed away.

SUMMARY OF THE CASE

Tina and her husband had lived together since they were teenagers and worked in the entertainment industry and would sing at venues at home and abroad.

Tina had a complex and long history of mental ill health, periods of alcohol use and self-neglect. Tina's diagnosis was of Bi-polar affective disorder, she had been struggling for decades with her mental health and had been sectioned under the mental health act (MHA) many times as well as informal admissions to a mental health hospital. Tina's mental health was further affected through the trauma of not being able to have children which resulted in an attempt to take her life in Aug 2003.

Records show a common theme of co-dependency between TINA and her husband, with both experiencing issues with alcohol use and multiple reports of domestic abuse, it is noted that domestic assaults were recorded as taking place against both parties.

TINA's husband was her main carer and kept her medications in a locked drawer, however there had been concerns raised that at times that her husband had mis managed her medication leading to acute episodes of mental ill health.

On the 17th March 2021, during a period where her mental health had deteriorated, and additional support was being provided. Tina accessed the keys to the medicine drawer and was later found unresponsive, surrounded by empty medication packets. Despite the efforts of her husband and the ambulance crew, Tina was pronounced deceased.

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Learning Briefs

Workforce Development Subgroup

- Joint subgroup with IW Childrens Safeguarding Partnership
- Identify gaps and trends and review impact of learning
- Learning Events:
  - Clare's Law & Sarah's Law
  - Chairing a MARM meeting
  - MARM Overview
  - Responding well to disclosures of domestic abuse (HSCP)
  - An introduction to recognising and responding to perpetrators of domestic abuse (HSCP)
  - Recognising and responding to coercive controlling behaviour (HSCP)
  - Recognising and responding to male victim-survivors of domestic abuse (HSCP)
  - Suicide prevention in the context of domestic abuse

Quality, Assurance and Performance Subgroup

- Review data and identify trends, informing Board strategic priorities
- Undertake multi-agency audits to highlight areas of good practice and areas that need improvement
- Provide assurance to Board that partners are consistently safeguarding adults

Spotlight on….
Multi-Agency Risk Management

Isle of Wight Safeguarding Adults Board

- What is MARM?
  - A framework for managing complex cases where adults are at risk but do not meet statutory safeguarding thresholds
  - Supports a coordinated, multi-agency response
- When to Use MARM:
  - When there are concerns about self-neglect, refusal of services, or fluctuating capacity
  - When risks are high but safeguarding criteria are not clearly met
- Key Principles:
  - Person-centred and rights-based
  - Proportionate and collaborative
  - Transparent decision-making
- Your Role:
  - Recognise when a MARM may be appropriate
  - Engage with partners to develop and implement risk management plans
  - Document and review actions and outcomes

IOW MARM Coordinator,
Sarah Cooke
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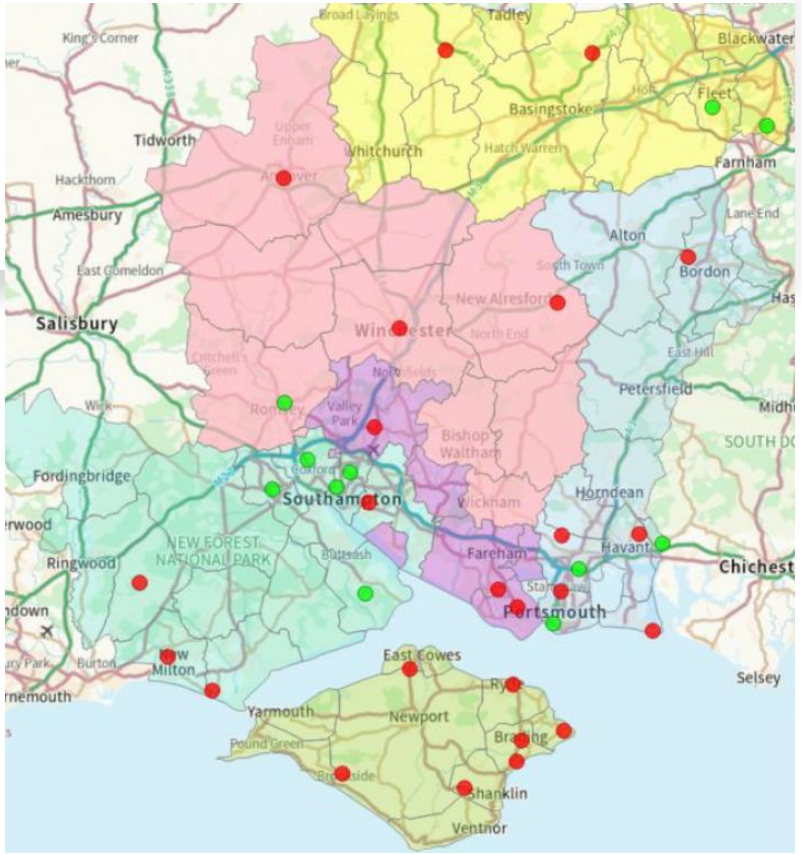
Hot off the press...

4LSAB Safeguarding Concerns Guidance and Multi-Agency Tool

2. Is it a safeguarding concern?

Types of Abuse or Neglect listed in the Care and Support Statutory Guidance

Type of abuse	Non-reportable	Requires consultation	Reportable
NEGLECT (AND ACTS OF OMISSION) **An ongoing failure to meet someone's basic physical or psychological needs.** Incidents relating to falls, pressure damage and medication concerns are addressed separately within this guidance document. **Neglect and acts of omission occur whenever an individual with responsibility for meeting the needs of an adult does any of the following:** • **Ignores their medical,**	Lower-level concern where it would be unlikely to meet the definition of a safeguarding concern. Internal policies and procedures should be followed and an internal written record of what happened and what action was taken should be kept. **Where there are several low-level concerns, consideration should be given as to whether the criteria may be met for a safeguarding concern due to increased risk and therefore should be reported as the local**	All appropriate action should be taken to reduce risk and internal policies and procedures followed. Consultation should be undertaken internally, refer to your local 4LSAB Safeguarding Adults Policy and Procedures and consider if consultation is needed with the local authority. Incidents at all levels should be recorded. **Following consultation, consideration should be given as to whether the criteria may be met for a safeguarding concern**	Incidents at this level should be raised as a safeguarding concern with the local authority. **Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.**



4LSAB Fire Safety Development Group Thematic Review 2022-2024

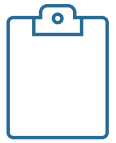
Upcoming Events

- ASC Conference (11th July)
- National Safeguarding Adults Week (17th – 21st November)
  - A week of awareness-raising, training, and community engagement
  - Opportunities to participate in webinars, workshops, and campaigns
- All Age Conference (Spring 2026)
  - A collaborative event bringing together professionals working with adults and children
  - Focus on Controlling & Coercive Behaviour

Key Takeaways

Attend multi-agency learning events.

Contribute to audits, surveys, and consultations.



Be professionally curious

Think family approach (wider household)

Think about fire safety

Read and reflect on SAR findings to inform and improve practice

Check out the SAB website www.iowsab.org.uk

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Thank You

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