



West of Berkshire

Safeguarding Adults Board

Reading, West Berkshire & Wokingham

Annual Report 2023-24

If you would like this document in a different format, contact Lynne.Mason@Reading.gov.uk

Concerned about an adult?



If you are concerned about yourself or another adult who may be being abused or neglected, in an emergency call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101 or contact Adult Social Care in the area in which the person lives.

In an emergency situation call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101.

If you are concerned about yourself or another adult who may be being abused or neglected, contact Adult Social Care in the area in which the person lives, on the numbers, email address or by completed an online form below:

Reading – call **0118 9373747** or email at CSAAdvice.Signposting@reading.gov.uk or complete an online [form](#)

West Berkshire – call **01635 519056** or email safeguardingadults@westberks.gov.uk or complete an online [form](#)

Wokingham call **0118 974 6371** or email Adultsafeguardinghub@wokingham.gov.uk or complete an online [form](#)

For help out of normal working hours contact the **Emergency Duty Team** on 01344 351 999 or email edt@bracknell-forest.gov.uk

For more information visit the West of Berkshire Safeguarding Adults Partnership Board website:

<http://www.sabberkshirewest.co.uk/>

Message from the Independent Chair



This is my third year as Chair of the West of Berkshire Safeguarding Adults Board (2023/2024). As I have commented previously, it really has been my privilege to see the dedication of staff from across the health and social care sector to provide the best care they can possibly deliver. At the beginning of this annual report, I want to pause to reflect on this further. We are referring to staff from across the formal, informal and voluntary sectors who work with some of the most vulnerable members of society. Although there is often a great sense of personal and professional pride in the fact that these staff can see the value of what they do and the difference it makes to peoples' lives, they often have to work under immense pressure in complex and difficult situations. As a society we recognise that the demand and need for care increases every year due to societal changes, yet the level of resource never seems to be able to keep up with this demand. It is therefore often front-line staff, caring for our most vulnerable who pick up and bear this burden. We owe them so much and so I want to say a big **THANK YOU** to all those staff and volunteers working on the front line to support and assist vulnerable adults in our community. You make an immense difference to those people that you care for and as the Chair of this Board I want you all to know that we really value and appreciate all your efforts. You are all an inspiration and, put simply, without you the fabric of our society would unravel - we all owe you so much.

I am pleased to be able to report that during the past year the Board has been able to increase its funding as members have agreed to increased contributions. Given the difficult economic times we live in, this is both a remarkable achievement and evidence of how much the work is valued by its members. This additional funding is designed to allow the Board to recruit an additional member of staff to allow the Board to undertake additional performance and quality assurance in the future. Care is a complex business, and we need to be constantly assured as a Board that it is effectively and safely delivered. This new post will aid us in this process, and it will allow us to be more effective in our communication strategies. I look forward to reporting next year as to how this additional resource has assisted the work of the Board.

I trust the content of this annual report speaks for itself in demonstrating the sheer hard work and endeavours of its members over the past year, coupled with its aims and ambitions for the coming year, and I commend it to you. I wish to conclude this message with my personal thanks to the Board Staff and Members. It is this team who delivers the outcomes mentioned in this report. They commit their time to Board meetings, subgroups and task and finish projects in order for this work to be undertaken, and it really is a privilege to work with you all. In particular, I want to comment this year on the role of the Business Manager. The Business Manager drives the activity of the Board and ensures its business is completed in a timely and effective way. We are so fortunate to have Lynne as our Business Manager; it is hard to put into words how valuable you are to the Board. Lynne you are 'Simply the Best', thank you.

Professor Keith Brown

Independent Chair, West of Berkshire Safeguarding Adults Board



About us

<p>What is the Safeguarding Adults Board?</p>	<p>The West of Berkshire Safeguarding Adults Partnership Board (SAB) covers the Local Authority areas of Reading, West Berkshire and Wokingham. The SAB is made up of local organisations which work together to protect adults with care and support needs at risk of abuse or neglect. Mandatory partners on the SAB are the Local Authorities, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and Thames Valley Police. Other organisations are represented on the SAB such as health services, fire and rescue service, ambulance service, HealthWatch, probation and the voluntary sector. A full list of partners is given in Appendix A the SAB structure in Appendix B.</p> <p>We work together to ensure there are systems in place to keep adults at risk in the West of Berkshire safe. We hold partner agencies to account to ensure they are safeguarding adults at risk and promoting their well-being. We work to ensure local organisations focus on outcomes, performance, learning and engagement.</p>
<p>Who do we support?</p>	<p>Under the Care Act, safeguarding duties apply to an adult who:</p> <ul style="list-style-type: none"> • Is experiencing, or is at risk of, abuse or neglect; and • As a result of their care and support needs, is unable to protect themselves.
<p>Our vision</p>	<p>Adult safeguarding means protecting people in our community so they can live in safety, free from abuse and neglect.</p> <p>Our vision in West Berkshire is that all agencies will work together to prevent and reduce the risk of harm to adults at risk of abuse or neglect, whilst supporting individuals to maintain control over their lives and make informed choices without coercion.</p>
<p>What is safeguarding adults?</p>	<p>Safeguarding adults means protecting others in our community who at risk of harm and unable to protect themselves because they have care and support needs, regardless of whether or not they are receiving support for these needs. There are many different forms of abuse, including but not exclusively: Disability hate crime, Discriminatory, Domestic, Female genital mutilation (FGM), Financial or material, Forced marriage, Hate crime, Honour based violence, Human trafficking, Mate crime, Modern slavery, Neglect and acts of omission, Organisational, Physical, Psychological, Restraint, Self-neglect, Sexual and Sexual Exploitation.</p>
<p>Safeguarding Adults Policy and Procedures</p>	<p>Berkshire Safeguarding Adults Policy and Procedures are used in the West of Berkshire and their purpose is to support staff to respond appropriately to all concerns of abuse or neglect they may encounter: Berkshire Safeguarding Adults - Berkshire Policies & Procedures for Safeguarding Adults</p>

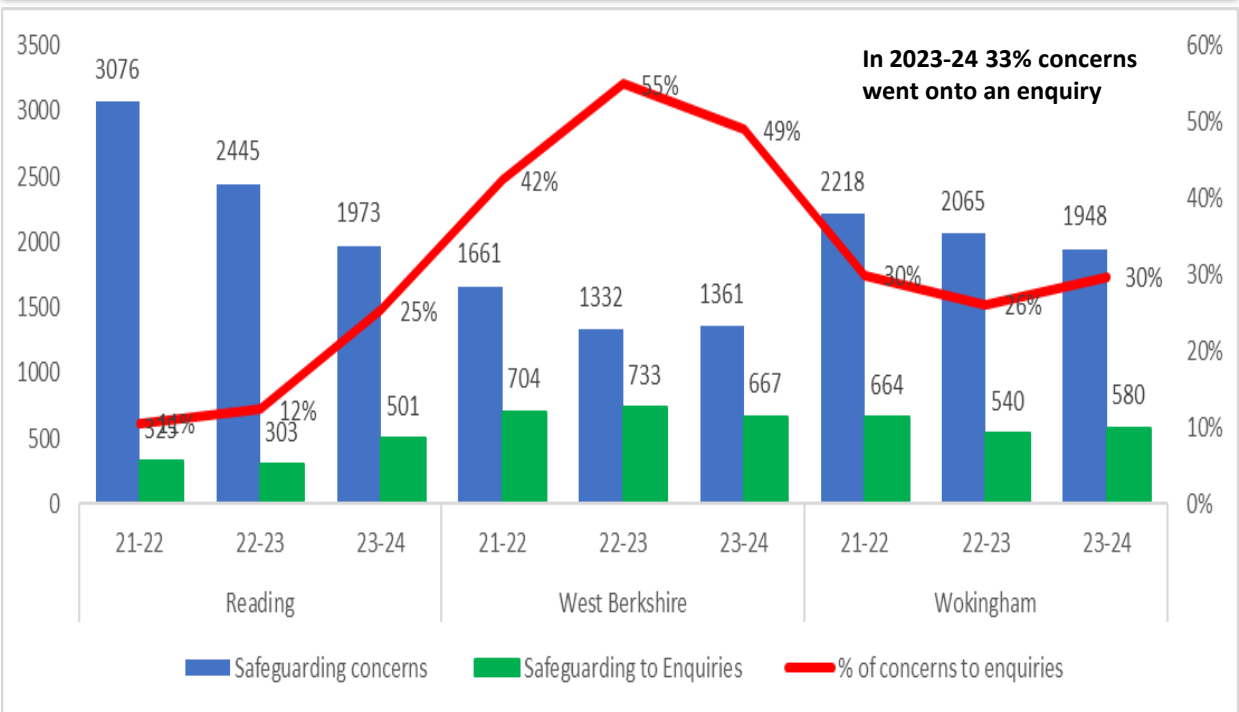
Number of safeguarding adult concerns and enquiries 2023-24

Due to the high % of out-of-scope safeguarding concerns received by our Local Authorities Partners from the Ambulance Service and the Police, there have been some changes to how Local Authorities manage these concerns to ensure that the concern is considered by the correct team and that it does not overwhelm their safeguarding pathways. For this reason, there has been a reduction in the number of safeguarding concerns from 21/22 to now, with a more consistent outturn between 22-23 and 23-24 and an increase in the % of safeguarding concerns that have led to a safeguarding enquiry.

The chart below demonstrates, in 2023-24 the total number of safeguarding concerns for individuals started in period - per 100,000 population, has decreased by 3% in the West of Berkshire, when comparing with 2022-23 and a 24% decrease when comparing with 2021-22. The SAB understands that this decrease is due to the amended pathways adopted by Local Authorities to address out of scope concerns and that there has not been an actual reduction in the number of in scope safeguarding concerns received.

It is important to note that this indicator will only count an individual once during the reporting period and therefore does not account for any multiple safeguarding concerns raised for individuals over the year, therefore the number of safeguarding concerns received is much higher than this outturn.

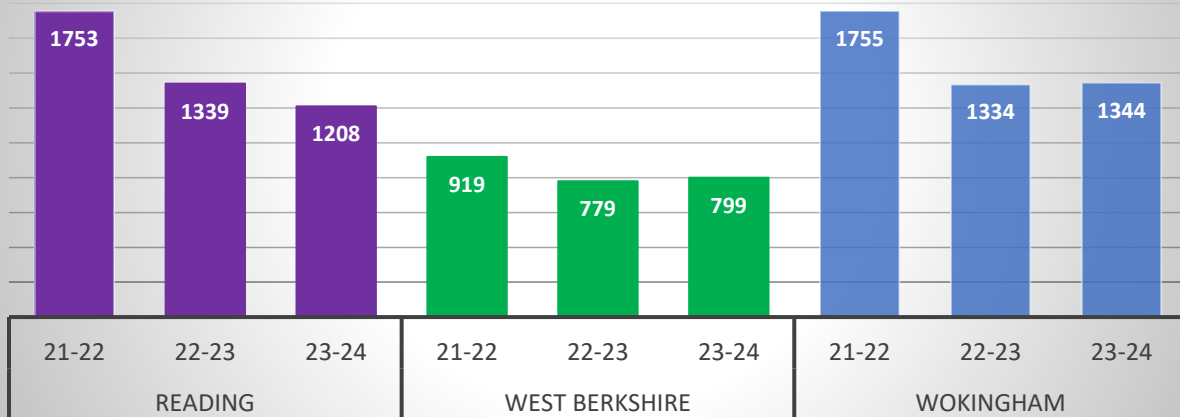
The table below demonstrates the number of safeguarding concerns, safeguarding enquiries and conversion rate between safeguarding concern and enquiry over the last three years by local authority.



In 2023-24 there were a total of 1748 enquiries started in the West of Berkshire

- 501 enquires in Reading an increase of 65% compared with 2022-23
- 667 in West Berkshire a decrease of 9% compared with 2022-23
- 580 in Wokingham an increase of 7% compared with 2022-23

Number of safeguarding concerns for individuals started in period - per 100,000 of the population



Safeguarding Concern Trends across the area 2023/24

Types of Abuse

As in previous years neglect and acts of omission was the most frequent abuse type, equating to 30% of enquiries. This was followed by financial, psychological or emotional abuse and physical abuse.

In 23-24 there was 362 enquiries with the abuse type of financial a 25% increase compared with the previous year.

Self-Neglect has also seen an increase of 27% with 287 enquiries completed.

There is a 35% increase in Domestic abuse which in the previous year had seen a 17% increase. 202 enquiries were completed.

Modern slavery saw the largest increase of 40% when compared with 2022/23, however due to the lower number of enquiries this equates to an increase of 2 enquiries.

Organisation abuse has seen the biggest decrease of 72%, there were 21 enquiries completed compared with 75 in 2022/23, which in that year this abuse type saw the biggest increase. The number of enquires in 2023/24 are like 2021/22 so it appears that 2022/23 was an outlier.

56% of enquires were in relation to women, this is consistent with previous years.

For the majority of enquiries (35%), the individual primary support reason was physical support, this is consistent with 2022/23. This was followed by no support reason, Learning Disability Support and Mental Health Support.

Social Support has seen a 490% increase with 124 enquiries completed this year compared with 21 last year.

Have seen an increase in the number of concerns raised by the fire service, as a direct result of the thematic [Fire Safety SAR](#) completed by the Board this year.

81% of enquires were for individuals whose ethnicity is White; this is a slight decrease with last year. The ethnicity of the remaining 19% of individuals is as follows: Not Known 8%, Black 4%, Other 4%, Asian 3%, Mixed 1%.

The Performance and Quality Subgroup (now referred to as the Scrutiny and Impact Group) routinely consider the ethnicity data to ensure it is consistent with our demographics.

Location of alleged abuse

64% of enquiries completed were where the alleged abuse took place in the persons own home, this is a slight increase compared with 22/23 and the first time in three years that an increase has been seen.

There has been a 5% decrease in enquiries completed where the location of abuse was in hospital, equating to a total of 83 enquiries.

Care Homes saw a decrease of 15, with a total of 357 enquiries.

There was a 2% increase in Service within Community (Commissioned service in community setting) with 48 enquiries.

59% of enquiries relate to people over 65 years in age, this has seen a minor decrease compared with last year.

25% of enquires completed were for individuals with no support reason, this evidences that Local Authorities are discharging their duty for self-funders, out of area placements and those not in receipt of services.

Risks and Mitigations

Challenges or areas of risk that have arisen during the year are recorded on our risk register, along with actions to mitigate the risks. These are some of the potential risks that we have addressed:

Risk	Consequence/Impact	Mitigation
People who raise safeguarding concerns do not receive feedback	Impaired partnership working.	Key Performance Indicator (KPI) in place to monitor percentage of referrers that receive feedback. As reported in the 22/23 annual report Reading Borough Council are currently unable to supply this information. Repeated assurance has been provided to the Performance and Quality Subgroup that plans are in place to address this.
There is inconsistent use of advocacy services to support adults through their safeguarding experience.	The voice of the service user is not heard.	Improve oversight of advocacy offer in the West of Berkshire: <ul style="list-style-type: none"> • KPI on SAB's dashboard, • Advocacy representation at SAB and subgroups, • Advocacy audit added to the SAB 24/25 Business Plan.
Responsibilities under the Mental Capacity Act (MCA) 2005 are not fully understood or applied in practice as a safeguard for people who may lack capacity (SAR finding)	Significant harm to adults as risk.	Learning resources around MCA is promoted by the SAB: Mental Capacity Act and DoLs West of Berkshire Safeguarding Adults Board (sabberkshirwest.co.uk) SAB Business Plan priority 23/24 and 24/25.
In response to the government's decision to delay Liberty Protection Safeguard (LPD) implementation there are capacity issues within the supervisory bodies to obtain timely DoLS assessments and provide appropriate authorisation.	Risks that vulnerable people do not have the opportunity to live within the least restrictive regime possible for their condition.	A KPI on the dashboard, concerns around performance have been highlighted to the SAB. KPI introduced to the dashboard in response to waiting lists for community DoLs, Performance and Quality subgroup are monitoring data and will update the SAB when data trends are understood.
The SAB is not complying with its Quality Assurance Framework (QAF).	That the SAB do not have assurance in regard to the quality of safeguarding in its area.	Action plan in place to monitor compliance with QAF.
Recruitment and retention of staff across all the partnership.	Staff shortages will impact on risk prevention and response to safeguarding concerns.	None identified, will address issues that are in the SAB's control as and when they arise.

Achievements through working together

Our priorities for 2023/24 and outcomes to those priorities were:

Priority 1: To seek assurance that quality of health and social care services delivered in the West of Berkshire or those commissioned out of area for West Berkshire residents is monitored effectively and there is a proportionate response to concerns.

- Berkshire West, Care Homes Strategic, Performance Forum delivered a presentation to the SAB, providing assurance on how health and social care partners work together to jointly lead on quality assurance and monitoring through scrutiny of identified issues, discussions and assurance of all Care Homes (inclusive of learning disability care homes, supported living establishments and domiciliary care providers who operate and deliver services.
- Creation of a webpage on [care governance](#) practice learning briefs on:
 - [Identifying and responding to concerns in health and social care services](#)
 - [Out of area reviews best practice guidance](#)
- Considered a reflective learning report on a large-scale organisational safeguarding investigation, involving multiple SAB partners completed in 23/24.
- Assurance sought on the timeliness and quality of reviews conducted by partners who have commissioned services for individuals outside their Local Authority boundaries, to ensure that the learning from previous SARS and assurance exercises was embedded.

Priority 3: Serious Violence and Exploitation, understanding the gaps from an adult safeguarding perspective

Agreed and published [Missing People Multi-Agency Response Guidance](#), implementation plan is in place and is expected to be delivered in 24/25.

Carried over priority into 24/25 as it had been previously agreed by this SAB this will be a priority for several years the next action for this priority will be: Sexual and Criminal Exploitation

Priority 2: Embedding a good understanding of Mental Capacity Act within the practice of our statutory partners

Undertook a survey with the aim being for the SAB to better understand the current support available and the challenges within the partnerships for those supporting vulnerable adults in identifying and managing and supporting people with issues around mental capacity. There were an amazing 199 responses to this survey and the results were considered by the Board in June 2023, this link provides a [copy of the presentation](#). Key learning from the survey was that there is a lack of confidence in practice in the:

- Assessment of executive function when assessing capacity
- Understanding the criteria for referring to advocacy services
- Assessing capacity when the individual has or may have fluctuating capacity.

Completed a full review of [MCA/DoLs webpage](#) and added additional WoBC guidance.

Safeguarding Adults Week – included a [webinar](#) on Executive Function.

Undertook a deeper analysis of SAB Dashboard data in relation to MCA.

Considered the internal MCA audits findings from partners and identified common themes and recommendations for the SAB.

SAB Partners are included in the local integrated care boards MCA steering group.

Partners have introduced advice sessions for practitioners to discuss issues they have about MCA.

Purchased MCA textbooks for all SAB statutory partners at a discounted rate.

Carried over the priority for 2024/25 to further support better understanding of practice in regard to MCA.

Priority 4: Review and relaunch of the [SAB Quality Assurance Framework](#) has been endorsed and published by the SAB and there is an implementation plan in place to support the SAB to follow the Framework.

Achievements through working together continued....

Safeguarding Adults Week 2023

In November 2023 the West of Berkshire Safeguarding Adults Partnership Board is supported the [Ann Craft Trust](#) Safeguarding Adults Week. Each day of the week our partners hosted a wide variety of free webinars to cover the themes on: Safeguarding yourself and others, these were open to all health and social care practitioners and volunteers within the West of Berkshire. The partnership provided learning resources to support awareness on these key themes. The week was a success with a total of 358 delegates attended the 8 webinars covering:

- Safeguarding Vs safeguarding
- Executive Function : understanding fluctuating mental capacity and how best to care with these issues
- Trauma informed approach to Safeguarding – 2 sessions delivered
- The Prevent Duty
- Learning from Safeguarding Adult Reviews
- Domestic Abuse and Adult Safeguarding
- Ask the Experts Session (adult safeguarding and domestic abuse)

All learning resources and webinars that were recorded can be found here: [Safeguarding Adults Week | West of Berkshire Safeguarding Adults Board \(sabberkshirewest.co.uk\)](#)

[Advocacy People Berkshire SAB presentation June](#) In June 2023, the Advocacy presented to the Board their advocacy offer in the West of Berkshire, also highlighting the importance of advocacy in safeguarding.

Commissioned and launched a new website after previous website host ceased trading.

Updated our [escalation protocol](#)

Modern Slavery in Care [Webpage](#) Created.

Published 4 Safeguarding Adult Reviews

Whistleblowing [Webpage](#) Created.

Created a pre-recorded [webinar](#) on the learning from the Pauline SAR.

Published a case study [A case study sharing learning from an internal review](#) in West Berkshire, following the death of a 70-year-old lady, who died in hospital with pressure wounds acquired at home.

The Department for Work and Pensions (DWP) have introduced Advanced Customer Support Team, whose role is to offer more support vulnerable individuals which will sometimes overlap with safeguarding interventions. In June 2023 the DWP delivered a presentation to the Board detailing the function of this new team and joined our SAB as a new member. [DWP Presentation June 2023](#)

In the absence of an effective Multi-Agency Audit Framework Strategy the SAB carefully considered learning from internal audits undertaken by its statutory partners over a 12-month period. A Task and Finish Group was also set up to review and relaunch a Multi-Agency Audit Framework Strategy which is due to be launched in early 24/25.

In response to learning from Safeguarding Adults Reviews the following guidance documents were produced in order to support health and social care practitioners in their response to safeguarding concerns:

- [Considerations before raising a safeguarding concern](#)
- [Pathways for Multi-agency Planning](#)
- [Multi-Agency Strategy Discussion-Meeting Guidance](#)

Launched a webpage for: [Recorded Webinars/Training Sessions](#)

Purchased [Hidden Harms](#), video focusing on Domestic Abuse and Older People, that was edited for the West of Berkshire.

MARM – Supporting Individuals to Manage Risk and Multi Agency Framework Key Performance Indicator introduced to monitor the effectiveness of the MARM across the partnership. Local Authorities provided [video guides](#) to support the partnership to under their processes for managing MARM.

Celebratory Points

- Being able to address and be part of the SAB that **enables better understanding of advocacy**
- Being part of the **safeguarding week plans** and events that take place under the SAB banner.
- Knowing that SAB takes **issues that arise from SARs seriously** and acts on the recommendations that come from the reports
- **Commitment and agility of the Voluntary, Community and Social Enterprise Sector.** Despite the plethora of societal challenges facing communities, the determination to support those most in need continues. Within this, some charities have been able to build in additional offers of service delivery, for example grants to support the heating of the homes of local people.
- **More consortiums and partnerships.** Whilst charities are having to work hard to support their own sustainability, many are realising the advantages of working in partnership. In the last year, Wokingham Borough has developed its Dementia Alliance and Carers Alliance. In both cases, three or more charities are working together to realise a collective ambition, utilising and sharing resources to best achieve for local people.

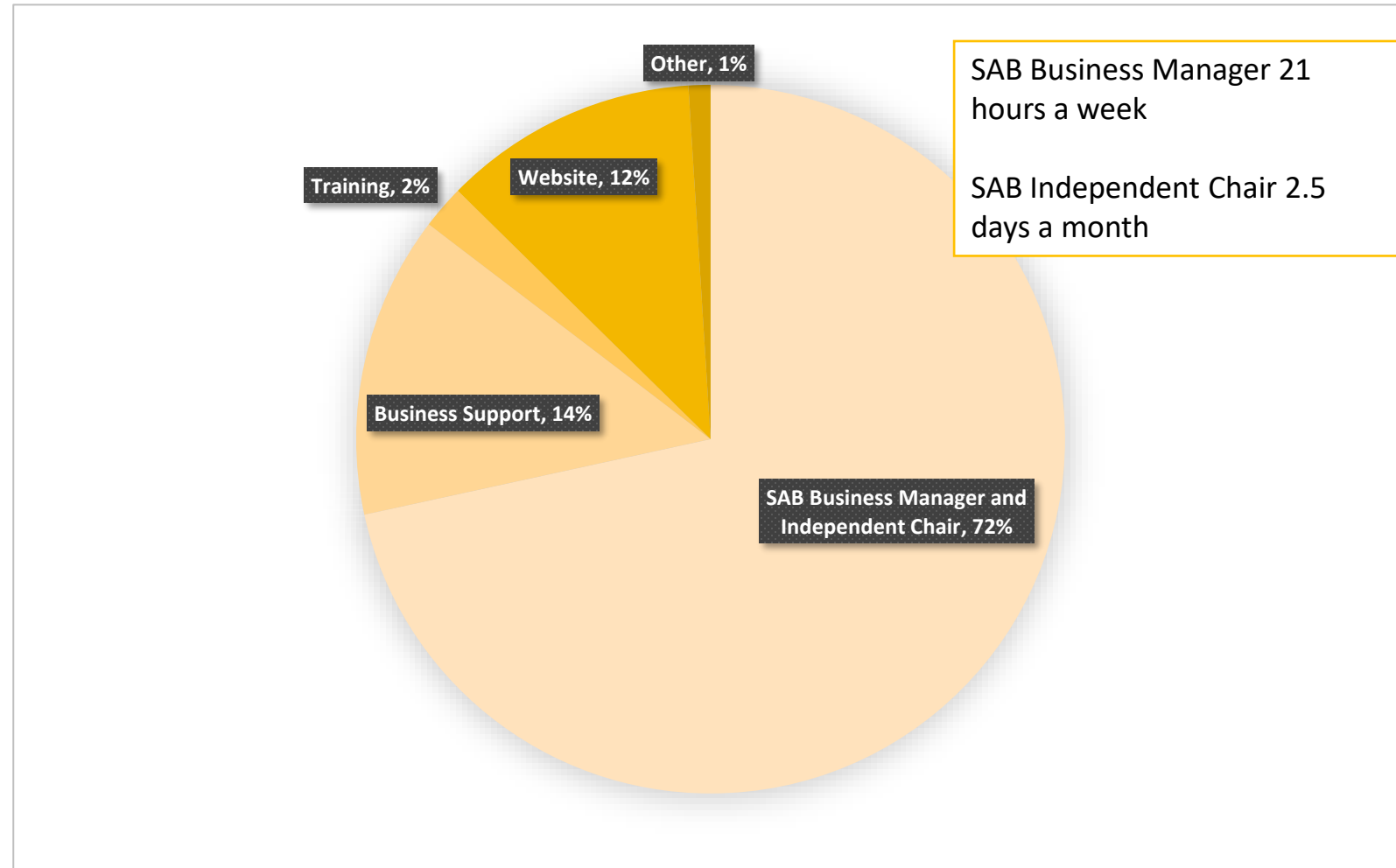
Emerging Issues

- Lack of enough **advocacy funding** to provide enough early intervention i.e. community advocacy to act as a prevention of escalating problems.
- Learning from SARs evidences there is **a gap in advocacy referrals.**
- **Support for Asylum Seekers.** There are many asylum seekers who are successfully receiving their leave to remain in the UK. Upon receiving this notification, these individuals are given 28 days-notice and are then required to move on from their temporary accommodation. This notification is often delayed in arriving with the individual in question which is then not allowing sufficient time for professionals and volunteers to help secure income, find housing and begin to build the lives of those who are often highly vulnerable.
- **Cost of Living.** There are an ever-increasing number of residents who are presenting to our foodbanks and who are working. Following increases to mortgages, rent, utilities and other outgoings, those who have previously lived well or sufficiently within their means are now in financial hardship. Approximately a quarter to a third of those coming to the attention of food services have never had to use these facilities before.
- **Statutory Funding Pressures and Impact on Local Charities.** As statutory organisations come under increasing funding pressures, funds historically allotted to the Voluntary and Community Sector are under increasing scrutiny. Whilst we have not seen any cuts to funding at this stage, the prognosis of this happening is ever more present. This, alongside the increasing competition for funds from national and local funding organisations will see income to charities and other community assets go down which in turn will see services reducing their provision, with a potential risk of insolvency.

Annual Budget and Financial Contribution, 2023/24

The 2023/24 annual budget for the Board was £79,488 the annual budget is established through a financial contribution from statutory partners. The SAB also had £43,859 carry over from previous years. The name of the agency and their contribution; shown as a percentage of the overall cost in the table below and the pie chart demonstrates where the money was spent.

Partner	Agreed % Contribution
Reading Borough Council	16.07%
West Berkshire Council	16.07%
Wokingham Borough Council	16.07%
Buckinghamshire, Oxfordshire, West of Berkshire ICB	16.07%
Berkshire Healthcare Foundation Trust	9.52%
Royal Berkshire Hospital	9.52%
Thames Valley Police	16.66%



The 2023/24 expenditure was £74,861 and the SAB have carried over £48,485 into 2024/25. Which will be used to support the SAB to achieve its priorities.

The SAB has a legal duty to carry out a SAR when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died, and abuse or neglect is suspected to be a factor in their death; or when an adult has not died but suffered serious abuse or neglect. The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The SAB has a SAR Panel that oversees this work.

During the reporting year, the SAR Panel have worked on 6 SARs of which 4 have been endorsed and published and the remaining 2 SARs are due to go to SAB for endorsement and publication in 2024/25. The SAR Panel also considered 3 notifications that were assessed as not meeting the SAR criteria.

The SAR Panel considered the SAR in Rapid Time guidance produced by the Social Care Institute for Excellence and concluded that its current SAR process complements the principles within this guidance and that there was not a requirement to adopt the rapid time module.

The SAR Panel remains focused on ensure that it produces learning from SARs that is helpful to the partnership and will support improved practice both locally and nationally. The SAB has a dedicated webpage for its SAR process and published learning: [Safeguarding Adults Reviews | West of Berkshire Safeguarding Adults Board \(sabberkshirwest.co.uk\)](https://www.sabberkshirwest.co.uk)

Sandra Full report on the [Case of Sandra](#) and [Practice Note](#)

Sandra was 65 years old at the time of her death in 2022, having died in hospital from a sepsis infection acquired from an injury received in her home. Prior to her death, Sandra had been living independently in a flat provided by a local housing association. Sandra had several long-term health issues. Sandra's health issues were supported by her GP and wider NHS services, who found it difficult to engage Sandra with this support. Sandra had two children with whom she was in contact, including a son who suffered from poor mental health and himself had significant needs. Due to his vulnerabilities, she felt compelled to support his needs despite this severely affecting her own wellbeing. The first concerns for Sandra's safety were raised 9 years prior to her death, with a report that her son had moved into her flat after being evicted from his own accommodation. There were concerns about him physically assaulting her, causing damage to the flat, and hoarding. Shortly after these concerns were raised, Sandra was evicted from the property due to its condition and was supported by the local authority in being rehoused. She was provided a flat with a single occupancy tenancy and a condition that no other person should reside with her. During the subsequent years several safeguarding concerns were raised about Sandra's son taking over her flat, whilst exposing her to physical, emotional, and financial abuse. At the time of her death, Sandra was actively being supported by Adult Social Care, who allocated a Social Worker to Sandra, following a safeguarding concern received.

Key Learning points from this review were:

- **The Assessment of Safeguarding Referrals and Social Care Prevention Pathways:** Improvement is required in the way that referrals and contacts are initially assessed and allocated for further social work. New prevention pathways are required to ensure that social work teams are structured and resourced to manage cases of differing complexity.
- **The Quality-of-Care Act Assessments and Management of Risk:** Social workers and managers need further guidance in how to prepare person centred Care Act assessments and safeguarding plans.
- **Multi-Agency Information Sharing and Planning:** There is a need to promote the current multi-agency arrangements to share information and develop joint safeguarding plans. This should include improving the understanding of when a referral would still be appropriate in the absence of consent.
- **Developing Professional Curiosity:** Agencies have identified how a greater level of professional curiosity by their staff would have helped to better identify vulnerability and improve the submission of safeguarding referrals.

Published July 2023

Tina Full report on the [Case of Tina](#) and [Practice Note](#)

Tina was a retired nurse living with her husband who was her main carer. A home care agency visited their home once a week to assist with housework and shopping, this was arranged and funded privately. Concerns were raised to adult social care about Tina's health and social care needs and how Tina and her husband were coping. Tina died shortly after being admitted to hospital.

Key Learning points from this review were:

Mental Capacity Act: if a person's decision making is putting them at high risk and/or they repeatedly make unwise decisions, that raises questions their mental capacity and should prompt a mental capacity assessment, this was not considered for Tina.

Professional Curiosity: would have been beneficial to establish why Tina was refusing support. There was mention of alcohol use on several occasions by agencies involved although professional curiosity was not applied to establish more information. No consideration was given to the impact alcohol may have on Tina's ability to make decisions.

Risk Assessment: there was an ongoing known history of Tina refusing equipment that she had been assessed as needing. A multi-agency risk assessment and management plan was not in place despite professionals identifying concerns and risks while working with Tina. A comprehensive risk assessment and management plan could have been completed to take full account of Tina's home situation, state of mind, and physical condition, this could have been shared with all agencies involved to enable a holistic approach to working with Tina.

Information Sharing: the limited multi-agency information sharing hindered a holistic view of Tina's evolving situation. It would have been valuable to have more information sharing between all agencies as not everyone involved with Tina and her husband were aware of the concerns and risks.

Care Act Assessment: was not carried out at any point. Carrying out an assessment of need was an important opportunity to understand Tina's whole situation and views. The objective of a needs assessment is to determine whether the adult has care and support needs and what those needs may be. No consideration was given to the Care Act 2014 Section 11 refusal of assessment, if an adult refuses a needs assessment the local authority need not carry out the assessment, unless the adult is experiencing, or is at risk of, abuse or neglect which the SAR found Tina clearly was.

Published November 2023

Fire Safety Full report on the [Fire Safety SAR](#) and [Practice Note](#) .

In late 2022 in the West of Berkshire there were 2 serious fire incidents involving people with care and support needs that lead to the SAR Panel commissioning a thematic SAR to look at the local and national picture around fire risk for vulnerable people.

The National Picture:

Older adults (65+) with care and support needs, particularly those who already exhibit self-neglecting behaviours or have reduced ability to meet their care needs due to frailty and immobility are more likely to die in fires.

Over the five years to 2020, 70% of all fatal dwelling fires happened in a living room, followed by the bedroom (though in some of these incidents the living room was being used as a bedroom).

The predominant source of ignition at fatal fires is smoking related (32% of all fatal fires), with a further 14% involving matches and candles. Heating and cooking equipment accounted for less than 10% each as the source of ignition for fires where there were fire related fatalities (including in dwelling fires)

In the year ending March 2022 there were 272 fire related fatalities (an increase of 15%). Because of numerous SARs into fire deaths nationally and national fire incident reports, the main contributory factors of a fire fatality have identified as:

- how able the person was to respond to the fire (i.e. were they mobile; were they awake; were they impaired by drugs or alcohol);
- how early the fire is discovered, how quickly fire service is called and the arrival time/response of the fire service;
- the materials involved in the fire (smoking, non-retardant bedding and pressure relieving mattresses, clothing or hoist materials, emollient creams all increase risk);
- the size and construction of the room/building;
- the proximity of the victim to the fire.

In response to this SAR the SAB have set the following priority for 23/24:

Fire Safety – to address the learning from the Fire Safety SAR in January 2024 and to improve awareness across the West of Berkshire around the increased fire risks for vulnerable people.

Published January 2024

Bree Full report on the [Case of Bree](#) and [Practice Note](#)

Bree died in February 2022 after falling from a bridge, she was 24 years old. An inquest held in June 2023 recorded a conclusion of suicide. Bree was a White British female who had learning difficulties and may have had undiagnosed autism spectrum condition.

Bree had been living in supported accommodation since 2019. The placement was within one local authority boundary but commissioned by another local authority. Bree received support from a care agency which specialises in providing support to people with learning disabilities and autism.

In January 2022 Bree's presentation deteriorated markedly. Her self-harming behaviours intensified as did her suicidal ideation. The Crisis Resolution and Home Treatment Team (CRHTT) supported her for a period and discharged Bree when her presentation appeared to have stabilised and at a time when her unhappiness in her supported accommodation was shortly to be addressed by a placement move.

However, the SAR has identified that Bree was living with complex trauma and a placement move would not have solved the underlying issues that led to Bree's her self-harming and suicidal ideation. The incident in which Bree fell from the bridge took place on the day after she presented at her GP practice expressing suicidal thoughts and was seen by a specialist mental health practitioner within primary care who considered referring her back to the CRHTT, but after consulting with the latter service, provided Bree with reassurance that her placement move was imminent.

Learning from this SAR identified that Bree had experienced traumatic events, including those that would fall under the category of abuse and neglect, throughout her life; which would have attributed to her self harming behaviours and suicidal ideation, therefore consideration of the safeguarding pathway would have been appropriate. This would have equipped all professionals working with Bree to understand the reasons why Bree's presentation had deteriorated significantly and to agree an appropriate risk management plan.

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How is learning from SARS embedded within in practice?

The SAB captures all recommendations from SARs on a SAR Multi- Agency Action Plan.

Actions are agreed for each recommendation that are then considered and signed off by the SAB when they endorse the SAR.

All SAR recommendations are allocated to a responsible agency and the most appropriate SAB subgroup. Update reports on SAR recommendation progress including themes is presented to the SAB on a quarterly basis.

When considering SAR recommendations, the SAR Panel will refer to the SAR Multi-Agency Action Plan to ensure that recommendations are not a duplication of previous recommendations.

Status of Current SAR Recommendations

From all SARs endorsed from the SAB since April 22 there are a total of 30 recommendations equating to 45 Actions. Of these 45 actions:

Action Embedded	40%
Action Completed	22%
Action being implemented and on track for completion within timescales	27%
Action not being implemented, or serious delays/concerns identified, or Action being implemented but with possible delays/concern	11%

Reflection

In December 2023 all SAB members were invited to take part in a SAB effectiveness survey, where the following areas of success and improvement were identified, this survey will be repeated every 2 years as per our Quality Assessment Framework requirements.

Success

Partnership

The SAB works in an atmosphere and culture of cooperation, mutual assurance, accountability and ownership of responsibility

Leadership

The SAB demonstrates effective leadership and coordinates the delivery of adult safeguarding policy and practice across all agencies, with representatives who are sufficiently senior to get things done.

Reporting Mechanisms

Reporting mechanisms (to the SAB and from the SAB to the LA's and the boards of partner organisations) are clear and effective.

Improvement

Links

Improve our links with Health and Wellbeing Board, Community Safety Partnership and Children's Safeguarding Board.

Engagement

Improve mechanisms to ensure that the views of people who are in situations that place them at risk of abuse and carers inform the work of the SAB.

Integration

Establish clear protocols that integrate different agency procedures.

Key Priorities for 2024/25

The SAB acknowledges that there are reoccurring themes from local and national learning from SARs that must be addressed. As in previous years we will continue to consider what the obstacles are in implementing recommendations and sustaining improvement and there will be a focus on good practice to promote learning, alongside an emphasis on good quality care principles and the role of effective support and supervision of the workforce to embed learning and inform future practice.

It is possible that changes to priorities will be made throughout the duration of this year in light of national and local learning in order to ensure that there is capacity within the partnership to deliver on the most pressing priorities for the West of Berkshire. Any change in priorities will be approved by the SAB.

Through its reflective learning practice, the SAB have identified the following priorities:

Priority 1

Embedding a good understanding of Mental Capacity Act within the practice of our statutory partners.

Priority 2

Serious Violence and Exploitation, understanding the gaps from an adult safeguarding perspective.

Priority 3

Fire Safety – to address the learning from the Fire Safety SAR in January 2024 and to improve awareness across the West of Berkshire around the increased fire risks for vulnerable people.

BAU

The Board will continue to carry out the following business as usual tasks in order to comply with its statutory obligations.

Appendices

Reference	Description
Appendix A	SAB Member Organisations
Appendix B	SAB Structure
Appendix C	Achievements by partner agencies
Appendix D	2022/23 SAB Business Plan
Appendix E	2023/24 SAB Business Plan
Appendix F	Partners' Safeguarding Performance Annual Reports:
	Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board
	Berkshire Healthcare Foundation Trust
	West Berkshire Council
	Wokingham Borough Council
	Royal Berkshire NHS Foundation Trust
	Reading Borough Council
	South Central Ambulance