BOURNEMOUTH AND POOLE ADULT SAFEGUARDING BOARD

MULTI-AGENCY ACTION PLAN FOR HARRY (KAREN & JOHN)

This action plan was put together following the joint Domestic Homicide Review and Safeguarding Adult Review report which concerns the death of a young man in May 2015.

Organisations were asked to work towards carrying out the recommendations within set timescales. Progress was monitored by the BPSAB SAR subgroup and reported to the Bournemouth and Poole Safeguarding Adult Board.

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 1 *That this report is shared with Dorset's Local Safeguarding Children Board and their Safeguarding Adults Board so that the Boards can make use of the learning from this review to seek assurance about the effectiveness of arrangements by which looked after children and other children with care and support needs are supported in their transition to adulthood.*		The summary of the report was received by the Dorset Safeguarding Adults Board in December 2016. The report and its implications for the two Children's Boards were considered by a multi-agency group and a report presented to Pan-Dorset SCR sub-group on 3rd May 2017. The Chair of the SABs has briefed the Chair of the Children's Boards.	**Blue**
Recommendation 2 *That this report is shared with Bournemouth and Poole Local Safeguarding Children Board so that that Board and the Bournemouth and Poole Safeguarding Adults Board can make use of the learning from this review to seek assurance about the effectiveness of arrangements by which looked after children and other children with care and support needs are supported in their transition to adulthood.*		The report and its implications for the two Children's Boards were considered by a multi-agency group and a report presented to Pan-Dorset SCR sub-group on 3rd May 2017. The Chair of the SABs has briefed the Chair of the Children's Boards.	**Blue**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 3 (for DCSCJB and SAB) *That Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership establish a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and MARAC agendas are more closely aligned and that professional practice in respect of safeguarding adults and tackling domestic abuse is as integrated as possible.*	**MARAC Steering group**	The MARAC Steering Group commissioned an independent reviewer to conduct a review of MARAC arrangements. (completion April 2017) Subsequently the Steering Group has worked with the Safeguarding Adults Board Policy and Procedure sub group to improve policy and guidance for MARAC and Multi Agency Risk Management (MARM) meetings. Appendix 6 has been created within the multi agency procedures to provide guidance to staff when working with adults with care and support needs who become subject to domestic abuse. An independent audit was commissioned in January 2019 to examine how far professional practice has improved in respect of people with learning disability who have experienced domestic abuse.	**Green**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 4 (for DCSCJB and SAB) *That the joint task and finish group referred to above, should also conduct a review of the IDVA (Maple project) service in order to identify what changes need to be made to ensure that:* • *the IDVA service is effectively integrated with the MARAC process* • *case closure is accompanied by an appropriate level of risk assessment* • *the service is accessible and sensitive to the needs of disabled people including people with learning disabilities.*	**MARAC Steering group**	The MARAC Steering Group took responsibility for implementing this recommendation as part of the MARAC review. The review included a focus on the relationship between the new Maple team (IDVA) and MARAC. It also included a review of risk assessments during case closure. A Leading Lights accreditation review of the Maple team has also been undertaken. This aims to achieve Leading Lights accreditation from Safe Lives. Specialisms have been identified within the Maple team, with specific Domestic Abuse Advisors (formerly IDVA) being upskilled in a range of specialist areas. All high risk DAA cases are subject to a further DASH risk assessment when a client engages with the service and at the conclusion of the intervention. The Domestic Abuse Advisors from the Maple Project are fully integrated within MARAC and attend to represent their client at the meeting. All DAAs have received Safe Lives training regarding 'safeguarding vulnerable adults' and have completed a workbook pp 34-40, Block 4, Key Choices, Options, Support Available to High Risk Clients, Safe Lives. It is noted that Bournemouth CSP employs a dedicated worker that specialises in working with clients that have specialist needs. It would be interesting to see how this develops and whether there is any shared learning that the Maple Project could review.	**Green**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 5 (a) *(a) That Bournemouth and Poole Safeguarding Adults Board monitor the Dorset Healthcare Trust review of knowledge and application of the Mental Capacity Act in order to gain assurance that the review fully addresses the learning from this DHR/SAR report.*	**DHC**	Dorset Healthcare Trust reports that this has been actioned by Head of Mental Health & Consultant Psychiatrist, Old Age Psychiatry and Lead for Old Age Psychiatry as follows: DHC undertook a baseline assessment of the recording of capacity and consent of all patients on its caseload and implemented actions to address gaps. DHC has reviewed its internal policy and procedural documents on the Mental Capacity Act, (MCA). An additional paragraph has been added to internal MCA policy to clarify actions staff should to take when inconsistent answers are given during MCA assessment Each Care Co-ordinator or Lead professional has reviewed the consent status of their current patient caseload. Staff are now expected to gain consent at the initial assessment and record it on the patient record. Consent has been reviewed as part of the Cluster and Care Programme Approach reviews and where applicable best interest assessments are completed MCA & Capacity Training is now mandatory for all DHC clinical staff. Bespoke training workshops were also arranged for various staff groups across the Trust (not just those highlighted in the report). The Care Programme Approach Policy has been amended to reflect the expectations of staff around Consent and Capacity.	**Blue**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 5 (b) *(b) Bournemouth and Poole Safeguarding Adults Board should ensure that the learning emerging from the review is shared across the safeguarding adults workforce.*	**Training & Workforce Development Subgroup**	In respect of (b) a synopsis of learning has been developed by the training and workforce development group of the SAB and workshops will be arranged following the conclusion of the inquest. The training and workforce development sub group have also established a task and finish group to look at how collaborative learning between the SAB, LSCB and CSP from a number of DHRs can be captured and disseminated across practice. Within this work consideration as to how the impact of learning can be evaluated will be undertaken. This evaluation will be across all agencies.	**Green**
Recommendation 6 *That Bournemouth and Poole Safeguarding Adults Board promotes the wide dissemination and use of resources including "easy read" materials to increase awareness of safe use of social media amongst people with learning disabilities and the range of partner agencies which provide support to people with learning disabilities.*	**Policy and Procedures Subgroup**	Organisations such as Dorset Healthcare Trust have a wide range of easy read leaflets available. The Learning Disability Partnership Board *Communication for All* workgroup has various resources available on safety and social media which can be accessed for individuals as appropriate. The outcome of this review will also be published in Easy read.	**Green**
Recommendation 7 *That this report is shared with Bournemouth and Poole Local Safeguarding Children Board in order that they can consider the learning from this review about the sexual exploitation of children with disabilities including learning disabilities.*	**Business Managers of BPSAB and LSCB**	Report circulated and discussed at Children's Board SCR subgroup. Further work will be undertaken following completion of the inquest, when the full review can be published and shared more widely.	**Green**

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Recommendation 8 *That Bournemouth and Poole Safeguarding Adults Board examines the insights gained from this review into the sexual exploitation of adults with care and support needs and consider how best to advance the further exploration of the "model" of sexual exploitation apparent in this case.*		The SABs endorsed a position paper on adult sexual exploitation which was presented to the Pan Dorset Community Safety Criminal Justice Board (CSCJB). This work is now led by the Sexual Violence strategy group which reports to the CSCJB.	**Green**
Recommendation 9 (for DCSCJB) *That MAPPA SMB seeks assurance that all agencies involved in the MAPPA process are clear about the criteria for referral to MAPPA where the concerns about the risks to public safety the individual is believed to present are based primarily upon multiple allegations rather than cautions or convictions.*	**MAPPA SMB**	MAPPA SMB have commissioned an annual cycle of MAPPA Awareness Training events to ensure that all agencies involved in the MAPPA process are clear about all aspects of MAPPA in Dorset. There have been 4 events completed each year since 2016 with 295 staff from a wide range of agencies attending. Further MAPPA Awareness Training is planned for 2019.	**Blue**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 10 *That Dorset Police review their safeguarding adults policies and practice in the light of this report in order to provide assurance to Bournemouth and Poole Safeguarding Adults Board that they are fully engaged in the safeguarding adults agenda at all levels and fully compliant with the requirements of the Care Act 2014.*	**Dorset police**	A review of Dorset Police's Adult Safeguarding arrangements has taken place. This has led to the appointment of a dedicated Adult safeguarding Detective Inspector and realignment of force resources. A project manager has been appointed to develop this area further. Changes have been reflected in revised policy and procedures, including those relating to vulnerable adults and intimidated victims and witnesses. The force has signed up to comply with the national vulnerability action plan and has an ambition to improve on the rating of 'Good' for vulnerability, as assessed by the HMICFRS. The force is developing a bespoke Adult At Risk investigation training and will train front line detectives regarding criminal investigations affecting individuals who are the most vulnerable and subject to the care act. Learning from the SAR and other reviews will be part of this training. The force is also delivering general vulnerability training to all front line staff, where learning from wider reviews, such as DHR and SCR will be included. The force continues to engage with partners, such as Dorset Health Care and the CCG on ways to improve information sharing processes to ensure members of the community that do not have care and support needs within the threshold of the Care Act have been signposted to a relevant agency. Within this work stream and in line with the proposed vulnerability training the force will provide front line officers with the information to ensure that officers and staff can identify vulnerability and know how to respond.	**Green**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 11 (for DCSCJB and SAB) *That Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership ensure that the learning from this case is widely disseminated and informs single and multi-agency training. They should ensure that understanding and mitigating risk should be a key focus of dissemination of learning and training arising from this review.*		A synopsis of learning has been developed from the case to be used across both social care and community safety agencies. This will be updated following the findings of the inquest. Findings from this review and other recent Serious Case Reviews in Dorset were presented to 2 conferences run jointly by the SABs and the Children's Boards in 2018. The conferences were attended by 500 front line staff and managers. Further presentations of lessons learned have been made to the Learning Disability Partnership Board and a special meeting of independent providers. The Chair of the SAB reminded providers of their responsibilities in respect of information sharing and risk management at the 2 annual provider conferences in 2019.	**Green**
Recommendation 12 *That Bournemouth and Poole Safeguarding Adults Board oversees the development of a multi-agency procedure which enables professional disagreements to be escalated and resolved.*	**P&P subgroup**	Guidance around escalation was included in the refresh of the multi agency procedures published in May 2018.	**Blue**

Recommendation	Planned actions	Commentary on progress with evidence	RAG rating
Recommendation 13 *That Bournemouth and Poole Safeguarding Adults Board writes to the Department of Health to recommend that the Department considers making arrangements for a national repository for SAR reports in order that the learning emerging from SARs is more readily accessible to the safeguarding adults community across England and Wales.*	**BPSAB Independent Chair**	In June 2018 Research in Practice for Adults (RiPfA) and Social Care Institute for Excellence (SCIE) announced that the Safeguarding Adults reviews library is live. This contains reports and associated resources to support those involved in commissioning, conducting and quality assuring Safeguarding Adults Reviews (SARs). The aim of the repository is to maximise the value of individual SARs through (a) supporting the quality of individual SARs and (b) enabling more widespread and effective use of the learning from SARs. Commissioned by the Department of Health, the repository was developed jointly by RiPfA and the (SCIE), working closely with colleagues from the sector. A SAR Champions programme is underway to provide support cross regions in using and developing the SAR library resources.	**Blue**

	Red	Serious challenge, remedial action required, out of tolerance
	Amber	Some challenges, mitigating action in place, within tolerance
	Green	On target
	Blue	Completed
	White	Not Started
	Black	Cancelled

Glossary of terms used in this action plan	
BPSAB	Bournemouth & Poole Safeguarding Adults Board
CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DAA	Domestic Abuse Adviser (previously known as IDVAs, see below)
DHC	Dorset Healthcare
DHR	Domestic Homicide Review A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.
DCSCJB	Dorset Community Safety & Criminal Justice Board
DSAB	Dorset Safeguarding Adults Board
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
IDVA	Independent Domestic Violence Advisors – now known as Domestic Abuse Advisers
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements MAPPA is not a statutory body itself but is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.
MARAC	Multi-Agency Risk Assessment Conference A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of

	local police, health, child protection, housing practitioners, Domestic Abuse Advisers, probation and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.
MARM	Multi-Agency Risk Management (meeting)
MCA	The Mental Capacity Act The Mental Capacity Act 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.
RiPFA	Research in Practice For Adults A not-for-profit organisation which aims to bring together academic research, practice expertise and the experiences of people accessing services to enable professionals across the sector to make evidence-informed decisions about the design and delivery of Adults' Services.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). The purpose of SARs is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.
SCIE	Social Care Institute for Excellence A UK charity which aims to improve the lives of people who use care services by sharing knowledge about what works. It is a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK.
SCR	Serious Case Review A review carried out by a Local Safeguarding Children's Board when a child is seriously harmed or dies as a result of abuse or neglect.