Safeguarding Adult Review

SANDRA

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1. INTRODUCTION AND METHODOLOGY

Background

In August 2022, the West of Berkshire Safeguarding Adults Board considered the case of Sandra who had died in June 2022. Sandra had been supported by services over a long period of time, with a number of safeguarding concerns identified and responded to. At the time of her death she was being supported by Wokingham Adult Social Care. The safeguarding board recognised the potential to improve the way in which agencies work together and commissioned this Safeguarding Adults Review (SAR)[1].

The review aimed to use the experiences of Sandra to identify learning and to continually improve the way that agencies support the wellbeing of adults at risk. A wide number of agencies from the safeguarding partnership took part and four key findings were identified. These are outlined in this report as follows:

a) The Assessment of Safeguarding Referrals and the Provision of Social Care Prevention Pathways
b) The Quality of Care Act Assessments and Management of Risk
c) Multi-Agency Information Sharing and Planning
d) Developing Professional Curiosity

Methodology

An independent lead reviewer was appointed to work alongside a panel of local professionals to undertake the review. Terms of reference were provided, outlining the safeguarding themes to be considered during the review and identifying the key date parameters as October 2016 to the date of Sandra's death.

Each agency analysed their own practice events and a multi-agency chronology was prepared to support an analysis of multi-agency working. Where necessary the independent reviewer met individually with the practitioners who had directly worked with Sandra and in April 2023 a multi-agency learning event was held to consider future improvements to partnership working. This overview report detailing the analysis and findings of the learning event was then prepared and submitted to the safeguarding board for its consideration. Due to complexities with Sandra's family it was decided not to involve them in the review process.

About This Report

This report outlines the recommendations in a concise format. It is written with the intention of publication and as such does not contain information which may identify those involved. The document aims to be as succinct and practical as possible and therefore does not contain a detailed chronology of events, or the 'working out' process for the review findings. The detailed analysis of events and the evidence underpinning this report are held in additional documents retained by the West of Berkshire Safeguarding Adults Board.

[1] https://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

2. CASE SUMMARY & KEY EVENTS

Sandra – An Overview

Sandra was 65 years old at the time of her death, having died in hospital from a sepsis infection acquired from an injury received in her home. Prior to her death, she had been living independently in a flat provided by a local housing association and had been registered with her local GP practice since 2014. She was seen frequently at the practice, who had not identified her as having any specific vulnerability.

Sandra had a number of long term health issues including obesity, orthopaedic problems, and poor mobility. Whilst Sandra's health issues were supported by her GP and wider NHS services, she found it difficult to engage with this support. There was a pattern of her not attending or arranging appointments and then being discharged from services without the intended support being provided.

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. Sandra was also in contact with her sister and brother in law, who continued to support her up until the point of her death. Sandra's sister would visit her regularly to help with daily tasks.

The first concerns for Sandra's safety were raised in 2013, 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 moving in a large volume of possessions that made it difficult for her to move around and access rooms. 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 a number of further safeguarding referrals were submitted about Sandra, all with similar themes relating to the risk of abuse from her son and the condition of her flat. Concerns included her son taking over her flat, whilst exposing her to physical, emotional, and financial abuse.

During early June 2022, Sandra received a minor injury in her home that became infected and led to her hospitalisation. Following her admission her condition continued to deteriorate and she died on 12th June. At the time of her death she was actively being supported by Wokingham Adult Social Care, following a safeguarding referral received in November 2021. This support had involved the provision of a social worker from the Social Work Assessment Team, which is intended to deliver a short term service over a six to eight week period.

Chronology of Key Events

a) On 6th October 2016, a safeguarding referral was submitted by the ambulance service to adult social care, after they had been called to Sandra's home. This was the third referral received about Sandra since 2013 and outlined concerns about her mobility and the condition of her flat, which was described as being unclean, damaged, and cluttered. Sandra had said that the condition of the flat was due to her son. In response social care sent a letter asking Sandra to contact them if she needed any support. Sandra did not reply.

b) On 3rd August 2018, Thames Valley Police received an emergency call from Sandra, reporting that her son was acting violently and causing criminal damage to her flat. The police attended and her son was subsequently arrested and charged with criminal offences. During the investigation Sandra disclosed that whilst it was a breach of her tenancy agreement, her son had been living at the flat for three years and that this was ruining her life. He had made her feel trapped in her own

home. Her son was later convicted at court and during his sentencing received a two year restraining order preventing him from going back to the flat. Whilst the police officers created a safeguarding referral for Sandra, this was never submitted due to an error in use of the electronic system. A safeguarding referral about her son was correctly submitted.

c) On 18th October 2018, the housing provider submitted a safeguarding referral with concerns about self-neglect and the condition of Sandra's flat. The volume of clutter within the flat had prevented Sandra from accessing her bathroom and she had not been able to shower or bath for over a year. Short term support was provided – arrangements were made to clean her flat and occupational therapy support was arranged to support her mobility difficulties.

d) On 22nd October 2018, a safeguarding referral was submitted by Thames Valley Police, following a report that Sandra's son was trying to force his way into her flat. A member of adult social care staff contacted Sandra by telephone, who said that she was fine and therefore no further action was taken. This contact was not recorded on the social care database as a safeguarding concern.

e) On 11th March 2019, the police became aware that a friend of Sandra's son had moved into her flat. It had been explained that the friend was a victim of 'cuckooing'[2] and had been forced out of his flat by persons who were using it to illegally supply controlled drugs. Whilst Sandra's son explained that she was happy with this arrangement, Sandra was never spoken with to confirm this, or to explore if she was the victim of any criminal activity. The police officers didn't identify the existence of the restraining order as they had not researched the police databases to identify what was known about those involved. The officers did however recognise that Sandra was vulnerable and may have been at risk from this arrangement. A safeguarding referral was submitted.

f) The referral was received by adult social care who contacted Sandra by telephone. She explained that she did not have any concerns and no further action was taken. This contact was not recorded on the social care database as a safeguarding concern.

g) On 21st February 2020, adult social care received a safeguarding referral from Sandra's housing provider. This related to the condition of Sandra's flat, specifically the lack of cleanliness and the volume of clutter that was preventing her from accessing some rooms. A social worker was appointed to conduct an assessment, that resulted in a support plan to improve the condition of her living accommodation. The assessment focussed on the issues of 'hoarding' and the cleanliness of Sandra's flat, rather than seeking to understand the underlying causes of these reoccurring issues. During the assessment the social worker identified that Sandra's son was living at her flat and that he was struggling with his own mental health difficulties. When this was raised with him, he stated that he did not need any support and whilst a safeguarding referral was considered, for this reason one was not completed.

h) As an outcome of the care assessment, it was agreed that a specialist cleaning company would be commissioned to conduct a deep clean of the premises. There were however difficulties in sourcing a suitable provider that resulted in delay and prevented a deep clean from being completed. Only a partial cleaning of the bathroom was achieved. On 3rd August 2020, the social care case was closed without having delivered the original objectives, nor the a long term plan to prevent the recurrence of safeguarding concerns.

i) On 28th April 2021, a safeguarding referral was submitted by the housing provider. This expressed concerns about the condition of Sandra's flat and that she was struggling to look after herself, being mainly confined to her bedroom. The social worker who had previously worked with Sandra in 2020, was appointed to conduct a further assessment. It was agreed that a deep clean of the

[2] Cuckooing' is when criminals target the homes of vulnerable adults so they can use the property for drug-dealing and other criminal activities.

flat would be completed, but due to the process of obtaining quotations this took six months to complete.

j) On 17th November 2021, a safeguarding referral was submitted by a member of Sandra's family, reporting that her son had assaulted her, stolen her money, and was hoarding his belongings in her flat. Following a review of the referral, a Section 42 safeguarding enquiry[3] was instigated and an action plan developed within the enquiry terms of reference. The case was subsequently allocated to Sandra's previous social worker and whilst regular contact was maintained by telephone, there were difficulties in visiting Sandra in person due to her reluctance to meet. This significantly delayed progress of the care assessment and completion of the safeguarding enquiry, which were not finalised before her death. The crime allegations were not reported to the police and a multi-agency strategy discussion was not considered.

k) On 12th January 2022, Sandra reported to her social worker that her son had been involved in a road traffic collision whilst driving her car and that the insurance company was now demanding a significant sum of money. The reasons for this demand were not explored or understood and a potential issue of financial abuse was not considered.

l) On 9th February 2022, the police received a crime complaint from a hire car company, reporting that a car provided to Sandra following the car accident had not been returned. The car was subsequently found in the possession of Sandra's son and returned to the hire company. The police databases were not researched in relation to those involved in this incident and therefore the safeguarding concerns from previous incidents were not identified. The potential that Sandra had been the victim of financial abuse by her son was not identified and a safeguarding referral was not considered.

m) Between November 2021 and June 2022, Sandra's case remained open and was managed by the social work assessment team. Consideration was given to the reallocation of Sandra's case to a different team for longer term services, however this was rejected until the care assessment had been completed and some support measures put into place. Despite regular management reviews timely progress of her case was not achieved and whilst regular telephone contact was maintained, she was never visited in person. Neither the Care Act assessment nor the Section 42 safeguarding enquiry was completed and the risks posed by Sandra's son never fully understood, preventing the development of an effective risk management plan.

n) On 6th June 2022, Sandra contacted her GP to seek treatment for an infected wound on her leg that she had injured in her home. She declined to attend the surgery for a face to face appointment and was prescribed antibiotics during a telephone consultation.

o) On 7th June 2022, Sandra's sister returned from holiday and visited her for the first time in two weeks. She was shocked at how Sandra's health had deteriorated over such a short period and also by the condition of her flat. She later told hospital staff that she believed Sandra had been neglecting herself and that her son, who lived with her, had also neglected her. Due to her medical condition an emergency call was made to the ambulance service. She was taken to hospital where her health continued to deteriorate and where she died on 12th June 2022.

p) At the time of their attendance, the ambulance service staff described the flat as being in a very poor condition. It was extremely cluttered to the extent that they had to remove items in order to gain access. Sandra was confined to her bed with limited mobility and they noted a lack of mobility aids installed in her flat. In addition to a badly infected leg, she had a number of infected

[3] Section 42 of the Care Act 2014. The duty of the local authority to conduct safeguarding enquires - https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

sores over her entire body. A safeguarding referral was submitted to adult social care to reflect the concerns of the ambulance service staff.

3. CRITICAL ANALYSIS AND LEARNING

During the learning event, the participants identified a number of multi-agency themes that affected the efficacy of support provided to Sandra. Each theme provides the opportunity for future improvement and is summarised within this section of the report alongside improvement recommendations.

Finding 1 – The Assessment of Safeguarding Referrals and Social Care Prevention Pathways

Learning:

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.

What Happened In This Case

Between 2013 and her admission to hospital in June 2022, Wokingham Adult Social Care received nine safeguarding referrals[4] about Sandra. Each was assessed by the duty 'Front Door' duty team[5], whose role is to conduct an initial contact assessment and to decide if further action is required. In many cases the duty team are able to immediately resolve issues and close the referral, whilst more complex cases are allocated to a social work team for further assessment.

Responses to the first six referrals were managed by the Front Door team, however the services offered to Sandra were not successful in delivering long term outcomes and this resulted in the recurrence of problems and repeated referrals. It was not until the seventh contact in February 2020, that a referral was allocated to a social work team for completion of a formal care needs assessment[6]. Despite the later safeguarding referrals being allocated to a social work team, safeguarding concerns continued to be raised. During the learning event two issues were identified that may improve the way in which referrals are assessed and responded to in the future.

A) The Assessment Of Referrals and the Consideration of Multi-Agency Information

During an initial assessment of the referrals, there had clearly been a failure to understand Sandra's circumstances and in particular the underlying cause of the safeguarding concerns. Instead of seeking to understand what was happening in her life, and to analyse why previous interventions had not provided longer term outcomes, the safeguarding response merely provided a practical solution to the presenting issues of hoarding and the condition of Sandra's flat. The fact that Sandra's son was a significant cause of her problems was not identified and therefore a critical and necessary aspect of any safeguarding plan was missed. As a result, concerns continued to be raised.

The lack of multi-agency information sharing at the point of assessing referrals was a contributing factor in preventing a holistic understanding of Sandra from being developed. Partnership agencies held information about the risk posed by Sandra's son and additional information that indicating that she would find it difficult to engage with any support offered. An effective information sharing process would have allowed all this information to be considered by the Front Door staff and for fully informed decisions to have been made. Whilst Wokingham Adult Social Care has clear procedures for the

[4] Safeguarding referrals - Procedurally referred to as 'contacts' by social care adult and children's services.

[5] Front Door – The point of entry for contacts and referrals to Adult Social Care services.

[6] Section 9 Care Act 2014 – https://www.legislation.gov.uk/ukpga/2014/23/section/9

conduct of formal multi-agency strategy discussions, these were not followed in Sandra's case and the review identified a need to ensure a greater consistency of their use.

B) Prevention Pathways and the Allocation of Cases

Between February 2020 and November 2021, three safeguarding referrals were allocated to a social work team for the completion of a formal care assessment. On each occasion these were allocated to a team whose role was to deliver short term services within a six to eight week period. Due to the nature of their role social workers in this team are required to manage a very high caseload typically managing between twenty to twenty five cases and receiving two new cases weekly.

Due to the complexities of Sandra's circumstances, the allocated social workers did not have the capacity to complete a high quality assessment and care plan within the six to eight week timescale. Each of the cases remained open for many months, eventually being closed without the intended services being fully delivered and without long term outcomes being achieved.

At the point of assessing subsequent safeguarding referrals, the Front Door team allocated them to Sandra's previous social worker for the continuity of relationships. Whilst the good motives of this allocation process are recognised, this merely repeated the mistake of allocating a complex case to a team who were not structured to manage it. During the final safeguarding case the team's manager held discussions to reallocate Sandra's case to a longer term team, however they declined to accept it until the Care Act assessment had been completed and support measures put into place. Sandra died without this being achieved.

<u>What's Needed To Deliver Future Improvement</u>

The assessment of referrals needs to be person centred, fully considering the person's relevant history and any relevant partnership information, seeking to understand the underlying causes of their needs. Each assessment should examine the outcomes of previous cases and seek to understand what worked well and what may need to be done differently to prevent further referrals. A key part of the assessment process should be the use of formal strategy discussions, with clear guidance provided to the 'front door' as to when they should be used. A programme of quality assurance is needed to ensure the consistent application of thresholds, linked to a performance dashboard that measures their use, timeliness, and the engagement of partnership agencies.

Safeguarding cases need to be allocated to a social work team which has the capacity and expertise to manage the specific case. In order to provide a continuity of service there should be an intention to prevent the unnecessary transfer of cases between teams, however pathways will always be needed to transfer cases if circumstances become more complex.

Wokingham Adult Social Care has already recognised these needs and is actively developing a new strategy for prevention pathways and procedures for the assessment and allocation of cases. This intends to ensure that the issues experienced by Sandra are avoided in the future.

Recommendation 1:	*Wokingham Adult Social Care should present to the adults safeguarding board its new strategy for prevention pathways, outlining how complex cases will be initially assessed and allocated to appropriate social work teams. Following this presentation, the safeguarding board should consider the development of a partnership data dashboard in relation to the consistent use and quality of multi-agency strategy discussions.*

Finding 2 – The Quality of Care Act Assessments and Management of Risk

Learning:

Social workers and managers need further guidance in how to prepare person centred Care Act assessments and safeguarding plans.

What Happened In This Case

Although cases progressed to the appointment of social workers and the completion of Care Act assessments, this still did not deliver successful long term outcomes for Sandra. In examining why it was clear that assessments and action plans again focussed upon the presenting issues of hoarding and the condition of the flat, rather than understanding and addressing the underlying causes. Whilst the risk posed by Sandra's son were known, this was not addressed and instead the social care response focussed upon a further clean of the flat. Sandra had informed professionals that her son was having a detrimental effect upon her and that she wanted this to change. If he had been provided greater support, whilst preventing him from residing in Sandra's flat, then this would likely have improved her wellbeing and helped to prevent the recurrence of safeguarding issues. At one point a safeguarding referral was considered for her son, however this was not done as he declined the support.

During their work with Sandra, social workers received reports of physical and financial abuse committed by her son and whilst the risks to her were known, these were not clearly articulated or effectively managed within a comprehensive risk management plan. In the latter stages of Sandra's life, she had withdrawn from personal contact with her social worker, who was not able to arrange a face to face visit. The risk of this disengagement was not fully identified and therefore a plan to manage it not developed. Whilst the social workers had never involved Sandra's sister in any care assessment planning, this may have helped to improve contact and manage the risks. Section 11 of the Care Act may also have been considered, which provides powers to support vulnerable people who refuse care need assessments.

Whilst working with Sandra the social workers did not have any concerns about her capacity to make informed decisions, but as she continued to disengage from their support a decision was taken to complete a Mental Capacity Act assessment[7]. The fact that safeguarding concerns continued to reoccur may have indicated that Sandra was not able to make effective decisions about her own care and the completion of a capacity assessment would have been appropriate. This was not however completed for two reasons: Firstly, the capacity of the social work team to actually meet with Sandra and complete the assessment, as fully outlined within Finding 2 of this report; Secondly there was a presumption that Sandra had full capacity and therefore completion of the assessment was not seen as a priority by the social worker.

Whilst the capacity of the social workers in the social work assessment team undoubtedly impacted upon the effectiveness of the social work, a number of key issues were also identified at the safeguarding review learning event.

a) Social workers do not have a consistent understanding of what high quality Care Act assessments and risk management plans should be.

b) Social work managers would benefit from further guidance in the supervision and closure of cases, to ensure that actions within plans are completed as intended and that long term outcomes are delivered.

[7] https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/#:~:text=

c) That there needs to be a greater consideration of multi-agency meetings to share information and develop comprehensive safeguarding and risk management plans. This issue is dealt with later in this report.

d) That where a pattern of reoccurring safeguarding issues exists, a Mental Capacity Act assessment should be prioritised.

What's Needed To Deliver Future Improvement

To improve the future effectiveness of social work, new guidance is needed for the completion of the Section 9 Care Act assessment and associated risk management plans. This guidance should include:

- How assessments are person centred, focussed on the underlying causes of concerns.
- How family and friends are engaged to support care act assessments and plans.
- The use of formal strategy discussions and multi-agency planning – including use of the voluntary sector and community support groups.
- How to manage cases of disengagement, including the escalation of activity in response to escalating risk. This should also consider how provisions within Section 11 of the Care Act may support a safeguarding response when a person refuses assessment and where a Mental Capacity Act assessment should be prioritised.
- Guidance for managers in the supervision and closure of cases.

Recommendation 2:	*Wokingham Adult Social Care should develop guidance for social workers and managers in relation to Care Act assessment and risk management plans. This guidance should include the use of assessments under both the Care Act (Section 11) and the Mental Capacity Act.*

Finding 3 – Multi-Agency Information Sharing and Planning

Learning:

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.

What Happened In This Case

The failure to make use of existing processes to share information and develop multi-agency planning was a theme throughout Sandra's case. This was evident within the initial assessment of referrals at the 'front door' and continued during Sandra's Care Act assessments. The social workers and managers who worked with Sandra identified the lack of strategy discussions and other multi-agency meetings as a key learning theme but were unable to say why at the time they had not considered their use. They were aware of the organisational policy and other partnership arrangements in relation to this but had simply not considered it.

The police and the health services had information that was not known to the social workers, which was therefore not considered when assessing Sandra's needs and in preparing risk assessments. Similarly, the social workers held information that should have been shared with other agencies, such as the commission of crimes against Sandra, the extent of Sandra's vulnerabilities, and the care needs of Sandra's son.

Had multi-agency meetings been held, then a holistic approach to Sandra's and her son's needs may have been taken, with a variety of agencies contributing to safeguarding plans. Social care and the health services may have supported her son, whilst the police and housing provider may have used their powers to ensure that he was removed from Sandra's flat. The GP could have flagged Sandra as vulnerable on the practice databases and utilised the practice care coordinator to provide Sandra with enhanced support and to support the social workers with the safeguarding plan.

What's Needed To Deliver Future Improvement

There are already a number of multi-agency processes available to professionals in Wokingham, that include both statutory safeguarding processes and other partnership arrangements. There is no requirement for the development of new processes, but there is a need to raise awareness of existing procedures and to ensure their consistent use when appropriate.

A multi-agency strategy discussion protocol would be useful to outline the threshold for discussions and help to clarify their purpose, whilst securing partnership agreement for agency participation. The development of performance data in relation to their use is discussed earlier in this report.

The participants at the learning event felt that it would also be useful to prepare a guide on the current processes for multi-agency planning, which should be promoted across the partnership. This should include statutory processes, for example the Community Mental Health Framework[8], and other partnership arrangements such as the Multi-Agency Risk Management[9] (MARM) framework. This guidance should also provide advice to professionals as to when referrals would still be appropriate in the absence of the person's consent. In this case a referral for Sandra's son was considered, but not submitted as he declined the support.

Recommendation 3:	*The safeguarding adults board should develop a multi-agency strategy discussion protocol. To outline the threshold for discussions, to clarify their purpose, and to outline arrangements for agency participation.*

Recommendation 4:	*The safeguarding adults board should develop guidance to promote the existing arrangements for multi-agency planning. This should include both statutory processes and other partnership arrangements. It should also provide guidance in relation to the submission of referrals in the absence of consent.*

Finding 4 – Developing Professional Curiosity

Learning:

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.

What Happened In This Case

Individual agencies have reflected upon their response to incidents involving Sandra and have identified how a greater level of professional curiosity by their staff would have helped to better

[8] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

[9] https://www.sabberkshirewest.co.uk/practitioners/marm-supporting-individuals-to-manage-risk-and-multi-agency-framework/

identify vulnerability and improve the submission of safeguarding referrals. Plans to deliver change are in place and as these are single agency improvement plans then there is no need to fully detail them in this report. They are however mentioned for context.

Thames Valley Police has previously identified that whilst dealing with incidents and investigating crimes, front line staff are not researching organisational databases to understand what is already known about those people involved, a process known as secondary investigation. This has led to the full context of incidents not being understood and people's vulnerabilities not being identified and responded to. This was a factor in Sandra's case which affected the submission of safeguarding referrals and the identification of potential criminal offences. Improvement plans are in place to address this issue.

The Southern Central Ambulance Service has identified improvements that would help their staff to better consider the needs of persons whom they respond to. Procedures are being developed to ensure that staff look beyond the presenting issues and try to understand the underlying causes in a person centred approach. This will help to identify vulnerability and improve the quality of referrals made to other agencies.

What's Needed To Deliver Future Improvement

As single agency plans are already in place, there is no need for this safeguarding review to make any further recommendations. The agencies involved may wish to consider how they update the safeguarding adults board with progress and the outcomes delivered by this change.

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Concluding Comments

This safeguarding adult review has identified key learning for the agencies within the West of Berkshire Safeguarding Adults Board, which provides an opportunity to improve the way in which they work together to protect adults at risk. The safeguarding partnership should now consider the recommendations outlined in this report and how they intend to deliver improvements to safeguarding practice.

Summary of Recommendations

Recommendation 1:	Wokingham Adult Social Care should present to the adults safeguarding board its new strategy for prevention pathways, outlining how complex cases will be initially assessed and allocated to appropriate social work teams. Following this presentation, the safeguarding board should consider the development of a partnership data dashboard in relation to the consistent use and quality of multi-agency strategy discussions.
Recommendation 2:	Wokingham Adult Social Care should develop guidance for social workers and managers in relation to Care Act assessment and risk management plans. This guidance should include the use of assessments under both the Care Act (Section 11) and the Mental Capacity Act.
Recommendation 3:	The safeguarding adults board should develop a multi-agency strategy discussion protocol. To outline the threshold for discussions, to clarify their purpose, and to outline arrangements for agency participation.
Recommendation 4:	The safeguarding adults board should develop guidance to promote the existing arrangements for multi-agency planning. This should include

	both statutory processes and other partnership arrangements. It should also provide guidance in relation to the submission of referrals in the absence of consent.