



Annual Report 2021-22

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Chair's Foreword



It is a privilege to introduce this Royal Greenwich Safeguarding Adults Board annual report and an honour to have been appointed its independent chair from October 2021. I must begin by paying tribute to the outgoing independent chair, Mark Godfrey. He has made a significant contribution to adult safeguarding in Greenwich but also nationally, not least in his emphasis on adult safeguarding in prisons and his work to include staff in custodial institutions in the governance of adult safeguarding and the multi-agency contributions of safeguarding adult boards. I have taken over leadership of a Board with a clear strategic plan and an effective approach to commissioning and completing safeguarding adult reviews, both of which are required by law.

In my first few months I met with every member of the Board to learn about what partner agencies felt was working well and where further improvements and enhancements were necessary. These meetings culminated in four recommendations to the Board, details of which are given in this annual report. Member engagement with me and partner support for the Board has been impressive, each of us supporting the work of the Board as critical friends and demonstrating what can be achieved for adult safeguarding through reflective appreciation.

I am pleased to report that a strategic executive has been established, as detailed in this annual report, which brings together the whole safeguarding system – adults, children, and community safety. There are issues and concerns that span all three safeguarding partnerships, namely domestic abuse, transitional safeguarding, young people, and adults who are carers, mental health, and embedding learning from domestic homicide reviews, safeguarding adult reviews, and child safeguarding practice reviews. Work is already underway to launch a think family – see the adult, see the child – protocol to ensure that practitioners across children's and adult services work collaboratively. Work is also underway to bring together and disseminate learning from reviews. I expect to see other joint initiatives unfold in 2022/23 and beyond.

A highly successful development event was held, as this annual report details. The Board's updated strategic plan and priorities can be found on its web platform. Members identified those topics and issues where the Board should seek assurance about the effectiveness of adult safeguarding and next year's annual report will provide details of the outcomes of this assurance activity, a central component of the Board's statutory mandate. The Board also agreed its priorities for the forthcoming year.

Chair's Foreword

Inevitably, an incoming independent chair will bring their own particular interests, but it has been heartening to see how my own have struck a chord with Board partners. We need to interrogate available data on adult safeguarding referred concerns and enquiries, to see where the system is working effectively and where improvements and enhancements can be made. Data analysis needs to include not just the work done within the local authority but also through the Clinical Commissioning Group, the Metropolitan Police and NHS Trusts. This work is underway, bringing together the quality assurance and performance reporting sub-groups.

The Board also needs to be assured that safeguarding adult practice is accessible to all the communities living in Greenwich. It is not unusual to find that the data on adult safeguarding referrals do not reflect the composition within a London Borough of different communities. Discussions have begun about how the Board can engage directly with communities, neighbourhoods, and faith groups, to raise awareness of types of abuse and neglect, and of adult safeguarding. The Board has already had a presentation from another Safeguarding Adults Board that has done successful work on engaging directly with citizens.

The forthcoming year will be challenging for all those involved with adult safeguarding. Adult Social Care departments will be inspected for quality assurance by the Care Quality Commission as a result of new legislation, the Health and Care Act 2022. This will include a focus on adult safeguarding. The same legislation will see Clinical Commissioning Groups replaced by Integrated Care Boards. The Board has sought assurance that place-based adult safeguarding will feature prominently in the new arrangements. Local authorities, NHS Trusts and other partners must also prepare for the introduction of Liberty Protection Safeguards and a new Code of Practice that accompanies the Mental Capacity Act 2005. There is nothing so permanent as change.

Finally, I would like to appreciate the contributions of Helen Bonnewell and Charlotte Reed who manage the business and administrative tasks of the Board efficiently and effectively. I would also like to acknowledge the work of practitioners and managers who are committed to keeping people safe in Greenwich.

Professor Michael Preston-Shoot
Independent Chair

What is the Royal Greenwich Safeguarding Adults Board?

The Royal Greenwich Safeguarding Adults Board is a **partnership** of agencies working across the borough. Its vision is to enhance the **quality of life, health, wellbeing, and safety** of adults at risk of abuse and neglect. It aims to enable people who need help and support to maintain **independence and wellbeing**; and to live a life that is free from **abuse and neglect**. Its role is to make sure local safeguarding arrangements are effective.

Under the **Care Act 2014**, the Safeguarding Adults Board has three core duties:

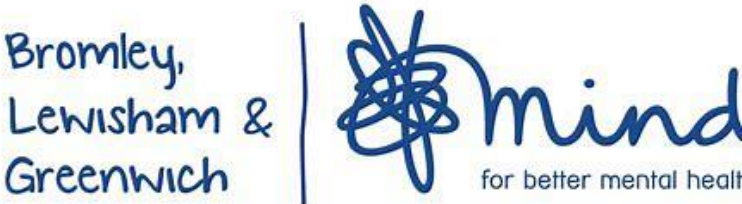
- ✓ Publish a **Strategic Plan** for each fiscal year that sets out how it will meet its main objectives and what the members will do to achieve these objectives.
- ✓ Publish an **Annual Report** detailing what the Safeguarding Adults Board has done during the year to achieve its main objectives.
- ✓ Conduct any **Safeguarding Adults Reviews**

The Safeguarding Adults Board was chaired by Mark Godfrey since 2015; however, this year a new chair has been appointed **Michael Preston-Shoot** who is **independent** of the Council and all the statutory and voluntary organisations in the Royal Borough of Greenwich.

The Chair reports directly to the local authority **Chief Executive** and meets regularly with the Senior Assistant Director, Health and Adults Services and other **key partners**. The **Board Manager** post sits within the **Safeguarding Adults Team** for the Royal Borough of Greenwich Council and is designed to ensure the Safeguarding Adults Board can confidently meet the requirements of the Care Act 2014 and deliver **better outcomes** for residents.

Members of the Board

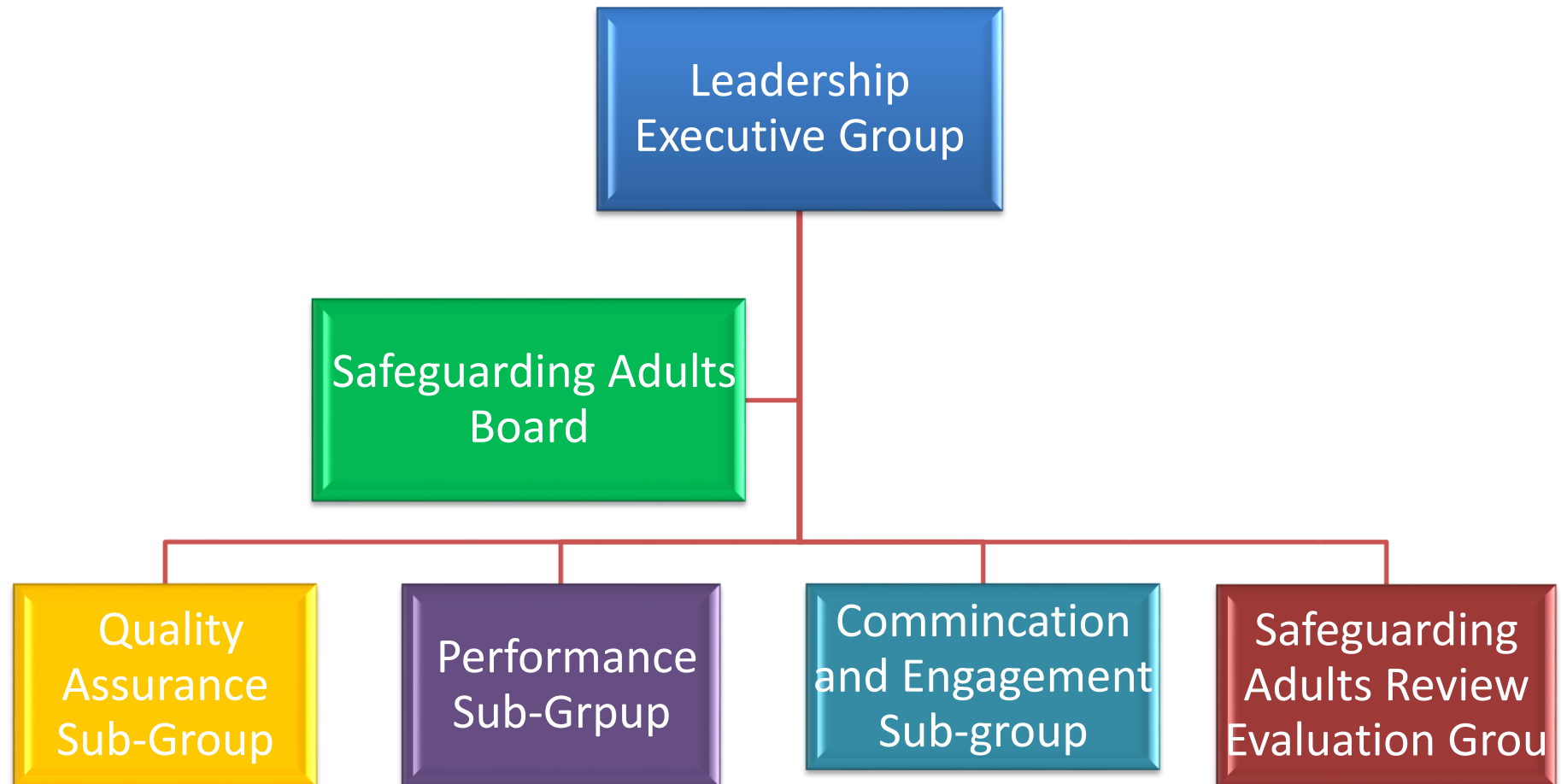
Lewisham and Greenwich 
NHS Trust



Royal Greenwich Safeguarding Adults Board Structure

The **work** of the Safeguarding Adults Board, including the work contained within the Strategic Plan, is **undertaken** by **sub-groups** with oversight from the Safeguarding Adults Board.

Different partners jointly chair sub-groups to ensure that there is **equal commitment** to achieving objectives.



Funding

Funding for the Royal Greenwich Safeguarding Adults Board is provided by the **partner organisations**.

The budget funds the cost of the **Independent Chair, Board Manager, Board Administrator and Safeguarding Adults Reviews**, along with the work of the Board in delivering the Strategic Plan. The budget for 2020/21 is detailed below

Royal Borough of Greenwich	• £34,500
Greenwich Clinical Commissioning Group	• £30,000
Lewisham and Greenwich NHS Trust	• £15,000
Oxleas NHS Foundation Trust	• £15,000
Metropolitan Police	• £5,000
London Fire Brigade	• £500

Links to other boards

The Royal Borough of Greenwich has a protocol for safeguarding partnerships which outlines the co-operative relationship between the **Greenwich Safeguarding Children Partnership, Safeguarding Adults Board, Health and Wellbeing Board and Safer Greenwich Partnership** to safeguard and promote the welfare of children and adults in the Royal Borough of Greenwich



The Safeguarding Adults Story in Greenwich



1166 contacts were raised by people **worried** someone might be at **risk of abuse**



217 of these contacts were **investigated** further and more **questions** asked.



49% of these contacts were about **neglect**



18% of these were about **financial abuse**



22% of these were for people from a **Black and minority ethnic** group



46% of abuse took place in the person's **own home**



Most referrals came from **Hospital**



97% of people felt their **outcomes** had been **met**

The Safeguarding Adults Story in Greenwich (cont.)

Royal Borough of Greenwich received 1,166 concerns this year. This is a 24% increase compared to last year.

- The four main referral sources for these concerns are: **hospitals, emergency services, Oxleas services and care providers.**
- Royal Borough of Greenwich started **217 enquiries** - a 4% reduction on last year. Therefore, the conversion rate dropped to 19% this year, compared to 24% last year.
- **221** enquiries were completed - a 18% reduction on last year.
- 49% of the completed enquiries were for **Neglect** cases and 18% were for **financial abuse**, which is more than last year.
- 46% of completed enquiries related to risks in the **person's own home**, which is more than last year.
- We have seen a reduction of cases happening both in care homes and in hospital. However, their proportions remain higher than the London average.
- **47% of risks were substantiated** (which means there is evidence to suggest that abuse occurred) – this is similar to last year (49%) and remains lower than London (67%).
- **94% of substantiated risks were removed or reduced.** The risk was removed in 35% of cases: this is an increase on last year (29%) and higher than the London average.

Safeguarding Adults Reviews (SARs)

The Royal Greenwich Safeguarding Adults Board has a statutory responsibility to undertake Safeguarding Adults Reviews under the Care Act 2014.

The Safeguarding Adults Review Evaluation Sub-Group meets to consider all referrals for potential Safeguarding Adults Reviews. Once a decision is made to undertake a SAR an independent reviewer is appointed.

The Safeguarding Adults Board has published **2** Safeguarding Adults Reviews this year, and 1 further review is in progress and will be published in 2022/23. There were 4 new case discussions for potential Safeguarding Adults Reviews considered by the Safeguarding Adults Evaluation Sub-Group during 2021-22.

The Board undertook **2** learning events across the partnership to disseminate and embed the learning from the Safeguarding Adults Reviews.

The Royal Greenwich Safeguarding Adults Board has published **2** Safeguarding Adults Reviews (SARs) this year

The SARs for Mr. G and Alexander are detailed on the next 2 pages

You can access the full Safeguarding Adults Reviews as well as the action plans by visiting our website

www.greenwichsafeguardingadults.org.uk

“Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult....Safeguarding Adults Boards must also arrange a Safeguarding Adults Review if an adult in its area has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect”- *Care and Support Statutory Guidance (updated Oct 2016)*



Safeguarding Adults Review - Mr. G

1- Background

Mr G was 62 and had lived alone in a first-floor council flat with no lift. Mr G was a wheelchair user and suffered from severe epilepsy following a brain injury. He was supported at home by his sisters, although neither lived locally and he had a package of home care. Mr G sometimes refused the daily home care, which he was offered from 2 different Home Care Providers and at times he was unable to allow carers access into his property. Mr G was found by his sister at home appearing to be barely conscious after a seizure. She called an ambulance and Mr G was admitted to hospital, where he was found to be suffering from pneumonia amongst other signs of possible neglect at home. Mr G sadly died within 5 days of being admitted to hospital.

2. Why was this SAR undertaken?

Section 44 of the Care Act 2014 (and the Care and Support Statutory Guidance 2016) states that a SAR must be arranged when an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

3. Findings and Recommendations

Where adults are housed in accommodation that they are unable to leave, due to a disability, this should be formally recognised as unsuitable and a priority for action by both Housing and Adult Social Care Departments

Adults with epilepsy require regular monitoring, at least annually (including blood tests) and case management, including home visits by Primary Care Services, in line with Nice Guidelines

4. Findings and Recommendations

There should be a more joined up approach to Police investigations alongside S42 enquiries.

Ensure links between physical health and mental health services to ensure difficulties are suitably assessed and managed in the community,

5. Actions to take?

A joint Social Services and Housing Complex Case Panel to be implemented where complex cases are brought to the panel to agree a shared action plan .

New tender for home care providers to address gaps in current provision.

6. Questions to consider

Are any challenges to someone's care at home being communicated and understood by the home care provider?

Have you considered someone's long term physical health condition as having an impact on their cognitive functioning?

How can you support someone in inappropriate housing with their application for suitable housing?

7. Further Reading

For more information and to read the full report and executive summary please visit

www.greenwichsafeguardingadults.org.uk

If you have any further questions please e-mail

safeguarding-adults-board@royalgreenwich.gov.uk

Safeguarding Adults Review – Alexander

1. Background

Alex was a 39yr old man. He was discharged from an in-patient setting into a 24 hour support living placement. Prior to this discharge previous attempts to support him in the community had not worked because he had failed to comply with his medication, broken placement rules and neglected his self-care and nutritional needs. Because of his complex needs and previous history of placement breakdown, he was placed in a neighbouring borough. Covid-19 restrictions meant he also had no face to face contact with family members during this period. He was admitted to hospital exhibiting signs of severe dehydration and malnutrition and passed away. A post mortem confirmed he had lost a significant amount of weight in the 8 weeks since his discharge. The cause of his death was a ruptured oesophagus (Boerhaave Syndrome), disseminated intra-vascular coagulopathy and urinary tract infection.

2. Why was this SAR undertaken?

Section 44 of the Care Act 2014 (and the Care and Support Statutory Guidance 2016) states that a SAR must be arranged when an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

3. Findings and recommendations

There should be more reference when care planning in relation to a person's ethnicity and cultural heritage.

The use of advocacy services should be explored further especially for those being placed out of borough

4. Findings and Recommendations

When risks are identified, the care plan should detail how those risks can be mitigated and what to do if risks are not reduced.

The Safeguarding Adults Board should seek assurance about how statutory partners will work collectively locally to increase the number of professionally qualified drug treatment staff

5. Actions to take

Greenwich safeguarding adults board to develop a self-neglect policy.

GSAB should seek assurance about how statutory partners will work collectively locally to increase the number of professionally qualified drug treatment staff

6. Questions to consider?

Is the GP fully engaged with care planning and the discharge process?
Have you considered how to mitigate risks of Self-neglect?
Have you considered involving an advocate?

7. Further Reading

For more information visit www.greenwichsafeguardingadults.org.uk. If you have any further questions please e-mail safeguarding-adults-board@royalgreenwich.gov.uk

Safeguarding Adults Review: Mrs A and Mrs B – Report and Action plan (July 2019) and Review (Oct 21)

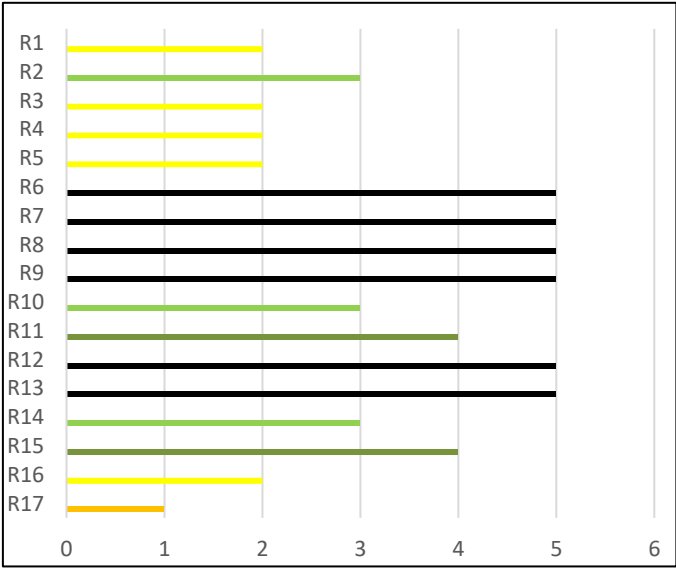
In February 2017 NHS England (NHSE) London and Royal Borough of Greenwich (RBG) Safeguarding Adults Board Commissioned a joint safeguarding adult review and independent mental health homicide investigation into the care and treatment of two mental health service users (Mrs A and Ms B) in South London following the homicide of Mrs A by Ms B in February 2016.

The terms of reference of the joint review required a follow up assurance review 12 months after publication of the joint review and investigation report. This was to provide an assessment of the implementation of the action plan. There were delays in undertaking this due to the pandemic and its associated pressures.

The report found there had been good progress made in relation to many actions, but there are still areas where actions have been started but not progressed substantially. The report gives suggestions for the agencies concerned in developing these actions. The assurance review focused on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report. Below is a summary of the recommendations and how they scored against the assessment category.

You can read the full report by visiting <https://www.greenwichsafeguardingadults.org.uk> (And selecting Safeguarding Adults Reviews)

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement



National analysis of safeguarding adult reviews

A national report was commissioned by CHIP - the sector-led Care and Health Improvement Programme, co-produced and delivered by the Local Government Association and the Association of Directors of Adult Social Services in England.

Authors: Michael Preston-Shoot, Suzy Braye, Oli Preston, Karen Allen and Kate Spreadbury.

This report presents the findings of the first national thematic analysis of published and unpublished safeguarding adult reviews (SARs) in England since implementation of section 44, Care Act 2014.

29 recommendations are made in the report.

On 15th July 2021 the Greenwich Safeguarding Adults Board undertook a development event in order to formulate an action plan of areas where Royal Greenwich could make improvements in relation to the recommendations of this report. A presentation was given by Professor Michael Preston-Shoot and the members worked in groups to discuss ways in which the board could implement the recommendations.

The Safeguarding Adults Board agreed out of the 29 recommendations there were 8 areas where it could implement actions to meet these recommendations, these included;

- Reviewing quality markers and methodologies
- Ensure ethnicity and other characteristics are included in the terms of reference
- Adopt a strengths based approach to focus on prevention
- Review information sharing protocol
- Identify and undertake thematic reviews
- Ensure learning is adopted from national and regional SARs



Safeguarding Adults Month (November 2021)

The Safeguarding Adults Board, in partnership with local organisations delivered a number of workshops for front line staff and voluntary sector colleagues, addressing some of the recurrent safeguarding adults' topics; these included:

- Domestic abuse
- Drugs workshop and accessing services
- Alcohol workshop
- Hate crime in relation to disability, race, and faith
- Modern Slavery and Human Trafficking
- Doorstep scams
- Fire safety awareness
- Safeguarding Adult Reviews (SAR) national analysis
- Safeguarding Adult Reviews (SAR) Local briefing
- Greenwich Mind services
- The role of the Approved Mental Health Professional (AMPH) as a safeguard to the Mental Health Act
- 2 Day Safeguarding Adults Manager (SAM) training
- A video screening of an honour-based violence documentary

"As soon as the workshop finished, I immediately called my client to offer her and her husband the service!"


"Every year I learn something additional, through these sessions. I will encourage colleagues to attend and report back to my line managers about what I learnt of interest."

Safeguarding Adults Month November 2021

A month of events and workshops to raise awareness of Safeguarding Adults within the Royal Borough of Greenwich for staff, partners and voluntary sector.

Unless stated otherwise please e-mail safeguarding-adults-board@royalgreenwich.gov.uk to book onto any event you are interested in attending, bookings will be made on first come first served basis.

Please note unless stated otherwise all talks will be via Microsoft Teams.









Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4	5
10am - 12pm Domestic Abuse Workshop (Various types of Domestic Abuse, signs & symptoms, Myths explored, how to approach the subject, how to support, Services in the borough, Legal protections)	10am-12pm - Drugs Workshop by Westminster Drug Project 2pm-4pm Accessing Services Easily workshop by Westminster Drug Project	2pm - 3:30pm Analysis of Safeguarding Adults Reviews by Professor Michael Preston-Shoot	Public Event Woolwich Centre Library - Come join us for information and advice	10am-12pm Memorial Hospital - Drugs Workshop by Westminster Drug Project 2pm-4pm Accessing Services Easily workshop by Westminster Drug Project Please note these workshops will be an in person event held at the Memorial Hospital.
8	9	10	11	12
2pm-4pm Understanding the Multi-Agency Risk Assessment Conference (MARAC) process- Greenwich Safeguarding Children's Partnership (see below for booking details)	12pm-1pm Murdered By My Family Banaz: An Honour Killing (Crime Documentary video screening)	10am to 11am Deaf Awareness session	10am - 12pm Doorstep scams Workshop- Trading standards	9am - 11am Domestic Abuse workshop (same workshop as 1 st Nov)
15	16	17	18	19
	9:30am-12pm Working with Parental Substance Misuse Greenwich Safeguarding Children's Partnership (see below)	10-12- The role of the AMPH as a safeguarding to the Mental Health Act- Ockbrook Mental Health Foundation Test 11am - 12:30pm Hate Crime Workshop (race/faith)- Greenwich Inclusion Project	2pm-3pm Mental Health Act Section 117 After Care and prisons Ordinary Residence- RSO Legal services	10am to 11am Fire safety workshop- London Fire Brigade. Aimed at front line staff and Housing
	10am - 12pm Alcohol workshop Westminster Drug Project 12pm - 2pm Modern Slavery and Human Trafficking Workshop- Safer communities 2pm-4pm Alcohol Workshop- Westminster Drug Project	2pm-3pm Disability hate crime Workshop- MehoGAD		2pm-3pm-Greenwich Mind overview and services
22	23	24	25	26
	10am to 11am London Fire Brigade- Fire safety workshop- Aimed at front line staff and Housing 2:30pm - 4pm Safeguarding Adults Review learning Event- Examining the learning from published SARs in Greenwich	2pm-4pm Safeguarding Adults Basic Awareness	2 Day Safeguarding Adults Manager (SAM) multi-agency training- All day 11am - 12:30pm Hate Crime Workshop (race/faith)- Greenwich Inclusion Project 3pm - 4:30pm Doorstep scams workshop- Trading standards	2 Day Safeguarding Adults Manager (SAM) multi-agency training- All day 9am - 11am Modern Slavery Workshop Human Trafficking Workshop- Safer communities' team

For Greenwich safeguarding childrens Partnership sessions please book via greenwichsafeguardingchildren.org.uk

Safeguarding Adults Month (cont.)

This is the first year there has been a joined-up approach across South East London Safeguarding Adults Boards for Safeguarding Adults week (15th-21st November).

All 6 South East London Boroughs (Greenwich, Bexley, Lewisham, Southwark, Lambeth and Bromley) produced a Programme of events to be shared across partners. This opened up a huge range of topics and an opportunity to learn from neighbouring boroughs, one of the benefits of holding virtual event

						
Tuesday 16 November	12:00-13:00 PREVENT – The Impact on Vulnerable Adults Rob Vale LBB BOOK HERE	09:30-12:30 Cultural Competency Anita Eader SSAB Practice Review & Learning Manager BOOK HERE	09:30-12:00 Working with Parental Substance Misuse Greenwich Safeguarding Children's Partnership BOOK HERE	10:00-11:00 Making Safeguarding Personal Anu Singh Lambeth SAB Chair BOOK HERE	13:00-16:00 Responding to Sexual Violence Workshop Alexandra Duffy Rape Crisis BOOK HERE	14:00-16:00 Safeguarding People with Multiple Disadvantages Taye Training BOOK HERE
	13:00-14:00 Work of the Bromley Safeguarding Adults Board Bulent Djouma SSAB BOOK HERE	10:00-12:00 Safeguarding Adults at Risk Training for Managers and Designated Safeguarding Leads Ann Craft Trust BOOK HERE	10:00-12:00 Alcohol Workshop Westminster Drug Project BOOK HERE			
		13:00-16:00 Online Grooming and Sexual Abuse: A Personal Account Seminar Ann Craft Trust BOOK HERE	12:00-14:00 Modern Slavery and Human Trafficking Workshop Safer Communities Team BOOK HERE	14:00-15:30 Safeguarding Adults: Cuckooing (for Voluntary and Community Sector) PC Daniel McLynn BOOK HERE		
			14:30-16:00 Alcohol Workshop Westminster Drug Project			



The Safeguarding Adults Board also organised a public library event which took place at the Woolwich Library. The board invited several partner agencies to join the initiative, by raising awareness around recurrent safeguarding and social care issues. Colleagues from local domestic abuse service, trading standards, fire brigade, and local voluntary organisations joined us and spoke to members of the public and professionals. Each agency brought along information sheets and leaflets, and spoke about the support their organisation can provide, pathways of referral and outcomes.

Overall feedback was positive from members of the public and from professionals, who were enthusiastic and receptive about the event. The networking between organisations has also led onto further joined up working opportunities.

We also showed the two domestic abuse videos, on the big screen in General Gordons square. These were shown multiple times each day to raise awareness of domestic abuse and how to get support as we are aware of the increased levels of domestic abuse as a result of the pandemic.



Research study: Responses to self-neglect and hoarding behaviour among older people: What works in practice?

A team of independent researchers at King's College London and the London School of Economics, and supported by colleagues at Age UK London, is undertaking research into responses to self-neglect and/or hoarding behaviour among older people. The research is funded by the National Institute for Health and Care Research School for Social Care Research. Aim of the explorative study is to improve understanding of what works in practice when supporting older people who hoard and/or self-neglect.

As part of the study, the research team has interviewed leads of adult safeguarding and senior managers in 31 Safeguarding Adults Board (SAB) areas and undertaken additional interviews with 93 managers and frontline staff employed by agencies and organisations represented on SABs in six areas. The team also conducted interviews with older people with lived experience and relatives and carers. The Royal Greenwich Safeguarding Adults Board has been selected as one of the areas involved in this research

Another aspect of the study was in-depth review of international research literature on self-neglect and hoarding behaviour. Finally, the research included exploratory evaluation of the economic impact of self-neglect and/or hoarding behaviour among older people. The research is ongoing and will be completed in July 2022. This study will also inform the ongoing work improving services in the Royal Borough of Greenwich.

More information about the research and published outputs can be found on the study website:

<https://www.kcl.ac.uk/research/self-neglect-and-hoarding-among-older-people>



Case Study – Keith

Keith is being used as a fictitious name to ensure confidentiality and protect the identity of the adult concerned

Keith is a 38-year-old Black, British African man who received services from the Oxleas Intensive Case Management in Psychosis Team. He suffered from a psychotic illness in relation to drug and alcohol misuse, had a long history of sporadic engagement, displayed a significant level of social dysfunction and a chaotic presentation. This included being taken to hospital after collapsing in a public place. Keith said that his flat had been taken over by a group of local youths, whom he later described as drug dealers. The youths had a key to his flat and had gained entry, bringing in their own sofa and TV. Keith was unable to say how the key was obtained, but the youths were smoking cannabis and he told his mother that he did not want them there.

Keith's mother raised a safeguarding adults concern with the police and the Mental Health services. His care coordinator discussed this with the Multi-Disciplinary Team, then raised a Safeguarding Adults Concern. She reported this to the team Safeguarding Adults Manager (SAM) who decided that the matter met the threshold for an Enquiry under s42 of the Care Act 2014. The SAM advised that the matter should be brought to the Cuckooing Panel. This is held at the Local Authority and comprised of representatives from the relevant agencies, including the police and housing team.

The care coordinator took Keith's concern to the Cuckooing Panel and the Royal Borough of Greenwich housing tenancy support officer helped with his move to temporary accommodation. The police officer at the Cuckooing Panel provided a letter of support for the move. This was a vital element in supporting a rapid move on, due to the nature of the risks of this "mate crime" to Keith. Keith was later supported to move to a new address thanks to the proactive intervention by the cuckooing panel and has since moved on from mental health services. His CCO completed the s42 Enquiry and reported back to the SAM for completion of the safeguarding and review of the plan. Keith felt much safer and happier in his new accommodation. The proactive intervention by multi-agencies from the Housing team, mental health teams and Police working together meant Keith was quickly supported and made safe.

Case Studies- Ellen

Ellen is being used as a fictitious name to ensure confidentiality and protect the identity of the adult concerned

Ellen is a 74-year-old white-British lady who was living on her own in a 3-bedroom house that she owned. Ellen's only family was a niece who resides overseas and a nephew who lived in another borough. Ellen suffered a fall at home which resulted in a hospital admission and concerns raised about her reduced mobility and poor nutritional intake. Ellen contacted her nephew whom she had not seen for several years and asked for support. The nephew came to stay with Ellen, and this is when professionals became concerned for her safety and wellbeing. Ellen's nephew quickly started to display controlling and aggressive behaviour towards Ellen and to professionals (i.e., Social Care assessors, dietician, Physiotherapist, therapist assistant, carers). The case was re-allocated to a Level 2 social worker.

The level 2 social worker was aware that the nephew would not allow professionals to speak with Ellen on her own, therefore she visited with a colleague who completed a carers assessment with the nephew in another room and the social worker used a visual aid to ask if Ellen was feeling safe and if she needed help. Ellen repeatedly told the social worker she was safe but would state "he is verbally volatile towards me." The Social worker decided to build a rapport with Ellen by visiting her each week over a period of 8 weeks. During this time, the nephew cancelled all care, took away all walking aids and was controlling what Ellen ate, including taking away her ensure drinks. She was declining physically and began to look frail and timid. The Social Worker put in a protection plan with Ellen's consent to have a carer take her out in the community once a week, away from the nephew, this enabled the social worker to meet with Ellen without her nephew's knowledge and week after week she started to open up. Ellen case was presented to the Multi-Agency Risk Assessment Conference, and she was assigned an Independent Domestic Violence Advocate. Eventually Ellen disclosed, verbal abuse, physical abuse, threats with a knife, financial abuse, coercion & control, and emotional abuse. Ellen agreed to be placed in a residential placement for her safety and consented to report the matter to the police. Ellen later learned that her nephew had previously been jailed for bank card scam against pensioners, this is when she finally disclosed financial abuse.

The nephew was eventually arrested for the abuse against a vulnerable adult. Ellen made the decision to remain living in a residential care home and has since sold her home to fund her placement. She has since appointed a Power of Attorney of her choosing, she is doing well, remains safe and has no contact with her nephew.

Case Studies- Amma

Amma is being used as a fictitious name to ensure confidentiality and protect the identity of the adult concerned

Amma is a 36-year-old Black African woman with a mental health diagnosis. Amma disclosed to the Police that her husband had assaulted her and threatened her with a knife by pointing it on her side, this was after reports of screaming from her property. She was unable to show any injuries stating it was because she had applied cream after a bath. The case was referred to a Multi-agency Risk Assessment Conference. A month later Amma was seen by the hospital social worker after being admitted under the Mental Health Act and disclosed that her partner had physically assaulted her at the beginning of their marriage more than once. She stated that he no longer physically assaults her but punches the walls at home. Amma stated that at times her husband used to come home for a few hours, give her money, then leave and she believed him to be seeing other partners. He restricts her mobile phone use when she is talking to family by taking the phone from her. Amma stated that he earns a lot of money from his job and does not want her to work and that he owns the house. He makes her delete her emails and has destroyed her bank cards. Amma said her husband “used a pillow to compress my neck” showing a bruise. He has threatened to kill her mother, and she said she believes him as he would cut himself in front of her and told staff that she had done this to him when he attended hospital. Amma alleges that he uses her mental health diagnosis against her.

A meeting was convened with an Independent Domestic Violence Advocate (IDVA) and the Enquiry Officer. The IDVA completed a risk assessment. Amma wanted to not rely on her husband for financial support, to receive benefits in her own name and to not return home to an abusive relationship. The Enquiry officer completed a CAT 1 housing form which was sent to RBG housing who were informed of her discharge date. Amma was assisted to obtain temporary accommodation outside of the borough due to the domestic violence on discharge from hospital. The Housing Support Worker also supported Amma to get emergency funds for bedding, etc and to apply for state benefits.

Amma continues to engage with the community mental health team and is being supported to bid for a property to hold her own tenancy.

What's Next?

The new Safeguarding Adults Board independent chair met with all members of the board as part of his induction to establish areas that were working well and where they thought improvements could be made. As a result of these meetings the independent chair made the following four recommendations to the board

Recommendation One: that the SAB mandates the Board chair to work with the Safeguarding Children Partnership and Safer Communities Partnership to establish a strategic executive.

Recommendation Two: that the SAB uses the next development/challenge event to review expectations of Board membership and attendance, one option being to have a smaller core group with agenda set well in advance when additional members are asked to attend.

Recommendation Three: that the SAB uses the next development/challenge event to review its sub-groups.

Recommendation Four: that the SAB uses the March meeting and the next challenge/development event to review the outcomes of its strategic plan and project work, and to renew its objectives and action planning for 2022/23.

All four recommendations were accepted. A strategic executive has now met and is agreeing priorities that will be pursued jointly in 2022/23, beginning with thinking family – see the adult, see the child. A development/challenge event was held and is discussed next.



Development Event

On 10th March 2022 the Safeguarding Adults Board held a development event with partners to identify areas of good practice and areas of challenge that can feed into the board's strategic plan for next year. Each partner was asked to complete an Audit tool. The analysis of the audit tools showed that:

- No Red areas reported
- Each partner identified challenges for the coming year
- An agreed area of challenge was to ensure we embed and share learning from Safeguarding Adults reviews

	A1	A2	A3	B1	B2	B3	C1	C2	C3	C4	D1	D2	D3
Royal Borough of Greenwich Health and Adult Services													
Oxleas NHS Foundation Trust													
NHS Southeast London CCG (Greenwich)													
Lewisham and Greenwich NHS Trust													
Westminster Drug Project							NA	NA	NA	NA	NA	NA	NA
Greenwich MIND								NA	NA	NA	NA	NA	NA

Areas of good practice	Areas of challenge
Good examples of how partners worked together during the pandemic	Implementation of Liberty Protection Safeguards (LPS)
High risk register and monthly review meeting	Resetting business as usual after the pandemic
Updated Safeguarding policies and training	Impact of Mental Health as a result of Pandemic
SAR Learning being disseminated	Pressure care/ Self neglect
Amended/ updated safeguarding forms to ensure making safeguarding personal	Think Family- implementing think family approach across providers
Responding to emerging trends	Increase of statutory reviews and pressure on services to imbed learning

Development Event (cont)

At the development event partners identified the following achievements over the past year

- Produced a Prevent leaflet
- Undertook 2 Safeguarding Adults Reviews
- Joined up approach with Southeast London Safeguarding Adults Boards
- Further engagement work with the GPs through designated Adult GP
- Established stronger links across adults services and Housing
- Adult Social Care and Children's Social Care undertook some focused work to respond to concerns that related to child deaths where there was a parent or carer with Mental Health support needs. There was awareness raising for practitioners and this has also fed into the see the adult see the child think family approach

The following areas have been highlighted as priorities for 2022-23 and will form part of the refreshed strategic plan.

Developing a pressure ulcer prevention strategy

Expand user engagement across the borough

Monitoring the use and quality of advocacy

Share the learning from statutory reviews

Create a cross cutting executive to agree strategic objectives and opportunities for shared working and learning

Ensure there are mechanisms in place to enable timely and appropriate feedback from S42 Enquiries raised by partners.

Stop Modern Slavery!

Modern Slavery is the **trafficking of people**, different types of **exploitation**, **forced labour** and **domestic servitude**

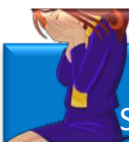
Trafficking



This is where children and adults are brought to the United Kingdom, often coerced or deceived by being promised a better life, only to be sexually exploited or forced to work for little or no pay

Trafficking can similarly occur where people in this country are taken to other countries

Exploitation



Sexual Exploitation can happen to children and adults. It includes physical abuse and sexual abuse, prostitution and making child abuse images and videos

Criminal exploitation is where someone is made to commit a crime such as pick-pocketing, shoplifting, drug trafficking etc. There are also other forms of exploitation such as forced marriage, forced benefit fraud, organ removal, forced begging and illegal adoption

Forced labour



This is where people must work long hours for little or no pay in poor conditions, and are often physically and/or verbally threatened with violence, or told that their families will be harmed

This can happen in lots of different jobs including building, manufacturing, catering, food packaging, farming and beauty treatments. Often there are lots of people all housed together

Domestic Servitude



This is where a person is forced to work, normally in someone else's home, doing household chores and caring for children

They may not be allowed to go out and often work long hours for little or no pay. 25% of reported victims of domestic servitude are children

How you can help us to stop it

If you think that you have seen someone or a group of people in Greenwich who you think might be a victim or victims of modern slavery, we are asking for your help to stop it.

Please telephone the Council or the Police (the telephone numbers are on the last page of this report). If you would like some more information about modern slavery; we have put some short films on our Safeguarding Adults Board website. www.greenwichsafeguardingadults.org.uk

Domestic Abuse



In England and Wales, one in four women and one in six men experience domestic abuse in their lifetime. In the Royal Borough of Greenwich, **over 23,000 women have experienced domestic abuse since the age of 16.**

Anyone can be affected by domestic abuse regardless of gender, age, ethnicity or sexuality. The most common type of domestic abuse occurs in relationships, although it also can happen between family members. Domestic abuse is an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour including sexual violence. There are different kinds of abuse but it's always about one person having power and control over another person.

If you or someone you know may be suffering domestic abuse, the organisations below provide support:

Greenwich Domestic Violence and Abuse Confidential Helpline – Telephone: **020 8317 8273**

National Domestic Violence and Abuse Helpline – Telephone: **0808 2000247**

Her Centre – Telephone: **020 3260 7772**, Legal Advice on 020 3096 6843 (domestic abuse matters)

or for in-person support go to the drop-in service on Fridays 10am-12pm at Woolwich YMCA SE18 5QG

Victim Support – Telephone: **0808 1689 111** or Victim Support line 24/7 – **020 8801 1777**

Men's advice line – Telephone: **0808 801 0327**

National LGBT helpline – Telephone: **0300 330 0630**

If you need urgent help and/or are concerned for your own or someone else's safety, call the Police on 999

Visit

www.greenwichsafeguardingadults.org.uk

to view the Safeguarding Adults Board
Domestic Abuse videos produced with the
Metropolitan Police

Getting Involved

If you **live** in the Royal Borough of Greenwich and would like to **become involved** in the work of the Royal Greenwich Safeguarding Adults Board, we would like to **hear from you**. Our Safeguarding Communication and Engagement Group provide an opportunity for residents and people who have used safeguarding services to **share** their **stories and views**. This helps other people **stay safe** from abuse and neglect and helps the Safeguarding Adults Board to **improve** safeguarding services.

If you would like to get involved, **please contact us** via safeguarding-adults-board@royalgreenwich.gov.uk

Tel: 0208 921 2378

Royal Greenwich Safeguarding Adults Board
The Woolwich Centre, 2nd Floor
35 Wellington Street
London
SE18 6HQ



Concerned about an adult at risk of abuse?

If a person is in **immediate danger** call **999** and alert the police. If you suspect a person is at risk of abuse or is being abused, **report it to the**

Contact Assessment Team.

- Phone: **020 8921 2304**

- Out of hours: **020 8854 8888**

- Email: aops.contact.officers@royalgreenwich.gov.uk

The Contact Assessment Team will put you in contact with the appropriate service or direct you to the right organisation

The switchboard is open 24-hours a day, seven days a week. Anyone who is concerned that abuse may be taking place or feels they are subject to abuse themselves should seek help.

For more information visit our website:

<https://www.greenwichsafeguardingadults.org.uk/>

Or the council's website:

<https://www.royalgreenwich.gov.uk/>