Darlington Safeguarding Adults Partnership Board

Learning from National and Regional Safeguarding Adult Reviews and Lessons Learned Reviews

March 2017

CASE	Learning
Purbeck Serious Case Review: Dorset SAB (2014) Residential setting for people with LD and an enquiry in respect of physical and verbal abuse/self- harm/financial abuse, violence, lack of health care.	• Training for staff and managers in identifying signs of abuse needed to be improved • Multi Agency Safeguarding procedures were difficult to follow • Safeguarding Database needs to ensure that there are search parameters for care home addresses • Services need clear rules about whistleblowing • CQC and local commissioners need to share information • Every resident needs access to Advocacy • Large numbers of people with complex needs living in big group homes is not necessarily a good thing. Residents were isolated and unable to use facilities in their community • It can be better to arrange and cheaper to arrange care in a 'person centred way' and there need to be smaller specialist homes for people with complex needs. • Commissioners need to be aware of how homes are managed
Sunderland SAB SCR (November 2014) A vulnerable Adult suffered sexual abuse and neglect for a number of years by a registered sex offender who had been present in his life since he was a child	• Lack of identification of safeguarding concerns by a number of professionals • Lack of knowledge/clarity around Safeguarding process amongst professionals such as school nurse/teaching staff/GP/Adult Services • Transition Process: Service user was not was not subject to Local authority Transition process and had not been considered a child in need • Lack of clarity regarding the undertaking of capacity assessments and best interest decisions (no formal capacity assessment was undertaken and there were differing views across agencies as to whose this responsibility would be). • Advocate not instructed • There needs to be clear procedures in respect of unexplained injury: Service user

	was examined by GO at request of ASC but GP did not think it their role resulting in a delay in obtaining forensic and medical evidence. Staff were unaware of existence of the SARC •
Somerset Safeguarding Adults Board February 2016 A young woman with learning disabilities was thought to be a victim of domestic abuse and sexual exploitation	• Failure to recognise key features of sexual exploitation including coercion and control, disclosures and retractions • Failure to recognise early signs of domestic abuse and failure to engage mainstream provision on behalf of the service user to address domestic abuse • There was an ill-informed assumption of capacity and a failure to implement formal tests of mental capacity in relation to specific and serious decisions. Robust capacity assessments are critical in determining the approach to be taken by professionals either to support the decision making of a capacitated adult or to intervene to protect the interests of the person who lacks capacity • Failure to see that the service user was a vulnerable adult or a person with 'care and support needs'. • There was a failure to keep the service users history in mind. • A chronology would have been helpful • There was no effective transition • Think Child, Think Parent, Think family Parenting Capacity is best assessed with the joint input of workers from adults and children's services

Nottingham Safeguarding Adults Board SCR (2011) A young adult dies of natural causes as a result of sudden death in epilepsy (SUDEP). The SCR found there were a number of areas where services could be improved.	• The need for much improved communication and information sharing across agencies • Need for increased awareness of adult safeguarding for all young groups • Young people and adults to be placed at the centre of assessments and care plans and their views actively sought • Need for increased awareness of Adult Safeguarding was highlighted • A transition Policy and procedure is required for young adults moving from Children's to Adult Services • A greater level of understanding of SUDEP is required
Essex Safeguarding Board (2012) Case involving self- neglect where an 89 year old lady who was viewed as 'cantankerous' and who consistently refused care whereby she was found in her home curled in the foetal position covered from neck to toe in faeces and urine	• The need for clear guidance on managing self-neglect in the context of mental capacity and best interests. • Better understanding of the MCA by agencies , particularly GPs, specifically as in this case where there was confusion between the application of the Mental Capacity Act and the Mental Health Act
Northamptonshire SAB (2009)	• Guidance should be provided to professionals on identifying and raising

Vulnerable male had Downs Syndrome, learning disability, epilepsy and complex needs and lived in a residential setting. He died unexpectedly whilst in hospital	Safeguarding concerns in regulated settings including hospitals • Safeguarding investigations should consider the risks posed to other vulnerable adults in any situation and not just to those who are the subject of the investigation. • Individual workers should have access to clear information explaining how to escalate concerns about care within or across agencies where concerns initially raised are not acted on. • Guidance should be provided about how safeguarding investigations apply where the individual has died.
Bristol Safeguarding Adults Board (2016) Male aged 61 known to Mental Health Services, Housing Services, Police, Primary Care and latterly Fire and Rescue services and Adult Social Care died in a fire at his flat in Bristol. The subject suffered from bi –polar disorder, used cocaine, had a propensity to start fires and self-neglect was evident. He was articulate and resistant to accepting help.	• More needs to be done in terms of helping staff develop a better understanding of the respective roles and responsibilities of partner agencies, for example members of the Housing team were unaware of the best way to approach Mental Health Services in order to get support for Mr C's mental health issues. • Because Mr C was articulate and resistant to receiving help staff seem to have taken his reassurances at face value but greater knowledge and understanding of capacity issues may have given staff greater confidence to try and work around Mr C's resistance. Mental capacity as an issue is mentioned but understanding the complexities of the concept appears under developed. People having direct contact with Mr C were too ready to accept his verbal reassurances about his well- being and ability to cope and did not ask Mr C to demonstrate how he was coping. The history of professional's interactions with Mr C shows possible deficiencies in the ability, confidence or willingness of professionals to challenge. • Strong multi agency protocols for working with people who self-neglect are needed with a view to promoting robust and consistent joint agency work, with action plans and strategies and programmed follow up when working with an individual who has a chronic mental health condition and who self- neglects and one with whom it is difficult to engage. The current trend for agencies to adopt a 'one touch' approach in

	dealing with requests for assessments with a view to swift onward referral to an alternative appropriate provider needs to be critiqued in the light of the disjointedness and lack of follow up that occurred in Mr C's case. • Mr C's circumstances were seen as a lifestyle choice but insufficient attention was paid to the threat his behaviours posed to others particularly in relation to the accumulation of rubbish in his flat and the propensity to start fire. This behaviour, in conjunction with his diagnosis of bi polar disorder should have lead to a thorough assessment of his mental capacity. The impact on others needs to be considered as a key part of assessing that appropriate response to the presenting situation. • The ability to challenge: Staff did not receive support or recognise the need to work more assertively in the light of the level of self-neglect and within the context of Mr Cs mental health issues.
Somerset Safeguarding Adults Board (February 2016) Ms C is a young woman with learning disabilities thought to have been the victim of domestic violence and sexual exploitation perpetrated by her partner Mr H who had a history of sexual offending.	• Failure to recognise key features of sexual exploitation, including coercion and control, disclosures and retractions: • Recognising the early signals of domestic abuse and failure to engage mainstream provisions to address domestic abuse • Capacity and the Mental Capacity Act: in some cases there will be genuine doubt about capacity. These situations are complex and need to be carefully assessed and the individual may need to involve advocacy. Robust capacity assessments are crucial • Failure to see that Ms C fell into the category of a Vulnerable Adult • Keeping a person's history in mind: • Effective person centred transition: Important information did not travel with these

	clients and salient parts of their history was lost or distorted including key assessments. There is a lack of effective planning for people using children's services who are approaching adulthood. Looked after children, young people with disabilities and carers are often amongst the groups of people with the lowest life chances • Think Child Think Parent Think Family: the well-being of children and families is best delivered through a multi- agency approach with different services working together. Children's Social Workers must know that they can make safeguarding adults alerts when face with any situation where n adult with care and support needs is deemed to be at risk in their own right. Consider the child behind the adult/the adult behind the child.
Somerset Safeguarding Adults Board (June 2016) In his early twenties Tom sustained a traumatic brain injury in a road traffic accident. He became a care giver for his partner who had also sustained a brain injury. He began to abuse 'hazardous substances' and his ability to sustain his relationship and continue in his role of carer deteriorated. Tom took his own life in 2014 aged 43**.**	• Supporting people with brain injuries: Capacity assessment: When people present with problems and ask for help they may not indicate that they have brain injuries and too often brain injuries are not identified. Brain injuries are complex and those that occur during childhood are different to those acquired in adulthood. • The fact of a brain injury is so critical that it must feature in assessments. • There was an assumption of mental capacity • Advocacy is crucial • Working with people with multiple and complex needs across a range of agencies requires coordinated assessment, care management and working with risk of harm together. There was no collaborative working within and across service provision. Assessment processes were not integrated and had no impact on inter agency working. • Think Family: Family involvement and that of significant others should be prioritised. It is clear that had professionals worked more closely with his family Tom's suicide

	could have been prevented.