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What is a Safeguarding Adults Review?

A Safeguarding Adults Review is held when an adult in the local authority area dies as a result of abuse or neglect whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult or when an adult in the area has not died, but the SAB knows or suspects that the adult has experienced significant abuse or neglect. The purpose of a Safeguarding Adults Review is to learn the lessons about how professionals and organisations work together and to consider how the learning can be used to improve practice for others in the future.

02 What happened?

Lola was brought to A&E in a severely emaciated state, she was put into an induced coma in the intensive care dept. Lola had lived with her mum and her partner, sister, and aunt. She spent time with grandmother who lived next door. SYP commenced an enquiry into the role of her family in possible Wilful Neglect. Prior to this concerns had been raised by Barnsley College about Lola's health and recurrence of head lice. That missed opportunities to raise concerns were noted by the GP, Hospital, Children's Social Care and out of hours GP services. Lola has a learning disability diagnosis and will struggle to make many decisions

03 Terms of Reference

1. Did organisations comply with requirements and practice detailed in both single agency and multi-agency policies, including sharing information with other organisations?
2. Was practice in line with the Mental Capacity Act and Making Safeguarding Personal. Was the issue of duress considered?
3. Was Lola eligible for transitional support? If so, did she receive appropriate support? If not, would she have benefitted from additional support as she reached the ages of 16-18?
4. Were assessments completed by all organisations in line with best practice and reflect the Think Family principles?
5. Were all assessments robust and demonstrate evidence of risk assessments and risk management plans?
6. Critical examination of our response to "was not brought" for adults who are unable to attend appointments without support.
7. Identify any areas of good practice.

07 consider the recommendations – impact on your practice

Monitoring and Review: Strengthening Systems within Primary Care for Learning Disability Annual Health Checks.

Monitoring and Review: Strengthening Systems within Primary Care to identify safeguarding 'flags.'

Staff Support: Training

Training leads within the BSAB constituent agencies, should address the training needs highlighted from this review, specifically:

Supporting the rights under the Mental Capacity Act of young people in transition to adult services

Working with disguised compliance within adult safeguarding

Using the good practice cited within this review as a model of effective multi-agency safeguarding.

06 Good practice

Excellent multi agency working once Lola admitted to hospital
Use of both MCA and DOLS to inform decisions (advocate involved)

Lola actively involved in move to supported accommodation – she is thriving.

Supervised contact with family in place

Police enquiry ongoing (October 2021)

Assessment of grandmother and aunt who have learning disabilities/difficulties by adult social care

Lola is happy in supported accommodation and has no wish to return home

05 Learning from children's reviews

Disguised compliance and false assurances were regularly given by Lola's mother to a range of professionals. To avoid questions, she limited contact with professionals e.g., using out of hours GP services and not attending repeat appointments or taking Lola for annual health checks. The NSPCC note - *Some parents and carers may say the right things or engage 'just enough' to satisfy practitioners. Practitioners in these case reviews tended to accept information from parents and carers as fact without displaying appropriate professional curiosity and investigating further*

04 Key Learning

- The review identified the importance of Early Help assessments in drawing out a wider understanding of family circumstances, adding context to apparent low-level indicators of neglect.
- The review highlighted risks of over reliance on care-givers views: the need to ensure the voice of the adult is heard, their rights under the Mental Capacity Act upheld and to be vigilant to disguised compliance.
- The review also highlighted the importance of annual learning disability health checks, providing a safety net for people and their families who are vulnerable, but may not meet criteria for more specialist services.
- The review identified some 'flags' that GP Practices should be mindful of, particularly for their patients with additional vulnerabilities –this includes missed appointments; lack of follow up on health care; 'invisible patients' who access emergency and out of hours services; health/dietary indicators of potential neglect.
- Services must consider what reasonable adjustments are required to enable people with disabilities to access services.