Adult 1

Older adult living in a residential care setting, with complex health needs which required the use of a catheter. He died of natural causes and no concerns were raised about the conduct of the professionals involved with his care by the Coroner's Court or the police enquiry. The case was considered as a potential Safeguarding Adults Review, but it did not meet the threshold, however the Board agreed that lessons could be learnt by reviewing the cases.

Each agency who had been involved in the care of Adult 1 completed an evaluation of their actions and identified areas that could potentially improve the care of other adults in care settings with complex needs. The board manager collated the responses and identified the following themes that would benefit from closer examination

1. Communication with partners, family members and other key agencies
2. Timeliness and quality of the safeguarding enquiry
3. Referrals to Disclosure and Barring Service and other professional registration bodies
4. Ability to deliver high quality organisational abuse enquiries
5. Role of professionals visiting care settings to address care standards and /or raise safeguarding concerns.
6. Risk assessments and identification of wider issues (e.g. shortage of skilled nurses available in the region)

The board manager was encouraged by the willingness of all agencies to engage with the exercise and feedback indicated that the review was a positive experience for all involved

Key actions were identified from the event and these have been included in the work plans for the Sub Groups of the Board and these include

- ✓ Improvements to the way in which we manage organisational abuse enquiries
- ✓ Exploring ways to provide families and adults with information to support them to choose appropriate care for themselves or their relatives
- ✓ Increasing the role of commissioners to make sure that employers make referrals to the Disclosure and Barring service or other professional registration bodies in a timely way
- ✓ Encouraging visiting professionals to increase their "curiosity" and issues that "don't feel or look right" and to share these if they are not able to resolve their concerns

A number of these actions have been completed, including

- ✓ Production of a Safeguarding decision support tool
- ✓ A new framework for managing organisational abuse cases
- ✓ The Board have been briefed on the impact of the lack of nurses on care homes
- ✓ A briefing session has been provided to the Independent sector forum

The Board and its sub groups will continue to monitor the progress of remaining actions to deliver the desired changes.

Adult 2

Adult 2, died of liver failure, as a result of an overdose (it was unclear if she intended to take her own life?)

Adult 2's death was considered as a possible Domestic Homicide Review guidance, but it was agreed that as the overdose did not appear to be linked to her abusive relationship that it did not meet the criteria

Adult 2 had left her husband and children to live with a man, who had a long history of domestic abuse, in other areas of the country. Her oldest daughter spent significant time with her mum and regularly reported concerns to the police about the violence her mum experienced from her male partner. The police visited Adult 2 several times but were unable to secure her agreement to press charges against her partner or to accept offers of help via domestic abuse services.

Adult 2 was subject to a sustained attack by her partner in the final week of her life, which resulted in him being arrested and held in police custody for 24 hours by the police. Whilst he was in police custody, three of his male friends visited adult 2 and plied her with alcohol and then raped her. Adult 2's daughter reported this to the police, who attempted to persuade Adult 2 to make a complaint about the rape – Adult 2 declined.

Later that day, Adult 2, took a large number of pain killers and continued to drink alcohol; she disclosed this to her partner when he returned home, however he did not take any action to obtain medical help. Three days later he called an ambulance when he discovered Adult 2 vomiting blood, he did not tell the ambulance staff about the tablets she had taken and did not travel to the hospital with her. The hospital obtained this information after admission, via a telephone call to him.

A multi agency group looked at this case and identified the following areas that would benefit from further examination

1. The quality of risk assessments and the narrow focus of these not taking account of the wider context of the situation
2. Did we share information in a timely way to prevent harm and respond to the needs of Adult 2 and her oldest daughter
3. Are workers able to identify the risks to others in the household beyond the person they are employed to provide care to (adult worker recognising the risks to children and vice versa)
4. Was the Mental Capacity Act use appropriately , as Adult 2 was often under the influence of alcohol and drugs
5. Are workers able to complete high quality domestic abuse risk assessments and make the necessary referrals to the MARAC process (Multi-Agency Risk Assessment Conference)

Following the review of this case we agreed that the following actions should be included on the work plans of the sub groups of the Board.

- ✓ All agencies to review information sharing systems and advice provided to workers when working with families affected by domestic violence
- ✓ BSAB and BCSB to consider a joint review of the quality of Domestic Abuse Risk Tool (DASH) and the assessments of domestic abuse cases at the Multi Agency Risk Assessment Conferences (MARAC). The review considered the option of extending the review to other South Yorkshire Local Authorities.

- ✓ Review knowledge of Care Act and Adults at Risk in Children's Social Care and implement measures to address any gaps ; including providing training, information sheets, etc to assist workers to identify young adults who may benefit from assessments in their own right.
- ✓ Boards to review their strategic plans to strengthen the robustness of transitions arrangements
- ✓ Review Children's Case Conference agenda with a view to implementing prompts to encourage assessment of parents/other adults vulnerability
- ✓ Review screening by Central Referral Unit within South Yorkshire Police.
- ✓ Review if the Person Posing a Risk process is robust within Barnsley
- ✓ Examine the role of the Public Service Hub in addressing Domestic Abuse cases that don't meet the MARAC threshold
- ✓ Embed knowledge of and use of Meghan's Law

Actions completed

- ✓ A local review of the quality of MARAC meeting has taken place and a series of actions agreed
- ✓ Increased information about Adults at Risk and the Care Act has been included in training delivered by the multi agency children's trainer
- ✓ Work has commenced with the Public Service Hub (now the Safer Neighbourhood Service) to agree thresholds
- ✓ A review of the children's case conference agenda has been completed, but this will be reviewed to evaluate impact on practice.
- ✓ The sub groups are reviewing how we respond to People in Positions of Trust and reports will be shared with the Board.