Barnsley Safeguarding Adults Board

Learning Brief – Safeguarding Adults Review or Lessons Learnt 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.

Learning Lessons are completed when a case does not meet the threshold for a SAR but BSAB believes that learning from the case can be obtained.

Adults may have died but they can be completed for adults who did not die, but were harmed.

The main reasons to complete a lessons learnt is to

- ✓ Identify good practice and cascade it
- ✓ Identify areas for individual agency or multi agency growth and change
- ✓ When appropriate agree an action plan that will be monitored by BSAB and its sub groups

Case Identifier – RG

Date of Review – Completed 2 November 2018

Date of learning brief – November 2018

Author (s) – Cath Erine – BSAB Board Manager

Date Agreed by Pathways and Partnership/BSAB - December 2018

Case Summary

- ✓ RG was 68 at the time of his death – cause of death confirmed October 2018 as Sertraline toxicity and Cirrhosis of the liver
- ✓ RG had a large number of tenancies (social landlord and private rented). Most failed due to his behaviour and /or self-neglect/hoarding
- ✓ He received care support at home, but was often abusive or inappropriate to carers (especially women) which put care packages at risk
- ✓ He had received mental health and psychology support in the past and he had a diagnosis of a learning disability (LD), which was later removed after new definitions for LD were implemented.
- ✓ RG relied heavily on his mum prior to her death, a female friend offered support, despite his making unfounded allegations against her of financial abuse.
- ✓ RG's repeated requested a place in 24 hour care, indicting a desire to be "looked after", however he was able to meet his own needs.
- ✓ A number of agencies worked with RG, despite him not having eligible needs and the housing provider continued to support RG despite loss of revenue, linked to the state of the property which affected lettings of adjacent flats.

Learning points and practice reflections

1. **Do we recognise and respond to inappropriate sexual or sexualised behaviour?**

Questions for practitioners

- ✓ Do we minimise behaviour in adults based on assumptions about learning disability or mental ill health
- ✓ If concerns exist about the adult's ability to control the behaviour would a specific mental capacity assessment be required
- ✓ How do we record and escalate examples of sexually inappropriate behaviour.
- ✓ How would you share this information to inform robust risk assessments and risk management plans with other agencies working with the adult
- ✓ At what point would you take advice from or make a formal complaint to the police
- ✓ Is this an area for further professional development for you and/or your team

2. **Do we consistently use the hoarding tools included in the Self Neglect and Hoarding Policy and do we know when to use it?**

Questions for practitioners

- ✓ Do we routinely evaluate the hoarding and the risks to the adult and others around them?
- ✓ Do we encourage the adult to take up a free home safety check from South Yorkshire Fire and Rescue
- ✓ Do we know how to make a referral to SYFR?
- ✓ Would we know when hoarding and /or self-neglect has escalated to the point a multi-agency response is required? If so how would you action this?
- ✓ Have you read the policy or received any training on managing self-neglect and/or hoarding?
- ✓ At what point would you consider seeking legal advice on options to manage the risks