BARNSLEY SAFEGUARDING
ADULTS BOARD

7 Minute Briefing: Gillian (pseudonym) - Approved May 2022

01 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?

Gillian, aged 39, was found in a house, shared with her mother who had been dead for several days before the police were alerted by a concerned neighbour. Gillian was so distressed she was admitted to a mental health unit for assessment. Gillian had very poor physical and oral health, due to not being supported to attend health appointments.

Gillian rarely left the house and struggled to understand "social norms" in relation to wearing clothes, boundaries with other adults and was verbally aggressive. Gillian and her family were reviewed under child protection due her highly sexualised behaviour from a young age. This prompted complaints from family and a discharge from services. She had limited contact with her father, who expressed concerns about the living arrangements.

03 Terms of Reference

Did you consider a capacity assessment for Gillian? Did you complete a capacity assessment for her – if so which decisions and when?

Did you assess Gillian in her own right – health, social care, mental health, etc. If not, what influenced this decision?

Did you complete a risk assessment(s) for Gillian? If so for what?

Did you seek the views of father about her health and social care needs? If yes, what was the outcome?

Do you feel your involvement with the safeguarding concerns raised was in line with best practice and reflected learning from SAR's?

Did you use / access all information available on Gillian to inform your actions? If you were unable to access information, please detail what prevented access.

What actions, if any, did you take about Gillian's non-attendance / was not brought to appointments?

04 Key Learning

- Gillian was not assessed in her own right; professionals accepted the views of her mum that no support was needed.
- No capacity assessments were completed, despite grounds to question Gillian's ability to make decisions.
- Gillian's nonattendance at health appointments were not flagged as an area for concern despite multiple safeguarding concerns being raised by professionals and neighbours. She had not seen a GP since 2014.
- Adult Social Care did not have access to the child protection records held by Children's Social Care to inform their risk assessments.
- Gillian was "statemented" as having a learning disability as a child, however she was not transitioned into adult social care
- Gillian did not leave the house and had little social interaction with anyone apart from her mum and dad.
- Assertions made by mum were not tested to establish the facts. Mum claimed that Dad was an active contributor to her life, however this was not true.
- Mum was identified as a carer by several organisations, but assessments were not offered and/or declined. Mum declined to provide contact details for her father.
- No risk assessments were completed to inform any escalation considering the concerns expressed about Gillian.

05 Learning from children's reviews

Disguised compliance and false assurances were regularly given by Gillian's mother to a range of professionals. To avoid questions, she limited contact with professionals and claimed to be a nurse to deflect attention and claim professional status that was not substantiated. The NSPCC notes - *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.*

06 Good practice

Once Gillian was discharged from the mental health hospital, a place of safety was found for her.

Father was contacted and has been actively involved in planning her future care.

Good joint working between Adult Social Care, Learning Disability Services and the centre providing her care.

A full assessment of her physical and mental health has been completed.

07 Consider the recommendations – impact on your practice

- Refusals by family members to allow access to adults, identified in need of safeguarding, must result in a risk assessment and escalation.
- Capacity assessments must be completed when there is reasonable grounds to question capacity.
- Checks are made to establish if an adult is on the learning disability register.
- Non attendance of health appointment, particularly if repeated should generate a risk assessment and /or safeguarding concern.
- Do you need support /training to develop the skills to work with families who refuse support, but care for an adult who cannot make their own choices?