BARNSLEY SAFEGUARDING ADULTS BOARD

7 Minute Briefing: Harry

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?

Harry died when he was 34 years old. He died as a result of Sepsis, Cellulitis and non-alcohol related Liver Cirrhosis. Harry was known as someone who could be difficult to work with. He was often threatening and abusive to workers and his mum and dad. He would sometimes refuse to engage with assessments and refuse support offered. In the final 18 months of his life Harry was suspended from accessing services from South-West Yorkshire Partnership Foundation Trust, although crisis services still remained open to him through Accident & Emergency. (SWYPFT) Harry had spent time in prison. In his final days, Harry was arrested again and detained under the Mental Health Act.

03 Terms of Reference

The review focused on the period from the 1 June 2018 until Harry's death on the 21 September 2021. The review period was chosen to understand the impact that Barnsley Safeguarding Adult Board's Self-Neglect and Hoarding Policy and Procedures may have had on practice with Harry.

In particular, the review was to understand how effectively agencies worked together. The review also reflected on the experience of Harry's parents when they adopted him and missed opportunities for support through Harry's childhood.

04 Key Learning

There was evidence of joint visits between individual practitioners, but no strategic joint working between agencies. There were not joint risk assessments or joint risk management plans. No single agency had all the information. Each agency struggled to support their workers experiencing abuse, but there were missed opportunities for joint responses to this. There was evidence of agencies being *"played off"* against each other as there was no joint plan.

It was not recognised that Harry was neglecting himself. It is likely that Harry had never really cared for himself and had been dependent on others for his cleaning, managing his money and support to access the community. There were also missed opportunities to offer his parents support as his carers.

It is possible that Harry's mental and executive capacity was overestimated, as he could articulate himself well and appeared to understand information. However, there was a lot of evidence about his impulsive behaviour and the negative impacts, which raises the question how well he would *"weigh up"* information when making decisions.

05 – learning from children's reviews

Understanding Harry's childhood and the challenges faced by Harry's birth mother could have assisted the practitioners involved with Harry to manage his behaviour. It is possible that Harry's behaviours may have resulted from Foetal Alcohol Syndrome Disorder (FASD). Early diagnosis and support for the child and their families is essential to limit the impact of the condition. There were missed opportunities to support Harry and his parents, as he was excluded from several schools from a young age. During the last 20 years, there have been changes in practice which may address some of these challenges; however, do people have access to services that can support the diagnosis of FASD.

06- Good practice

There was collaboration between individual workers, when conducting joint visits. Workers from some agencies, identified Harry's inability to meet his needs and attempted referrals to statutory services. Some workers developed clear boundaries with Harry, that enabled them to continue to work with him despite his challenging and aggressive behaviour traits. There was recognition from managers that some of Harry's behaviour to workers were unacceptable and they sought to protect their workers from these.

07 consider the recommendations – impact on your practice

Escalate incidents of abuse to managers. Identify other works and agencies working with the same person. Conduct joint risk assessments and agree plans to manage risks. Consider enforcement action, legal avenues, and multi-agency panels for high intensity users. Ensure the impact of any suspension or withdrawal of services are assessed.

Ensure assessments of mental capacity consider the person's ability to weigh up information to make informed choices. They should also consider the person's ability to act upon their decisions (their executive functioning).

Consider the needs and experience of family carers. Their needs may be unique to those of the adult requiring support.