

SEVEN POINT BRIEFING

Safeguarding Adults Review for Claire

Introduction

1

Wakefield and Barnsley Safeguarding Adults Board agreed to review the sad death of Claire at her home aged 40, as a non-statutory Safeguarding Adults Review. The Care Act did not require us to complete a review, but we agreed that we should explore the impact on adults seeking support across “boundaries” created by geographical location, commissioning arrangements and lack of shared records within health and other services.

2

About Claire

Claire’s family described her as a larger-than-life character who hid her emotions behind a tough exterior; workers said she was “funny and full of life.” Claire struggled with alcohol misuse for most of her adult life, this increased after she lost contact with some members of her family. Claire developed significant health problems due to her alcohol use and needed support to stay safe and well. Claire had a long history of domestic abuse and struggled to leave her partner.

3

What happened?

Claire died at home, found by her (ex) partner who called an ambulance. The coroner ruled she died of natural causes (liver cirrhosis and chest infection). An initial review identified that Claire accessed support from services in both Barnsley and Wakefield, however recording systems, specific to individual hospitals meant that Claire’s full needs and risks were “unavailable” to services, until we completed the review. Her postal address was Wakefield; however, she had a Barnsley GP which complicated her access to alcohol support services.

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Key findings

- Workers and services worked creatively and in a tenacious manner with Claire.
- The learning review provided a multi-agency/cross boundary discussion space, this did not take place whilst Claire was alive. Wakefield did hold local discussions, but they did not include information held by Barnsley.
- Claire’s access to alcohol support services were frustrated by eligibility criteria around GP, postal address etc. Claire did receive support from alcohol services in both Barnsley and Wakefield on an intermittent basis.
- An absence of a shared health record across hospital services prevented a robust assessment of her health and care needs.
- Claire’s reluctance to engage with services to meet her needs should have led to a multi-agency response using the Wakefield self-neglect and/or hoarding policy to assess her risks and manage these. Wakefield did identify the risk but were unable to coordinate a response in line with the policy.

5

Recommendations - Barnsley and Wakefield safeguarding boards will monitor progress.

- ✚ Commissioners of drug and alcohol services in South and West Yorkshire will review contracts to maximise access to services for people who live on “boundaries.”
- ✚ Barnsley and Wakefield hospitals to flag complex patients and set up an information sharing system.
- ✚ Barnsley and Wakefield Safeguarding Boards to ask the Multi Agency Risk Assessment Conferences, supporting victims of domestic abuse, to improve their information sharing systems across geographical boundaries.
- ✚ Wakefield Safeguarding Board to support production of a multi-agency risk assessment tool and audit its impact.
- ✚ Workers will receive training and resources to support them to deliver person centred responses, when working with adults with complex lives.
- ✚ All organisations to evaluate the accessibility of their records to all relevant staff within their own organisation.

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Next steps

The purpose of this non-statutory review has been to identify opportunities for future learning and improvement – what happened to Claire has provided a ‘window’ on the system to reduce the likelihood of similar harm occurring again.

- ✚ Barnsley and Wakefield Safeguarding Boards will produce detailed action plans to evidence improvements to practice and processes.
- ✚ Both Boards will share information about progress against their action plans
- ✚ We will inform the family of the outcomes of the learning from the review.
- ✚ Both Boards will share learning with all organisations involved in the review and include the key principles in safeguarding training.

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Further information

Barnsley

Alcohol Support - <https://humankindcharity.org.uk/service/barnsley-recovery-steps/>

Domestic Abuse - <https://www.barnsley.gov.uk/services/children-families-and-education/domestic-abuse-and-sexual-violence/>

Safeguarding Adults - <https://www.barnsley.gov.uk/services/children-families-and-education/domestic-abuse-and-sexual-violence/>

Nationally

Alcohol Change - <https://alcoholchange.org.uk/>

Wakefield

Drug & Alcohol Support - <https://www.turning-point.co.uk/support-we-offer/drugs-and-alcohol>

Domestic Abuse - <https://www.wakefield.gov.uk/our-people-and-communities/protecting-our-communities/domestic-abuse/>

Safeguarding Adults - <https://www.wakefield.gov.uk/adult-social-care/safeguarding-adults-from-abuse/>