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

Case Identifier – "Jack "

Date of Review – Completed August 2018

Date of learning brief – September 2018

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Date Agreed by Pathways and Partnership/BSAB -

Case Summary

Fire and rescue service, ambulance service and police attended a house fire at Jack's address. When crews arrived the ground floor of the property was well alight and Jack, aged 68, was found deceased in the bedroom

Jack was the older of two boys and had been born and spent his early life in Barnsley. His younger brother and Jack's daughter survive him. From a young age he had a difficult relationship with his father, but was in close contact with his mother until her death in 2015.

Jack is described as a stubborn boy who was very intelligent and did well at school. He became a teacher of History and English and had a keen interest in politics and Russian history. He worked as a teacher in early adulthood; he married and had one daughter. His wife left him after about 3 years of marriage and after that he lived alone. Until his mother died she was a major support for Jack, ensuring he ate, cleaned his clothes and himself. Following her death Jack was supported by his younger brother, however he was not able to influence Jack in the same way as their mother.

Jack's brother would visit him on the same day at the same time each week and take food. Despite this his brother was often unable to access the house, although sometimes Jack would ask him to fetch things, eg logs. Often Jack was rude to his brother, but would later apologise.

Jack was self-sufficient and lived a frugal life more like that of the 1920s – not using electricity, making potions to heal local animals owned by neighbours

Jack was under the care of mental health services (MH) for part of his life and his family members were aware that Jack had "heard voices" Prior to discharge from mental health services (2007) Jack had stopped taking his prescribed medication as he did not like the side effects, which included losing "his sharpness". He was described as uncomfortable with people, especially those he didn't know, and contact with him was only on his terms

He came to the attention of South Yorkshire Police (SYP) on several occasions and on three occasions he was referred to Barnsley Adult Social Care (ASC).

The issue of self-neglect was first flagged to ASC in January 2017 when a Department for Work and Pensions (DWP) visiting officer contacted ASC because of concerns about Jack's living conditions and neglected appearance.

Learning points and practice reflections

1 – Professional curiosity and persistence – when working with adults who would prefer us to leave them alone?

Questions for practitioners

- ✓ **How do you contact adults to discuss making arrangements to see them? - Phone, letter, in person?**
- ✓ **Are your attempts at contacting the adult recorded and available to you if additional contacts/concerns are shared about the adult?**
- ✓ **Would you check with other organisations about their knowledge of the adult to inform your risk assessment and actions/non action?**
- ✓ **Would your organisation support repeat visits/contacts to adults to self-neglect /hoard – if not how do you manage any professional "questions" about not visiting more than once?**
- ✓ **What would encourage you to consider use of the self-neglect and hoarding policy/risk assessment?**
- ✓ **What might help you to develop a relationship with an adult who would**

2. – Role of family in self-neglect cases.

Questions for practitioners

- ✓ **Do you check if family have any legal powers to speak/make decisions on behalf of the adult, especially if we have no reason to question their capacity to make decisions**
- ✓ **How can you be sure that family members are "a force for good" and their actions are not coming from a place of self-interest or embarrassment about the self-neglect/hoarding**
- ✓ **If family are likely to bring about positive engagement or behaviour, how can you engage them and still stay within GDPR legislation**
- ✓ **How do you know that families are accurately representing the views of the adult, especially if accepting their views will result in the adult having no contact with services**
- ✓ **Would you consider checking with other services what contact they have had with family members and its impact on the adults**
- ✓ **Do we recognise family members as carers and offer them assessments**