

Safeguarding Adults Review

7 Minute Learning Summary

Paul lived with his cousin Bruce, prior to his death Paul's Uncle/Bruce's father lived with them also. Paul and Bruce had a volatile relationship but were close. When they were required to move from their family home after the death of Paul's Uncle/Bruce's father, their volatile relationship became more problematic.

Both Paul and Bruce were known to Adult Social Care and both had complex needs. Paul did not engage with services, but Bruce did. Paul's son was concerned that his father was self-neglecting.

There were numerous allegations made by Bruce that Paul had hit him, however the response from the local authority in regards to these allegations was not compliant with Section 42 of the Care Act and did not follow best practice in regards to Domestic Abuse.

Paul was discovered on the floor in his home by a visitor. He had been there for more than 24 hours, Bruce did not/could not raise the alarm. Paul passed away in hospital. There was an initial concern that Bruce had caused harm to Paul but a police investigation concluded there was no evidence of this. After his death Bruce struggled to cope and was eventually detained under the Mental Health Act.

Lessons

- Paul and Bruce's needs were assessed by Adult Social Care individually but without consideration of them holistically.
- Paul did not engage with services but this was exacerbated by the staff turnover in adult social care which was not conducive to building a relationship with him.
- Commissioning of support could have been improved to provide feedback on the home life situation of Paul and Bruce.
- Pauls' refusal of services was accepted by Adult Social Care without consideration of the risks to Paul and Bruce, or the concerns raised by Paul's family about possible self-neglect.
- Section 42 processes were not followed, and the risks to Paul and Bruce were not effectively addressed.
- Paul and Bruce were spoken to together regarding the concerns regarding Domestic Abuse, best practice is that perpetrator and victim should never be interviewed together as this can result in greater risk to the person.
- Paul's case was closed by Adult Social Care even though there were ongoing safeguarding concerns.
- Use of advocacy was identified for Bruce but not for Paul.
- Paul and Bruce were not identified as each others carers. Paul was sometimes identified as Bruce's carer but not the other way round. Neither Paul or Bruce were offered carers assessments.
- When a strategy meeting was held people who needed to be involved in the case were not at the meeting, meaning that not all the risks were identified or addressed.
- Support given to Bruce after Paul's death was lacking, there was a poor partnership response to Bruce.
- Making Safeguarding Personal principles were not applied.
- Learning from previous SARs, commissioned by the Board, has not been embedded into practice.
- The Board requires assurance regarding the quality of supervision across the partnership.

Thankyou for taking the time to read this practice note. If you would like to provide any feedback or have any questions regarding the Board please contact: Lynne.Mason@Reading.gov.uk

The full SAR report for Paul can be found here:

<http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/>

7-minute Learning Summary

Safeguarding Adults Review Paul

Confidence in Safeguarding Practice

During the SAR process, a questionnaire was drawn up for practitioners and managers who deal with Section 42 concerns and enquiries. The questions used are useful questions to ask yourself and discuss the answers with your manager:

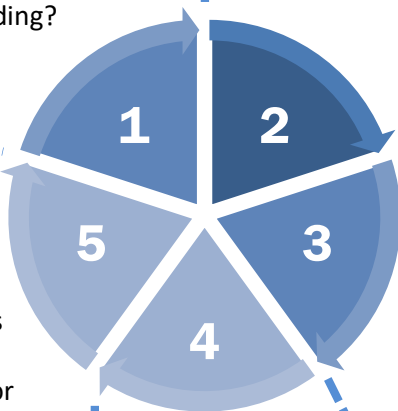
- How confident do you feel in leading on Adult Safeguarding Work?
- Do you understand the advice and guidance given by managers and are able to confidently follow it?
- How confident are you in knowing that a safeguarding enquiry is needed?
- What would help you to improve your safeguarding practice?

If you are a manager who supervises practitioners who lead on safeguarding, ask yourself this question also:

- Do you feel that your advice is understood and followed in relation to Adult Safeguarding?

Self Neglect

- Encompasses a wide range of behaviour – neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.
- Professionals can find working with people whom self-neglect very challenging.
- The key to effective interventions in self-neglect is building relationships to effectively engage with people without causing distress and reserving use of legal Powers to where they are proportionate and essential.
- Safeguarding processes may be required when working with people that self-neglect, but much of the work is long-term work, which happens under other frameworks
- The following legislation may be helpful:
 - Care Act 2014 (statutory guidance)
 - Human Rights Act, Article 8
 - Mental Health Act 2007
 - Mental Capacity Act 2005
 - Public Health Act 1984
 - Housing Act 1988
- Social Care Institute for Excellence has useful information on self-neglect: <https://www.scie.org.uk/self-neglect/at-a-glance>
- Refer to the Pan Berkshire policies and procedures website for more information



Domestic Abuse

Domestic abuse in adult safeguarding is often more complex than what is perceived as "typical" domestic abuse since not only is there abuse between husband and wife, but also between various family members like Paul and Bruce. There are often issues of interdependency and caring which makes it much harder to separate the person from their abuser.

What is the Safeguarding Adults Board (SAB)?

The West of Berkshire Safeguarding Adults Board covers the three local authority areas of Reading, West Berkshire and Wokingham.

The main objective of the Board, as set out by the Care Act 2014, is to gain assurance that local safeguarding arrangements help and protect adults with care and support needs who are at risk of or experiencing abuse.

The Board aims to make sure that all of the organisations involved have effective safeguarding policies and procedures and work together in the best way possible to protect adults at risk. The three core duties of the Board are to:

- Publish an annual strategic plan;
- Publish an annual report;
- And Conduct Safeguarding Adults Reviews of serious cases in specific circumstances

The Board has a dedicated website: <http://www.sabberkshirewest.co.uk/>

People who are unpaid carers, caring for their partner or relative, friend, can abuse the person that they are caring for. This can sometimes be due to the person not being able to cope with caring or not knowing how to care for someone. This still needs to be seen as abuse but can be dealt with in a much more sensitive manner.

Care Act Responsibilities for Carers

- Paul and Bruce were carers for each other, whilst Paul was sometimes recognised as Bruce's carer, no carers assessment was carried out. Bruce was never recognised as Paul's carer.
- A carer means an adult who provides or intends to provide support for an adult with care needs. A carer cannot be someone who is providing support for payment or as voluntary work.
- Carers are recognised in the law in the same way as those they care for.
- Where it appears to a Local Authority (LA) that a carer may have need for support now or in future. LA's are required to assess if the carer has needs and what those needs are, currently or in the future.
- Support is determined as emotional and practical support.
- Carers have the right to refuse Carers Assessments.
- LA's can combine a needs or carer's assessment with an assessment it is carrying out in relation to another person if the adult to whom the needs or carer's assessment relates agrees.
- The Care Act does not deal with assessment of people under the age of 18 who care for others. However, they can be supported under the law relating to children.
- If deemed eligible under LA criteria carers are entitled to a support plan and services from the LA.

Further information can be found here:

<https://www.gov.uk/government/publication/s/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-8-the-law-for-carers>