

# LEARNING FROM SAFEGUARDING ADULTS REVIEWS

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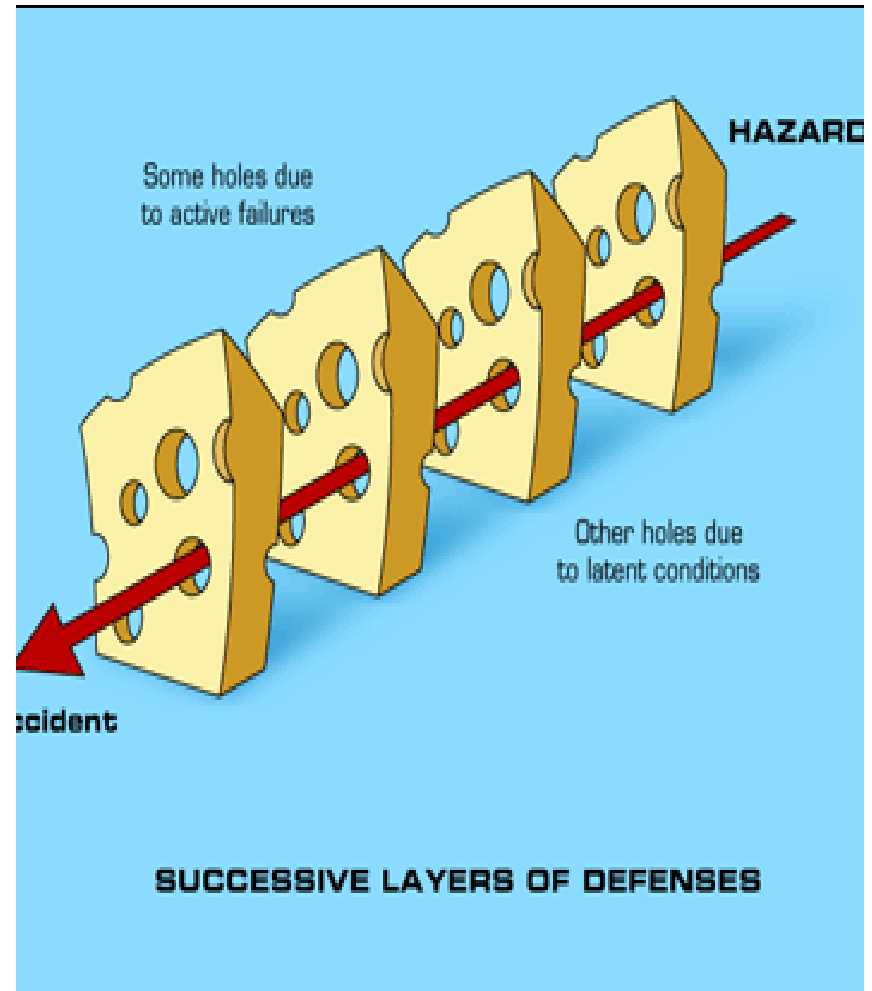
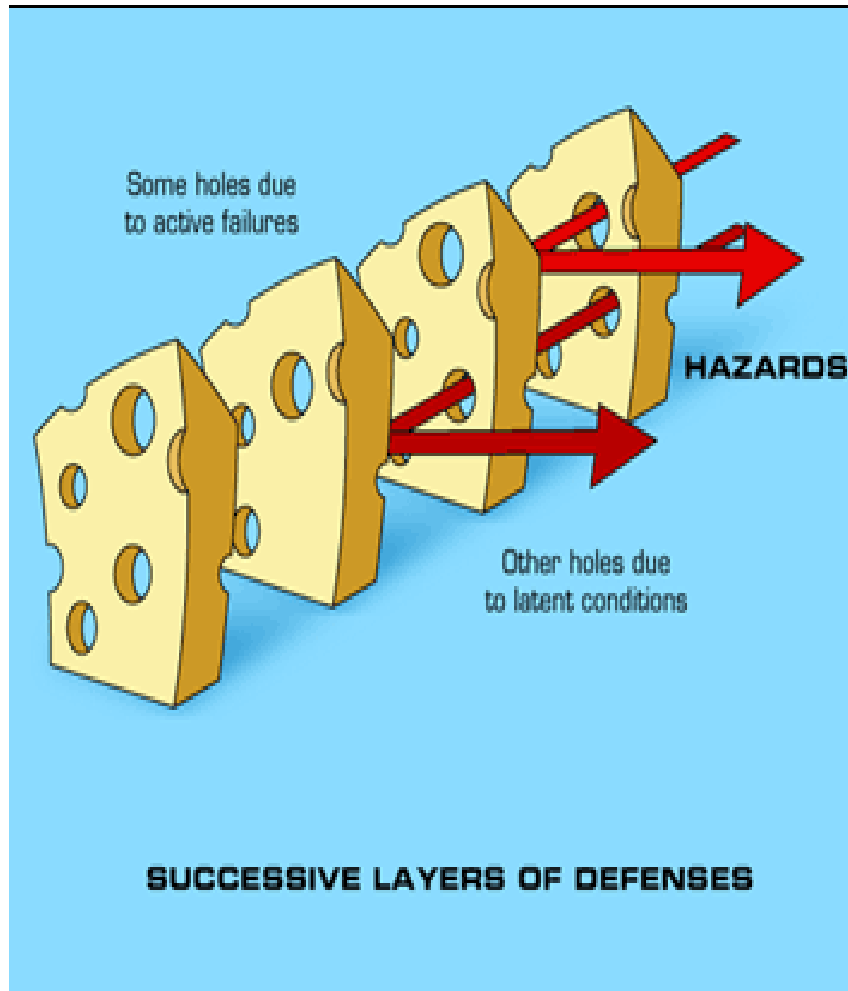
Suzy Braye  
Suffolk Safeguarding Adults Board  
6<sup>th</sup> November 2018



# Whole system understanding



# Safe and unsafe systems



# The national picture

Thematic studies by region  
(e.g. London / SW)

Thematic studies by topic  
(e.g. care homes / self-neglect)

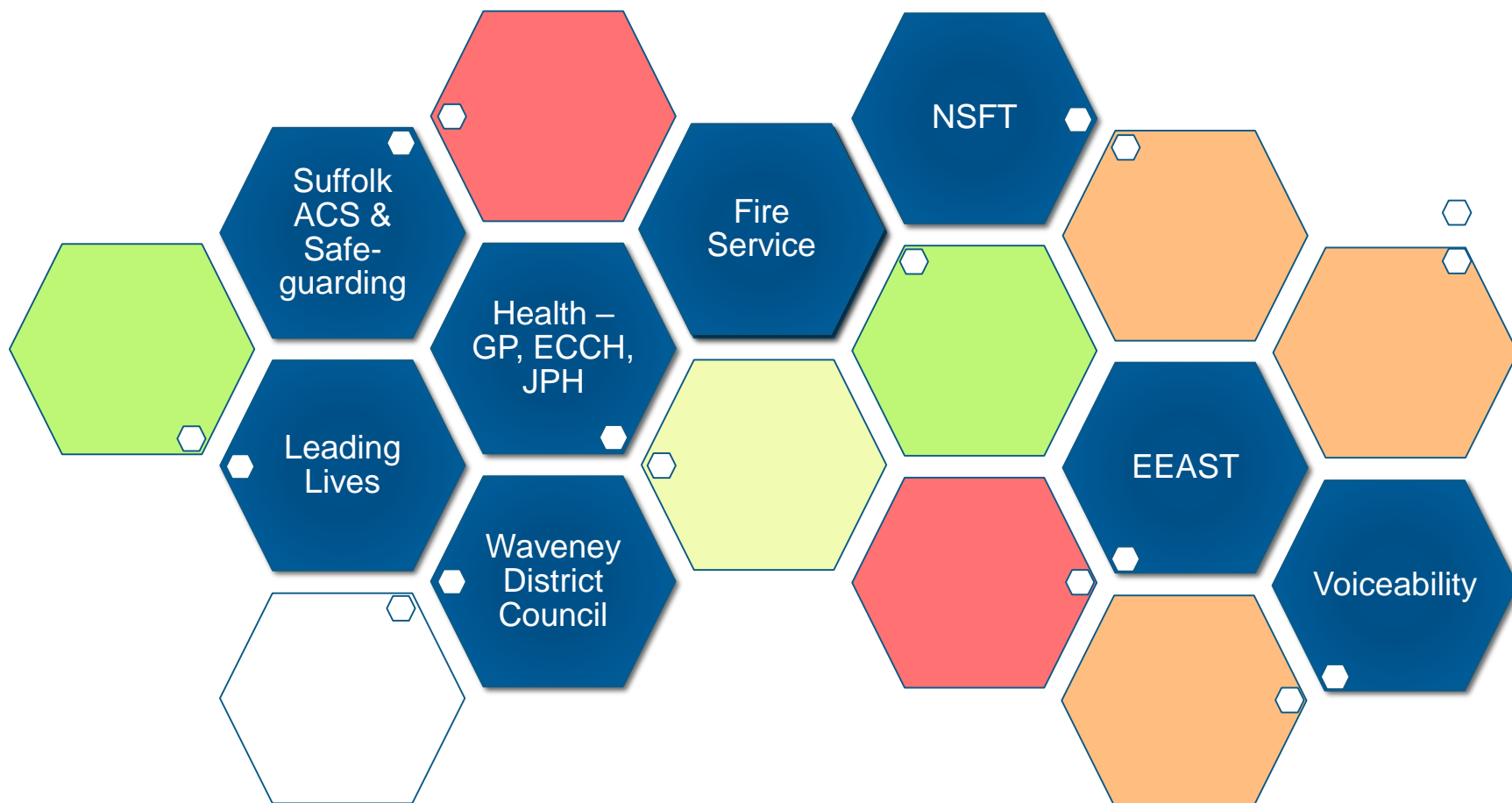
Methods and quality markers

National library

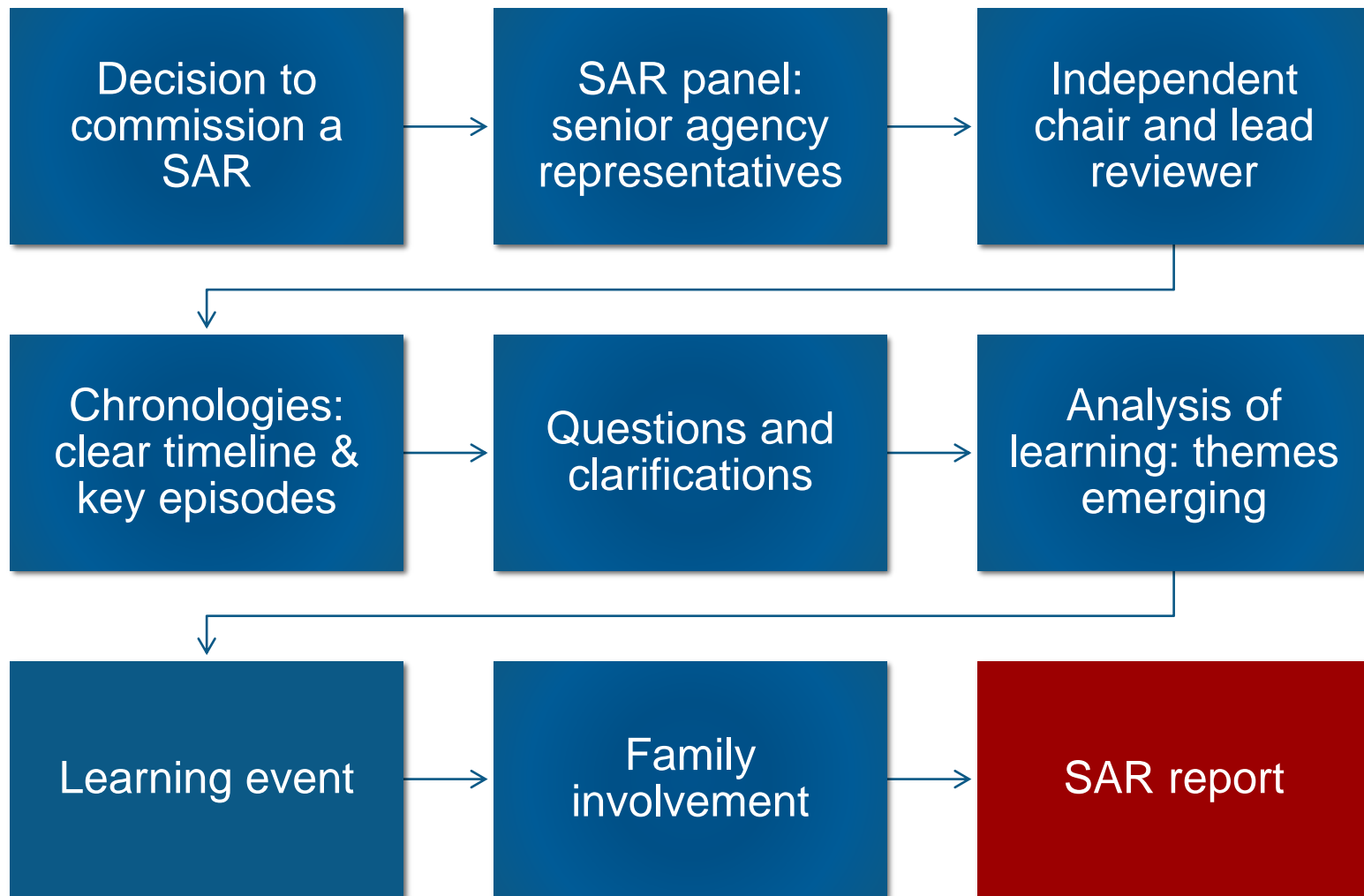
# Mr AM: a pen picture

- Early 60s; mild learning disability; family home; bereavement impact; isolated
- Befriended; lived with friends/lodgers; concerns about home conditions/hygiene; removal of dogs
- Stroke; impaired mobility & speech; difficulties securing adaptations; friend/lodger as 'carer'; further decline in personal care & state of house; episodic involvement with agencies; assumptions of mental capacity
- Reluctance to accept help and support at home; complex relationship; self-neglect/neglect?
- Safeguarding concerns: neglect; financial exploitation
- Interagency work to secure change in hygiene and conditions; hostility and aggression from carer; gradual development of relationship; mental capacity assessments
- Compliance with health and personal care intervention; referral to mental health services - CPA; refusal to change home conditions
- Death in accidental fire

# Piecing the picture together

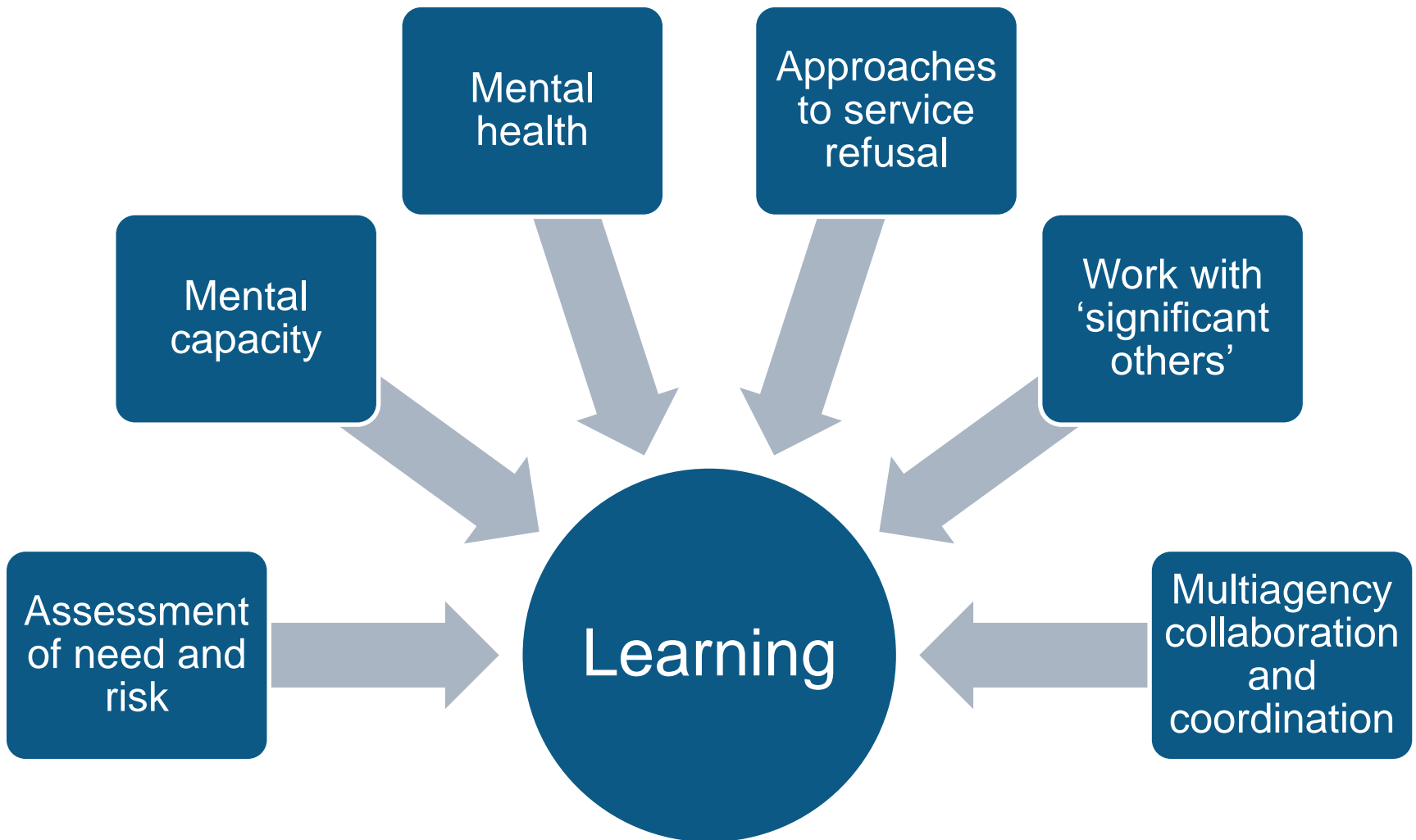


# The SAR process





# Emergent learning themes



# Assessment of need and risk

- Early missed opportunities to conduct care & support needs assessment: “no identified needs”
- Outcomes of OT assessment frustrated by absence of home ownership proof
- Safeguarding concerns identified but:
  - Difficulty engaging with AM – relationship with friend / carer
  - No evidence of care & support needs assessment
  - No comprehensive risk assessment – fire / willful neglect
- Delicate balance of negotiated vs imposed solutions
- Trust-building interventions pursued without appropriate risk-management strategies
- Lack of momentum in the safeguarding plan

# Mental capacity

- Reliance on assumption of capacity rather than formal process of assessment
- Mental capacity assessments
  - (i) finding of capacity not evidenced
  - (ii) examples of excellent practice
- Significance of absence of capacity
  - Closed down certain options and opened others
  - No explicit best interests decision-making process

# Mental health

Mental health needs recognized late in the process

Earlier observations on changes of mood not communicated

# Approaches to service refusal

- AM's assurances taken at face value
  - Absence of professional curiosity
  - Failure to pursue proactive engagement warranted by level of risk
  - Culture of case closure resulting from resource and caseload pressures
- Loss of momentum in response to continued refusal to deal with the state of the property

## Relationships with significant others

Friend/carer's needs not fully recognized

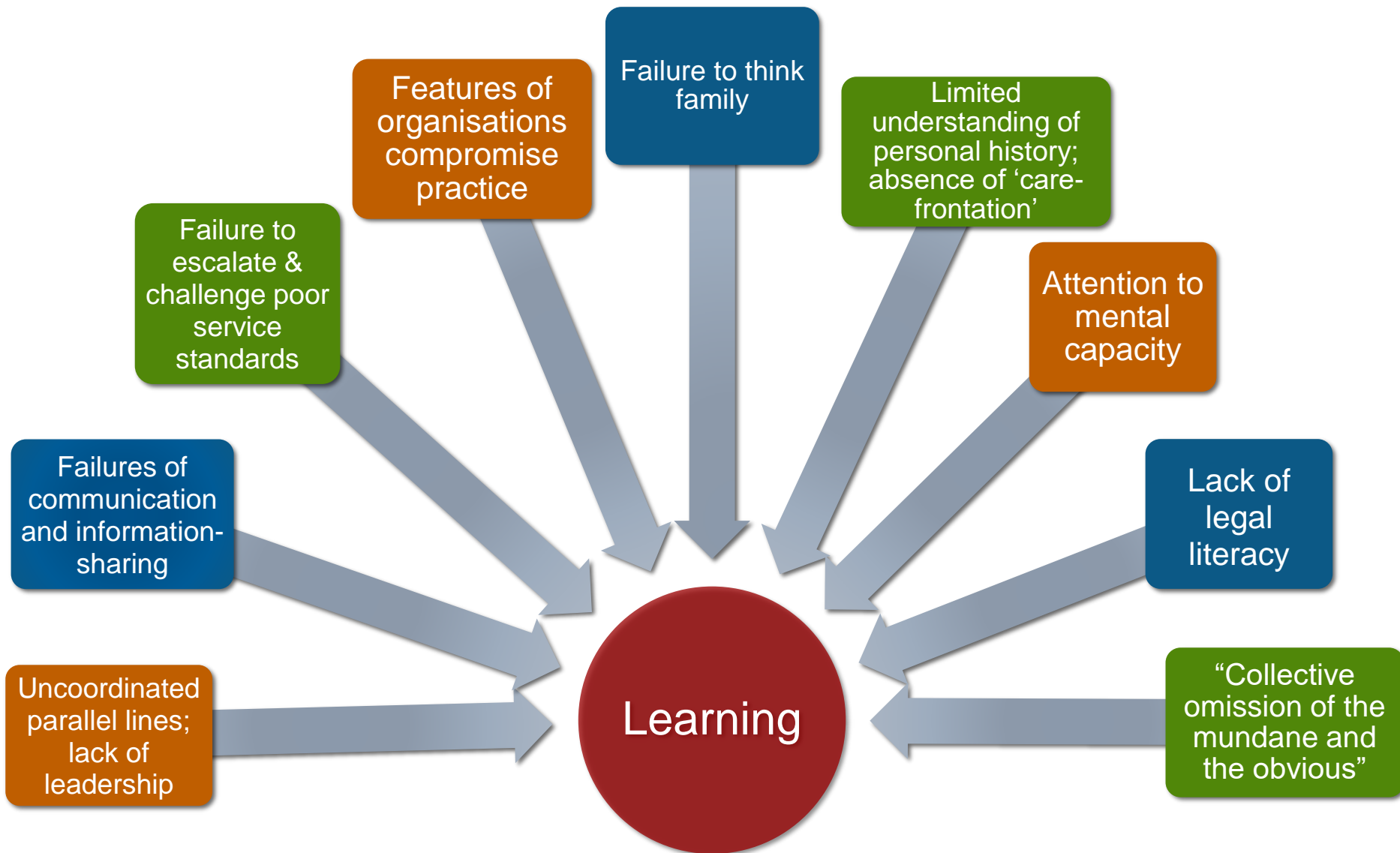
Coercion and control of AM recognized but not addressed

Intermittent contact with AM's family - missed opportunities

# Interagency collaboration & coordination

- Some good practice
  - Effective communication over specific matters
  - Safeguarding meetings provided effective forum for some agencies to coordinate their involvement, strong legal presence
  - Effective communication between ACS and NSFT
- But - missed opportunities; disagreements about responsibilities
- Significant gaps in communication/coordination
  - Fire Service
  - Police
  - GP
- How effective was the safeguarding process? – delay in moving forward

# Resonance with national SAR findings?



# Ways forward...

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- Further development of the policy
  - Monitoring of implementation
  - Mental capacity
  - Training on self-neglect
  - Service responses to self-neglect

# Further information

Please contact me if you have any queries:

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