South Tyneside Safeguarding Children and Adults Partnership

7 Minute Briefing

SAFEGUARDING ADULTS REVIEW
Adult AS and Adult AT

WHAT IS A SAFEGUARDING ADULTS REVIEW?

Care Act 2014: Statutory duty of the Safeguarding Adults Board to conduct a Safeguarding Adults Review

"Where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, AND There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult".

OUTCOME

To identify lessons to be learnt from the case and apply those lessons to future cases (not to allocate blame or responsibility) AND to improve how agencies work, singly and together, to safeguard adults.

ADULTS AS AND AT – BACKGROUND TO THE REVIEW

Adult AT, a 73-year-old lady lived with her son Adult AS, 33 years, in a rented property, after moving to the UK from America some years earlier with her husband, who died in 2004. As a result, both mother and son experienced considerable mental distress and grief, consistently expressing a wish to return to the USA, but said financially that this was not possible (the real picture suggested otherwise). They became increasingly isolated, had no friends, rarely saw neighbours, and relied on takeaway food.

The Post Office manager noticed a deterioration in how Adult AT presented in the final year when withdrawing money and shopping (a weekly routine). She was unkempt, would sit on the shop floor and appeared "vacant."

Around this time, Adult AS was markedly losing weight, and there was a suggestion that he could have an undiagnosed learning disability which meant at times, Adult AT could be impatient with him.

Mother and son were sadly found deceased in their property due to cardiac arrest, hypothermia and emaciation.

THEMES OF THE CASE

Service Refusal / Engagement
Loss and Grief
Adult Social Care and Safeguarding
Mental Capacity / Mental Health
Multi-Agency Collaboration
Housing and Finance
Self Neglect
Social Isolation
Think Family

KEY LEARNING

Cases involving a lack of self-care often require lengthy, flexible, and creative involvement from practitioners. This can be contrary to eligibility criteria for services and other organisational pressures. Safeguarding referrals and assessments should be appropriate, timely and clearly reference desired outcomes (including Making Safeguarding Personal).

Understanding the mental capacity of the person is crucial to managing risks associated with someone who is neglecting their health and care needs.

Mental capacity assessments should include a specific focus on self-neglect, executive functioning and the understanding of the five principles within the Mental Capacity Act 2005.

Where there is a significant/critical risk of harm as a result of a lack of self-care, safeguarding adults' procedures should be used to share information and to manage risks.

If concerns persist and/or risks increase, there may be a need to seek additional advice and support. This might be from legal services, senior managers and/or safeguarding/MCA specialists.

Operational and strategic managers should ensure that workloads are manageable and that supervision of cases involving adults at risk ensures that plans are implemented, and their outcomes reviewed.

Practitioners should use managerial and supervision support to discuss cases which might benefit from a different approach beina taken.

Commissioners should ensure there is appropriate provision for individuals experiencing longstanding, fluctuating and ongoing mental health issues.

Practitioners should use multi-agency risk management meetings to determine levels of risk and expected outcomes, considering all aspects of Making Safeguarding Personal

Link to Full Report:
Local Safeguarding Adult Reviews - South Tyneside Council

QUESTIONS FOR CONSIDERATION

What can I learn from this case? How in my role and organisation can I help to ensure that there is no re-occurrence?

Am I fully competent around the Mental Capacity Act, Self-Neglect, Service Refusal and Engagement and Loss and Grief (Trauma) or are there existing gaps in my knowledge that I need to address? What do I need to achieve this?

How do multi-agency partners work together with local communities and businesses to raise the awareness of Abuse and Neglect, including spotting signs and indicators and reporting concerns?