

# Learning Briefing

## Adult B Safeguarding Adult Review

The Safeguarding Adult Review in respect of Adult B was published on 23rd March 2017.

### Case Summary

Adult B - "Tom" - was a kind and caring man who once held a responsible position working within the charitable sector. Unfortunately, Tom began to misuse alcohol and his lifestyle changed. He lost his career, his long-term relationship ended and he began living on his own. Tom began to associate with a group of people who had a similar lifestyle to his own and alcohol was a common bond. These people frequented his home, some with the permission of Tom but others were not welcome and abused Tom's hospitality. There is evidence they stole personal possessions from him and money from his bank account. Tom was found dead at his flat in Spring 2016 and a man was charged with his murder, and subsequently sentence to 21 years imprisonment.

### The review highlighted key learning and themes which are listed below:

Several agencies had contact with Tom and contributed to the strategy meetings that were held. However it was not clear which, if any agency or professional was responsible for managing Tom's case.

***Learning - early identification of a lead professional and agency for an adult safeguarding case helps ensure structure and accountability is maintained in the process.***

There were examples within the review of occasions when Tom was seen by professionals and his mental capacity was considered. There were references to Tom 'having capacity' however these lacked detail as to why this conclusion had been reached or whether it was a formal assessment or a decision that Tom met the first principle in the Mental Capacity Act i.e. a presumption of capacity.

***Learning - It is important that, when either a first principle decision or a full assessment of mental capacity is undertaken, that it is documented. The record should include the nature of the assessment (e.g. 'first principle' or full assessment) together with the evidence for reaching the decision as to capacity. This improves information sharing between agencies and helps ensure the nature and level of risk faced by a vulnerable adult is understood.***

Tom was very attached to his flat and this was implicit in many of the things he said to professionals. The reasons for this might have been identified had professionals spoken to his ex-partner and Tom's family in Liverpool. In turn that might have led to exploring housing solutions that were acceptable to Tom and might have led to the reduction of arrears and the opportunity to separate him from untoward visitors.

***Learning - engaging and involving families and exploring family background is helpful when seeking to solve problems and protect vulnerable adults such as Tom.***

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There was a good relationship between Tom's ex-partner and a support agency and a regular exchange of information between them as to Tom's whereabouts. However, that relationship was not visible to other agencies and its existence was not shared at the strategy meeting. Other agencies were unaware of Tom's ex-partner and the value she may have had in helping to act as an intermediary in discussions with Tom.

***Learning - it is important to ensure that at strategy meetings, all relevant information is shared between agencies. This is important for the development of options that help address the risk a vulnerable adult might face.***

The panel felt the current approach to safeguarding adults, particularly in the way that strategy meetings are conducted and risks recorded are not as structured as they should be. The panel felt the model set out in the Multi-Agency Risk Management (MRM) model provides more rigour.

***Learning - adopting a common approach and templates for recording issues like minutes, actions and risks etc. provides more rigour and consistency. This improves information sharing between agencies and helps ensure the nature and level of risk faced by a vulnerable adult is understood and documented consistently.***

There is no evidence agencies shared information with the bank (or banks), or that they were included within the strategy meeting plans to reduce the risks Tom faced.

***Learning - when financial abuse is known or suspected early contact with banks might help ensure that plans can be agreed and put into place that helps protect the victim from further abuse.***

Professionals referred on several occasions to Tom displaying the signs of being 'a drinker'. There were also references to Tom being part of a group of other 'drinkers'. In fact, Tom was someone who misused alcohol and was therefore vulnerable.

***Learning - it is important not to stigmatise or label individuals as 'drinkers'. Such an approach means that an analysis as to the reasons why that individual is misusing alcohol does not take place and opportunities to help them may be missed.***

### Reflective Questions for Professionals

- To what extent do I critically reflect on cases?
- How do I avoid fixed thinking?
- To what extent do I understand the effects of alcohol abuse, the risks of relapse and the impact on the person?
- Have I identified all sources of support for the adult and explored family connections?
- Is information being shared appropriately?
- Do I understand how to assess the individual's capacity for change?
- Have I the confidence to respectfully challenge other professionals if I believe that a person's needs are not being met by existing multi agency plans?
- Am I familiar with the procedure for escalating cases?