RBSAB
ROCHDALE BOROUGH SAFEGUARDING ADULTS BOARD

Adult E
Safeguarding Adult Review

1 Background information

Adult E was in his 70's when he was admitted to hospital under Section 2 of the Mental Health Act following a significant decline in his ability to care for himself at home. The scope of the review focussed on a time period of just under 3 years prior to Adult E's decline in health, and explored alcohol use, mental health and self-neglect.

Adult E was supported by a number of agencies throughout this time period (apart from a 12 month period in 2018) including Adult Care, STARS, District Nursing, Home Care, Hospitals, GP and GMP.

2 Learning – Multi-Agency Safeguarding Response

Adult E was referred to Adult Care 6 times in 4 months, but not all contacts were recorded as safeguarding concerns, meaning that there weren't always multi-agency safeguarding procedures initiated as a result. The referrer was not notified of the outcome of the safeguarding referrals.

The MRM process was not considered; this was a missed opportunity for all professionals working with Adult E to develop an action plan.

3 Learning – Self-Neglect

Adult E was self-neglecting for a period of time and had varying levels of engagement with professionals.

As noted above, the MRM process was not considered.

The importance of the 4 key tests for executive functioning, including *weigh up and use* are crucial in circumstances similar to those of Adult E.

4 Learning – Professional Curiosity

There was a lack of professional curiosity and respectful challenge regarding Adult E. Professionals did not always consider or investigate underlying issues, or consider the impact of an immobile and incontinent adult, i.e. pressure ulcers.

Information provided by Adult E about personal care was unrealistic when considered against physical evidence in the home. Agencies did not always attempt to corroborate information given by Adult E with family members.

5 Learning – Mental Capacity and Executive Functioning

Some interventions were based on his perceived capacity rather than completing necessary assessments and documenting the evidence of this. The review found that only one agency shared their formal mental capacity assessment.

More frequent mental capacity assessments may have been beneficial when considering how best to address Adult E's mental and physical health needs.

The *weigh up and use* question to test executive functioning was not used effectively.

6 Learning – Information Sharing

Information sharing between agencies following periods of support and intervention were not always robust. For example not all hospital staff were aware of Adult E's previous safeguarding history.

Adult E was, on occasion, reluctant to engage with services, which resulted in some care packages being withdrawn as the providers were unaware of the full impact of Adult E's self-neglect.

7 Conclusions & Next Steps

Am I able to utilise the Mental Capacity Act 2005 in my role and am I asking the right questions regarding *weigh up and use*?
Am I aware of executive functioning and how this links in with the Mental Capacity Act? More information is available Rochdale Safeguarding Partnership Board - Multi-Agency Policy, Procedures, Protocols and Guidance
Am I aware of the MRM process and how this is relevant to me in my role?
Am I aware of the Rochdale Safeguarding Partnership Board - Self-Neglect & Hoarding policy and am I able to identify self-neglect in practice? Information on training is available Rochdale Safeguarding Events