HILLINGDON SAFEGUARDING PARTNERSHIP
7-MINUTE BRIEFING
ADULT C LEARNING REVIEW

1. Introduction

Adult C was the main carer for their relative. There was a history of concern about the impact of alcohol use on C's capacity as a carer, including allegations of physical abuse and neglect causing harm to their relative. Adult C was not not considered to have care and support needs in their own right until shortly before their death from unknown causes.

This briefing summarises the outcome of the multiagency learning review.

2. Learning Review

The case review was completed in partnership with all involved agencies and identified the following areas of learning:

- Agencies could have shared information more effectively
- Adult C's needs were overlooked, their relative was considered to be the 'primary client' however they too were ineffectively safeguarded
- Practitioners should consider history when risk assessing new information
- Escalation processes were not used
- Agencies need to ensure that services are person-centred
- Practitioners did not consider the impact of alcohol use on neglect/self-neglect

3. Communication & Information Sharing

Communication between, and within, agencies should avoid jargon. When sending a referral practitioners should ensure this has been received, and understood, by the receiving agency. All case related information should be recorded in line with agency standards.

If you are unsure about the meaning or purpose of information shared always ask for clarity.

4.Safeguarding

Effective practice requires a personalised approach to safeguarding adults. In this case there was a lack of practitioner recognition of the risks C's alcohol use posed regarding their capacity as a carer. The review highlighted missed opportunities for an adult safeguarding response due to allegations of the physical abuse and neglect of Adult C's relative. Practitioners did not actively consider that C was at risk of self-neglect.

Self-neglect is a lack of self-care to the extent that it threatens personal health and safety. It includes neglecting personal hygiene, health or surroundings, inability to avoid harm, failing to seek help or access health and support services, and the inability or unwillingness to manage personal affairs.

You can access more information here: SCIE

5.Risk Assessment

Practitioners should ensure that new information is understood in the context of known history.

Where this is not clear a chronology should be written, this ensures that risks are properly considered and is especially important in identifying issues of neglect and self-neglect.

A chronology is a tool for assessment that highlights date, significant event, and outcome. It ensures that any decision is fully informed, and allows patterns to be seen. For Adult C, and their relative, it is likely that a chronology would have resulted in more effective safeguarding, supporting practitioners to understand the 'whole' situation, rather than responding to new contacts in isolation.

Always think about the wider implications of known information for all who could be affected, especially where there are children or adults who could have care and support needs.

6. Escalation

Practitioners in this case were not satisfied that Adult C, was being effectively safeguarded. There was no escalation in response to multiple safeguarding referrals in respect of the care of C's relative.

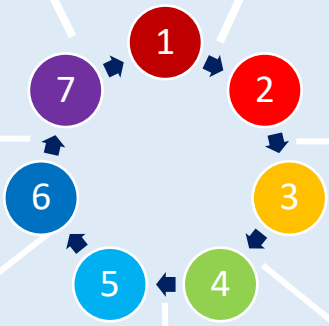
Professional discord can be emotive and result in a disorganised approach to escalation. All agencies have a process that should be followed when concerns arise. Ensure that you are familiar with your agency policy and know how, and who, to escalate concerns to.

7. Review

The purpose of any case review is to establish learning and improve local safeguarding practice where necessary. Think about the learning from this case, discuss with colleagues and in your team meetings. Is there anything that surprises you? What changes can you make in your service to embed the learning?

Feel confident in asking if you do not understand jargon – you will not be the only person! Be proactive in ensuring that other people understand any jargon your service uses.

Do you need more information or training around recognising and responding to neglect or self-neglect? What about working with people who misuse alcohol?



January 2021

Hillingdon safeguarding adults board

Hillingdon SCP safeguarding children partnership