Safeguarding Adult Review – John – Discussion paper.

Facts	Discussion topics
John is a 37-year old man with a learning disability and autism who is currently settled in a residential care home outside the Borough of Solihull.	
Between 2008 and February 2016 John lived with his mother and step father at 3 addresses in Solihull. John has a large and complex family with 15 siblings, some of whom have criminal convictions. John's mother is described as having a strong personality – being a 'character'. John's step father is a Schedule 1 offender, was convicted of murder in 1984, served 20-years and since 2015 has care and support needs. John's step-fathers convictions were not identified as a possible risk until September 2015.	What are the issues in relation to large families? Positive and negative. How can we make use of the positives? How can we mitigate the negatives? How do we/can we plot an individual's family tree? Genogram or Ecogram? *John's mother is described as having a strong personality – being a 'character'* – what does this mean? How should we work with her? *John's step father is a Schedule 1 offender, was convicted of murder* – what does this mean? Does this have risks? What are they? How do we mitigate them?
In 2008 John moved from a residential care home in Birmingham, into the family home to be cared for by his mother. A full explanation as to why or how this came about is not available. Solihull Adult Social Care's first contact with John was in September 2008 when they were approached by John's mother requesting support to find something for him to do during the day. In 2009 a Direct Payment as provided.	How and why John was moved from a residential care home in Birmingham, into the family home to be cared for by his mother is not known. Is it important to know? Why? How can we be sure we find this out now?
Initially the Direct Payment was used to commission support from a Domiciliary Care Agency to support John to access the community, however within 2 months this support was cancelled.	If a support plan is cancelled or changed significantly within a short space of time – What does this trigger? What should it trigger?

Between 2008 – September 2015 Solihull Adult Social Care's contact with John/his mother was reactive in that the contact was responding to the GP or John's mother when they felt she felt no longer able to care for him. The contact resulted in no change in care or trying to ascertain how John's Direct Payments were being used for him. John's contact with Health professionals in this period was very limited.	How are concerns about the use of an individual's Direct Payment picked up and responded to now?
Professionals only saw John in the company of his mother. John's contact with Health professionals in this period was very limited. Health and Social Care reviews were irregular and did not pick up on his deteriorating physical and mental health, which was used to access changes in housing accommodation and the provision of aids and adaptations	Professionals only saw John in the company of his mother – in such situations how can we be sure this is always appropriate? Should professionals question this? Should professionals try and see individuals alone? How could they do that? Given the comments above about John's mother, sept-father and family should professionals have made more effort to see John alone or provide him with independent advocacy? John is a 37-year old man with a learning disability and autism whose physical and mental health was deteriorating – why did professionals not pick this up? Who should have noticed John's physical care needs appeared to be deteriorating and yet he was just 37 years old?
The first formal safeguarding activity was in September 2015, a second safeguarding concern was recorded in February 2016 after John had moved out of the family home. The safeguarding concerns included financial abuse (misuse of Direct Payments), verbal/emotional abuse, physical abuse, domestic abuse and sexual abuse. Independent Advocacy was not instructed for the safeguarding activity. To date no criminal proceedings have been initiated by the police.	Have can we ensure safeguarding supports adults like John to access the criminal justice system? Would an advocate have helped?

In February 2016 John was placed in a residential care home outside the Borough of Solihull following an incident the night before when it is alleged John assaulted his mother and police were called to the family home.	
John remains in the residential care home outside the Borough of Solihull, is the subject of a DoLS, received support from an Advocate and has accessed a range of health services such as GP, SALT, Psychology, Optician and Dentist. He has also accessed a range of community services such as a hairdresser and various social activities. It is clear, that John is making good progress in his physical and mental health since moving from the family home in February 2016, where he is settled and well supported. He is gaining some independence and is in regular contact with one of his sisters who is impressed at the care he is receiving now.	John has made significant progress physically and mentally since moving from the family home – could or should his physical and mental deterioration in the family home have been spotted? How? By whom?
The safeguarding Adult review concluded:	
John was "unseen" by very many agencies both physically and metaphorically.	How can we ensure individuals do not go "unseen"?
It was clear from this review that John was unlikely to disclose abuse or neglect himself, however greater professional curiosity in day to day work with John to ascertain what was going on in this family and what Johns 'lived' experience was might have identified concerns when dealing with an un-associated issue. Particular care is required to ensure pre-conceived assumptions about an individual's diagnosis, needs and abilities do not influence practice and actions. All agencies identified John's anxious behaviours and lack of verbal communication and accepted it as 'normal' behaviour for him/adult with learning disability.	How can we exercise professional curiosity? How can we ensure pre-conceived assumptions about an individual's diagnosis, needs and abilities do not influence practice and actions? For example: *All agencies identified John's anxious behaviours and lack of verbal communication and accepted it as 'normal' behaviour for him/adult with learning disability.*

In situations like John's where there are unremarkable circumstances to easily identify a safeguarding concern, it relies on professionals who come into contact with an adult with care and support needs routinely to have: good record keeping as failing to keep basic and accurate records can put people at risk, effective information sharing processes and good partnership working so as to maintain individual's safety and wellbeing and avoid harm and abuse.	Are we confident that we routinely have good partnership working so as to maintain individual's safety and wellbeing and avoid harm and abuse? When we have a current safeguarding – do we routinely consider who else needs to know about the safeguarding? Does that include the GP? Housing? Etc.

The full Safeguarding Adult Review Report can be found on the SSAB website www.SSAB.org.uk

http://www.ssab.org.uk/ssaboard/about-solihull-safeguarding-adults-board/safeguarding-adult-reviews-sars-84.php