Introduction

Safeguarding Adults Reviews are undertaken when an adult in the local authority area with care and support needs either dies, or suffers serious harm, as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect the adult.

Safeguarding Adults Board may also commission discretionary Safeguarding Adults Reviews where the above criteria is not considered to be met but valuable learning opportunities are identified.

The purpose of a Safeguarding Adults Review is to learn lessons about how professionals and organisations work together and to seek to prevent similar abuse or neglect occurring again in the future.

Learning Briefing

Brighton & Hove SAB Safeguarding Adults Board

Andrew

Andrew was a 51-year-old white, British man who had a severe learning disability and had previously been assessed as being unable to make capacitated decisions regarding his care and support needs. He also had longstanding health issues that included concerns around hid nutritional intake and weight loss.

Andrew had lived for over twenty years in a small local authority run Residential Care Home setting and he also received a high level of care and support from his sister.

In 2019 Andrew was assaulted by another resident who had recently moved to the Care Home. He sustained significant injuries, which led to him being admitted to hospital. He experienced further illness whilst in hospital, with his weight loss continuing.

After two months Andrew's condition was felt to have stabilised, and a decision was made that he return to the Care Home. However, his condition declined further and despite being readmitted to hospital Andrew passed away a few days later.

The Brighton and Hove Safeguarding Adults Board commissioned a discretionary Safeguarding Adults Review (SAR), in the form of a 'Desk-top Review' to understand the circumstances leading up to the death of Andrew.

A number of investigative and enquiry processes had already been undertaken by the agencies involved in supporting Andrew. The aim of the desk-top review was to bring together the various processes already undertaken to identify and share multi-agency learning in seeking to prevent a similar situation occurring again in the future.

An Independent Reviewer was appointed and Terms of Reference agreed for the review that included a focus on the safeguarding processes, knowledge and awareness of Safeguarding Adults Reviews locally, the suitability of the Care Home as a setting for Andrew to return to, as well as the multi-agency discharge arrangements in place when Andrew left hospital initially.

The Independent Reviewer identified a wide range of findings and grouped these into seven themes. These seven themes are **Residential Care Home Practice**, **Safeguarding Practice, Care Management Practice and the Care Act, Mental Capacity Act, Hospital Discharge Process, Multi-agency Practice**, and **Good Practice**.

From this they made six recommendations to the Brighton and Hove Safeguarding Adults Board that are summarised below. These recommendations will be taking forward by developing an Action Plan with the agencies concerned.

1) **Assurance the local authority's Residential Care Home's procedures and processes in relation to the admission, review and management of needs and recording have been reviewed and revised.**
2) **Assurance that all partner agencies, and the Specialist Community Disability Service department in particular, have appropriate procedures and processes in place to respond to safeguarding concerns in a timely manner with staff supported to enable evidence-based decision making in ensuring outcomes are line with statutory responsibilities.**
3) **Assurance that the Specialist Community Disability Service has reviewed and revised procedures and processes to ensure it is meeting their statutory duties with regard to arranging, managing, and reviewing Care Home placements in a timely manner and commissioning independent advocates where appropriate.**
4) **Assurance that the Specialist Community Disability Service and the CCG (as commissioner of the acute hospital provider) have reviewed and updated their Mental Capacity Act policy and guidance in meeting their statutory duties.**
5) **Assurance that the Specialist Community Disability Service and the CCG (as commissioner of the acute hospital provider) have reviewed and updated joint policies and procedures to ensure effective multi-agency working arrangements to implement and review care and support plans.**
6) **The examples of good practice are recognised and shared with staff and managers.**

Further Learning

If you are working with someone with learning difficulties who you suspect may be experiencing, or at risk of, abuse or neglect they can watch this 'Tricky Friends' video here to help them identify if this is the case.

If you are unsure whether abuse or neglect may be taking place you can consult the pan-Sussex SAB Safeguarding Adults Threshold Guidance here. This contains examples under each category of abuse and neglect within the Care Act to help professionals identify whether a safeguarding concern should be raised, or if not alternative actions that could be considered.

If you are looking to improve your knowledge in relation to the Mental Capacity Act you can read the learning briefing produced by the BHSAB here.

All of these resources can be found at the BHSAB website -