Learning Brief: Safeguarding Adults thematic review

Supporting Adults with Learning Disabilities at risk from hoarding behaviours

The Review:

The BSAB commissioned a thematic review in response to two cases involving adults with learning disabilities who experience harm associated with hoarding and neglect.

- In Case A, the adult at risk died as a result of poorly controlled diabetes. She has been assessed as having capacity, though there were doubts regarding her ability to execute decisions regarding health and social care needs.
- Case B involved a woman with learning disabilities who, despite numerous attempts by her GP and social care, had not had a review of her needs since leaving education. Professionals and neighbours had raised concerns regarding the family's living conditions and ability to meet her needs, but offers of support had been refused by her parents. Sadly both her parents became acutely unwell during the first lockdown, necessitating intervention by health and social care. She now has full support and is reported to be thriving. Partners believed the poor state of her family home and lack of formal support likely had significant impacted on her development and wellbeing.

Whilst neither case met the s44 criteria for a mandatory review, BSAB commissioned a thematic review of the two cases to better understand how to respond to concerns regarding neglect and hoarding for adults with learning disabilities and to explore opportunities for improved practice across safeguarding partners to prevent similar harm occurring in future.

The review was undertaken by an independent reviewer, Janice Woodruff, with expertise in learning disabilities. Attempts were made to contact family members involved, but unfortunately they did not wish or could not take part in the review. Practitioners involved in both cases did meet with the reviewer to share their experiences. In addition, the reviewer met with relevant designated safeguarding leads to discuss her findings and understand what steps had already been taken to improve practice.

Key messages for Front Line Practitioners:

- **Use the BSAB's self-neglect and Safeguarding Adults policies to reduce risk and prevent the escalation of health needs.**

The reviewer found that in both cases risks associated with hoarding and neglect of health conditions were identified, but there was considerable drift as practitioners struggled with the complexity of both cases. All service providers and partner agencies are required to have clear safeguarding policies and staff are expected to recognise and report safeguarding concerns. In both cases practitioners did seek to offer support, but despite clear safeguarding policies and procedures, practitioners accepted their actions didn't reduce the risks and cases were not escalated in line with the multi-agency safeguarding policy.

In Case A, the provider raising concerns felt these were dismissed until they could justify a case for increasing the commissioned package with little regard for the complex nature of the adult's needs or understanding as to why she had 'disengaged' from statutory support.

Also, housing maintenance staff and health professionals had identified that the housing conditions in both cases made it unsafe for them to complete their responsibilities, it was therefore troubling that this did not trigger recognition that this would likely mean (in both cases) the adults were at risk.

In addition, the review found that efforts to refer for legal advice were frustrated as too little information as to the circumstances and previous involvement of services were provided to the legal department.

- **Understanding a person's capacity to make and execute a decision is vital to reducing risks. Look for reasons behind behaviours, be tenacious, but act with respect and compassion.**

Practitioners in both cases reported difficulties in assessing capacity, particularly someone's capacity to execute a decision. It can make it harder for professionals to offer additional support if earlier, less invasive, offers were refused or professional advice wasn't followed.

In both cases more timely, effective interventions would have prevented harm and the escalation of needs. For example, adopting a more proactive approach to enabling access to healthcare and ensuring take up of annual health checks.

The reviewer was concerned that, in case A, the adult was discharged from specialist clinics due to non-attendance with seemingly no regard to her disability and how this might make it difficult for her to accept support or attend appointments. In Case B, professionals accepted family members' refusal to attend for health checks. Given this was not in her best interests, this should have been actively challenged including, if necessary, through a s42 enquiry process.

We know how important these annual checks play in maintaining health and wellbeing from national LeDeR reviews reports. It is vital therefore that within each care plan there is clarity about who will lead on making arrangements and what action will be taken if the health check is missed. CLCH have implemented a 'did not bring' policy and GPs, social care and families are advised to consider this to enable improved practice going forward.

- **When safeguarding concerns arise, work creatively with the adult and their 'family unit'.**

In both cases, when s42 enquiry duties were triggered, these did not address the concerns through the lens of the 'family' unit. In case A the adult had been prevented, due to financial abuse concerns, from contact with a close friend who helped manage her health. Whilst there was no criticism that action may have been required to reduce the risk of financial abuse, the reviewer did question if practitioners took sufficient account of the adult's wish or the impact that such action would have on the adult's ability to manage her own health. A s42 enquiry was also conducted in case B, but because the subject of that enquiry was her mother it failed to consider risks to her daughter despite clear indications that her disability would mean she was unable to protect herself.

Neither safeguarding enquiry addressed the ongoing risk (incl. fire safety) of hoarding.

Recommendations:

1. Practitioners should include within care or treatment plans what arrangements and reasonable adjustments are necessary to enable adults with learning disabilities to attend their annual health checks and what steps will be taken if they do not attend or are not brought.

2. Practitioners are encouraged to attend the safeguarding forum and BSAB's monthly 'lunch and learn' webinars.
3. With the adult at risk and their family unit, build in contingency and escalation/ de-escalation plans to protect against drift in complex cases.
4. Ensure you understand when and how to refer to the Multi-agency risk panel, Community Learning Disability Team's Complex Care Panel, Multi-agency Safeguarding Hub or legal services.

Steps already taken to improve outcomes

Practitioners were able to identify changes that have already been implemented in the intervening period. The BSAB Self-Neglect policy enables practitioners to explore cases from different perspectives- promoting creative approaches for family support. It requires that, if risk is not reduced, cases are escalated to the 'Multi-agency Risk panel'.

CLCH reported on the improved practice that implementing a 'did not bring' policy has had on supporting adults with a learning disability to access healthcare and work with their carers or family to ensure reasonable adjustments are made. The review recommended all partners, particularly those providing support to adults with a learning disability, adopt this policy.

Practitioners across all agencies were also aware of the Community Learning Disability team's Complex Case Panel and spoke of the opportunities this provided to collectively consider needs to prevent safeguarding risks emerging or escalating.

The new 'safeguarding champions' programme and more accessible training should also improve implementation and use of the safeguarding policies and the application of equality and mental capacity legal obligations. Similarly, safeguarding leads from all agencies felt the new BSAB escalation protocol and guidance for third sector groups on 'Making Safeguarding Personal' would improve practice.

Key messages for Management and Strategic Development

1. Working with hoarding risks and behaviour that challenges is complex. Balancing rights to decline care with reasonable steps to engage the person in change will likely mean progress may be incremental; they rely on building relationships over time. Support staff with time and resources to be creative and flexible.
2. Equip staff understand how and when to refer to multi-agency panels and legal services and when to use BSAB safeguarding and the self-neglect policies through supervision and training. Develop mechanisms for monitoring use to provide assurance to the BSAB that staff are using these effectively.
3. Consider developing a peer support group for diabetes management targeted at adults with learning disabilities.
4. Work with private landlords so they too are aware of BSAB's Hoarding policy and safeguarding duties.
5. Provide assurance reports to BSAB on:

    a. timeliness of s42 enquiries;
    b. effective use of policies to reduce safeguarding risks and prevent the escalation of need;
    c. application by clinicians and service providers of reasonable adjustments so that adults at risk with a learning disability access necessary health reviews;
    d. emerging themes or concerns regarding unmet needs as reported by the High Risk or Complex Case Panels to BSAB's Performance and Quality Assurance sub-group.