Brent Safeguarding Adults Board

Response to the Safeguarding Adult Review – Sean (Adult D)

Today sees the publication of the Brent Safeguarding Adult Review Executive Summary concerning Sean (Adult D). We are using this name at the request of his brother and sister-in-law to whom the Safeguarding Adults Board offer their sincere condolences. This is a distressing case of a man who died at home and was not found for some time because services were no longer visiting him.

There are clear lessons to be learned from this case. Central is how adult social care and healthcare practitioners and care providers work with people who, as in Sean's case, are reluctant to engage and are inclined to withdraw. This was a recurring pattern with Sean and is a common feature of cases involving people who self-neglect. Unfortunately, in this case, it led to services withdrawing and to no-one visiting Sean to check on his health and wellbeing.

There are other lessons also. In cases of self-neglect, especially where there is a pattern of someone initially accepting care and support but then dis-engaging, practitioners and providers should not withdraw until a multi-agency meeting has concluded a risk mitigation and management plan and agreed which services will attempt to remain in contact. There is an evidence-base of what best practice consists of when working with people who self-neglect. That evidence-base is a clear reference point when working with people who self-neglect.

An action plan has been agreed by the Brent Safeguarding Adults Board to ensure that all the recommendations in the Safeguarding Adult Review have been implemented and the necessary changes to policy and practice fully embedded. Indeed, self-neglect now forms a key component of the Board's strategic plan and some work has already been completed with respect to the review's recommendations. A self-neglect policy and set of procedures has been developed and launched, which provides a framework for multi-agency partnership work concerning cases of self-neglect. Training has been provided on working with people who self-neglect, including at the Board's annual conferences in 2019 and 2020. Future meetings of the Brent Safeguarding Adults Board will seek reassurance that implementation of the recommendations and the development of the self-neglect policy and procedures have resulted in service improvements.

The learning from this Safeguarding Adult Review will continue to be disseminated widely across all organisations within Brent with roles and responsibilities for safeguarding adults. They will be required to give an account of how they have disseminated the learning within their staff groups and ensured that policy and practice have changed to reflect the recommendations in the review.

Professor Michael Preston-Shoot

Independent Chair

November 2020