LEARNING BRIEFING

Safeguarding Adults Review Josh

Teeswide Safeguarding Adults Board

1 Background

Josh was a young man who was homeless and had diabetes. When his parents separated, Josh turned to substances to block out emotions, leading to anti-social behaviour and a broken relationship with his mother. Josh was taken into care.

Josh was later cared for by his aunt and uncle. He continued with substance misuse: his lifestyle and behaviour impacted on the family unit and their support was withdrawn.

Josh had tried to live independently but became homeless as he moved across different localities to flee drug dealers.

Josh began to take overdoses of insulin, resulting in admissions to hospital. Following a significant overdose of insulin, he suffered a permanent and life changing brain injury; Josh passed away unexpectedly in hospital three months later.

The Safeguarding Adults Review considered 5 themes and identified 17 learning points.

2 Theme 1: Homelessness

Josh effectively made himself homeless to flee drug dealers and sought housing in a different locality. He had unrealistic expectations of where he could be housed and wanted to be away from people who used drugs: the options for young men in this situation are limited.

Professionals were unclear about the processes and restrictions on the terms of securing housing in this situation. There was a lack of multi-agency oversight of the situation Josh found himself in.

Josh took an overdose at the housing office when his situation could not be resolved.

Josh's case predated the implementation of the Homelessness Reduction Act 2017.

3 Theme 2: Response to repeat attenders at hospital

Josh misused his medication and was admitted to hospital on several occasions.

A frequent attender meeting was held; the right people/agencies did not attend the meeting. A multi-agency approach would have better supported Josh to address his complex issues.

A plan to support Josh was developed: some practitioners disagreed with the plan but felt unable to professionally challenge the decisions made.

4 Theme 3: Substance Misuse and Mental Capacity

Josh regularly used illicit drugs in addition to his prescribed Methadone; the dangers of this level of misuse were discussed with Josh by substance misuse workers.

Josh moved between 2 local areas: some of his history was lost as his existing risk assessment was not transferred across to the new locality. Josh didn't engage well with services and missed appointments when he was in hospital.

Commissioning arrangements for substance misuse services impacted on the support Josh received. Services are re-commissioned on average, every 2 years; the contract requirements can change and the case records do not transfer in all cases.

It is not known if Mental Capacity assessments were robust: it was not clear if consideration was given to fluctuating capacity and the impact of drugs on decision making. Staff were not aware of the level of drug misuse in this case.

5 Theme 4: Care Act, Self-Neglect and Safeguarding

There was an inconsistent approach to safeguard Josh and some professionals did not fully understand self-neglect within the Care Act 2014.

A Social Worker in the Mental Health hospital undertook some really good work with Josh, particularly around housing issues, but they did not communicate or use Local Authority systems, so some information was not shared on a Multi-Agency basis.

Professionals were not clear about high risk and vulnerability panels and whether these were operating in the Local Authority area (they were not). These panels provide a multi-agency, co-ordinated response for individuals who self-neglect and lead complex lifestyles and would have provided a framework of support for Josh.

6 Theme 5: Communication between professionals and family

Josh told practitioners that he was estranged from his family; the review found that he had had close relationships with his aunt, uncle, and other family members albeit they had been unable to provide support due to the lifestyle he led.

Josh expressed to some practitioners that he wanted to rebuild his family relationships; this was not explored any further. There seemed to be a lack of professional curiosity.

7 What to do now and next

- Reflect on how the above themes link with your direct practice with adults, families and practitioners. Think about what changes you can make to your practice in similar areas.
- Share within your team and explore any training needs you may have.
- Read the full report
- Check out the following resources;

  Duty to Refer Briefing
  Professional Challenge and Curiosity Briefing
- Check www.tsab.org.uk for up to date policies, procedures and guidance, including the Professional Challenge Procedure.
- Implement any identified changes required into practice.

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