Learning from OSAB SARs: Joshua

Background

A Safeguarding Adult Review (SAR) is a multi-agency process that considers whether or not serious harm experienced by an adult at risk of abuse or neglect, could have been predicted or prevented. The purpose of the SAR is to promote learning and improvement action to prevent future deaths or serious harm occurring again. It was a unanimous decision of the Oldham Safeguarding Adults Board (OSAB) SAR Subgroup that the SAR criteria were met in relation to 'Joshua'. Joshua was a young man with a learning disability alongside autistic spectrum disorder. He suffered from epilepsy which was monitored and managed with medication. He was able to express himself in simple language. He lived with his parents who both had disabilities and health issues. Joshua's father was carer for both his son and his wife. During his adolescence, Joshua began to demonstrate behaviour that professionals and his family found challenging to manage however, he could also be calm, happy and loving.

What Happened?

Joshua and his family were known to Children's Social Care. Joshua was subject to Child in Need and Child Protection plans which focused on the home environment and Joshua's care. Joshua's father self referred to numerous agencies indicating carer stress and an inability to cope with the intensive demands of caring for Joshua. Joshua sadly died at 18 years old. The SAR was commissioned to understand and learn from the circumstances surrounding Joshua's care. There was preliminary information which led to a reasonable assumption that his death could be linked to neglect of his care, support and medication needs. The SAR determined that Joshua's father did not feel listened to, he reported that when he asked for help the usual reply was that no further practical support could be offered. On reflection, Joshua's father felt that the best way to support him with his own health and wellbeing, would have been to offer more support with Joshua.

The Importance of the MCA From Age 16

The SAR states that prior to formal Transition to Adult Social Care, young people aged 16+ who are known or thought to lack mental capacity should be assessed by Children's Social Care in line with the Mental Capacity Act (MCA), in relation to their ability to participate in making specific decisions e.g. care and support, treatment. These assessments should be reviewed if circumstances change. For more information see the OSAB MCA Policy and Practical Guide.

Long-Term Neglect

The SAR highlighted the challenges of making sound single and multi-agency safeguarding judgements in cases of ongoing, fluctuating unintentional neglect including how to judge when the capacity of a family to sustain care for a young person with complex needs has reached a tipping point, considering and differentiating the impact on the young person and how developmental and behavioural changes during adolescence should inform safeguarding decisions and future planning.

Multi-Agency Working

Communication and information sharing across practitioners and services who were supporting the family was fragmented and incomplete, with some services who had worked with the family for a long time still being unaware of some wider safeguarding context and/or the ongoing welfare concerns for Joshua. Whilst practitioner discussions as part of the SAR found that different teams and services were strongly motivated to work together, and safeguarding concerns were appropriately raised by different agencies, the impetus and will of individual practitioners and agencies did not convert into integrated and holistic support for the family in practice, partly because of important gaps in insight and information sharing. One of the factors that may have hampered effective response was a combination of over-optimism and desensitisation to the family situation and care scenario. There was a sense that practitioners were 'willing' the family to improve the care they could provide but because neglect had fluctuated, practitioners were also blinded to the presentation and impact of long-term neglect on Joshua, especially as he entered adolescence.

Transitions

The SAR recognised that there was a gap between ideal Transition practice and what happened in reality. Factors that influenced this included a backlog in the numbers of young people requiring Transition planning and the challenges of working with the reality of a reduction in provision once young people move into Adult Social Care services. Although some Transitions conversations took place, there was little evidence of purposeful multi-agency risk management and planning. The eventual Transition appeared to be a transaction between services and did not propose or plan for any substantive changes to Joshua's or his father's care and support. It was not the considered and person-centred approach it is intended to be, which sets out a secure plan for adulthood that anticipates the needs of the young person, and family carers. For more information see the Oldham Transitions Policy and a 7-Minute Briefing.

Supporting Carers

There was limited critical thinking about Joshua's father's ability to cope as Joshua got older, his capacity to sustain caring for two adults with complex care and support needs, and how his residual coping capacity is likely to have been severely undermined by the restrictions created by the response to the Covid-19 pandemic. Sadly, there is a sense that Joshua's father's needs went unnoticed to some extent and whilst he was supported with compassion and advocacy when he seemed to reach crisis point, this did not always go far enough or result in any substantive change in support for the family. The SAR detailed that parent carers should always receive a Carers Assessment in their own right, especially prior to formal Transition to Adult Social Care services. Find out more about Carers Assessments via a separate OSAB 7-minute Briefing.

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