Adult G Safeguarding Adult Review Learning Brief
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Case Summary

Adult G was a 51 year old man who lived alone in rented accommodation, was unemployed and in receipt of benefits. Adult G was known to services including mental health; Adult G had attempted to take his own life in January 2017 and as a result had been admitted as an inpatient on an informal basis. He had memory problems which appeared to result in him accruing overwhelming debt to the point where he could barely afford to eat and he often did not attend appointments leading to him being discharged from services, or not receiving medical treatment. Sadly, Adult G took his own life in June 2017, he was found by his son.

This learning brief covers key learning themes from the Review, if you require more detail or want to see all of the learning the full SAR report is available on the LSAB website.

1. This case highlights the importance of **clear and concise referrals** which should document all risks and vulnerabilities. It is important that practitioners completing referrals, in which, self-neglect may be a concern, make this explicit within the referral to ensure the correct processes are implemented.
2. A **robust and holistic assessment** was required to underpin all the risks and vulnerabilities being experienced by Adult G, to truly understand the impact of his debt and cognition on his capacity to make informed decisions. His finance difficulties directly impacted on the food he was consuming which in turn was effecting his cognitive ability. This was never fully understood by agencies working with him. The Consultant Psychiatrist from the Memory Assessment Clinic was of the view a vitamin deficiency was contributing to his memory problems.
3. **Self-neglect** was felt to be a factor for Adult G; however, this was never fully explored utilising a multi-agency meeting. Click here to view the LSAB self-neglect framework which aims to support professionals in how to respond when concerns of self-neglect have been identified.
4. This review has highlighted that Adult G was eligible for the **Care Programme Approach** and he should have been allocated a **Care Coordinator** prior to discharge from inpatient care. This would have made a significant impact to Adult G's life and the impact on his family, as his son was 17 years old and had some caring responsibilities; although he didn't live with his father.

   The key areas below were applicable to Adult G in meeting the CPA criteria:
   - Risk of suicide
   - Self-neglect
   - Being a vulnerable adult for example having cognitive difficulties
   - Having the need for multi-agency input such as housing, physical care, employment and access to voluntary agencies

   CPA is a statutory process which focusses on service users who have severe, enduring or complex Mental Health problems and should always be considered for service users admitted as inpatients where there are concerns about their mental health.
   Please see the CPA Carers Leaflet for further information.
5. From the information made available to the Review, there were no recorded formal decision specific capacity assessments undertaken for Adult G, that's not to say that professionals were not assessing his capacity throughout their involvement with him. It is expected practice and as outlined in the **Mental Capacity Act Code of Practice (MCA)** to accurately record any capacity assessments and best interest decisions in a timely manner.
6. It is clearly recorded that Adult G was struggling with his memory and was in need of a memory assessment. He was discharged from the Service as he did not attend his appointment; this was due to his poor memory. The review suggests services should consider different ways of working with patients who have cognitive difficulties, given the inherent risk of appointments being forgotten by those referred to the service.

The Review noted the **good practice** by the Police officer who found Adult G in a park, in a very disorientated state, after being reported missing. The officer took Adult G to the emergency department, bought him something to eat and drink and submitted a vulnerable adult referral. Other examples of good practice are also noted within the report.