

7. Further Information and resources

- ❑ [Mental Capacity Guidance Note: Assessment and Recording of Capacity | 39 Essex Chambers](#)
- ❑ https://learning.nspcc.org.uk/media/1334/learning-from-case-reviews_disguised-compliance.pdf
- ❑ [Briefing for practitioners - Analysis of Safeguarding Adults Reviews | Local Government Association](#)
- ❑ [NCASP Professional Curiosity 7-minute guide](#)

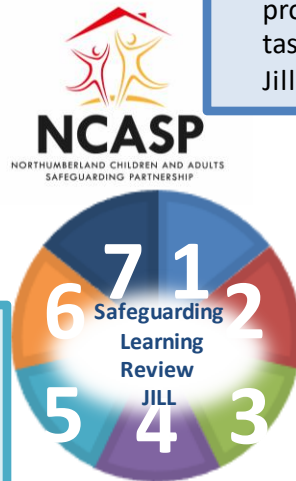
6. Recommendations

The Safeguarding Partnership seeks assurance that

- ❑ Individual Agencies who identified their own learning, recommendations and actions have completed these.
- ❑ MCA is embedded and understood by staff.
- ❑ Attendance at safeguarding meetings is prioritised by all agencies.
- ❑ Professional curiosity is embedded within training.

5. Key Learning (form the themes above)

- ❑ Missed opportunities to complete capacity assessments.
- ❑ Safeguarding procedures were inconsistently followed.
- ❑ Concerns were dealt with in isolation.
- ❑ Inconsistent attendance at safeguarding meetings by professionals.
- ❑ Jill was not routinely seen alone.
- ❑ Professionals focused on Barry's actions rather than Jill's lived experience.
- ❑ Records suggest she felt very close to her brother however they were not contacted for their views and input into Jill's care and support.
- ❑ Independent Advocacy was considered but inconsistent.
- ❑ Education or challenge was not provided to Barry consistently to promote Jill's voice.
- ❑ Lack of professional curiosity.
- ❑ Missed opportunities for agencies to intervene.
- ❑ Police were not routinely contacted when concerns were raised.
- ❑ Legal services were not routinely asked for advice.



1. Background

- ❑ Jill has a diagnosis of Learning Disability; Cerebral Palsy; Autistic Spectrum Disorder and is also profoundly deaf with no verbal communication, she can understand BSL and will use written communication.
- ❑ Jill was known to Northumberland Adult Social Care from 2010, after moving to the area with her stepfather "Barry" almost immediately following the death of her mother.
- ❑ Jill has 1 brother and sister-in-law who have maintained contact with Jill throughout the last 12 years.
- ❑ At the point of moving to Northumberland, Jill was subject to adult safeguarding procedures in her own Local Authority, due to concerns raised about Barry's ability to provide appropriate care for Jill and that he was carrying out intimate personal care tasks in the absence of formal carers. Safeguarding procedures were initiated on Jill's arrival to Northumberland.

2. Concerns

- ❑ In 2021 concerns were raised when Barry had cancelled care provision and was refusing to allow carers into the property.
- ❑ In the MASH Review several historical concerns were identified which included Barry being convicted of the murder of a female dating back to 1969, and an allegation of sexual abuse of a female with Learning Disabilities. Records also indicated previous concerns had been raised of financial abuse, physical abuse, neglect, and a level of control and coercive behaviour towards Jill but had not been robustly acted upon.
- ❑ As a result of the MASH enquiry, Barry was recalled to prison and Jill was placed in 24-hour care.

4. Good Practice

- ❑ There were strengths identified within the review and areas of very good practice, particularly in 2021 when staff demonstrated tenacity, understanding and commitment to support Jill and mitigate risks.
- ❑ The MASH enquiry in November 2021 was an excellent demonstration of how MASH should work and the positives of multi-agency working.
- ❑ There were pockets of good practice throughout the 12 years in which Barry was challenged and Jill was seen on her own, however this was inconsistent.
- ❑ The Day Centre and 1 Home Care Agency in particular raised concerns appropriately.

3. Key Themes from the review

- ❑ Mental Capacity Assessments not being considered or completed
- ❑ Safeguarding Adults Policies and Procedures not being followed
- ❑ Jill's lived experience
- ❑ Lack of professional curiosity
- ❑ Multi-agency Involvement