SAFEGUARDING ADULTS REVIEW (SAR)

LEARNING BRIEF - BAKAR

Safeguarding Adults Review (SAR)

The purpose of a Safeguarding Adult Review is to use learning for the case under review to promote and reinforce effective practice and identify where improvements or adjustments to the system need to be made.

The Care Act 2014 states that a Safeguarding Adults Board must commission a SAR when:
(1) an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult,
(2) an adult in its area has not died, but the adult has experienced significant abuse or neglect, whether known or suspected.

Bakar's background information

Bakar, who was in their 50s, died by suicide following a period of ill mental health, increased alcohol consumption, and not taking medication for both physical and mental health conditions. Bakar identified as they/them.

Bakar was originally from Somalia and moved to the UK where they resided with a family member. Bakar was often worried about the political tensions in Somalia where the rest of their family still lived.

This review highlights the social and wider pressures that Bakar experienced in their life, such as transphobic and homophobic discrimination, several accommodation moves, a lack of basic facilities, and increased social isolation.

Safeguarding Adult Review (SAR) process

The review period was 2018 to 2022. Two independent authors were appointed to complete the review. Seven agencies contributed to the SAR process. The review aimed to focus on lessons learned to improve future practice.

Themes: Mental health, transphobia and homophobia, alcohol consumption, and substance use.

Key Findings

Organisational environment

(a) Care Act 'thresholds and criteria' did not assess Bakar's full needs.
(b) There were gaps in safeguarding knowledge and practices in agencies.
(c) The learning from the Keeping Adults Safe work should have been implemented in a suicide prevention strategy.
(d) Training on protected characteristics should be implemented.

Governance and leadership

(a) The police response was effective when Bakar was unwell, such as transporting them to safe accommodation.
(b) There was a lack of accessibility and supply of supported housing.
(c) The engagement of the Community Safety Partnership is essential in improving the system.

Inter-organisational working

(a) There were examples of disagreements in cross-working between agencies.
(b) The review indicated difficulties in Care Act pathways and safeguarding thresholds.
(c) There were miscommunications around hospital discharge.
(d) A lack of clarity of existing panels was highlighted, as well as ambiguity in who to call for a multi-disciplinary team meeting.

Direct practice

(a) Discriminatory abuse had not been highlighted in referrals despite recorded disclosures.
(b) The review highlighted the need for alcohol and substance use pathways.
(c) There were concerns in the gaps of mental health services which consequently led to an escalation. (d) The review indicated assumptions of mental capacity.
(e) Support for immigration processes should have been signposted.
(f) Gaps in communication regarding basic living facilities resulted in months without white goods.

Recommendations

Direct practice

Recommendation 1 *- Better awareness of the unique dynamics of discriminatory. An audit to be completed.*

Recommendation 2 *– Alcohol pathways should be reviewed and audited.*

Recommendation 3 *– Agencies to develop guidance for closing cases.*

Recommendation 4 *– Mental Capacity assessments should be done by partner agencies for people experiencing complex needs.*

Recommendation 5 *– KBSP and the voluntary sector to create pathways for people with severe unmet basic needs in their area.*

Inter-organisational working

Recommendation 6 *– Ensure that referral technology is functioning through audits and testing.*

Recommendation 7 *–Review closure decision making when a person is in hospital.*

Recommendation 8 *– KBSP should audit out of area mental health hospital discharge arrangements.*

Recommendation 9 *– KBSP should review pathways and ensure that all partners are informed of what exists and to develop proposals for any identified gaps.*

Organisational environment

Recommendation 10 *– Review the policies and procedures to clarify mental-ill health and substance misuse.*

Recommendation 11 *– Agencies to monitor the interface between their services regarding self-neglect referrals.*

Recommendation 12 *– Review the safeguarding adults strategic plan, regarding self-neglect, suicide prevention strategy and action plans.*

Recommendation 13 *– KBSP should ensure that all partners are offered training on discriminatory abuse.*

Governance and leadership

Recommendation 14 *– KBSP should seek assurance about the implementation of the policy 'Right Care, Right Person' and welfare checks regarding bed unavailability.*

Recommendation 15 *– Consider escalation of the issues of scarcity of supported housing, health inpatient beds and places of safety at a national level.*

Recommendation 16 *– KBSP to engage the Community Safety Partnership function of the partnership.*

Examples of good practice

1. **Person-centred relationships**: Most of the relationships between agency workers and Bakar were person-centred and engaged in escalating issues, such as ensuring that actions were carried out to meet the needs of Bakar, such as changing house locks and rehousing.
2. **Proactive agency engagement within the review**: Agency representatives identified barriers that were in place which sadly prevented Bakar from receiving the support, as well as the learning from this review.
3. **Implementing learning into practice**: Agencies have begun to input the learning from the review into practice, such as the consideration of implementing training on transgender people's needs. This is important as training within agencies promotes the understanding of individual circumstances and needs.
4. **Agency cross-working**: Several agencies involved strived to work together to safeguard Bakar, such as advocating for statutory housing and mental health services. The request for a multi-agency meeting highlights good understanding of when to escalate concerns through cross-working.

Support

Mental health services

Nilaari is a Black, Asian and Minority Ethnic led community-based emotional wellbeing and mental health charity.

Call 0117 952 4742 or email nilaari@nilaari.co.uk.

Drug and alcohol services

Bristol Drugs Project provide free and confidential support. Call 0117 987 6000 or email info@bdp.org.uk.

Developing Health and Independence (DHI) run Community Recovery Hubs in Bristol where you can get free and confidential help. Call 0117 440 0540 or email roads@dhi-services.org.uk.

Hate Crime

Easy Read leaflet about Hate Crime and Discrimination service.

SARI provides free and confidential support for anyone who is a victim of hate crime. To contact SARI, call 0117 942 0060 or email sari@sariweb.org.uk.

Call 999 if a crime is happening now or you're in immediate danger.

Where to find us:

KBSP@bristol.gov.uk

@KBSPartnership

www.bristolsafeguarding.org