SAFEGUARDING ADULT REVIEW (SAR)

LEARNING BRIEF - DANIEL

Safeguarding Adult 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.

Background Information

Daniel, in his 60s, was living in a mental health hostel run by a charity. Daniel had several health diagnoses, such as Chronic Obstructive Pulmonary Disease (COPD), HIV, and Paranoid Schizophrenia.

He was found in his room malnourished with burns and blisters covering his body. It was alleged that another resident had thrown boiling water from a kettle over Daniel. Daniel's condition declined whilst he was in hospital until he passed away. The cause of death was confirmed to be due to Bronchopneumonia and his health diagnosis of COPD.

Themes: neglect, self-neglect, mental health, risk of homelessness, long-term health conditions.

Key Learning

Collaborative Working Between Agencies

Despite Daniel being in contact with several agencies, the review had highlighted a lack of partnership working between agencies. For example, agencies did not attempt other means of contact, such as through Daniel's social worker, when there had been non-engagement. Additionally, the review highlighted occasions where agencies' Did Not Attend policy was not initiated. Other examples include the GP not being informed of Daniel's admittance to the Emergency Department, and missed opportunities between agencies to work together to contact Daniel in the days leading up to his death. These examples highlight missed opportunities of cross-working between agencies which have been addressed in the review.

COVID-19's Pressures on Services

COVID-19 played a role in the pressures agencies faced with their services and their engagement with Daniel. Agencies were restricted in ways to communicate with Daniel. Nevertheless, Second Step exhibited good practice by ensuring that Daniel had their phone number in case he needed to contact them during the pandemic. Additionally, HomeChoice was closed during the pandemic so there wasn't an option to bid for housing until after the COVID-19 pandemic.

Multi-Agency Safeguarding Adults Policies and Procedures

The review highlighted the importance of multi-agency safeguarding adults policies and procedures. For example, the review highlighted a lack of joint processes to coordinate the Care Programme Approach (CPA) assessments to support Daniel, as well as missed opportunities between agencies to raise and escalate safeguarding concerns.

Good Practice

Cross-Working Across Cities

There are examples of good practice throughout the review between services in Bristol and in another city where Daniel previously lived. For example, Avon and Wiltshire Mental Health NHS Partnership Trust (AWP) had liaised with Daniel's previous mental health agency to prompt information sharing so that AWP could support Daniel better using the information provided.

Good Rapport and Commitment to Daniel's needs

The review highlighted good examples of staff engaging with Daniel to support his needs. When a rapport was built with Daniel, he felt comfortable to discuss his concerns with professionals. For example, the Salvation Army support workers reviewed housing options, needs and finances with Daniel and his preferences were recorded and communicated to other agencies.

Consistent Follow-Ups and Responses to Non-Engagement

There are several occasions where staff who were involved with Daniel made follow-ups when there had been missed calls from Daniel, or non-engagement. In addition, when Daniel voiced concerns these were responded to by those who were in contact with him within an appropriate timeframe.

Both health centres would regularly contact Daniel to ensure he attended several medical appointments via letters and text messages. In one instance the health centre recorded an attempted phone call from Daniel but it was unclear whether Daniel was feeling unwell, or had hung up. The GP attempted to ring him back, and had left a voicemail message and text message advising Daniel to call back. The GP also attempted to speak to Daniel the day after. This example highlights the health centre's understanding of the importance of continuing to contact the individual when faced with non-engagement.

Daniel's Active Engagement in Decisions

The review highlighted events where Daniel had active participation in decisions that affected the support he received. For example, Daniel expressed that he wished to remain in his current accommodation to Bristol City Council - Adult Social Care (ASC), AWP and the Salvation Army which was granted by the agencies supporting him. Additionally, Daniel was in attendance for the development of a Wellness Recovery Action Plan where discussions were carried out around Daniel's mental health, diagnosis of HIV, as well as the structure of his daily routine. By encouraging Daniel's participation, agencies were able to support Daniel's needs better and cater to outcomes which would significantly impact Daniel's quality of life and autonomy.

Recommendations

Recommendation 1: *AWP and ASC to have reviewed and revised their Joint Care Programme Approach (CPA) Policy and Procedures.*

Recommendation 2: *AWP and ASC to have reviewed and revised their Community Mental Health Framework Policy and Procedures.*

Recommendation 3: *AWP and ASC to ensure that Policies and Procedures in Recommendations 1 and 2 have been promoted across their joint workforces and their implementation supported by a multi-agency programme of staff development opportunities.*

Recommendation 4: *ASC to review their current assessment process to ensure this is strengthened in line with Care Act (2014) requirements.*

Recommendation 5: *AWP to revise their Supervision and Case Work Management Policy and Procedures to include back office support systems which support staff when they are out of the office.*

Recommendation 6: *Second Step to review and revise its Recording, Supervision and Case Work Management Policies and Procedures.*

Recommendation 7: *Salvation Army to review and revise as appropriate its referral, information sharing and monitoring systems and processes.*

Recommendation 8: *Integrated Care Board (ICB) to review and share best practice guidance in relation to Did Not Attend/Was Not Brought to ensure that it includes:*

- *Guidance for coding of recorded vulnerabilities and appropriate responses to these*
- *Reasonable adjustments required in relation to communication needs*
- *ICB to provide assurance that Did Not Attend/Was Not Brought guidance has been effectively embedded within primary care.*

Recommendation 9: *The ICB to review guidance to ensure that primary care is clear on how to record medication prescribed by specialist health providers.*

Recommendation 10: *The ICB to provide training to primary care in relation to best practice when working with patients where self-neglect may be indicated.*

Recommendation 11: *The ICB to review the health centre's safeguarding policy and procedures are up to date and in line with local safeguarding arrangements.*

Recommendation 12: *The ICB to share learning from the review in relation to accurate record keeping and the use of codes when referrals are shared or received.*

Recommendation 13: *ASC to review and revise as necessary the Procedures under which s42 Enquiries are completed.*

Recommendation 14: *Avon & Somerset Lighthouse Safeguarding Unit for Bristol to provide assurance that they have reviewed their triage processes in line with ASC thresholds and they create a marker on their system to highlight properties of multiple occupancy.*

Recommendation 15: *That the Keeping Bristol Safe Partnership seek assurance from member agencies that they, and the services they commission, are ensuring that staff are acting in accordance with the Mental Capacity Act (2005) and its supporting Code of Practice, particularly in cases of actual or potential self-neglect.*

Recommendation 16: *That the Keeping Bristol Safe Partnership should acknowledge the examples of Good Practice identified and seek assurance from the relevant agencies that this has been brought to the attention of the relevant staff and their managers.*

Support

Homelessness

Bristol City Council provide advice on night shelters, and temporary accommodation.

Shelter also offers advice and support, including 1:1 personalised help with housing issues.

Contact number: 0330 175 5121

Self-Neglect

Self-neglect is defined as a broad range of behaviour in which an individual is neglecting to care for their personal hygiene, health, or surroundings. You can find out further information about self-neglect here.

Mental Health

VitaMinds is a free mental health service. You do not need to visit your GP to get help from VitaMinds. Call 0333 200 1893 or self-refer online.

Where to find us:

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www.bristolsafeguarding.org