SAFEGUARDING ADULTS REVIEW (SAR)

LEARNING BRIEF - GEORGE AND PETER

Safeguarding Adults Review (SAR)

The purpose of a Safeguarding Adult Review is to use learning from 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 Adult 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 - George and Peter

A thematic SAR was commissioned for the cases of George, 66, and Peter, 70, who both had been identified as dependent drinkers with cognitive impairment. George and Peter did not know each other.

The Dementia Wellbeing Service (DWS) concluded George's cognitive impairment was secondary to an alcohol-related brain injury. George sadly passed away in January 2024 due to a fire in his home.

Peter was identified as being alcohol dependent and had been referred to DWS who were unable to assess him due to the amount of alcohol units Peter was consuming. Peter was found unconscious in his home and later died in hospital in February 2024.

Key Themes

Working with Alcohol Dependency

The review found that both George and Peter were diagnosed with significant cognitive impairment from alcohol-related dementia. However, there was a difference in how George's and Peter's dependent drinking was managed. George's alcohol use had been identified by practitioners, and he was receiving outreach support from Supported Independence. In comparison, the steps taken to address the risks Peter faced due to his alcohol use lacked an effective outcome.

During hospital admissions, two referrals were made to the University Hospital Bristol and Weston Trust (UHBW) specialist alcohol team, which is good practice. However, there is no documented record of any outcome from either referral. In addition, Peter was referred to Developing Health and Independence (DHI) on two occasions, but when methods to attempt contact with Peter were unsuccessful, the referrals were closed.

The review also highlights the challenges of engaging dependent drinkers. Research by Ward and Preston-Shoot (2020) suggests that effective engagement strategies involve persistent, assertive services, built on relationships, harm reduction and motivational interventions; likewise to some services offered by DWS which could have benefitted George and Peter. However, the review identified that DWS typically requires abstinence from alcohol, for three months or a reduction in alcohol use under 14 units per week, which may have been difficult for George and Peter to achieve.

Bristol Horizons are the new provider for drug and alcohol support services.

Self-Neglect

Practitioners identified the risk of self-neglect in both George and Peter's cases although the level of safeguarding referrals made for George significantly higher. The review noted that there was limited recognition of self-neglect in Peter's case despite his difficulties with self-care and alcohol misuse. The lack of consistent safeguarding referrals may suggest a limited awareness or gaps in protocols for managing patients with self-neglect and associated vulnerabilities.

The review promotes the use of the Bristol City Council Adult Social Care (ASC) safeguarding advice line which enables practitioners to speak to an experienced social worker about safeguarding concerns, such as self-neglect cases.

Mental Capacity

The review found that the use of mental capacity assessments in Peter and George's cases was inconsistent.

- George and Peter had completed many mental capacity assessments, but an Independent Mental Capacity Act Advocate was only considered in George's case.
- In another assessment, the social worker did not include consideration of George's executive capacity whereas for Peter this was considered.

However, when George and Peter were assessed to not have capacity, there was no documented record of any best interest decisions and this was identified as a gap for agencies.

Barriers to engagement

The review found that a number of services had regular contact with George and Peter, but their engagement with the services offered was inconsistent:

- The GP adapted their practice after recognising that George had a potential learning difficulty and was unable to read or write.
- Outreach alcohol support services were invested in George, however, there was no documented evidence to try and secure Peter's engagement with the service.
- The review identified that having episodic contact provided little to no opportunity to build relationships with both George and Peter.

Use of Section 42 Framework

The review recognised that there had been examples of good information sharing between agencies in both cases, including the submission of several safeguarding referrals. The review, however, highlighted that there was no documented consideration of using the Section 42 framework under the Care Act 2014 to enable a joint, co-ordinated response to mitigate risk in both cases. This was concluded as a missed opportunity for partnership working.

Deteriorating Health Conditions including Mental Health

George and Peter had significant physical health needs and had regular contact with health services. In both cases, their cognitive impairment and alcohol use had a negative impact on the ability for health professionals to treat their health needs. For example, Peter's records suggest that he could not be prescribed normal medications for some conditions due to risk of falls, haemorrhage, and persistent alcohol use.

Exploitation including Financial Abuse

The review explored concerns from agencies that Peter may have been financially exploited. When questioned by the police following Peter's allegations of financial abuse, he would deny that these persons were accessing his money without his permission. Police records documented that partner agencies had informed them that Peter had the mental capacity to make decisions about his financial affairs. However, the review identifies this as a lack of partnership working as health and social care practitioners determined Peter did not have capacity to make decisions, particularly with respect to financial matters.

Fire Risk

George and Peter had contact with Avon Fire and Rescue Service (AF&RS). In Peter's case, the AF&RS attended a fire in his home and identified that alcohol use was a factor for future fire risk. The AF&RS made a referral to Bristol ROADS, however this did not result in any effective engagement with Peter and feedback was not provided to AF&RS. The review highlighted that this was a missed opportunity to mitigate the fire risk and to better safeguard Peter.

AF&RS completed a Home Fire Safety Visit at George's home following a referral from ASC in July and appropriate steps were taken to reduce the fire risk. However, additional incidents occurred when George was reported to be burning holes in the communal carpet with cigarettes, but this did not result in a referral to AF&RS which was a missed opportunity to mitigate risk. George sadly died from a fire in his home which was as a result of George smoking in bed.

Good Practice

- The GP had contacted Peter by telephone but Peter had declined to speak to the GP. The GP had been concerned for Peter's capacity, home environment, and confusion, and had arranged for a home visit in the following week. This was seen as good practice as the GP had **professional curiosity** to better understand the home environment.
- A IMCA had been involved whilst George was admitted to hospital. He had been deemed not to have capacity for discharge. Using an IMCA was seen as good practice to **represent George's best interests.**
- A **joint home visit was arranged** between Sirona and the social worker to engage Peter with their service and complete a falls assessment. Whilst the assessment was not fully completed due to Peter being intoxicated, the risks in the environment were identified and this information was shared.
- There were **escalation of concerns for George and Peter's safety** at being discharged at home.
- The GP had carefully **documented medication reviews and the medication discussions** with other professionals who were involved in George care and support.
- **A Home Fire Safety Visit was completed at George's premises following a referral from ASC in July.** As part of the visit, appropriate steps were taken to reduce the risk of fire within George's flat.

Recommendations

1) The Safeguarding Adults Board (SAB) should reassure itself that there is a consistent and effective response to addressing the risk of harm faced by service users with cognitive impairment, who are identified as dependent drinkers.

2) Avon and Somerset Police should promote the signposting of individuals to relevant support services where it is apparent they may be misusing substances including alcohol, alongside completing BRAG assessments and onward referrals where appropriate.

3) Bristol Horizons to work with the police to provide training, and to create a pathway, for police colleagues to refer people misusing alcohol for support services.

4) ASC should ensure that practitioners system wide are aware of the safeguarding advice line and how the service can support practitioners with adult safeguarding decision making.

5) The SAB should reassure itself that practitioners system wide, understand the need to document their decision making and to record their best interest considerations, where adults have been assessed as not having the mental capacity to make a decision.

6) The SAB should seek reassurance from Bristol Horizons that their non-engagement policy meets the needs of service users who may have complex needs and who may have difficulty engaging with services.

7) ASC should ensure that relevant practitioners understand how to apply the Section 42 criteria in cases involving self-neglect, substance use or the risk of exploitation. This would include adults at risk of one of these issues or where all three risks may apply.

8) The SAB should ensure that practitioners system wide recognise the importance of making fire safety referrals where a fire risk is identified and the case involves adults who are cognitively impaired or who are recognised as being dependent drinkers.

9) Bristol Horizons should provide assurance to the SAB that they have the appropriate policy in place to ensure that where a referral to their service is closed without engagement with the service user, feedback is provided to the referring agency to enable risks to the service user to be appropriately managed.

Support

Bristol Horizons

Horizons is a collaboration between nine community organisations, offering inclusive and accessible support to help anyone in Bristol make informed choices.

Horizons offer resources and advice to make positive changes around drugs and alcohol.

Email directly at BristolInfo@horizonsbristol.co.uk or call 03005551469.

Home Fire Safety Visits

AF&RS provide further support to eligible members of our community in the form of a home fire safety visit, which is a free pre-arranged visit to the home to carry out a fire safety assessment and provide advice to minimise fire risks.

For agency referrals, it is necessary that your client gives you consent to pass their details to AF&RS to contact them and book a home visit.

Mental Capacity

The Mental Capacity Act (MCA) helps and protects people who have limited mental capacity to make decisions. This includes people who have limited capacity due to illness, injury or disability. The MCA aims to help these people to make decisions or to be involved in decisions as much as possible.

Resources: MCA Leaflet and Making Decisions: A Guide for Advice Workers

Adult Social Care - Safeguarding Enquiries Line

The safeguarding enquiry team hotline **0117 903 6629** can be used by agencies to speak to an experienced social worker and access advice about safeguarding matters or referrals to Adult Social Care.

Where to find us:

KBSP@bristol.gov.uk

@KBSPartnership

www.bristolsafeguarding.org

Keeping Bristol Safe Partnership