SAFEGUARDING ADULTS REVIEW (SAR)

LEARNING BRIEF - RICHARD

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.

Where to find us:

KBSP@bristol.gov.uk

@KBSPartnership

www.bristolsafeguarding.org

Background Information - Richard

Richard was a 53-year-old man who lived in a supported living flat in Bristol. Richard had a history of anxiety, social phobia, and agoraphobia. He also experienced hallucinations and was diagnosed with Schizophrenia, Psychotic Depression, Type 2 Diabetes and Hypertension.

Richard had many hobbies, engaged in activity groups, and enjoyed paid and voluntary work.

In February 2024, Richard's upstairs neighbour reported hearing him shouting and banging. The service coordinator contacted the mental health crisis team, 101 and 111. They were uncertain whether Richard required emergency medical assistance, so no call was made to 999. The following day support workers discovered Richard deceased, and the coroner concluded Richard died from self-inflicted wounds whilst suffering from an acute psychotic episode.

Key Themes

Mental Health

In December 2023, one week before his admission to the Mental Health Unit, Richard lost his employment and was unable to drive due to issues with his car, which disrupted his routine. Richard disclosed he had experienced a 'major breakdown' and that his auditory hallucinations and depression had escalated. He stated he had become forgetful, which resulted in him neglecting his medication. The documentation did not indicate that this had been explored to consider potential causes therefore it would be challenging to develop an effective care and treatment plan.

Richard was admitted to a Mental Health Unit approximately thirty miles from his home, as there were no beds locally. Richard stated he was unprepared to return home as he was uncertain whether his mood would be 'okay' if he did so.

Discharge Planning

Richard's discharge from the Mental Health Unit seven days before his death, despite ongoing psychotic symptoms and his family's concerns, represented a missed opportunity for further risk assessment and intervention. Transitioning from hospital to community care is high-risk, necessitating robust crisis planning and family engagement.

Richard was not referred for a Care Act Assessment during his admission or discharge in order to reassess Richard's care and support needs. Adult Social Care were also not informed that Richard had been discharged. This highlights the lack of information sharing which subsequent risk management reviews could not be adequately reassessed.

Medication interactions with physical health concerns

The impact of medication on Richard's physical health was not thoroughly reviewed despite known risks.

Anti-psychotic medication prescriptions can increase the risk of poor physical health such as weight gain and disruption of glucose metabolism which are potential mechanisms for the association between diabetes and anti-psychotic use. There is a need to increase awareness of this to establish a safe treatment plan for patients.

Good Practice

Milestones Trust staff demonstrated diligence in attempting to seek help for Richard on the night before his death.

The coroner's inquest provided detailed insights into Richard's final moments, informing learning for future cases.

Between 2018 and 2023, Richard's mental health was effectively managed with the support of this family, Milestones Trust, and a consistent routine. This stability allowed him to maintain his wellbeing.

The Adult Social Care support plan showed person-centred care and collaborative decision making by identifying the support he needed and the aspects of his life that he enjoyed.

Learning

- Ensure timely and inclusive Care Act Assessments post discharge.
- Facilitate multi-agency involvement, especially with community and family stakeholders.
- Enhance physical health monitoring for those on antipsychotic medication.
- Implement clear discharge protocols aligned with Care Act and Mental Health Act guidance.
- Improve documentation and communication around carer support and risk assessments.

Recommendations

Recommendation One: Strengthening Discharge Planning

- Develop a structured multi-agency discharge plan incorporating input from relevant agencies, family, and friends (where appropriate) and include a crisis and contingency plan. The plan should specifically address the needs of individuals at risk of deterioration.
- Develop and implement a post-discharge monitoring system that clearly outlines the roles and responsibilities of involved agencies to prevent relapse.

Recommendation Two: Enhancing Multi-Agency Collaboration

- Establish explicit protocols for collaborative work among ASC, AWP, and Milestones Trust.
- During scheduled reviews, all key stakeholders should be invited to enhance decision-making and facilitate the exchange of information.

Recommendation Three: Enhancing Knowledge and Understanding of Mental Health Crisis Support

- To provide staff members training on the duties and responsibilities of Mental Health and Adult Social Care, safeguarding, and mental health crisis intervention.
- Establish a unified protocol or handbook outlining AWP's mental health crisis support referral pathways, limitations, and responsibilities.

Recommendation Four: Embedding Learning from the Review

- To ensure that the lessons acquired from the review are incorporated into policy and practice through ongoing training and supervision to reflect on cases and discuss best practices in safeguarding.
- Establish a feedback cycle to ensure that recommendations result in measurable improvements.

Support

Hub of Hope

Hub of hope is a mental health support directory where you can find a service to help you feel better or if you want to support someone who is struggling. Find them at www.hubofhope.co.uk

Social Anxiety Bristol

Social Anxiety Bristol support group runs a meeting twice a month (7:00pm – 9:00pm) on Thursdays at Totter down Baptist Church, BS4 2AX. Find out more information at www.socialanxietybristol.org.uk

Bristol Mind

Bristol Mind work by supporting anyone in Bristol with mental health concerns. This could be via their Community Wellbeing Services, Counselling, or Telephone services. For support, get in contact at www.bristolmind.org.uk anytime or call 0117 203 4419 Wednesday to Sunday 7pm to 11pm.

Further Resources

NHS - Every Mind Matters - offers free practical tips about ways you can look after your mental health.

NHS - Easy Read Guide on talking about your health.