Bath & North East Somerset Community Safety & Safeguarding Partnership

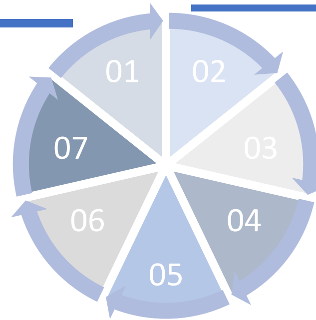
BCSSP – 7 Minute Briefing

Safeguarding Adult Review (SAR) – Martin Evans

01. Rationale for a Safeguarding Adult Review (SAR): The BCSSP has a legal duty to review any case it is made aware of where an adult with care and support needs has died, or sustained serious injury, as a result of abuse or neglect (including self-neglect); and there is reasonable cause for concern that partners did not work together effectively to safeguard the individual.

The purpose is to identify lessons learnt so that these can be applied in future safeguarding work. The full report can be found on the BCSSP website: https://bcssp.bathnes.gov.uk/node/112

02. What happened in the case of Martin? Martin died when he was 36 years old. He had a long history of mental health concerns and alcohol use. He was found unresponsive at his home address and could not be resuscitated. Martin was known to a number of agencies and was regarded as a 'high risk' drinker. He lived alone and concerns had been raised regarding self-neglect. Martin wished to move to a supported environment in which he could become alcohol free. His father supported him with his finances and was closely involved in number of aspects of his care. Martin has been described to this review as a 'gentle giant', with the exception of times of anger and frustration, was polite and always asked for help. He is said to have hated being a burden to his father.



03. Learning Point 1: Timeliness of Assessment & Management of Risk. Risks were assessed by different services involved as high but there was no completed care and support assessment, no risk management strategy and no crisis intervention plan. His medical conditions were kept under review by his GP surgery and by the RUH during hospital admissions. However, while in the final months of his life his non- attendance at surgery appointments to discuss medication caused concern, repeat prescriptions continued to be issued without review in the context of his deteriorating health and self-care.

04. Learning Point 2: Mental Capacity & Executive Functioning. Best practice in self-neglect advises thorough mental capacity assessments, which include consideration of executive functioning; assumptions should not be made about people's capacity to be in control of their own care and support. Martin's mental capacity did not receive sufficient attention. Other than some assessments by SWASFT and RUH, capacity was either not considered at all or was inconsistently addressed, with an over-reliance on assumed capacity and an absence of formal assessment, despite the potential impact of his alcohol use. Executive function does not appear to have been considered as a factor in his decision-making on drinking and self-care.

Actions taken in direct work with Martin do not reflect those that would be indicated in relevant procedures. Recourse to the MARMM was late and even when a MARMM took place it did not produce a viable or coordinated intervention plan.

05. Learning Point 3: Inter-agency Co-ordination & Communication. There were some good communications between some of the agencies involved. Virgin Care attempted to explore sources of support for Martin, and some joint visits involving different agencies took place. One hospital discharge showed particularly robust liaison between hospital and community facilities. There were, however, shortcomings in interagency coordination. Some agencies experienced difficulties in communications with other agencies and there was some misunderstanding of agency roles in relation to hospital discharge planning. Referrals between agencies did not always share key information that would enable levels of need and risk to be judged.

06. Learning Point 4: Organisational Features. Some agencies experienced resource pressures during the period under review. As a result, staff turnover posed challenges of continuity, potentially damaging Martin's trust in his supports, and breaks in communication between agencies. It also compromised staff familiarity with, and understanding of, policies and procedures. There are questions about the availability of services for people with significant levels of mental ill-health but who are not acutely in need of care and treatment from secondary mental health services. Coordination of provision in complex and challenging cases clearly remains a challenge and it is possible that the multiple commissioning and funding arrangements result in services that don't quite fit together into a coordinated picture.

07. Learning Point 5: Work with Martin's Family. Several agencies had frequent contact with Martin's father. He received considerable support from the community matron, who recognised the impact of caring for his son in the context of his own emotional needs, although he declined her suggestion of carer's support. It seems that a 'think family' approach was missing, as was any attention to how family dynamics might be impacting on Martin's behaviour.