B&NES COMMUNITY SAFETY AND SAFEGUARDING PARTNERSHIP
PRACTITIONER BRIEFING – 'MARK'

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

Under the Care Act 2014, a Safeguarding Adults Board has a legal duty to review any case in which:

- An adult with care and support needs has died (or sustained serious injury)
- As a result of abuse or neglect (including self-neglect)
- Where there is cause for concern about how agencies worked together to safeguard the individual

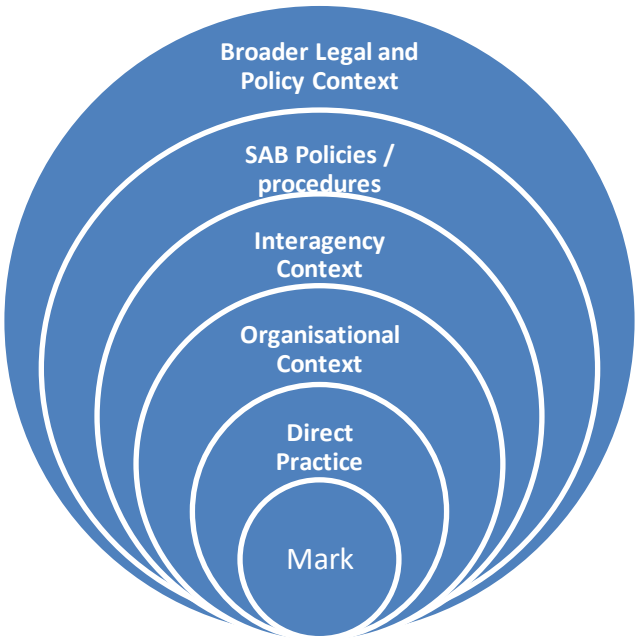
The purpose is to identify lessons learnt so that these can be applied in future safeguarding work.

THE SAFEGUARDING ADULTS REVIEW

The Review Panel received written information from all the agencies that had contact with Mark between the 12th March 2018 and 11th March 2019. In addition, practitioners who had known and worked with Mark attended a 'learning event' to contribute their perspectives and ensure that the review was informed by those closest to practice.

Mark's family were aware that a review was being undertaken and they have received a copy of the final report. They have requested that the Review report is not published, but the learning from the review is shared through this practitioner briefing and assurance is obtained by the Community Safety and Safeguarding Partnership Board that the learning has been implemented across all agencies.

The Panel's analysis sought to identify not only what happened but also why: to focus on the organisational, interagency and broader contexts that influence practice.



MARK – A PEN PICTURE

Mark was 63 years old when he died. He had been diagnosed as having Obsessive Compulsive Disorder (OCD). Mark understood how his OCD manifested itself on a day to day basis and could articulate this in detail. He knew that the thoughts and actions were irrational and at times sought and responded to help, if offered, to manage the symptoms that he found distressing. At other times he endured his illness, became depressed as a result and withdrew or obscured the symptoms by drinking alcohol. His OCD also impacted on his physical wellbeing for example, his management of his diabetes; diet and medication management.

Mark had lived in London for a number of years before moving to the B&NES area. He had friends, both locally and across the country. It appeared he had contact with these friends when he was well but could be isolated at other times. Mark enjoyed music.

Mark lived in supported accommodation and was in receipt of support from health and social care professionals. He also had a package of care, primarily to support him to manage his housing and make sure that he was not neglecting either his physical or mental health. Mark feared throwing anything away as he was concerned that he may lose something valuable, including parts of his own body. He, therefore, had to check everything before he threw or washed it away. This led to him storing things and there had been ongoing concerns regarding his hoarding behaviour.

In the days before his death, staff at Mark's supported accommodation had raised concerns about self-neglect and hoarding. They mentioned that his room was piled high with clothing but there was a pathway to his bed. It was later noted that Mark was not using the bathroom, which was outside his room, and was no longer allowing staff to see his room. A safeguarding referral was made, and Mark's lead professional was made aware of the concerns, however, no urgent action was taken by the lead professional, despite the level of risk described in the referral. The safeguarding referral was also not passed to the Council for a decision in the timescale required by the Safeguarding Procedures, therefore, the safeguarding process did not begin until after Mark's death.

What we learnt / what we need to do differently

Working together to meet all the person's needs

The arrangements for managing Mark's physical health and mental health were separate and yet intertwined. The GP managed Mark's physical health and issued him with prescriptions (including psychiatric medication) and carried out an annual mental health review which was a comprehensive health review that included mental health needs. Whilst the Mental Health Team supported his mental health needs and care and support needs. The GP held an annual mental health review that the mental health team were not invited to. The Mental health team held reviews that the GP was not invited to.

The impact of Mark's declining mental health on his ability to manage his physical health was not considered. For example, him isolating himself and not eating well was not seen to have an impact on his diabetes. Nor was the fact that he had not seen his GP for seven months prior to his death.

Mark did not have a care plan that clearly outline the support that he required for both his physical and mental health needs and how that was to be met.

There was no clear risk assessment in place. Nor was there an agreed escalation arrangement in place. This meant that those working with Mark did not have a clear understanding about what escalating risks would look like for Mark or who the responsible professional was that others could contact regarding any concerns that his needs were developing.

Learning for Practice

Any review of a person's situation should include all the agencies that support them. Reviews should not be undertaken in professional silos. Both physical and mental health professionals should have training to improve their understanding of the impact on each other of mental health and physical health needs.

Risk assessments should be completed for people where there are known risks present.

If a person is living with a number of risks, there should be an agreed escalation process in place. This needs to include information about what the "signs" are of escalating risk and who should be contacted with concerns, this should include an organisational contact as well as a worker's details to ensure cover if the named worker is not available.

A person receiving support from any health or social care agency should have a care plan in place. This plan should describe the support the person requires and how/by whom that will be provided. Care plans, risk assessments and escalation plans should be provided to all the agencies and people working with the person and updated regularly.

Organisations should have a way of monitoring nonattendance for those viewed as being vulnerable/at risk. There should also be a procedure in place that outlines the action that then will then be taken.

Mind the gap

Mark had been in receipt of support from a mental health team since 2009. He had the same worker for several years, but when this person left in April 2018 a new worker was not provided. Mark was allocated a new worker in August 2018, but they did not contact him until October 2018.

Mark's social care needs included support with personal care. The supported accommodation provider was not, however, registered to provide this type of care. His worker did not appear aware of this and the provider did not highlight this to them. Parts of Mark's care and support plan were, therefore, not met.

Mark's health and social care records contained information regarding the factors that would indicate an escalation in his mental health. All these factors had occurred in the months before Mark's death, yet none of the professionals working with Mark referred to these factors or appeared to know how his risks would exhibit themselves.

The supported accommodation provider was not aware of the Self Neglect Policy or Safeguarding Escalation which had been in place for over a year. It appears that Mark's mental health worker was also not familiar with either of these policies.

Learning for Practice

Commissioners of services should make sure that providers are aware of new policies and procedures. This should include sending out links to the new policies and having an agenda item on contract meetings or providers forums for policies and procedures.

Anyone commissioning services from a provider should check that they are registered to provide the service being requested.

Providers should read through the person's care plan and assessment information before they confirm that they are able to meet their needs. If there are needs on the plan that they are not able to provide this should be discussed with the person commissioning the service immediately.

Organisations should have clear processes for identifying work that needs reallocating if the worker is off sick or on leave. This should include being aware of the legal duties that need to be met and how these would impact on the timescales for reallocating work.

Managers should ensure that all relevant documents have been completed for a person, for example assessments and escalation plans. Any new worker should then read these before meeting with the person.

Safeguarding

Mark was referred for consideration under the safeguarding procedures by the supported accommodation organisation. This was done after the concerns had been discussed with Mark's lead professional, as the staff remained concerned about Mark's wellbeing.

Neither the provider nor Mark's lead professional appeared to be aware of the Self Neglect Procedure, despite this having been in place for over a year.

They also did not appear to be familiar with the safeguarding process. Neither the provider or Mark's lead professional appeared aware that safeguarding concerns for people known to mental health teams should be referred to the mental health teams rather than another health and social care agency.

When the safeguarding referral was passed to the mental health team no immediate action was taken. This was even though the mental health team's records contained detailed information regarding Mark's self-neglect factors/pattern and that the worker had been aware for some weeks about the concerns that Mark's health was deteriorating.

Two days after the safeguarding referral was received by the mental health team, the provider reported that Mark had not come out of his room for two days, had not used the toilet which was outside his room and would not allow staff access to his room. Mark had told staff that he had not taken his medication for three days. Mark's lead professional visited, and Mark refused to let them into his room but did tell them he was not feeling well. The worker sought advice from health and social care professionals in their team and the next day two colleagues from the team visited Mark. As they could not gain entry to Mark's room an Ambulance was called, and the Fire Brigade had to attend to break into the room. Mark was found to be experiencing delirium and hyperglycaemia. His room was full of belongings including some bodily matter (urine and excrement). Mark was taken to hospital where he was treated for sepsis secondary to liver abscess and he had extensive bilateral community acquired pneumonia. He died three days later.

The safeguarding referral made by the provider did not reach the Council's safeguarding team for decision making until after Mark's death.

Learning for Practice

When a safeguarding concern is identified consideration should immediately be given to whether any urgent action is needed to keep the person safe. This can be done by a provider agency contacting social care, by a family member or by the social care worker receiving the referral.

As part of the initial information gathering, details should be sought regarding the person's life history and any previous known incidents of abuse or self-neglect.

Organisations employing staff on a short-term basis must provide them with information regarding safeguarding and self-neglect before they start working with individuals.

Management discussion or supervision should be used to confirm that the staff member has understood the requirements.

Any exploration of legislative tools that could be used to support a person, should be recorded on the person's records, even if a decision is made not to pursue any of the options. This includes consideration of legal action under the Mental Capacity Act, the Mental Health Act.

Organisations should ensure themselves that all their staff are aware of the referral process for people known to Mental health teams and that this process is clearly detailed in all safeguarding procedures.

Organisations, particularly provider agencies, need to make sure that their staff are aware of the safeguarding escalation process. This can be used to raise concerns about how a safeguarding matter is being responded to from the initial point that a concern is raised to the completion of a safeguarding enquiry.

FEEDBACK, SUGGESTIONS AND IDEAS

- Tell the B&NES Community Safety and Safeguarding Partnership (BCSSP) how you have used this briefing in your team by Email : Kirstie_webb@bathnes.gov.uk
- Please also let us know if you identify work that could be completed by the BCSSP which would support multi-agency professionals to implement the report's findings.
- You have any questions about the Briefing, or the BCSSP actions, please contact the Business Manager Kirstie_webb@bathnes.gov.uk
- www.safeguarding-bathnes.org.uk