Institutional Discharge - Learning from Safeguarding Adult Reviews

Emma Coleman, Nottingham City Safeguarding Adults Board Manager

What is a Safeguarding Adults Board?

Established under section 43 of the Care Act 2014

14.133: “Each Local Authority must set up a SAB”.

The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 42

Nottingham City Safeguarding Adults Board

What the Board must do

Publish a Strategic Plan which is reviewed annually

Publish an Annual Report

Conduct Safeguarding Adults Reviews (SARs) in accordance with s.44 Care Act

What the Board doesn't do

- Receive or process safeguarding referrals
- Have involvement in operational cases
- Act as an industry regulator for agencies involved in safeguarding
- Handle complaints about agencies or staff members
- Look at wider system issues outside statutory safeguarding for individuals who meet criteria set out in the Care Act (2014) statutory guidance

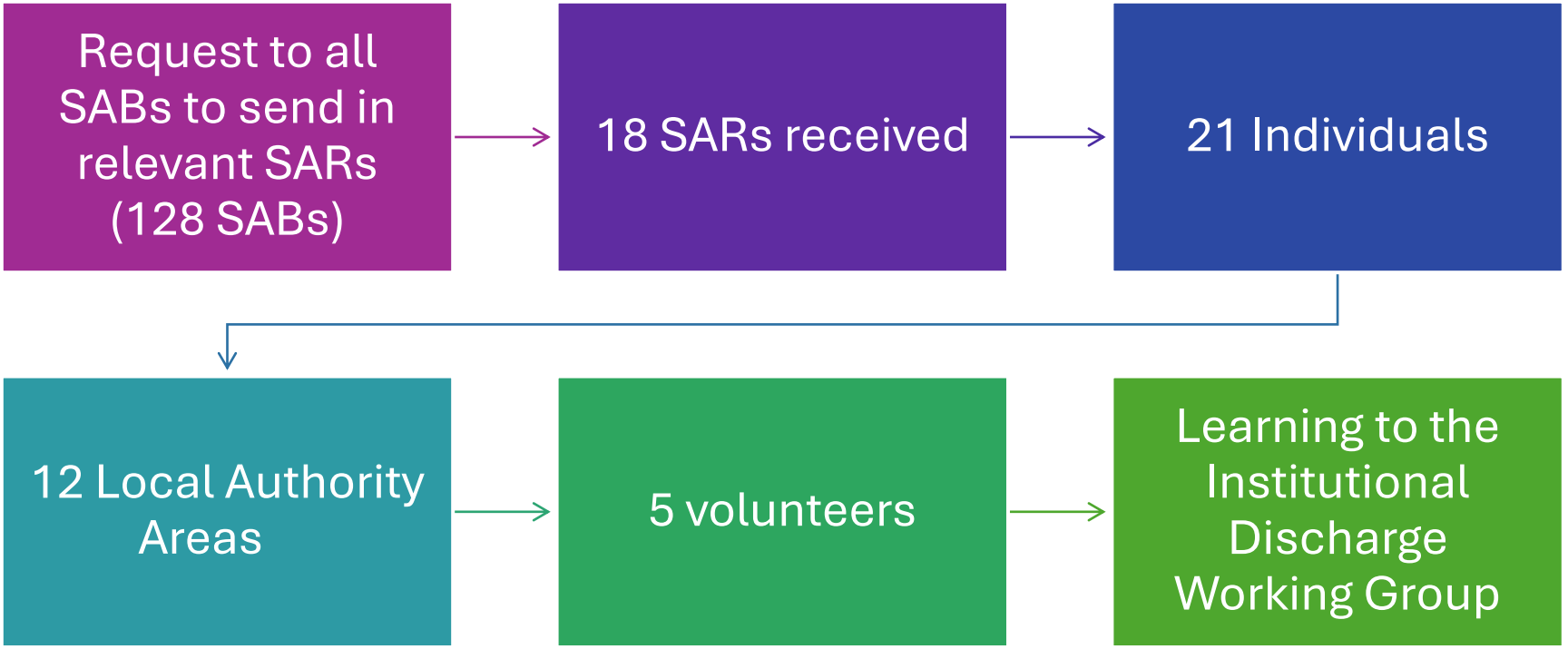
What are Safeguarding Adults Reviews?

The Care Act (2014) requires local SABs to arrange a SAR when an adult with **care and support needs**, in its area, **dies or experiences significant harm as a result of abuse or neglect** (whether known or suspected), and there is **concern that partner agencies could have worked more effectively to protect the person at risk.**

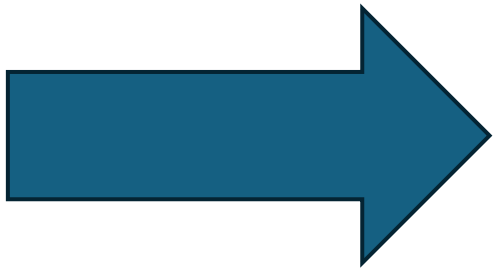
The purpose of a SAR is not to hold any individual or organisation to account as there are other processes and regulatory bodies available for that; they are about learning lessons for the future so that all organisations involved can improve as a result.

SARs are separate from other investigations that may be occurring, for example by the police, CQC, Coroner, or civil and criminal courts; however, the findings of those investigations (if available and in the public domain) can help to inform a SAR.

How was the information collected and reviewed?



Key areas in analysis



Potential leads for support/resources

Potential policy/ process change/ addition

Learning to be added into training: Examples of good practice and tips for front line practitioners

Approach for sharing learning

3 cases

Key learning

Crossover with 2nd National SAR Analysis

Tools

‘Thomas’

27 years old

Found dead by police in 2020 in a flat he had recently moved in to

Diagnosis of mental and behavioural disorder and unstable personality disorder; it was believed these disorder were exacerbated by the use of drugs and other psychoactive substances

Open to mental health services since 2012

History documents numerous challenges including drug and alcohol misuse, suicidal ideation, mental health hospitalisation, self-discharge from hospital, self-neglect, housing crises and periods of non-engagement with services. He also had features of PTSD.

Thomas had been a victim of violence and also had offences for assault, burglary, public order, shoplifting, vehicle crime, dating back to 2011 which included serving a prison sentence for 2 years when he was 19.

Experienced difficult early life – taken into care aged 5, biological father imprisoned for murder, physically abused at home from age 7

Inquest recorded cause of death to be Multiple Drug Toxicity

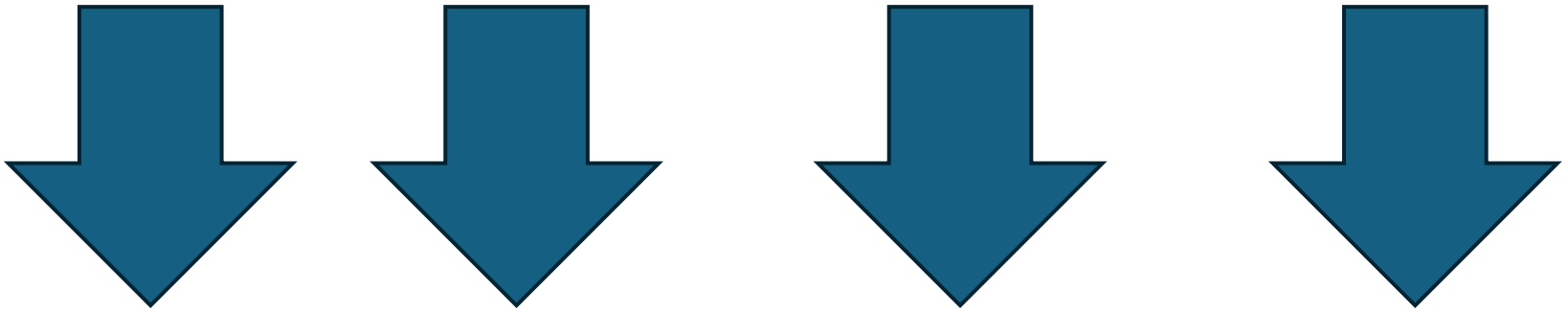
‘Thomas’

Key areas of learning:

- Assessed as ‘not priority need’ when attempting to arrange accommodation for his discharge from psychiatric hospital, however the application did not have key information due to ASC not being involved in the discharge planning.
  There is no evidence of this being challenged.

- Assessing mental capacity, and considering executive and decisional capacity was an issue

- Practitioners did not make a safeguarding referral as Thomas did not consent – misunderstanding about when consent can and should be overridden



Professional curiosity

Multi-agency working

Mental capacity

Information sharing and consent

‘Thomas’

Any other key themes?.....

Trauma informed practice

Escalation and challenge

Checkpoint and discussion....

Are these themes what you expected?

Are they new to you, or do they reinforce what you already knew?

Why are they so difficult to overcome? What are the barriers?

Tools and resources to support good practice – Professional Curiosity and TIP

Professional curiosity – National SAB network toolkit

Nottingham City SAB 7 Minute Briefing

Working with information from other services as well as finding information out

Professional curiosity in safeguarding adults: Strategic Briefing (2020) | Research in Practice

Video by Equation

Trauma Informed Practice Work Streams – Nottingham Practice Development Unit (PDU)

Trauma-informed practice: learning from experience - GOV.UK

Howard

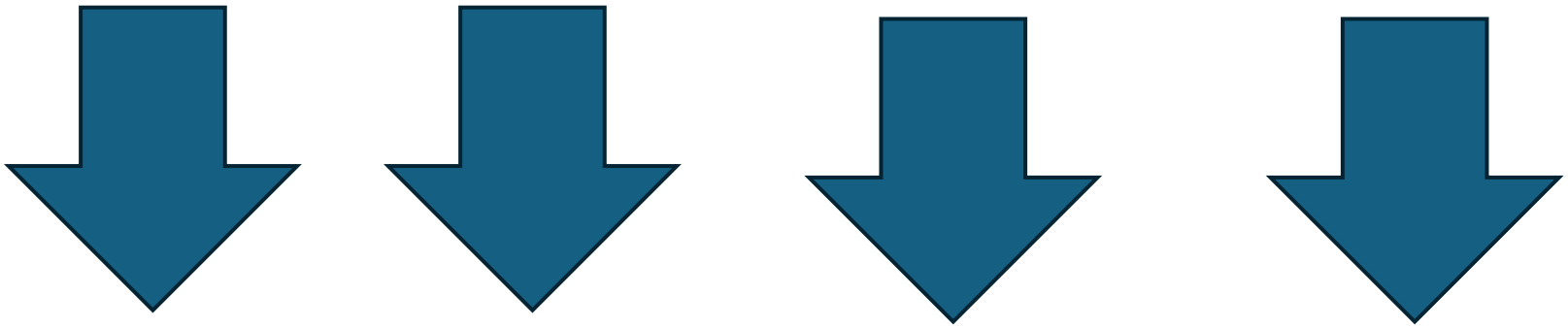
- 53 years old
- Found dead by a member of the public in a bus shelter
- Homeless at the time of his death
- He had a heart condition for which he took prescribed mediation, although his use of medication was described as ‘chaotic’ and he was frequently taken to A&E with atrial fibrillation
- Long history of alcohol use – drinking increased heavily following the death of his mother. He neglected his business and was subsequently jailed for fraud
- On release from prison, a cuckooing gang moved in on him and he was soon permanently homeless
- The only homeless hostels in the area did not allow alcohol – view that he clearly didn’t want to be housed if he kept drinking and that he had ‘ample opportunities to stop drinking’
- Frequent victim of exploitation, theft of his medication, and violence while street homeless
- The cause of death was found to be cardiac arrest, ischaemic heart disease and coronary heart atheroma, and alcoholic liver disease

Howard

Key areas of learning:

- Multi-agency meetings not well attended by key people
- Lack of communication between services in two different areas
- Lack of safeguarding referrals made, and self-neglect not recognised
- Each encounter with services was seen in isolation
- Perception that alcohol was a 'lifestyle choice'
- Lack of understanding of other services pathways and thresholds
- Little evidence of formal assessment of mental capacity, and no evidence that executive capacity was considered
- Absence of feedback from ASC made professionals assume that the case was already being looked in to, or that making further referrals was pointless as it did not result in a positive response
- Howard's case was approached essentially in crisis management mode rather than through a coordinated response focusing on prevention and protection
- Housing did not class Howard as priority need or vulnerable, however they did not have the full range of information that other agencies held like his medical needs or the risks he faced from financial exploitation, assaults and having his medication stolen

Howard



Lack of understanding of other agencies roles and responsibilities

‘Lifestyle choice’

Mental capacity assessment, recording

Information sharing

Checkpoint and discussion....

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Tools and resources to support good practice – alcohol and substance use, mental capacity

Alcohol Change UK – training, policy insights, factsheets, publications and Blue Light Bulletin

Learning from tragedies – research and output

Using the mental capacity act – Alcohol Related Brain Damage

Social Care Institute for Excellence – MCA e-learning

39 Essex chambers – resources, reports, legal case studies, newsletter

Nottingham City SAB – 7 Minute Briefing on Mental Capacity – coming soon

Single agency MCA training and refresher courses

Recording decisions and action taken essential – SCIE guide is aimed at social care sector, but the principles are applicable across all agencies

‘Robin’

27 years old

Diagnosis of diagnosis of autistic spectrum disorder (ASD), paranoid schizophrenia and seizures

His history had been characterised by not wanting to engage with professionals generally, or his family, and wanting to be left alone

Had a number of hospital psychiatric admissions and contacts over the course of his life

His history contains a number of social isolation indicators signifying multiple disadvantage, including mental health challenges, self–neglect, alcohol use, eating disorder concerns, and a lack of understanding about his physical and mental health diagnoses

Showed a reluctance to engage with agencies and professionals, living a secluded life in often very poor physical conditions

Found dead is his flat following an unrelated police call – his body was in an advanced state of decomposition and so a medical cause of death could not be concluded

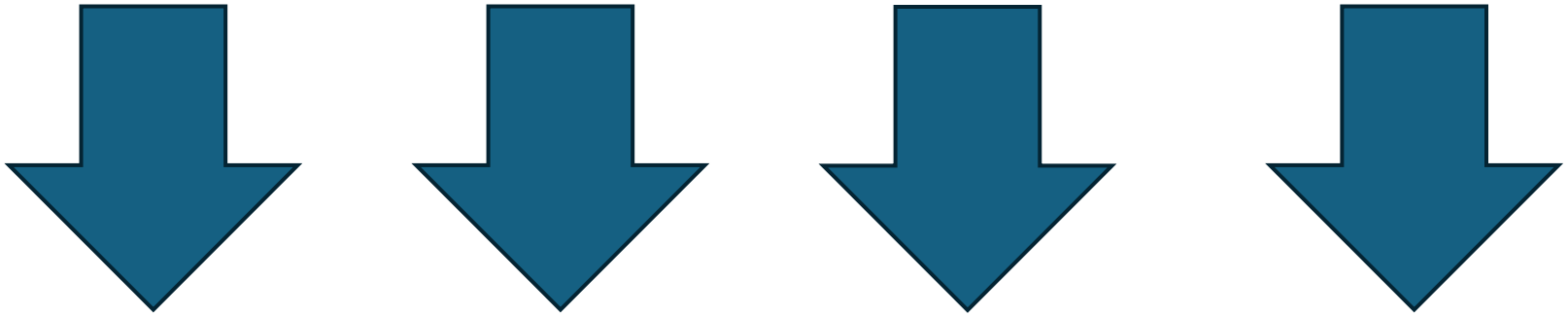
His family have expressed upset, anger and confusion that he was not in supported living as this was what they thought was in place

‘Robin’

Key areas of learning:

- Crossover between non-engagement and self-neglect
- Discharge was uncoordinated and did not include GP or include that Robin was entitled to s117 aftercare
- Letters were sent out without consideration to Robins state of mind and whether he was able to understand the contents, the onus was on him to get in touch despite a history of being unable to engage
- Need to use of specific toolkits and resources to optimise communication and understanding where individuals have autism and/or ‘hard to reach’
- Professionals took Robin’s self-reporting at face value and decisions were made in the absence of relevant knowledge and consideration of complex history of mental illness, special needs and non-compliance with taking medication to control delusional thinking
- Missed opportunity to explore with Robin’s family what indicated to them he was relapsing
- Non-engagement was not viewed in terms of his mental illness, learning difficulties or suspected autism.
- Limited professional curiosity
- Professionals unfamiliar with self-neglect guidance
- Missed opportunities to assess capacity
- When Robin could not be contacted, professionals did not consider the ‘worst-case scenario’
- Relevant information about Robin’s history of ASD and that he had an EHCP was not shared and known widely, so was not incorporated into any assessments

‘Robin’



‘Non-engagement’

Professional curiosity

Lack of family involvement

Toolkits, guidance and resources

Checkpoint and discussion....

Are these themes what you expected?

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Why are they so difficult to overcome? What are the barriers?

Tools and resources to support good practice – Non-engagement

Why language matters: reframing responsibility for accessing services | NSPCC Learning

Nottingham City Improving Agencies' Engagement with Service Users Framework

Crossover with 2nd National SAR Analysis - themes

- Analysis of learning from SARs between 2019 and 2023 (652 reviews)
- Self-neglect – 60% - highest of all Care Act abuse and neglect categories
- Poor risk assessment/management/use of safeguarding (82%)
- Poor attention to living conditions (23%)
- Poor attention to substance misuse (20%)
- Absence of professional curiosity (44%)
- Poor recognition of trauma/lack of trauma informed practice (24%)
- Absence of attention to Mental capacity (58%)

Crossover with 2nd National SAR Analysis – good practice

Direct practice:

- **Risk assessment and risk management (31%)**
- **Use of person-centred approach/making safeguarding personal (29%)**
- **Good continuity/perseverance with the individual (22%)**
- **Trauma informed practice (5%)**

Personal qualities

- **"Compassion, kindness, care, empathy and sensitivity were all noted, along with commitment, dedication, professionalism, skill and diligence"**
- **"The ability to see beyond the presenting problem, and to find and respect the person beneath"**
- **Relationship based practice – "the efforts that practitioners made to build relationships that were sometimes the key to agencies being able to maintain contact"**

Final thoughts.....

- Can be assumptions about what other agencies can/can't/should/ shouldn’t do - communication is the key to better coordination

- People come into the care sector not just because they want to care for people, but because they care about people

- Leadership skills within all of us no matter the role, leadership isn't just at the top

What are your final thoughts?

Nottingham City Safeguarding Adults Board

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Working together to safeguard adults at risk

What is abuse or neglect? →

Welcome to the Nottingham City Safeguarding Adults Board. Our website is mainly aimed at professionals working in Nottingham City that work with or support adults. There is also some useful information for members of the public, although we would recommend that members of the public also access the Nottingham City Council Adult Social Care hub.

www.nottinghamcitysab.org

Nottingham City Safeguarding Adults Board

Any Questions?