Safeguarding Adult Review – Adult C

7 minute briefing

1 – What is a Safeguarding Adult Review?

The SAB as part of its statutory duty, is required to carry out a Safeguarding Adult Review (SAR) under the following circumstances:

- When an adult who has care and support needs, in the 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 effectively to protect the adult
- When an adult who has care and support needs has not died, but the SAB knows or suspects the adult has experienced serious abuse or neglect
- SABs are also free to arrange a SAR in any other situations involving an adult in its area with care and support needs

The aim of a SAR is…

- to promote effective learning and improvement by determining what might have been done differently
- to explore examples of good practice, as well as those areas that were not so good
- to identify learning which can be applied to future cases

A SAR is not…

- an inquiry into how an adult died
- to apportion blame or to find any particular agency or professional cupable
- a replacement for other investigation processes, suck as criminal proceedings, disciplinary procedures or professional regulation

2 – Adult C

Adult C was a 64-year-old man who sadly died from natural causes while living in temporary accommodation. He had recently moved from his home address due to concerns around his living conditions and the safety of his previous address. Agencies became aware of his circumstances only in the final months of his life, when concerns emerged about his living conditions, self-neglect, and possible hoarding.

Review methodology

The SAR Executive Group agreed that although there is no evidence or suspicion that abuse or neglect contributed to Adult C's death, a discretionary SAR would be undertaken. Multiple professionals were involved with supporting Adult C and the SAR would explore whether partners could have done more to support him given previous concerns being raised in relation to his ability to look after himself.

The review was undertaken using a concise investigation and significant event methodology as set out in our SAR Framework. This methodology brings together managers and practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing recommendations for learning and development.

A key part of undertaking a SAR is to gather the views of the adult at risk and their family members. Upon Adult C's death, there were challenges in locating a next of kin as he had confirmed previously that he had no family or friends. Adult C led a very private life and he did not share information freely. No agency had any contact details for any other family members or friends. It was agreed that therefore, in line with Adult C's wishes, we would not contact anyone else to be involved with this review.

3 – Strengths and good practice

Timely multi-agency response
Once concerns were raised, agencies worked together efficiently. A joint visit involving NLC Environmental Health, Humberside Police, Humberside Fire and Rescue Service, and NLC Adult Social Care was arranged without delay. Environmental Health used their legal powers appropriately, and emergency accommodation was sourced the same day.

Flexible, person-centred practice
The NLC Home First Community Reablement Team made persistent efforts to engage Adult C, including visiting locations he frequented and keeping his case open despite limited engagement. The police officer who first raised concerns built a positive rapport that helped gather essential information about his needs and personal history.

Effective use of legal and housing pathways
Environmental Health acted quickly to prohibit occupation of the unsafe property, and the NLC Housing Advice Team secured emergency accommodation despite Adult C being a homeowner.

Strong reflective practice
Agencies produced high-quality reports and engaged openly in the multi-agency workshop. Practitioners also demonstrated that they had applied learning from previous self-neglect cases.

4 – Learning themes

Over-reliance on the use of PITSTOP

PITSTOP (partnership integrated triage) is a multi-agency meeting which jointly considers police information (that has already been through police decision making processes and determined that partnership triage is required). The aim of the meeting is to share information to improve early identification and understanding of need, harm and risk. Should information suggest that a person has a level of need, appropriate action will then be taken in line with the Care Act 2014.

In this case, both referrals to adult social care were raised via PITSTOP. The review considered whether concerns should have been raised directly with adult social care or the adult safeguarding team directly if staff were concerned about a vulnerable person. It was also noted that when PITSTOP agreed to make the second referral to the adult social care, not all of the information in the PITSTOP referral was shared with them. It was explained that because PITSTOP had received 2 referrals for Adult C within a short a space of time, the detail contained within the written referral was not discussed as part of the meeting.

There was also learning in terms of the feedback loop to PITSTOP where no further action was taken as a result of the first referral. It was noted that there is no formal process in place which feeds back the outcome of referrals to PITSTOP.

Working with people who self-neglect

Self-neglect is a challenging area of practice and practitioners are not always clear when this would escalate into a safeguarding concern.

Learning was also identified around the importance of building positive relationships and taking advantage of 'reachable moments' which are crucial when supporting people who do not feel able to engage with support.

Professional curiosity

All agencies who were supporting Adult C held small pieces of information about him and his life however it was a challenge for the group to fully understand the lived experience of Adult C.

During the review of records, it was highlighted that there was very little information recorded on Adult C's GP record. This was noted to be unusual. This highlighted the need for practitioners to recognise the long-term risks and signpost appropriately.

Empowering the community

Communities including local businesses have a huge part to play in keeping people of all ages safe from abuse and neglect. Adult C was noted to frequent a number of local businesses and community areas, yet no referrals were made to adult social care by members of the public. It was identified that there is further work to do to engage with our local communities and businesses to break the stigma of safeguarding and empower them to have conversations with vulnerable people.

Utilising the skills and expertise of partners

This review reflected around whether there are enough mechanisms in place to have multi-agency conversations around complex cases, in particular those in which the person does not want to receive support. Although there were positive examples of partners working together in this case, it was acknowledged that self-neglect is not uncommon and due to the length of time it takes to build rapport with the person, the risk can remain high for some time with little progress being made. It was noted that many of the available frameworks for multi-agency discussion, such as the Vulnerable Adult Risk Management (VARM) process, are for cases where there is risk of significant harm or death and there is little available for those 'stuck' cases to be discussed at a lower level.

Trauma informed practice

The importance of trauma informed practice was a theme in this case. The impact of bereavement was highlighted as a potential reason for Adult C not wanting to be inside his property and potential trigger for his self-neglect and hoarding. Without consent, bereavement support could not be provided, however practitioners working with Adult C could have utilised trauma-informed approaches to working with him.

Use of language and terminology

The review reflected on the use of language in some of the case records, particularly around non-engagement and around how Adult C's living conditions were described by some professionals. There are many reasons why a person might find it difficult to access help and language can be a barrier in allowing practitioners to recognise the complex reasons behind why someone might struggle to take up services being offered.

Understanding of mental capacity and executive functioning

When a person is presumed to have mental capacity or has been assessed as having capacity, their autonomy must be respected, and efforts should be directed to building and maintaining supportive relationships through which services can in time be negotiated if required. However, where there is self-neglect, practitioners should consider whether the presumption of capacity can stand. It was noted in records that Adult C appeared to have capacity and understood the implications of not consenting to assessment. However, it is not clear whether considerations were made around his executive functioning.

5 – Conclusion of the review

The review did not identify significant missed opportunities. Once the multi-agency partnership became aware of Adult C's circumstances, action was taken to support him and once alternative accommodation was accepted, the offer was timely. With the benefit of hindsight, the package of support could potentially have been strengthened but there is no suggestion that this impacted upon his death, or that it was a modifiable factor which could have prevented his death.

The review recognises that working with people who self-neglect is challenging for practitioners and this was evident in this case. It is recognised that working at a person's own pace where people experience hoarding and self-neglect is often a fundamental principle to continued engagement. Through this review, there is evidence to suggest that learning has been embedded from previous reviews relating to self-neglect. Practitioners and managers were able to articulate how they had utilised learning from past cases and practice wisdom to change the way in which they worked with Adult C.

The report does not identify any systemic issues that require escalation to the Safeguarding Adults Board or to any wider local, regional or national forums.

6 – Considerations for the Safeguarding Adults Board

Where agencies have made their own recommendations in their Agency Review Reports, the SAB will seek assurance that action plans are underway. The below considerations were made to the SAB as a result of the learning in this case:

- Further raise awareness of and enhance practitioner understanding of working with people who self-neglect and how to determine when this meets safeguarding criteria
- Consider what mechanisms and/or processes are in place for partner agencies to discuss complex or 'stuck' cases where the person is potentially vulnerable
- Undertake further training and awareness raising about the importance of executive functioning and mental capacity
- Strengthen understanding of the importance of the language that is used to describe the people that we support, particularly in relation to those who self-neglect and those who do not want to receive support
- Continue to promote tools and resources to encourage practitioners to be professionally curious
- Undertake further work within the local community and with businesses to empower them to have conversations with vulnerable people and to report their concerns if they may be at risk of harm
- Strengthen practitioners' understanding of the implications on long term health for people who do not have a registered GP, ensuring that they discuss this with the person so that they can be signposted to address any unmet health need
- Continue to raise awareness of and promote tools and resources around trauma informed approaches in adult safeguarding
- The SAB should ensure that a review of PITSTOP is undertaken to consider and address the learning in this review

7 – Next steps

Upon endorsement of the final SAR report at the SAB, the SAB Quality, Performance and Learning Group will develop an action plan to respond to the considerations contained within the report. This group, in collaboration with the SAB and the other subgroups, will oversee the action plan to ensure that the actions are progressed and completed.

A series of briefings will be developed and disseminated to share the learning widely across the partnership. The SAB will also ensure that the learning will be included in and/or inform future safeguarding training.

For further information, visit our website

www.northlincssab.co.uk