Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Peter

What is a Safeguarding Adult Review (SAR)?

According to Part One Section 44 of the Care Act 2014 Safeguarding Adult Boards (i.e. Cambridgeshire and Peterborough Safeguarding Adult Partnership Board) must undertake a Safeguarding Adult Review (SAR) when:

1. An adult in its area with care and support needs (i.e. an adult at risk) has died as a result of abuse or neglect whether this was known or suspected before the adult died and there is concern that partner agencies could have worked more effectively to protect the adult.
2. An adult in its area with care and support needs (i.e. an adult at risk) has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a Safeguarding Adults Review is to **learn the lessons** about how professionals and organisations work together, and to consider how the learning can be used to improve practice for others in the future.

(Adapted and Taken from Care Act 2014 and Cambridgeshire and Peterborough Safeguarding Adult Partnership Board Website)

Peter

The name Peter is used as a pseudonym within this briefing to anonymise and protect the adult at risk's identity.

Background

Peter was a 45 year old man who was born in Poland and came to the United Kingdom around 2008. Peter was employed in Poland as an IT consultant, but was unable to find employment once he arrived in the UK. He was married twice and became estranged from his second wife, at a time which it is recorded that he sought support from his general practitioner for suicidal ideation and alcohol misuse.

Peter returned to Poland for a short time and whilst there he sustained a serious head injury. Peter explained to some people that the injury was from being assaulted and to others that he had been involved in a car accident. As a result of the incident Peter's frontotemporal region of the brain was damaged and he experienced memory difficulties, headaches and black outs.

On returning back to the UK from Poland he had no recourse to public funds, due to his immigration status, and as a result was homeless spending 'extensive periods' living and sleeping on the streets. Peter suffered from alcohol dependency and due to his lifestyle was regularly admitted to hospital. It is recorded that he attended hospital on 25 separate occasions either due to being intoxicated or from sustaining injuries whilst falling down inebriated.

Several charitable agencies were involved in trying to support Peter both with his accommodation and engaging him to access support services in relation to his drug and alcohol use. Peter refused to engage and explained that he would continue to 'drink alcohol everyday if he could'.

Medically the general practitioner, hospital, dual diagnosis team and substance misuse agencies all tried to support Peter. Agencies stated that when Peter was sober he appeared to have capacity and to be able to make decisions but did not want to access the help offered.

As time went on and winter approached Peter's health deteriorated and the risks to his wellbeing and safety increased. Agencies assessed that Peter might die during the colder months and they actively responded by working together and involved adult social care with a view to finding him supportive accommodation to get him off of the streets.

Tragically during 2018 after attending hospital and being discharged Peter fell into a river and later died of a cardiac arrest.

Key Learning Points for Professionals

There were a number of organisations, and individuals working within them, who worked very hard to support Peter but he often did not accept the support available or was unable to due to his alcohol dependency and inability or unwillingness to abstain from alcohol.

- **Mental Capacity**

Peter suffered from depression, was prescribed anti-depressants and on occasions felt suicidal. Given that Peter abused alcohol and to a lesser extent controlled drugs these factors presented as a challenge for professionals to **effectively assess his mental capacity**.

Peter was rarely sober but on the two occasions noted where he was, he was assessed as having capacity. When admitted into hospital it was recorded that there were no safeguarding or capacity issues, even though health professionals were aware that Peter had a brain injury, was homeless and had suicidal ideations.

Nice guidance recommends that all new cases referred to alcohol treatment services should have an assessment of cognitive function. However, despite a number of requests Peter declined any support from these services. The general practitioner within this review made reference to research on Alcohol Related Brain Damage (ARBD) which describes the impact of alcohol on high risk groups and the lack of awareness of ARBD as a mental health condition. The report on ARBD recognises that the condition may impact on an individuals' willingness to understand their circumstances and of any intervention being offered that ultimately effects their engagement and willingness to accept and access support.

It was recognised in a report by Alcohol Change UK (2019) from findings of SAR's with alcohol dependency as a factor, that both the Mental Capacity Act (2005) and Care Act (2014) offer little guidance on how to support people with alcohol issues who might need care and support The report concludes '*At the national level, work is required to clarify how the Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol. In particular, the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided.'*

- Professionals need to have greater understanding of the long-term effect of alcohol misuse on an individuals' mental capacity
- When undertaking assessments, professionals need to be aware of Alcohol Related Brain Damage as a mental health condition and how this may impact on an individual's behaviour

- **Were there barriers to Peter accessing services?**

There were a number of key service areas for Peter that were difficult for him to access for a variety of reasons:

Alcohol services. Peter was offered access to alcohol and substance misuse services but declined that support. In some part this might have been due to his own mental health (ARBD)

Secure Accommodation. A number of charitable housing associations offered Peter somewhere to sleep and a place of safety. However, on occasions Peter either removed himself or continued drinking which excluded him from being able to use one particular shelter's provision. A further shelter was also unable to offer support as Peter's health deteriorated and he became double incontinent.

Two weeks prior to Peter's death the local authority progressed a housing application with the support of the agencies working with Peter. Unfortunately the application was denied due to his immigration status. However the local authority was able to provide accommodation once adult social care accepted that funding could be made available under the Care Act 2014.

- Professionals need to have a greater understanding of the duty of care under the Care Act 2014 and what is available for those individuals' who have no recourse to public funding

Dual Diagnosis Street Team. The team constantly supported Peter and had the professional guidance of a social worker as well as health professionals. This support could have been enhanced if the social worker on the team had linked in with adult social care.

Adult Social Care. Earlier attempts had been made to involve adult social care by referrals made from agencies for safeguarding concerns. Unfortunately at those times Peter's case was either assessed as not meeting thresholds or that the criteria for a section 42 enquiry had not been met as there was no evidence of abuse. However, Peter was demonstrating severe self-neglect which impacted significantly on his health needs meaning that arguably he did meet the criteria for a section 42 **safeguarding enquiry.**

Interagency Working Together. At the time of Peter's case the **Multi Agency Risk Management Guidance** (MARM) was not in place in Cambridgeshire and Peterborough. It is recognised that if it was deemed that Peter had capacity, continued to place himself at risk of serious risk or harm and failed to engage with services that the MARM process would have provided a more structured approach to identify and put in place a multi-agency response.

- Professionals should be aware of the Cambridgeshire and Peterborough **Multi-Agency Risk Management Guidance** and consider its use for working with and supporting vulnerable adults at risk who struggle to engage with services

- **Influencing change resistant drinkers**

The damaging effect of Peter's alcohol use was recognised but despite numerous attempts to engage Peter with alcohol and substance misuse services he chose not to engage and regularly articulated his lack of desire to alter his drinking habits. How to work with those who are resistant to change is a challenge and during the SAR practitioner's event all agencies strongly believed that there needed to be a whole systems and holistic approach and emphatically emphasised ***'Come what may, do not give up on them'.***

Much of Peter's money to fund his lifestyle was achieved by street donations from well-meaning members of the public. Community protection warning notices were issued to prevent Peter from frequenting areas where he could gain income from passers-by. Although this measure was deemed as a supportive measure to help Peter the warnings were put in place far too late in Peter's drinking pattern and at a time when Peter's health had significantly deteriorated. If a **co-ordinated professional response** had used these preventative tools **earlier** on, this might have positively impacted on Peter's behaviour and restricted his drinking habits. There was also recognition by agencies that more effort needs to be made in order to encourage members of the public to give support to the homeless by other means instead of direct cash donations.

- **Hospital Attendance and Discharge**

The hospital had in place a hospital discharge process for patients who are homeless with a view to finding suitable accommodation on discharge. On each occasion that Peter was admitted into hospital this protocol should have been followed. However, it was noted that there were a number of occasions when Peter self-discharged and when he was discharged by the hospital that the **protocol and procedures** were not followed. This omission resulted in accommodation not being sought and potential accommodation providers and agencies working with Peter not knowing about his hospital admissions and health issues (**i.e. Information Sharing and Working Together**)

- Professionals working within hospital settings should be aware of the Homeless Hospital Discharge Protocol and ensure that it is consistently applied for each and every homeless person's hospital admission
- The Local Authority, District Councils and Housing providers should also be aware of the Homeless Hospital Discharge Protocol and of their roles and responsibilities within it

Further Information

Adult Safeguarding Partnership Board Website
http://www.safeguardingcambspeterborough.org.uk/adults-board/

Multi-Agency Safeguarding Training
http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Safeguarding Adult Reviews
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/sars/

Multi-Agency Risk Management Guidance (MARM)
http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/multi-agency-risk-management-guidance/

Leaflets, Resource Pack, Training slides, Virtual training and Useful Information
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/leaflets/
https://www.safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/

Multi-Agency Policies and Procedures
https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/

Self Neglect
http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/selfneglect/

Mental Capacity Act
https://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/deprivation-of-liberty-safeguards-dols/

Social Care Institute for Excellence
https://www.scie.org.uk/self-neglect/at-a-glance

References

Alcohol Change UK – Learning from Tragedies 2019
https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

Alcohol Related Brain Damage / Report and Professionals resources
https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-related-brain-damage

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