Bracknell Forest SAFEGUARDING BOARD

Learning Brief on the GH Safeguarding Adults Review (SAR) November 2019

This briefing is one of the ways in which the Board aims to share learning as widely as possible to support practice and development in our commitment to safeguarding adults at risk. Thank you for taking the time to read it.

The briefing aims to pull together key messages and lessons learnt from the review to enable you and your teams to reflect and challenge your thinking with a view to implementing positive change and promoting better outcomes for adults at risk.

We ask that you take time to read this brief (you can access the full report here) and consider the following questions:

→ Does this case identify any learning for my individual practice?

→ Does it help identify any training or development needs?

→ Does anything need to change within my team or service to implement this learning and support best practice?

What were GH's vulnerabilities and needs?

- Smoked cannabis, was on controlled drugs: not known to be using drugs intravenously at this time
- Was a possibility he would require amputation of his left leg .
- Was reported to have very low mood swings.
- The notified intention to evict him due to the behaviour of his friends and problems with his dog
- 7 days before his death, his dog was taken away and subsequently had to be put down
- A few days before his death, he called ASC as he had been served an eviction notice which was received on the same day his dog was put down. The eviction notice was being addressed with support from ASC and his SW.

Which agencies worked with GH and were involved in the review?

Thames Valley Police, GP & E. Berks Clinical Commissioning Group, Bracknell Forest Council, Berkshire Healthcare Foundation Trust, South Central Ambulance Service, Sheltered housing provider, Domiciliary care provider, Emergency Duty Team.

Who was GH?

GH, a 62-year-old male, was receiving dedicated adult care within the community. He had been admitted into hospital in 2015 and had a below-knee amputation and became a wheelchair user. It took time to find him appropriate settled accommodation and in the intervening period he moved from hotel to hotel. He had a pet dog which was not allowed to be with him for most of this time. His social worker described GH as "distraught" with the possibility of not finding accommodation which would enable his dog to live with him.

Following his hospital discharge his Social Worker (SW) obtained him sheltered accommodation in a flat that allowed his dog to live with him. GH was initially reluctant to accept offers of support, although a package of support was eventually put in place for him. The SW maintained regular contact to support him regarding housing, tenancy, support for personal care, money and debt management.

Background History

GH was a long-term drug user. His first contact with the ACT was in Feb 2015 but he was not yet engaging with DAAT. The SW noted he had episodes of low mood swings, possible suicidal ideation. The SW was in contact with health services for him. He told her he was lonely with erratic friends and family. These concerns were assessed and managed by ASC.

In September 2018 he received a Notice of Seeking Possession (NOSP) because, on several days in June 2018, visitors to his property were rude and abusive towards other residents which caused a nuisance, upset and fear. His visitors caused alarm by kicking the communal front door and it was believed they were using illegal drugs within his property where drug paraphernalia was found. GH and some of his family members were known to social services historically and, at times, required a high level of input from ASC. It was believed GH shared his medication with his family members, but he stated that they had taken it from him.

Seven days before his death, his dog was taken away by the RSPCA due to its poor health and condition, and unfortunately for GH, had been put down on the 17th September 2018. On the same day, he had been served an eviction notice by his housing landlord.

Despite support from ASC and his SW, he unfortunately died from an overdose of prescription drugs in the early hours of the morning while at home.

If a Section 135(1) warrant is granted, it should be executed as soon as reasonably possible.

Do you know what your agency's policies are with regard to executing a warrant? There is an inter-agency Partnership agreement with guidelines for health, local authority and Thames Valley police staff – including EDS. Do you know where to find the policy?

If the Section 135(1) warrant is not executed a full risk assessment must be carried out. This should record the rationale for such a decision and have agency supervision, oversight and agreement to ensure safeguarding is in place.

There is a need for enhanced governance and supervision oversight with regard to Section 135(1) warrants. Is your manager aware of this? Do you have a format / template in preparation for completing and updating a risk assessment during an on-going situation?

Your organisation should have robust policies and procedures in place for safeguarding. All frontline staff need to ensure they are familiar with safeguarding procedures and thresholds, not only in terms of statutory requirements to undertake a section 42 enquiry but in terms of Care Act 2014 requirements to undertake other safeguarding enquiries. In this case, particularly the management of risk and the reassessment of risk as changes develop in a safeguarding plan. All partner agency's staff must comply with the national & local safeguarding adults Policy & Procedures in the management and reassessment of risk.

Do you routinely use the Pan Berkshire Adult Safeguarding Policy and Procedures? Do internal safeguarding policy and procedures support decision making as to when take a concern into either a section 42 or, in this case, not to execute a S.135(1) warrant? If the decision not to progress is made, is this fed back to the referring agency / supervisor / line manager to enable further discussion and professional challenge? Is a Risk assessment completed, following Policy & Procedures guidelines for managing risk and reviewing the plan?

To apply the six adult safeguarding principles, when dealing with a vulnerable person

The 6 safeguarding principles are core to how we should work with a vulnerable person - do you know what they are and what they mean in practice?

Police should not be requested to conduct a safe and wellbeing check as an interim measure instead of executing a Section 135 (1) warrant.

Confusion and lack of clarity over the use of language in different organisations is a recurring theme in SARs. All practitioners should be explicit in what they require of another organisation and not presume that they will know what you mean.

All Safeguarding Board partners to be reminded of the need to audit records to ensure the rationale of decision making, handover of cases, changes of safeguarding action to be taken and outcomes of risk assessments are diligently recorded.

As a manager, do you routinely audit records to ensure diligent recording of decision-making and risk assessments?

An updated risk assessment displaying professional curiosity must be made to ensure all known factors and possible risks are considered and acted upon to safeguard an individual, applying the six adult safeguarding principles.

Is everyone within your organisation actively encouraged to use professional curiosity on all occasions? Combined with the 6 safeguarding principle this makes a powerful move towards safeguarding adults effectively.

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