Southwark Safeguarding Adults Board
Safeguarding Adults Review – Adult A
Learning Summary

Please use this summary as a means of informing your staff and teams about the learning from this Review. There are seven points in this summary and so, as a minimum, it should take just seven minutes.

1) What is a Safeguarding Adults Review?

All Safeguarding Adults Boards must conduct a review when a person with care and support needs has died or experienced serious harm from abuse and / or neglect and there are concerns about how agencies have worked together. This is set out in the Care Act 2014 and is called a Safeguarding Adults Review (SAR). It is focused on learning and improving our safeguarding responses, not on blame.

2) What happened to Adult A?

Adult A was a man of Nigerian heritage born in Southwark. He was diagnosed with Schizo-affective disorder in 2002 and Type II Diabetes in 2008. He had a lot of contact with Police as he behaved in ways that broke the law; he went to prison and he became subject to a criminal reporting system, which he didn't respond to as he should and was regularly arrested for this as well as for other crimes. He was estranged from his family who also lived in Southwark.

He was seriously mentally unwell in early 2012 & in May he was detained under Section 3 of the Mental Health Act (1983) and became an in-patient within a local Mental Health Trust.

While detained he was also critically unwell with Type II diabetes and was rushed by ambulance to a local A&E. He was in Intensive Care for two days before being returned to the Mental Health Trust. Before he left, a Diabetes Nurse tried to explain how he could manage his diabetes better. It is not clear if he had the capacity to understand what was being described to him.

Three weeks later, he was considered fit to leave the specialist hospital, but on a Mental Health Act (1983) Community Treatment Order (CTO). He left hospital without accommodation and with 2 weeks' worth of medication in a bag. The hospital had not checked if he had a current registered GP and he didn't; this meant that there was no-one in the community to coordinate his care. He went to Southwark Housing Department by himself. They knew him and had supported him well before. They could not give him supported accommodation at this stage, as his discharge had not included planning with them and so he was given B&B accommodation nearby.

After this, he did not turn up for appointments with his psychiatrist or Care Coordinator, but the only response was one of writing a letter and asking him to come to another and another and another appointment. He did not respond. There wasn't any contingency plan if he didn't engage after his discharge even though this was quite likely and he hadn't been talked to about his hopes and fears after he left hospital.

The Metropolitan Police Service was also surprised that he had been discharged and that information about his criminal risk had not been shared; officers were concerned that his criminal risk had not been discussed at all over the time he had been detained and were disappointed not to have been included in discussions regarding his discharge; not least as this meant he was placed in accommodation that may place others at risk as well as himself.

Adult A was found dead in his room by a maintenance worker at his B&B accommodation. He had clearly been dead some time.

3) Coroner view

Adult A's Inquest concluded in 2014. The Assistant HM Coroner stated the cause of Adult A's death to be:

1 a) Hyperposomalar non-ketotic coma 1 b) Diabetes Mellitis types II (insulin dependent), schizoaffective disorder

2) Natural causes to which neglect contributed

The Assistant Coroner recorded that there, '*were many failures in relation to his care and his discharge planning and his discharge follow-up'*.

'*But for one or more of these gross failures, the deceased would not have died when he did*'.

4) Safeguarding Adults Review

The Review was undertaken with an independent chair and author and all relevant organisations also took part.

The Review considered how well organisations had worked together and what could have been done differently.

5) Safeguarding Adults Principles

The Department of Health published the following safeguarding adults principles in 2011 and required in the Care and Support Statutory Guidance (2015) that they be reflected on in all SARs:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.
Prevention – It is better to take action before harm occurs.
Proportionality – The least intrusive response appropriate to the risk presented.
Protection – Support and representation for those in greatest need.
Partnership – Local solutions through services working with each other and their communities.
Accountability – Accountability and transparency in delivering safeguarding.

These are really useful principles to use to reflect on our own services and performance. When Adult A's care and support was considered in relation to these principles, it was found wanting in each area.

6) Safeguarding Adults Review - Learning

Clear learning in this SAR was:

- The vital significance of people having registration with GP practices and the need for organisations providing health and social care for people such as Adult A understanding the importance of primary care services;
- The importance of risk assessment and sharing information with and across partners;
- The need to understand how mental health conditions and physical conditions inter-relate;
- The obligations of practitioners across agencies to work together to meet their legal duties – in this case relating to the Mental Capacity Act [2005], the Crime and Justice Act [2003 and the Mental Health Act [1983];
- The importance of seeing Adult A as a human being, deserving of dignity rather than as a statistic passing through a system;
- The absolute importance of good discharge planning, with the person at the centre and across partnerships.

7) Learning prompts

Please reflect on this SAR and Adult A's experience. Please consider:

- What may have prevented people from working with Adult A in a way that met the six safeguarding adults principles?
- What could have been done to address this?
- Do any of these challenges remind you of those you deal with in your areas of work? Can you take any of the learning from this situation and apply it to your work?