

This is a Rapid Time methodology review of the sad death of Richard. The focus of this review is to highlight the key systems findings that have been identified through the review of Richard's death.

Safeguarding Adult Review Richard

Rapid Time Methodology

Lee Aldridge, Quality Assurance and Safeguarding Service Manager, Adult Social Care, Swindon Borough Council.

Introduction:

This document is the final output of the SAR In-Rapid-Time developed by SCIE. This report focuses on the systems findings that have been identified through the process of the SAR In-Rapid-Time. They focus on social and organisational factors that will make it harder or easier to help someone who is self-neglecting, like Richard, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately. Each systems finding is first described, then a short number of questions are posed to aid the Safeguarding Partnership in deciding appropriate responses.

The Safeguarding Partnership would like to extend their condolences to the family of Richard and thank his sister for her involvement in this SAR and sharing information on Richard and his life.

Brief Overview of Richard:

Richard was a white British man who lived alone in Swindon. He was 70 years of age. Richard was a qualified Physicist, having studied in Oxford University. In his younger years Richard worked in research, he enjoyed building amplifiers and computer programming. Richard is described by his sister as having a keen sense of humour and who loved to make 'puns'. Richard enjoyed listening to music, particularly opera's such as Wagner and Strauss. Richard also enjoyed listening to pop music such as Madonna.

Richard's sister, who spoke with him regularly, explained that he was diagnosed with Paranoid Schizophrenia in his early 20s. She mentions that Richard did not accept his diagnosis and was often resistant to treatment. At times, he was very unwell and reluctant to receive visitors at home. His sister describes him as challenging to engage with at times, due to his delusional beliefs, often being 'in his own world.' Additionally, she discusses how his deteriorating physical health affected his mobility and ability to manage tasks such as shopping, noting that he was often out of breath after walking short distances. Richard's sister has expressed frustration over the lack of communication from professionals and agencies involved in supporting Richard and how she was never contacted regarding her brother.

The Reason for this SAR:

Swindon Safeguarding Partnership received a Safeguarding Adult Review (SAR) referral on the 18/01/2024 from Adult Social Care following the sad death of Richard.

Richard had longstanding needs related to his mental health and physical health due to Chronic Obstructive Pulmonary Disease (COPD). Since September 2016, he received two hours of weekly support with shopping and meals provided by a care provider. Richard was also open to Avon and Wiltshire Partnership Trust (AWP), an integrated service with Swindon Borough Council (SBC) at that time, which conducted annual reviews until their disaggregation in April 2023. Post-disaggregation, AWP continued to support Richard with regular depot injections.

Richard was highlighted to the Adult Safeguarding Team on 17th August 2023, citing self-neglect and fire risks due to smoking. The Safeguarding Team closed the safeguarding concern and instigated a referral to Swindon Borough Council Mental Health Team.

This SAR was commissioned as there was evidence of concerns regarding the multi-agency response.

Findings:

Finding 1:	Decision to reduce Richard's home care package (October 2022).
System findings:	
<p>A decision was made to reduce Richard's support from two hours a week to one hour per week. This decision was made by the Care Coordinator in the Recovery Team (AWP) following a conversation with the care provider. The care provider reported that Richard was not allowing home carers into his property to assist with cleaning, indicating no need for this support. Therefore, it was decided that Richard would receive support with shopping only from this point onwards.</p> <p>During the practitioner's workshop, it was noted that the housing provider and care provider were unaware of each other's involvement with Richard. Both agencies were in contact with AWP separately, but these communications were not coordinated or discussed as part of a multi-agency team supporting Richard.</p> <p>The housing provider noted during this time there were no significant signs of deterioration in Richard's flat. The housing provider would see Richard on most days, he never discussed his care provider's support or any reduction.</p> <p>It was also reflected that there was no formal assessment or review under the Care Act or face to face discussion with Richard to reduce the support he was receiving.</p>	
Questions for SSP:	
<p>1.a. How can the Safeguarding Partnership be assured that all agencies take responsibility to organise a multidisciplinary meeting when there are concerns or reasons to review a person's care and support needs?</p>	
Recommendation 1;	
<p>The Swindon Safeguarding Partnership to reach out to front line practitioners to ascertain the effectiveness of multidisciplinary working across agencies. These findings should be fed back to the partnership to determine how to improve multi-disciplinary team meetings.</p>	

Finding 2:	Richards request for support with cleaning (May 2023 – August 2023).
System findings:	
<p>Richard requested additional support with cleaning in May 2023, stating that ‘he was not managing well at home’. His care provider contacted SBC Mental Health Team to request an increase in support for Richard.</p> <p>In this time period, it would seem Richard’s mental well-being was deteriorating; AWP records demonstrate an incident in Richard’s bank, whereby he was expressing delusional thoughts. AWP records also highlight concerns in regards to hoarding, cleanliness and fire risks in Richard’s accommodation.</p> <p>Following the referral to the SBC Mental Health Team, Richard was placed on a waiting list for a Care Act assessment. During this period, the SBC Mental Health Team did not visit Richard, despite attempting to contact him via telephone without success. Although the Mental Health Team’s case notes indicated that Richard’s referral was a priority, this priority status was not clearly defined, resulting in the referral not being prioritised for allocation within the team.</p>	
Questions for SSP:	
<p>2.a. How can the Safeguarding Partnership be assured that SBC Mental Health team accurately assess risk in order to prioritise timely allocations within the team?</p> <p>Recommendation 2;</p> <p>Safeguarding Partnership to request evidence of how the SBC Mental Health Team accurately assess the risk of referrals to ensure timely allocation to the team.</p>	
<p>2.b. How can the Safeguarding Partnership be assured that SBC Mental Health Team endeavour to speak to individuals who have been referred for an assessment to ensure they are central to the process?</p> <p>Recommendation 3;</p> <p>Safeguarding Partnership to request evidence from the SBC Mental Health Team around how the team are engaging with adults who have been referred to the service, and how they ensure the triage process is appropriate to the level of need and risk identified.</p>	

Finding 3:	Handover from Recovery Team to Complex Intervention Team (26th July 2023 – August 2023).
-------------------	--

System findings:

In July 2023, Richard was transferred from the Recovery Team to the Complex Intervention Team within AWP. Around this time, signs of deterioration in Richard's presentation, well-being, and need for further support became apparent. There were also differing perspectives between the teams regarding how to support Richard, the risks associated with his health and well-being, maintaining his property, and his nutritional needs. The Recovery Team showed limited escalation and multidisciplinary collaboration, but shortly after the handover, the Complex Intervention Team made referrals to the SBC Safeguarding Team and the Fire Service.

AWP have since reflected there are opportunities to improve 'handovers' and internal pathways between teams, ensuring that all teams are aware of a person's history, recent involvement and risk.

AWP have also discussed that increased professional curiosity might have encouraged a deeper exploration of Richard's situation, rather than accepting his assurances that he was fine and his refusals to allow professionals into his accommodation. AWP reflected that by being more inquisitive, workers might have gained a better understanding of his condition, identified any triggers or signs that he was struggling, and assessed how he was managing day-to-day tasks.

AWP furthermore acknowledged missed opportunities to take a more active role in organising and leading multi-disciplinary meetings. This issue has been highlighted in previous safeguarding reviews and reflects a recurring theme across the partnership. Additionally, AWP noted the need for more robust risk assessments and regular reviews of these assessments as areas for improvement.

Questions for SSP:

3.a. How can Swindon Safeguarding Partnership be assured that detailed handovers including risk and salient information regarding a person's circumstances, take place when transferring between agencies and internally within teams?

Recommendation 4;

All agencies to provide evidence of what processes they have in place to ensure handovers are clear and effective, when transferring internally between teams and external agencies, so that information is not missed. In all cases whereby self-neglect is a concern, a lead practitioner / agency to be explicitly identified as part of all handovers.

3.b. How can Swindon Safeguarding Partnership be assured that agencies are professionally curious and make efforts to explore a person's circumstances and presenting need?

Recommendation 5;

Swindon Safeguarding Partnership to understand the barriers in practice to being professionally curious and ensure that this understanding informs the ongoing development work within the Partnership.

Finding 4:	Decision that Safeguarding concern did not meet S42 criteria and subsequent referral to the SBC Mental Health Team (August 2023).
System findings:	
<p>A safeguarding concern was raised by the Complex Intervention Team (AWP) to SBC Safeguarding Team. This highlighted safeguarding concerns regarding hoarding, cleanliness of property, fire risks and the need for further support.</p> <p>Subsequently, a decision was made by the SBC Safeguarding Team that these concerns did not meet the s42 safeguarding criteria for an enquiry. The outcome, rationale and reasoning behind this decision was not communicated to AWP.</p> <p>Furthermore, a comprehensive handover, which should have included a determination and documentation of the risks associated with Richard's situation, was not conducted between the SBC Safeguarding Team and the Mental Health Team.</p>	
Questions for SSP:	
<p>4.a. How can the Safeguarding Partnership be assured that SBC Safeguarding Team regularly confirm the outcomes of safeguarding concerns and enquiries to referring agencies?</p>	
Recommendation 6;	
<p>SBC Safeguarding Team to provide evidence through dip sampling that the outcomes of safeguarding concerns and enquiries are communicated effectively to referring agencies and agencies involved in the safeguarding enquiries.</p>	
Recommendation 7;	
<p>Safeguarding Partnership to ensure safeguarding policy and procedures are explicit that in all self-neglect cases there is an identified lead professional or agency.</p>	
Recommendation 8;	
<p>Swindon Safeguarding Partnership Executives should request an update in 6 months' time on whether actions from all the above recommendations have had a positive impact on practice. If Executives are not assured of any positive impact, escalation to relevant organisations should be considered and whether there is a need for a risk management plan.</p>	