Safeguarding Adult Review (SAR) in-Rapid-Time

Systems Findings Report

'Ferdynand'

Always have a willing hand to help someone, you might be the only one who does

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1. Introduction

1.1 This SAR was commissioned by Swindon Safeguarding Partnership (SSP). The Partnership acts as and has the responsibilities of a Safeguarding Adult Board (SAB).
A decision was taken to conduct a SAR In-Rapid-Time to learn from the response of all partners to events leading up to the death of Ferdynand. SSP is conducting the SAR under Section 44 of the Care Act. This gives SSP authority to initiate a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked more effectively to protect the adult.

1.2 This SAR was commissioned using the 'in-rapid-time' methodology as this gives the best possible chance to deliver learning in a systemic format at the earliest opportunity. It should be noted from the outset that, whilst the SAR was commissioned by SSP, the circumstances involved more than one geographic area. Systems Findings and recommendations will reflect this.

1.3 It is important when considering Partnership work and the role of SSP in providing for rough sleepers and the homeless, we consider recommendations made in a letter to SAB Chairs from the Minister for Housing & Homelessness and the Minister for Social Care. This letter, sent in May 2024 states that, '*while individual case management and one-to-one support for individuals rough sleeping will always be taken forward by local frontline professionals**,** SABs are crucial in ensuring that the necessary partnerships, policies, and resources are in place to support this work'.* This means that the SSP need to ensure that the best possible systems are in place to help support people who find themselves in similar positions to Ferdynand.

2. The Report

2.1 This document forms the final output of the SAR In-Rapid-Time process. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on multi-agency factors that will improve responses to individuals that are in similar circumstances to those encountered by Ferdynand. There is the potential for learning across several professional areas, both within and outside the geographical commissioning area. 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.

3. Brief Circumstances

3.1 Ferdynand was a 61-year-old who has been described as pleasant and challenging in equal measure, depending on his mood, circumstances and the impact of his illnesses. He was well known to professionals in both Swindon and Oxfordshire areas and may have spent some time in London. He had been intermittently homeless and rough sleeping, moving between Swindon and Oxfordshire. The issue of his 'ordinary residence' was significant in this case and forms part of the report. Setting that aside, it is clear that he was very well known to health and social care professionals over a period that extends beyond the remit of this review.

3.2 Ferdynand had a high level of mental and physical health needs. Professionals observed that in the period considered by this review (October 2023 to October 2024) there were concerns that his cognitive state had deteriorated. The referral that led to the commission of the review noted that he was presenting as lacking in capacity to make decisions about his accommodation/residence, care and support. He was unable to protect himself from the harms he experienced. The same document detailed issues regarding which area should be taking responsibility for his care and support.

3.3 He had significant physical health problems including acute renal failure, chest pain, heart failure, acute kidney injury, type II diabetes and 2 previous myocardial infractions. His mental health diagnosis was bipolar affective disorder. These illnesses resulted in several contacts with health professionals, including admissions under the mental health act.

3.4 On 15 October, aged 61, Ferdynand died whilst a patient in an acute inpatient ward. He was found slumped between his bed and bedside table by staff. Efforts to revive him were unsuccessful. His Majesty's Coroner found that Ferdynand died of natural causes, citing acute chronic cardiac failure and ischaemic and hypertensive heart disease.

3.5 This review has been unable to establish contact with Ferdynand's family or friends. Whilst there is mention of him visiting Poland to see his mother, professionals have been unable to identify any family or friends.

4. Purpose and Aim of the Safeguarding Adult Review

4.1 When commissioned the reviewer was asked to consider the following in terms of 'purpose of the review'.

4.2 The objective of a SAR is not to assign fault. It encourages effective learning and improvement to prevent future fatalities or serious harm.

The objectives include establishing:

- Lessons to be learned from how professionals and their agencies collaborate.
- How successful the safeguarding protocols are, as well as examples of good practice.
- Local inter-agency practice improvement or development requirements for one or more services or agencies.

Lessons learnt are shared to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

5. Systems Findings

Each system finding is laid out for the reader. A short number of questions are posed to aid the SSP and partners in deciding appropriate responses. These findings are arrived at through analysis of the information provided by agencies involved with the individual, meetings to discuss this analysis and discussions with representatives of agencies involved. The SAR In-Rapid-Time does not afford the author the opportunity to be as comprehensive as other 'traditional' methodologies. There will inevitably be areas that are not included that

would be described in other SAR reports. It is important that the reader understands the methodology and intended outcome of the report before reading it.

5.1 System Finding 1 – Ordinary residence concerns outweighed provision of appropriate care.

There is evidence that professional concerns / disagreements regarding where Ferdynand was ordinary resident impacted on him receiving timely care and support. Therefore, the systems that are in place did not result in the best possible care and support being provided to an exceptionally vulnerable man.

Ferdynand was intermittently homeless. He moved between Swindon and Oxford, occasionally travelling to London. It was recognised that in addition to his health concerns Ferdynand was at high risk of self-neglect and had care and support needs. It is noted by more than one agency that his mental health was in decline. One report summarises the general view describing him as *'exceptionally vulnerable and unable to protect himself from the harms he experienced'.* This is a view that this review concurs with. For these reasons systems in both Swindon and Oxford should have been in place to ensure professionals engaged with him at the earliest opportunity, assessing his needs and putting in place appropriate interventions, care and support.

The initial referral to SSP is described in this way *'The concerns relate to how his health and social care needs were being met by the services responsible for him and where he was able to repeatedly drift away from Swindon to other areas, predominantly Oxfordshire where he was homeless, destitute and where his health and social care needs could not be met'.* This statement is indicative of a culture where professionals feel under pressure to ensure they are dealing with people based on where they are resident rather than on their needs. Terms used in focus groups included *'What can we do to hand this off?' 'We are working in silos', 'Senior managers have pressures on funding'* and perhaps most telling of all *'This was preventing us making ethical decisions'*.

It is important that this review recognises that there are examples of good practice in this case. System finding 5 in this report details the action taken by professionals to assess and meet Ferdynand's needs, without prejudice, whilst the issue of ordinary residence and who had 'responsibility' was considered.

SSP should consider the following:

- Are agencies fully conversant with the concept of ordinary residence? Is there a need to address this with a SSP led awareness campaign?

- Is this concept understood at practitioner and manager level across the entire Partnership? Is there a need to develop a multi-agency training package to ensure partners have this knowledge?

- Do partners adhere to the principle that the determination of ordinary residence must not delay the process of meeting needs, no matter where the person is

located? In cases where ordinary residence is not certain, the local authority should meet the individual's needs first and then resolve the question of ordinary residence subsequently. This is particularly the case where there may be a dispute between two or more local authorities.

- Is SSP assured that systems are in place that will afford best practice? Ensuring that there is a culture that supports the principle of not delaying the process of meeting a person's needs?

- Is there a need for a cross-border policy / memorandum of understanding that will support practitioners and managers to feel empowered to make ethical decisions that put the care of individuals before resolving ordinary residence issues.

- SSP should consider raising this systemic gap with Senior Leaders across both geographic areas (and any other similar borders) with a view to gaining a clear, agreed position on how similar cases will be dealt with going forward.

5.2 System Finding 2 – Discharge from medical care (physical and MH) did not adequately consider Ferdynand's needs.

Discharge of Ferdynand from various health settings show little evidence of risk management and forward planning. This resulted in him being discharged from medical settings into the community where he remained at risk without his care support needs being met.

Ferdynand had a significant history of contacts with Emergency Departments (EDs) in Swindon and Oxford. His attendance at EDs was so frequent that he was identified as a high intensity user (frequent attender plan) in both areas. He was also known to and treated by mental health professionals in both areas. These periods of treatment resulted in admissions under the Mental Health Act (MHA) and an acknowledgement that he should receive section 117 aftercare under the same act.

Both the EDs that had frequent contact with Ferdynand reported consistent concerns about his capacity to make decisions regarding his residence, care and treatment. Representatives from health were open about the challenges they face on a day-today basis. Whilst the identification of Ferdynand as a high intensity user offered opportunities for cases to be discussed on a regular basis it did not result in multi-agency planning for discharge. It is simply not possible, given the demands on our EDs and the commissioned role they have, for staff to call for a multi-agency risk management meeting when people in Ferdynand's circumstances present in their department. It was noted by health professionals that even the submission of a safeguarding referral is challenging in terms of time and resource management. Whilst staff are filling out referral forms, seriously ill patients may be requiring treatment, such is the pace of work and demands put on ED staff.

This review would like to acknowledge the honesty and integrity of health professionals that took part in this process. They made some striking contributions including comments and observations that should cause SSP and senior leaders to consider if systems that are in place are fit for purpose. They informed the review that there were other people in similar circumstances to Ferdynand, that EDs struggled to deal with some homeless people and that they found themselves in a position where a person's death was not a surprise to them. Whilst the system in place affords an opportunity to develop a care plan that highlights the need to consider residence when front-line staff are dealing with the person, the reality is that demand makes this incredibly difficult. There is very little evidence of any significant planning in terms of many of his discharges. The current system does not afford front-line practitioners the opportunity to plan discharges in complex cases such as Ferdynand's.

Ferdynand had a history of treatment for mental illness. He was well known to Swindon mental health services and had been admitted to hospital under the MHA on more than one occasion prior to the start date of this review. He was discharged from Swindon MH services in January 2023 following non-engagement. He then presented to Oxford MH services on several occasions, usually through attending ED. This led to further admissions to hospital under the MHA. During this period there were discussions and escalations regarding who had responsibility for his care with Swindon disputing that they had responsibility under section 117 of the MHA.

A further example of this occurs in July 2024. Swindon Community Mental Health Team contacted Oxford Adult Mental Health Team seeking a referral regarding Ferdynand. The referral had been expected but did not arrive. Once it was received it was declined by Swindon as no intervention had been in place for some months. There was no defined role for Oxford and Ferdynand's whereabouts were unknown.

There is a degree of 'mirroring' System Finding 1 in that professionals spent significant time discussing where Ferdynand should be admitted to, and who had responsibility for his section 117 aftercare. One practitioner commented on a specific presentation 'availability of beds puts pressure on the system and leads to focus on where the patient is registered rather than meeting their needs'.

Whilst there was a substantial history of professional contact with Ferdynand there is little done in terms of co-ordination and understanding of risk prior to June 2024. Whilst he was always treated for the 'presenting illnesses' there is a lack of any multi-agency, cross border care plan being developed to reduce the risks to him and provide for his care and support needs. The disputes regarding responsibility clearly impacted on this lack of planning. These issues should have been addressed in a cross border, multi-agency forum at the earliest opportunity.

SSP should consider the following:

- SSP should seek assurance that a system is in place to assist ED practitioners to give full consideration when discharging patients from their care. This system must afford them time to show professional curiosity, make appropriate referrals to partner agencies and seek assurance that partners have plans to support people post-

discharge. The review recognises systems that are currently in place to deal with high intensity or frequent attendees can highlight unmet care needs. This is illustrated by the fact that it was the High Intensity User team that made the referral to the SSP in March 2024. SSP may wish to consider where and how this system might be better supported by the entire Partnership.

- A system should be developed that will lead to early identification of people with complex physical health and / or mental health needs that require multi-agency discharge planning. This system should consider involving agencies with information that may assist risk assessment and discharge plans who are not located in the same geographical area as where the person is being treated.
- SSP should consider using this case or similar cases to highlight the benefit of early discharge meetings to ensure a coordinated approach to providing for the person's care needs and 117 aftercare needs. This could form the basis for an awareness raising campaign that could be rolled out to all partners.

5.3 System Finding 3 – Systems did not support and promote good multi-agency information sharing.

There is evidence that there was a lack of information sharing between agencies in different geographical areas. There is also no apparent forum or system in place to discuss cross border, complex cases of this kind.

Whilst there was a wealth of information known about Ferdynand, information exchange, particularly between Swindon and Oxford colleagues was not always good. Chances were missed to make referrals, consider his history in a holistic way and to involve other non-statutory agencies.

This led, in part, to a lack of cross border, multi-agency planning. The main source of information exchange happened when discussions regarding who had responsibility for his care were being had, rather than what his needs, risks and vulnerabilities were.

There is no specific system in place that would improve the opportunity to discuss cases that are similar to Ferdynand's. Practitioners and managers did not seek to bring all interested parties together, save for two multi-discipline Team Meetings (one of which was not well attended). This should have happened at the earliest opportunity. One of the main barriers appears to be a lack of a forum to bring these cases to. Had Swindon and Oxford colleagues met at an early stage in this case issues including ordinary residence, section 117 responsibilities, assessments and appropriate professional support could have been planned in a multi-agency, collaborative setting.

SSP should consider the following:

- SSP should seek assurance that systems are in place to ensure appropriate rapid information exchange between agencies. They should give specific thought to removing any barriers to information exchange between agencies, including cross border requests.

- SSP may seek to introduce a forum where complex cross border cases can be brought for multi-agency planning. This forum would afford opportunities for cases like Ferdynand's to be discussed and appropriate agency responses agreed.

5.4 System Finding 4 – Lack of suitable accommodation for those with complex needs.

There is a lack of suitable housing / residential offers for homeless people with complex needs.

This review has concluded that finding suitable accommodation for Ferdynand was not possible given his circumstances, physical and mental health and the behaviours that these sometimes caused. Despite professionals' best efforts, options were sometimes limited to Ferdynand being housed in hotels or being admitted to hospital, neither of which was the best environment given his needs. Observations from front line staff and managers have made it clear that this is not an isolated case. There are a significant lack of appropriate accommodation offers for homeless people with complex needs.
It is acknowledged by this review that this is an issue across much of the country, however, it is equally important for it to be raised as a systemic issue for Swindon. Given Ferdynand's mental health and issues regarding him not taking medication it is not surprising that his stays in hotels were not successful. His behaviour could be challenging and without skilled support it is difficult to conceive how a settled residence with any degree of permanence could have been achieved.

SSP should consider:

- SSP should consider making representations, locally and nationally, seeking specialist residential provision for homeless people with complex needs.
- SSP should make enquiries about other similar provision or solutions to this problem and consider if they are transferable to Swindon.
- SSP may seek to engage with the Local Authority housing department to seek alternative provision and solutions for this issue.

5.5 System Finding 5 – Systems that do work took too long to be used.

There are appropriate systems in place for care and support to be given to people in similar circumstances to Ferdynand. When professionals were facing challenges about who had responsibility for Ferdynand's care there were instances of good practice, with individuals recognising his need for care and support. They provided positive assessment and action, proving that systems are in place to afford agencies the ability to provide good service when disputes are running in parallel.

It is important that this review highlights good practice as an opportunity to learn and improve systems. Some of the findings in this report will suggest significant systemic change. This finding will suggest that SSP considers systems that are already in place, examples of how they can be used well and develop them to afford agencies and individuals the best possible opportunity to improve. This will help partners to provide the best care and support to people in similar circumstances to Ferdynand. There were examples where agencies pursued the best interests of Ferdynand despite barriers and difficulties. This

shows a positive culture where professionals are prepared to challenge each other to promote adults with care needs.

SSP chose to invite an advocate to be involved in this review process. This was good practice, and their engagement enhanced the review. It was noticeable that advocacy did not seem to be considered by those who were caring or treating for Ferdynand. It is important that people are offered independent support at critical points in decision making. This is an area that needs to be re-enforced.

The review was also provided with the opportunity to meet and speak to an individual who had lived experience similar to Ferdynand's. This conversation highlighted the view that people who are homeless or rough sleeping often have little knowledge about how to seek assistance. They simply don't know where to go or who to turn to. Given that many have a varying degree of needs, have suffered significant trauma and are extremely vulnerable it is imperative that the system and community do all they can to support them. It also highlighted the positive impact Partnership support can provide to people who are in this situation. The outcome for this individual was life changing. This was a humbling conversation and highlighted the need to engage with people at the earliest possible opportunity.

Many of the individuals who had direct contact with Ferdynand contributed significantly to the review. People involved in his housing, medical care and supporting him whilst he was homeless all offered valuable information and ideas for improvement to the process. They were able to offer an insight into his lived experience and describe the person. It is imperative that, when considering multi-agency meetings, information sharing and risk assessment, these people are involved wherever possible. The knowledge they bring is crucial to making appropriate decisions.

Decisions taken by practitioners and management in Oxford regarding Ferdynand's assessment and care should also be highlighted as good practice. Decisions taken by managers and subsequent good practice from partners afforded Ferdynand an opportunity to be supported both in terms of his care needs and section 117 aftercare. This was achieved whilst the disagreement about ordinary residence remained unresolved and had been escalated to legal services. The fact that managers from the local authority took a decision to allocate Ferdynand's case on a 'without prejudice' basis was good practice, treating him according to need.

SSP should consider:

- SSP should seek assurance from all partners that they are aware of local and national advocacy services.
- SSP should consider a dip-sample of cases similar to Ferdynand's to ascertain if advocacy services are offered to people.
- SSP should advocate for the inclusion of non-statutory partners in MDTs, promoting the knowledge those who are often directly involved with people can bring. This would provide a richer understanding of the person's lived experience and enhance risk assessment and care and support plans.

- SSP should recognise the good practice in this case and use it to promote a culture where a person's needs are always addressed as a priority, even when other matters are being contested.

5.6 System Finding 6 - There is no distinct multi-agency governance structure or policy in place to deal with the issues and challenges practitioners faced in Ferdynand's case.

There was little evidence of appropriate multi-agency governance structures, leadership, escalation and problem solving in this case. This was particularly apparent in terms of the SSP / SAB representation.

Whilst issues around who had responsibility for providing Ferdynand with care and support were escalated within individual agencies this review found that there was a lack of coordinated governance that could have remedied such disputes.

Local authorities, commissioned services and health all discussed Ferdynand to varying degrees with colleagues from their own agencies or the equivalent in other areas. This led to some escalation, particularly seeking legal advice. There was no information provided to this review that indicated escalation to senior members of the Partnership. There appears to be no process or policy in place that would allow leaders to consider complex cases such as this one.

The letter from Ministers mentioned at the start of this report says, *'It is important that the governance structure of SABs incorporates clear and sufficient accountability mechanisms for partners with responsibilities towards people rough sleeping.*

SABs should take an active role in promoting outcome driven discussions around governance. This should centre on system-wide change and the integration of experience informed practice relating to safeguarding people rough sleeping'. If such a governance structure had been in place, Ferdynand's situation may have been the subject of some clear guidance from people at a leadership level.

SSP should consider:

- SSP should ensure that all partners are aware of the lead within its own structure for rough sleepers and the homeless. This person acts as an advocate for these groups, promoting their needs and representing them at other statutory boards. It is imperative that partners link in with them when systemic issues arise.
- SSP should nominate a lead within its own structure to have responsibility for developing cross-border policy and agreements.
- SSP should develop clear guidance on escalation for cases such as Ferdynand's. This escalation should be made to an appropriate level and involve policy for dispute resolution.

6. Conclusion

This review in rapid time has identified five Systems Findings that SSP should consider and take steps to address.

Ferdynand was a man with complex needs. Had he resided in one geographical area his case would have stretched professionals and involved resources across several fields and disciplines. The fact that he was transient made this case even more challenging.

Concerns and disagreement about who had responsibility for his care impacted on the care and support he was given. There is a real need to examine the systems that deal with cross-border disputes such as those that occurred in this case. The development of a forum to discuss complex cases with similar circumstances should be prioritised.

The review found that practitioners and managers showed a genuine appetite for systems to be introduced that will assist them to improve. They were open to change and this is a positive for the Partnership.

Chris Robson