

7 Minute Brief – SAR Ferdynand

Reason for SAR and background:

Swindon Safeguarding Partnership (SSP) commissioned a mandatory [Safeguarding Adult Review \(SAR\)](#) to explore how well partners respond to concerns of rough sleeping, mental health & working across local authority boundaries.

Ferdynand, a 61-year-old white Polish male, described as pleasant & challenging in equal measure, depending on his mood, circumstances & impact of his illnesses. Known to both Swindon & Oxfordshire health and social care.

Ferdynand died on an acute inpatient ward of natural causes; acute chronic cardiac failure & ischaemic & hypertensive heart disease.

Ordinary Residence

Ferdynand was known to both Swindon & Oxfordshire, there was an ongoing disagreement on who held Ordinary Residence that remained unresolved. This led to delays in support being offered.

However, there was excellent practice by the practitioner in Oxford who assessed and supported Ferdynand without prejudice, while the dispute continued.

Ordinary Residence became increasingly confusing due to Ferdynand being eligible under the Mental Health Act for S117 aftercare.

You can find out more on Ordinary Residence [HERE](#)

Learning Resources:

[7 Golden Rules of Information Sharing](#)

[Process for the Resolution of Professional Disagreement](#)

[Museum of Homelessness](#)

[Professional Curiosity](#)

[Rough Sleeping](#)

[7 Minute Brief Video](#)



Discharge Planning

Planning for discharge from acute physical or mental health setting is essential from the earliest possible stage.

A lack of discharge planning from acute settings led to important information and planning for Ferdynand to not take place. He was regularly discharged to street homeless and without any assessment of needs. The Local Authority were also not aware of agreed S117 arrangements.

[Nice Guidelines 35](#)

Working across borders

A cross border protocol/memorandum of understanding for sharing information & concerns across local authorities needs to be developed, enabling the best outcomes for the person are met & remain central.

Disagreements should be addressed, utilising local escalation policies & not delayed due to professional disagreements.

Accommodation for complex needs

It was apparent that meeting Ferdynand's needs through the available homelessness options, was not appropriate. The agencies who supported Ferdynand did their utmost to meet his needs. However, these services did not have the resources to support him with his mental health and social care needs. This left both Ferdynand and those agencies supporting him struggling. Commissioning of housing options for those with complexity needs to be revisited.

You can find more information on homelessness [HERE](#).

Information Sharing

Lack of information sharing between agencies, in particular decisions made under the Mental Health Act and discharge planning was not shared with the Local Authority.