Safeguarding Adult Review Adult F – 7 Minute Briefing

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Recommendations

DSAB seeks;

1. Assurance from commissioners (RDASH) in respect of the process by which patients are discharged from the Alcohol Service, in particular risks are assessed and that other agencies working with the patient are notified.
2. Assurance from DBHFT that all relevant agencies will be involved in discharge planning. Assurance should also be sought from RDASH that Magnolia Lodge consults relevant community based services when appropriate.
3. The extent to which relevant local services are informed when a Doncaster resident is admitted to an out of area hospital.
4. Assurance from DCCG over the process by which GP practices monitor and support vulnerable patients such as Adult F.
5. The attention of professionals to the need to make reasonable adjustments for service users with a disability and to falls risk policies.
6. To develop a system for reporting and analysing activity related to safeguarding adults concerns which do not meet the statutory duty to carry out a S42 enquiry, to assure themselves of the types of concerns being received, the responses made and the outcomes for the adults concerned.
7. To share learning and ensures that self-neglect is highlighted together with the opportunities to invoke the Multi-Agency Self-Neglect and Hoarding Policy.
8. Each agency involved in Adult F's case to state the specific actions they plan to take in the light of this SAR to improve the response of their staff to mental capacity issues including the issue of someone persistently making unwise decisions.
9. To share the learning about the response to Adult F's attempt to take his own life with those responsible for the Doncaster Suicide Prevention Plan, to inform awareness raising for professional actions to take in response to suicide attempts.
10. The issue of how negative perceptions of Adult F may have obscured his vulnerability is highlighted.
11. To ensure that the benefit of multi-agency meetings or discussions is highlighted when sharing learning.

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Background

After not being seen for several days, Adult F was found deceased in the bungalow in which he lived in December 2019. He was 51 years old. He had sustained injuries consistent with an assault and four males were later charged with his murder. Three of these males were later convicted of his murder or manslaughter. Some of these males were also involved in a previously reported Hate Crime during which Adult F, who was gay, received abuse relating to his sexual orientation.

During the months prior to his death, Adult F was in contact with a range of agencies as concerns escalated about his physical and mental health. Adult F was a heavy drinker with mobility problems arising from earlier strokes who had sustained serious injuries after repeatedly falling in the street. He was considered to be at high risk of accidental self-harm, including alcohol relapse, overdosing and falls. In addition to his fractured ankle, he had had a stroke and suffered from right sided weakness of limb and mouth drop and his mobility remained compromised although he was able to mobilise around his home and for short journeys close to home.

In the months prior to Adult F's violent death his vulnerability to abuse and neglect was increasing at a time when his support from services was falling away and he was increasingly seen as a perpetrator of anti-social behaviour and a person who was making excessive demands on emergency services.

Adult F was described by his mother as an extremely bright, funny, kind and well liked person who was a very good listener.

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Key Learning

Discharge from services

Discharge from hospital and from drug and alcohol services took place without adequate multi-agency information sharing or risk assessment;

- Following the hospital detox there was an opportunity for Alcohol Services and partner agencies to play a role in post detox support but this did not happen.
- Hospital discharges were deemed unsafe as they did not inform Alcohol Services of Adult F's discharge to ensure continuity of case in the community
- Decision to discharge Adult F from Alcohol Services without making efforts to locate him and check on his welfare was unsatisfactory and carried risks
- Adult F's compromised mobility and high risk of falls made it challenging for him to attend appointments.

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Adult F's voice

- Attendees at the practitioner learning event arranged to inform this review felt that Adult F was 'voiceless'.

Compromised mobility and risk of falls

- There was a lack of follow up by Adult F's GP practice as they did not explore why he was not attending appointments.
- Adult F's GP practice did not appear to make a link between his compromised mobility and the fact that the practice was situated 13 miles away from his home when responding to his failure to attend appointments.
- Adult F's high risk of falls inside and outside his home did not appear to generate any falls risk assessments.
- Professionals need to make reasonable adjustments for service users with a disability

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Mental Capacity

- There was a lack of focus on Adult F's mental capacity and no exploration of the mounting number of 'unwise' decisions Adult F was taking to decline services - which could be injurious to his physical and mental health.

Self Neglect

- Adult F's self-neglecting clearly put him at risk of a range of adverse health outcomes including premature death. However, there appeared to be little professional consideration of self-neglect or exploration of invoking the Doncaster Multi-Agency Self-Neglect and Hoarding Policy.

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Safeguarding referrals

There was insufficient information gathering before decisions not to proceed with safeguarding enquiries were made; and that agencies concerned about Adult F at different times missed the opportunity to raise safeguarding concerns with the local authority.

- Fact finding was incomplete. Had fuller fact finding been achieved in this case, it could have been established that Adult F was no longer being supported by Alcohol Services, that he had been taken to hospital several times, that his frequent contact with the police and ambulance service presented a very concerning picture of a person in crisis who had recently been the victim of a Hate Crime.
- No multi-agency meeting or discussion appears to have taken place as concerns about Adult F began to escalate

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Risk of abuse / exploitation

- Adult F's vulnerability to abuse or exploitation by others may have been masked by the perception that he was a perpetrator of anti-social behaviour

Risk of suicide and self harm

- Adult F took overdoses of prescription drugs in combination with alcohol on a number of occasions. Information sharing about the incident was incomplete and the fact that the overdose involved drugs which he was prescribed did not lead to any review of prescribing practice in respect of Adult F.