Mr D – Safeguarding Adult Review 2022

1.What happened?

Mr D was 59 years old at the time of his death and had lived in a bungalow as part of a residential care home for 6 years. He had a complex physical and mental health history and needed access to staff support 24/7. Mr. D had a history of suicide attempts and self-harm, including cutting his neck with a knife in May 2020. He had a known history of violence, use of weapons, admission to secure settings, and arson.

At the time of his death, Mr. D was awaiting the outcome of a decision by the Crown Prosecution Service, following an incident when he had assaulted staff members from the Care Home. He was on bail with conditions which restricted his access to support, he had been served notice to leave the care home and after assessment he was shortlisted for ordinary housing in a one bed flat.

Mr D took his own life in November 2020, an inquest later determined the cause of Mr. D's death was suicide.

2.Learning from the review

1.Mr D was experiencing anxiety over having to leave the care home and the criminal investigation, particularly the impact they could have on him seeing his mother.

2.On two occasions, safeguarding alerts were raised by the staff at the home, however, their concerns appeared to be minimised with limited action and when staff requested Police assistance their response was below the minimum expected standards.

3.Mr D repeatedly told professionals about his anxiety and worries for the future, yet decisions were being made by agencies working in isolation, without the inclusion of Mr. D and without clarity around his care and support needs.

4.Whilst incidents had escalated more quickly than previously and Mr. D's mental health had deteriorated, the crisis plan, and multi-agency response was not reviewed.

3.Good practice

Mr D was able to be provided with 24/7 supported care whilst living relatively independently in a bungalow, he was very happy there.

Communication with community staff and their continued input with the placement worked well.

4.Recommendations

- to ensure that there is a multi-agency response when there have been significant events within an individual's life
- ensure staff are aware of how to escalate concerns in relation to multi-agency working.
- that decisions are being made which are centred around the individual and clearly document the individual's involvement
- provides access to a glossary, where professionals can find further information on key definitions, and processes regarding housing and accommodation
- that the contractual arrangements with residential accommodation service providers are current and up to date

5.Multi-agency Learning

1.Missed opportunities strategically and operationally for agencies to have worked together effectively.

2.All relevant agencies should be part of multi-agency meetings

3.The sharing of information between partner agencies, is a key factor in enhancing and supporting multi-agency working.
4.The multi-agency working needs to clearly articulate how and when information was to be shared amongst agencies.
5.All staff need to understand the processes to resolve and escalate multi-agency disputes.
6.Increased understanding of the different terminology in relation to Mental Health Act assessments
7.All decisions should be centred around the person, the risks to themselves and others, and the impact of those decisions.

6.Learning - snapshot

Multi-agency Working
Person-Centred Decision Making
Fit for purpose and updated Care Plans
Contractual Arrangements
Understanding of terminology around the exact nature of a person's accommodation and the difference between residential care and supported living
Escalation processes

7.Resources

Multi-Agency Professionals Meeting Guidance

CSAB-Self-Neglect-policy-2018.pdf

ma-safeguarding-adults-policy-procedures-2019

Resolving-Professional-Disputes-and-Escalation-Procedure.pdf