SAFEGUARDING ADULT REVIEW (SAR)

LEARNING BRIEF - MICHAEL

Safeguarding Adult Review (SAR)

The purpose of a Safeguarding Adult Review is to use learning from the case under review to promote and reinforce effective practice and identify where improvements or adjustments to the system need to be made.

The Care Act 2014 states that a Safeguarding Adult Board must commission a SAR when:
(1) an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult,
(2) an adult in its area has not died, but the adult has experienced significant abuse or neglect, whether known or suspected.

Background Information

Michael was a white British man who was 44 when he died in September 2024. Michael was described by his mother as an outdoors person who loved animals, music and dancing.

Michael's cause of death was confirmed as drowning in his bath following an epileptic seizure and drug use. Michael had early trauma arising from an accident in childhood which left him with a brain injury and epilepsy. He was unable to sustain employment, became dependent on drugs and was targeted, exploited and abused by others.

Michael was, at times, aggressive and abusive to others and had served time in prison for assault. He had frequent attendance at the Hospital Emergency Department arising from seizures and intoxication. His intake of epilepsy medication was erratic, and this led to uncontrolled seizures and often falls. Michael had poor nutrition and neglected his health.

Key Themes

Safeguarding, Risk and Mental Capacity

The review identified that Michael could have been more effectively safeguarded if there had been a sustained collaborative and inclusive approach. Michael responded well to a personalised and appreciative way of working. Engaging advocacy and family support and introducing specialist services to inform practice, would have been of benefit. A shared multi-agency safety plan combined with an emergency plan, discussed with Michael and available at his home, would have been inclusive and helpful.

The SAR noted the impact of mental stress on staff working in circumstances where there are threats of violence against them. This has an impact on wellbeing at work and more overt recognition and inclusion of this in safety planning would be of benefit. Mental capacity assessments and actions taken did not adequately protect Michael. It would have been helpful if there had been a recognised process in place to share the mental capacity assessment outcomes as this would have informed a more collaborative and coordinated approach to safety planning for Michael.

Cuckooing and Exploitation

Cuckooing is a form of criminal exploitation where people are coerced, controlled, or intimidated into sharing, providing or offering up their accommodation to criminals. The incidents of cuckooing and assault on Michael were prolific.

There was no engagement of a trusted person or advocate to meet and build up rapport with Michael. There were few attempts to engage with family members who potentially could have been influential in a risk management and safety plan. There was little evidence of a joined up safeguarding approach or enquiry to collate all known incidents and manage this through a holistic and strategic approach.

Self-Neglect

Michael lived in basic conditions, the possessions he had were frequently stolen from him or he lost them. His brain injury, past and present trauma and non-engagement with support led to self-neglect. People working to support Michael were aware of the challenges he experienced, and some steps were taken to try to mitigate the risks of self-neglect though there were issues which impeded success.

SAR partners reflected that discussion with Michael about the best ways to communicate with him had a positive impact. There are noted times when Michael responded well to personal respect. Helping people who are self-neglecting is most effective when there is multi-agency partnership planning and a trauma informed practice approach in place.

Information Sharing, Partnerships and Collaboration

A practice approach and clear methods to communicate with Michael and respectfully gain his agreement to share information with his mother and across the multi-agency partnership would have been helpful.

There was evidence of good sharing of information between the police, Adult Social Care and Michael’s keyworker. The outcomes from professionals' meetings were insufficiently communicated and roles, responsibilities, agreed actions and timescales were unclear from the records.

Recommendations

1. **Safeguarding Safety Planning:** the Keeping Adults Safe (KAS) Board should seek assurance that Safeguarding safety planning is guided by Making Safeguarding Personal principles.
2. **Emergency Planning:** Bristol City Council - Adult Social Care (ASC) and Health partners should consider using the referenced resources to develop a template for a shared safety and emergency plan.
3. **Personal Support Plans (PSPs):** UHBW should review the effectiveness of PSPs.
4. **Mental Capacity Assessment:** ASC should review the mental capacity assessments undertaken with Michael.
5. **Mental Capacity Act (MCA) Training:** The KAS Board should seek assurance that training and learning opportunities should include specific reference to the effects of substance use and regular audits of practice are periodically completed by statutory partners to provide assurance about the impact of training.
6. **Advocacy:** ASC and Health partners should ensure that there is appropriate and available advocacy representation in accordance with The Care Act.
7. **Legal Literacy:** SAB statutory partners to consider how best to ensure that practitioners access legal literacy learning opportunities.
8. **Cuckooing:** the KBSP to review and update the KBSP Cuckooing protocol to include the learning from and resources referenced in the SAR.

Support

Bristol Horizons

Bristol Horizons is a collaboration of community organisations, offering inclusive and accessible drugs and alcohol support to help anyone in Bristol make informed choices about their wellbeing. Email BristolInfo@horizonsbristol.co.uk or call 0300 555 1469.

Headway Bristol

Headway Bristol run a monthly Care and Connect group, open to anyone affected by brain injury (including carers) on the second Tuesday of the month, 7pm–9pm at the Wellspring Settlement. This is at Beam Street, Barton Hill, Bristol, BS5 9QY. Headway also offer other services to support individuals with brain injuries.

Where to find us:

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www.bristolsafeguarding.org

Keeping Bristol Safe Partnership