Robert Safeguarding Adult Review 6 Step Briefing

The Background

Robert was a 60 year old man who lived in Southampton. Robert had a history of mental health issues, and experienced intermittent episodes of psychosis from 2003 to 2015. In his late 40s, Robert developed Glaucoma, causing blindness in one eye. Robert was registered as blind and was noted to suffer from regular eye infections which caused him to have low moods. In 2012, Robert had been receiving direct payments to help meet his domestic and personal care needs as well as to reduce social isolation. These direct payments were reduced in 2017 which lead to Robert cancelling his direct payments, and funding his care himself. Between 2017-2020, concerns were raised around Robert being able to afford his care, as well as the amount of care being afforded to him, Robert not taking his medication, and social isolation. In 2019, Robert applied for extra care housing and in December 2020, Robert was accepted in to the Potter's Court extra care unit. Robert moved in to a flat on the fourth floor in June 2021. In September 2021, Robert was admitted in to hospital, and was diagnosed with late stage cancer.

The Incident

On 09 November 2021, Robert passed away. Robert was found on the ground below his balcony by another resident of the unit having appeared to have fallen from his balcony. A wooden chair was seen to be tipped over on Robert's balcony, although a property inspection found that the hand rail and window bars were compliant with building regulations.

The Review

The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory SAR and this was agreed by the Southampton Safeguarding Adults Board (SSAB). The timeframe for the period under review was November 2019 to November 2021.

An independent reviewer was appointed to complete the SAR, and the reviewer used evidence from the serious incident report completed by Southampton City Council, a multiagency combined chronology, and information gathered from involved agencies during a practitioner event in December 2022. The independent reviewer also met with Robert's two daughters to discuss their views and concerns.

Key Lines of Enquiry

- The effectiveness of transition planning from Robert's previous accommodation to the accommodation on the fourth floor.
- Was the package of care in place for Robert following his discharge from hospital, communicated to all relevant agencies involved in his care and felt to be sufficient to meet his needs?
- Where Robert was known to a number of different care agencies with subsequent changes to his package of care, what processes were in place to allow for a comprehensive handover?
- Is there evidence that agencies involved in Robert's care completed, implemented and monitored risk assessments and safety plans in relation to Robert's accommodation/living arrangements as well as his mental health?
- Is there evidence that agencies worked collaboratively and effectively together to help meet Robert's needs whilst acknowledging his views and wishes?
- Following his diagnosis of cancer in September 2021 , was Robert given information and was the support available discussed with him?
- How were Robert's family involved and were the concerns from the family addressed adequately?

Findings

- Sensory assessments undertaken in September 2020 did not identify that Robert needed a ground floor flat and did not consider Robert's training needs outside of his flat. It was felt that there was insufficient communication between professionals involved in Robert's transition to Potter's court, and record keeping in the housing and independence services need to be strengthened in the future to assist with this.
- The care agency, Apex Care received a risk and task plan from the Care Placements Team, however no information was provided in relation to Robert's previous package of care. This lead, in particular to issues in relation to Robert's medication management.
- Robert was visited by both the CMHT and a sensory worker when he moved in to Potter's Court. No concerns were raised in relation to Robert's ability to use the balcony, and the CMHT had also noted that Robert appeared happy with his flat. However, discrepancies with information from Apex Care suggesting Robert had settled in well and was coping, and concerns raised by carers and the family about Robert's ability to cope were not reflected within assessments.
- When Robert was diagnosed with cancer in September 2021, there is evidence that this diagnosis was discussed with Robert, and the prognosis discussed with his daughter, although there were limited opportunities for Robert's family to speak with medical professionals due to the Covid-19 pandemic. The review noted, however, that following Robert's attendances at hospital, there was reported miscommunication between the Hospital Discharge Team and Apex Care which lead to issues with the care provided to Robert at Potter's Court.
- There is evidence of Robert's views and wishes being heard by agencies, however, whilst there was multi-agency liaison with regards to Robert, there were gaps in this communication throughout the last year of Robert's life. Concerns raised by Robert's family and the carers involved did not appear to have been addressed.
- There were concerns that the impact of Robert's diagnosis and treatment on his mental health was not considered fully.
- Robert's daughters continued to raise concerns around Robert's care and informed the reviewer that they felt that no one cared that they were constantly chasing for support. The review also noted that Robert's daughters were not offered carers assessments

Recommendations

- For SCC to demonstrate how they gain assurance that homecare providers ensure that their staff are aware of how to raise safeguarding concerns about the care of individuals.
- SCC, the ICB, Southern Health NHS Foundation Trust, and Apex Care should review their procedures for how family, informal carer, feedback is used when there is a care package in place for an individual.
- Southern Health NHS Foundation Trust should ensure that staff are aware that when an individual is known to have a significant history of mental health issues and is open to CMHT, the risk assessment must be shared with the social care provider, with the consent of the individual.
- There should be a review of discharge planning at UHS, between SCC, UHS and Solent to ensure that those being discharged on pathway 0, are those who do not have packages of care. This means that pathway 1 should be used for those who have packages of care, to ensure that they have the support they need, even if there are only minor changes to the package.
- Apex Care should undertake a review of care plans to evaluate the impact that learning has made on improving staff practice in helping residents with medication management. This should then be shared with SSAB, SCC and the local Care Provider forum, to be considered as a model for good practice.
- For SCC, there needs to be a section to record the 'family views' in assessments and reviews for packages of care commissioned by SCC, or the individual's request not to include the family.

Useful links for Best Practice

1. SAR Robert Full Report
2. Spot the Signs of Abuse and Speak Out (southampton.gov.uk)
3. 4LSAB Multi-Agency Safeguarding Adults Escalation Policy