North Yorkshire Safeguarding Adults Board

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7 Minute Briefing

Safeguarding Adult Review: Anne

Section 1 What is a Safeguarding Adults Review (SAR)?

A SAR is a multi-agency review process, which seeks to determine what relevant agencies and individuals involved could have done to have prevented harm or death from taking place. It will establish whether there are lessons to be learned and promote effective learning and improvement to prevent future deaths or serious harm happening again. A SAR should reflect the safeguarding principles of **empowerment, prevention, proportionality, protection, partnership and accountability**

Section 2 Background

Anne was a 34-year-old mother of 3. She became a resident in supported housing accommodation in February 2015. Following assessment it was identified that she needed support with anti-social behaviour, recovery from substance misuse, physical and mental health needs and support to maintain a tenancy.

Anne had a history of mental health problems and was supported by mental health services as well as the on-site staff where she lived. Following a referral in March 2015 into the Drug and Alcohol Recovery service by the supported housing provider, Anne disclosed substance misuse issues in relation to alcohol, diazepam and mephedrone.

Anne initially engaged well with the Drug and Alcohol Recovery service, abstaining from alcohol and, in May 2016 following assessment it was reported that she was making exceptional progress in relation to addressing her substance misuse issues. Anne was discharged from the Drug and Alcohol Recovery service in September 2017 owing to the positive progress they felt she had made.

In the days up to her death, Anne was appearing unwell and under the influence of substances. She was found dead in her flat on 4th January 2018 and the cause of death was subsequently given as drug toxicity.

Section 3 Key Learning: Supported Housing

Anne lived in supported housing, which provides housing with intensive outreach support. This type of housing is not regulated and is not registered with the Care Quality Commission, despite many of those living there having complex needs. In response to recommendation one within the SAR report, North Yorkshire County Council will arrange an external review of Supported Housing to identify opportunities for further development and improvement in the service provision.

Section 4 Key learning: Self-Neglect

Concerns were raised by supported housing staff and TEWV's Care Co-ordinator in 2017 that Anne may have been supplementing her prescribed medication with illicit substances. Despite these concerns, no action was taken.

Anne was considered by TEWV to have capacity to understand the risks associated with her medication. At the time of her death, a structure that provided a coordinated response other than a safeguarding enquiry was not established in North Yorkshire.

Since Anne's tragic death, the 'City of York and North Yorkshire Multi Agency Practice Guidance for working with Adults who self-neglect' has been developed and highlights when a Multi-Agency Self Neglect meeting (MASM) will be appropriate to manage the risks. In response to recommendation eight in the SAR report, work will be carried out by Health and Adult Services to implement the self-neglect guidance and MASM across North Yorkshire, and the NYSAB will promote the existence of the guidance amongst partners and those working with adults at risk of neglect.

The guidance can be found here on the Board website.

Section 5 Key Learning: Information Sharing

Different agencies involved with Anne held information about her, but they rarely shared it between themselves. This included the police, who were receiving information about possible illicit drug pur-chases in the community. As a result, no agency had a full and complete picture of Anne's life and the associated risks, which meant opportunities to safeguard her were missed.

The sharing of, and access to, information is vital when working collaboratively to provide the appropriate level of support to individuals in their services.

In response to recommendation nine within the SAR report all agencies are to be aware of the 'One Minute' guide on information sharing to North Yorkshire Police, **available here on the North Yorkshire Safeguarding Adults Board website.**

Section 6 Key Learning: Support Planning

There was a lack of an effective support support plan in place for Anne whilst she was residing within Supported Housing. Agencies did not consistently deliver the support outlined in the plan and did not utilise existing frameworks, such as the **Care Programme Approach**, to better manage the risks. Collaborative support plans, involving the resident, provider and involved agencies are to be in place for all vulnerable people who may take up residence within supported housing.

Section 7 Key learning: Safeguarding Training

In the lead up to her death, Anne's presentation changed, possibly due to the influence of substances. Support workers did not consider the need to intervene and therefore no safeguarding concern was ever raised. It is important all agencies ensure their staff have appropriate safeguarding training in place. Links to the new North Yorkshire Safeguarding Adults Board Safeguarding Level 1 & 2 competencies, training standards document and on-line **training menu of courses delivered via NYCC can be found here on the Board website**

For the full SAR report click here