BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

Safeguarding Adult Review Report
Stephen

Executive Summary

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1 Introduction

This is the Executive summary of the published report made by the Birmingham Safeguarding Adult Board (BSAB) following a Safeguarding Adults Review (SAR). The full report can be found on the BSAB website.

2 Background to the Safeguarding Adults Review

The Birmingham Safeguarding Adults Board (BSAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) when the Criteria for a SAR is met.

The SAR Sub-group of the BSAB Executive Board considered this case against the SAR criteria and concluded the case did not meet the statutory criteria for a SAR, however decided to follow its discretionary power to still carry out a review. The Independent Chair of the BSAB ratified this decision. It was decided to commission someone independent to carry out the review and use reflective learning sessions as a methodology for the review.

3 Stephen's Lived Experience

Stephen was a 65 year old man born in UK.

Stephen was divorced and had children, He was university educated and previously had a successful career.

Stephen suffered trauma from the suicide of his sibling and this led to him drinking and his mental health deteriorating. He later lost his job, his marriage came to an end, including less contact with his children. Some years on he lost his property and a large sum of money. This trauma is believed to have impacted on his drinking and mental health over time.

Stephen ended up in various accommodation, receiving criminal convictions including detention in prison.

Stephen was accommodated in Washington Court following release from prison in January 2018. Services were working towards providing appropriate long term accommodation and support to meet his needs. He had had a history of alcohol abuse and rough sleeping.

It would appear that Stephen slept on a public bench on the 4 July, where he was found collapsed the following morning. In spite of attempts by paramedics to revive him life was pronounced extinct. The Coroner recorded the death to be natural causes to be as a result of Hypertensive Heart Disease.

4 Themes for Reflective Learning Sessions

An independent reviewer was commissioned to lead reflective learning sessions with frontline staff looking at the following areas and then a report was written:

1. Self-Neglect, Mental Health and Mental Capacity: the review considered the interrelation between Stephen's self-neglect, mental health and mental capacity

2. Housing: the review looked at the challenges experienced by professionals in finding suitable placements for Stephen pre-release and post release from prison in January 2018, taking into account his complex health presentation, self-neglect and offending history (MAPPA sex offender registration requirements.)

3. Adult Social Care: the review considered the most recent assessments of need undertaken with Stephen to identify whether assessments of need identified how his complex mental and physical health needs were leading to self-neglect which impacted upon his eligibility for care and support

5 Key Learning Points

5.1 Key Learning in relation to Self Neglect:

Learning Point: Where there are concerns relating to self-neglect, practitioners should carry out a multi-disciplinary identification of those needs, as well as identifying risk.

Learning Point: Capacity assessments should be considered in relation to each of those identified needs.

Learning Point: Practitioners should distinguish between *'micro'* and *'macro'* decisions in relation to self-neglect. This requires recognition that an adult may have capacity for decisions in relation to some element of their identified needs but may not have capacity in relation to the holistic impact of all the identified needs and vulnerabilities upon their wellbeing.

Learning Point: Practitioners should be mindful of the impact of anxiety or depression upon self-motivation.

Learning Point: Self-neglect can be a response to trauma and/or neuropsychological impairment.

Learning Point: Where there are alcohol-related concerns combined with self-neglect, practitioners should identify the impact alcohol abuse has upon capacity.

Learning Point: Multi-disciplinary meetings with an identified lead professional are always helpful in agreeing a support plan for self-neglect.

Learning Point: A safeguarding referral should be considered where an adult who self-neglects refuses all support, remains at a high risk of harm and, as a result of their refusal, is unable to protect themselves from the risk of self-neglect.

Learning Point: Capacity assessments should be considered in relation to each of those identified needs.

5.2 Key Learning in relation to Mental Capacity:

Learning Point: Practitioners should record all steps taken before a capacity assessment, to maximise an adult's ability to make that choice.

Learning Point: In relation to capacity assessments, practitioners should ensure they have identified the decision to be made the choices, as well as the consequences of each choice, before starting to assess capacity.

Learning Point: Practitioners should note that, in relation to capacity assessments, the civil burden of proof applies; they need simply to be *'reasonably satisfied'* an adult has or does not have capacity (sometimes referred to as the *'51% rule'*).

Learning Point: The presumption of capacity should not be used as a reason not to assess capacity in relation to self-neglect, where there are clear indications that self-neglect is present.

Learning Point: Practitioners should ensure that the function test precedes the two-stage impairment test to avoid discrimination.

Learning Point: Practitioners should not record simply *'…person X had capacity'*. Capacity assessments should be recorded in sufficient detail to identify the nature of the decision and how the adult demonstrated understanding of those choices, as well as how they used or weighed the relevant information.

Learning Point: Where executive function[1] may be in doubt, practitioners should be aware that an adult may appear to be able to describe what they intend to do but be unable to carry those plans out in reality. Practitioners should therefore be alert to this possibility and look for these repeated *'disconnects'* before reaching an assessment.

5.3 Key Learning in relation to Homelessness and Rough Sleeping:

Learning Point: Where a homeless person presents with convictions or an antecedent history that could lead service providers to invoke an exclusion, professional should ensure that they have clear, detailed information

[1] **Executive function**: A set of mental skills that include working memory, flexible thinking, and self-control. We use these skills every day to learn, work, and manage daily life. Trouble with **executive function** can make it hard to focus, follow directions, and handle emotions (among other things).

concerning those behaviours/convictions. This should include any known history or risk assessment that suggests the risk has been effectively managed, or the risk has been reduced.

Learning Point: Consider challenging refusals in relation to arson based upon alleged insurance requirements.

Learning Point: Avoid *'over playing'* the vulnerabilities.

Learning Point: Ask if there are reasonable steps that could be taken to circumvent exclusion.

Learning Point: Where a person is rough sleeping, or has been and is at risk of homelessness, a Homeless Application carried with it more duties upon the Local Authority than a Part 6 application and should be the default route into local housing.

Learning Point: Where someone who is homeless is given temporary accommodation, for example hostel accommodation, the workers supporting the person should ensure that there is a homeless application with the Council that is still live for the individual.

6 Conclusions

The SAR has recognised that in 2021, Birmingham's current RSI is better equipped to support homeless people like Stephen. It is to be hoped that funding is maintained so the improved provision can continue to have such a positive impact on the wellbeing of the homeless and on their transition to safe accommodation.

The recognition of need and multi-disciplinary approach to the homeless who self-neglect, appears to be in place and providing a more joined-up response to their needs. For the majority of the homeless who self-neglect, this is not a *'lifestyle choice'* and it is not appropriate to see it in this light. Most are reacting to their changing social and environmental factors.

The challenge of supporting adults who self-neglect (including the homeless) requires both Homeless Pathways and Adult Self-Neglect Guidance to be mindful of the complexity of self-neglect in relation to adults with care and support needs (like Stephen) and those that may not have care and support needs but are vulnerable, to ensure they do not develop care and support needs.

Senior leadership teams should take from this SAR the learning that their professionals working with adults who self-neglect need be confident with early multi-disciplinary work to identify needs and display a clear understanding of mental capacity in relation to self-neglect. These are the pre-requisites for reducing the harmful impacts of self-neglect.

7 Recommendations

Recommendation 1: The Self-neglect Guidance is currently being re-drafted and it is recommended that where cases are complex, the guidance considers the use of multi-disciplinary meetings to bring agencies together, as well as identifying escalation processes when risk is high and there are difficulties in finding solutions to support and individual who is non-compliant.

Recommendation 2: Birmingham City Council's Neighbourhood Directorate to ensure that front-line practitioners along the homeless pathway have a basic understanding of the legal rights of multiply excluded homeless people in relation to housing and homelessness legislation and the Mental Capacity Act, and ensuring that there is a robust case recording of assessments, support and engagement with homeless people.

Recommendation 3: National Probation Services, Community Rehabilitation Company, Trident and Shelter to ensure that their Birmingham workforce receive training on Mental Capacity Act and that these organisations consider Mental Capacity Act training for their workforce wider than the Birmingham area.

Recommendation 4: Commissioners of supported accommodation in Birmingham include within commissioning services, descriptions and specifications that prevent exclusion ground where reasonable steps could be taken to remove the need for *'blanket bans'*.

Recommendation 5: The SAR would recommend that Birmingham Public Health consider and explore the possibilities of prison in-reach for substance misuse.

Recommendation 6: HMP Birmingham review their release process in relation to the health needs of vulnerable prisoners at risk of multiple exclusion homelessness.

Recommendation 7: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust should review their Emergency Departments admissions process to ensure that appropriate offers of referral are made when patients present with alcohol related conditions.

Recommendation 8: Birmingham City Council's Adult Social Care to look towards ensuring their systems for informing citizens of outcomes of needs assessments are communicated in a timely manner and includes information on how to challenge the outcome.

Recommendation 9: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust to ensure their process for

where a citizen self-discharges includes triggers for staff to consider self-neglect and referrals to appropriate services.

Recommendation 10: The Birmingham Safeguarding Adults Board to seek assurance from Birmingham City Council Adults Social Care that safeguarding concerns are being dealt with in a timely manner.

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