7 minute briefing

Duncan

Safeguarding Adult Review

Background

Duncan was born in April 1983 and died at the age of 35 in October 2018. He was White British and had fallen from a building. The cause of death was regarded as a possible suicide. Records indicate he had been adopted at the age of 7 but later his relationship with his adopted parents is said to have broken down but he didn't speak about his life.

Duncan had longstanding mental health problems dating back to around 2008, with several hospital admissions under Sections 2 & 3 of the Mental Health Act 1983. He had various diagnoses recorded including paranoid schizophrenia. There is a history of concerns around suicidal ideation. He experienced periods of homelessness and of living in hostels. He was known to misuse substances.

Terms of Reference : To consider

- Assessment and risk assessment
- Mental Capacity assessments (executive functioning)
- Responses to homelessness and temporary accommodation
- Agencies working together
- Information sharing
- Responses to substance misuse
- Provision of Mental Health services and support.

Lines of Enquiry:

- Responses to Mental Health
- Responses to substance misuse
- Staff support
- Working together and multi agency meetings
- Risk assessment
- Making Safeguarding Personal
- Street-based living and hostel provision

Making Safeguarding Personal

Duncan did not readily engage with offers of support. There was a repetitive cycle of hospital admissions, hostel accommodation, substance misuse, lack of compliance with medication. Duncan wished to live independently but this option was not pursued.

- How well are we working with people who present multiple needs who find it difficult to engage?
- Are they not engaging with us or are we not engaging with them?
- How do we know the people we are working with?
- Is there sufficient focus on the impact of trauma and adverse experiences?

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Responses to Mental Health

Are we assured about the effectiveness of the Care Programme Approach (CPA)? Duncan was ultimately discharged from the CPA without an updated risk assessment and with ongoing mental health concerns. Is this common practice?

How well do secondary mental health services work with GPs when individuals have long term mental health needs?

Risk (and care and support) assessment

There were missed opportunities to update and share Duncan's risk assessment. Are we assured about the quality of risk assessments, including suicidal ideation? How accessible is assessment for care and support needs for people with mental health and/or substance misuse concerns, who may be homelessness or insecurely housed? How easy is it to provide wrap-around support for individuals like Duncan?

Responses to Substance Misuse

How well do services respond to and work with individuals with both mental health and substance misuse problems? Is there a dual diagnosis pathway? Are there any gaps in provision, such as assertive outreach?

Responses to homelessness

How assured are we about the quality of hostel provision and provision of wrap around care? How well is the Homelessness Reduction Act 2017 working?

Working Together

There were examples of practitioners working together to address Duncan's needs and sharing information. There were also assumptions made that another practitioner would pick up responsibility for Duncan's support.

Are we assured about how services and practitioners work together? Are there still barriers to information sharing?

Recommendations

- Decision making on SAR referrals.
- Reviewing practice on GP registration and support for patients with multiple needs.
- Review of care and support assessments, use of section 42 and use of multi-agency meetings for people with complex and multiple needs.
- Audit of section 117 after-care and of CPA.
- Review of how mental health and substance misuse providers work together.
- Summits to reflect on gaps in provision for people experiencing multiple exclusion homelessness and on case closure practice.
- Review need for guidance and training on self neglect, co-occurring conditions and multiple exclusion homelessness.
- Monitor single agency changes.
- Working with other SABs to follow through on recommendations from Kerslake and Black reports.
- The CSAB should consider with partners a sequence of webinars to support staff develop knowledge and skills to work with people experiencing multiple exclusion homelessness.

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