7 minute briefing: SAR Lee
For all those working with adults, children and families

Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

01 What is a SAR?

A Safeguarding Adults Review (SAR) takes place when an adult with care and support needs is seriously harmed or has died due to abuse and/or neglect and there are concerns about how agencies have worked together. The purpose of a SAR is to look at what happened / why / what action will be taken to improve practice as a result of the review's findings. On this occasion, a full SAR was not considered necessary as there was some systems learning that could be taken from the serious incident (SI) review carried out by NELFT and therefore acts as a 'light touch SAR'.

The SI, along with a multi-agency learning event highlighted the following themes and areas for improving practice across the partnership ♦Self-neglect ♦Mental capacity ♦ Thresholds ♦ Information sharing / record keeping / escalation

02 Lee's story

Lee was a 35 year-old man who at the time of his death lived alone in a council flat. He had been adopted as a child and had little contact with his family. He had struggled with his mental health for many years and had schizophrenia. Records also show a history of drug induced psychosis.

About a year after a short stay in a mental health ward, and some moving around, Lee moved into a new flat with support from family and professionals. Initial concerns for Lee were raised when he was spotted unkempt and undressed in the communal area of his home. He wasn't paying rent or responding to calls.

Some time later he was seen to have visibly lost weight and concerns were escalated further. His family became increasingly worried about his lack of self-care which was apparent in both his appearance and his home. Deemed as having capacity, Lee frequently denied health workers access to his flat, despite these mounting concerns around his weakness, weight and low mood.

Over time Lee's physical health deteriorated, resulting in 2 hospital stays, in between and after which, he was booked in to B&Bs while his flat was cleaned. One of the B&Bs reported that Lee was reliant on support from others and refused to accommodate him on the second occasion because his support needs were too high.

Lee eventually moved back to his flat which had been cleaned (despite 2 services refusing because of its condition). He had in place carer support 3 times per day. Concerns for his health and ability to live independently continued to be raised by family and some professionals.

4 months after his admission to hospital, Lee was found unresponsive, at home, by a carer. He had sadly died of bronchopneumonia.

03 Findings on SELF-NEGLECT

Lee's story has highlighted the importance for practitioners to be aware of what constitutes self-neglect and that it is possible that we can all become desensitised when regularly having to support those with multiple and complex needs, such as mental health, self-neglect .

04 Findings on MENTAL CAPACITY

There was a view at one point that Lee's problems were purely financial and rent-related and meant that an onward referral to mental health services wasn't made.

Fluctuating capacity: Although Lee had been assessed many times as having mental capacity there were 3 occasions where he did not have mental capacity (in six months leading to his death), but no action was taken in these instances. His family said his polite and compliant nature made it harder to ascertain mental capacity issues.

05 Findings on THRESHOLDS

Lee's story has also highlighted some confusion amongst practitioners of when to raise a safeguarding concern.

Different agencies reported Lee's weakness, weight loss, severe self neglect and incontinence. His family and housing association escalated their concerns around his ability to live independently. Lee often presented as mentally stable and declined support. Reports show an assumption that he could manage his needs if motivated to do so, and therefore didn't meet the criteria for crisis intervention.

06 Findings on INFORMATION SHARING / RECORD KEEPING / ESCALATION

For Lee, there had been a real need to "join the dots" about his physical health deterioration and its seriousness. There was scope for better communication which between various health agencies, was too often in the form of email, from one clinician to another. This exposed referrals and vital pieces of information being inadvertently missed, with evidence of missed emails, for example as a result of annual leave and general accidental oversight.

Staffing issues made it difficult to arrange joint visits with other mental health teams which had an impact on effective handovers and information-sharing. Expertise was lost when staff moved on and newer staff took on the complex support for Lee's.

Concerns for Lee were shared and raised by his family, one of the B&Bs he stayed in and multiple professionals. At no point was the escalation process followed. Read on overleaf.

07 Read on overleaf for **WHAT YOU CAN DO**

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07

WHAT CAN YOU DO IN YOUR ROLE?

CONSIDER:

- using **Team Around the Person**
- a **Care Programme Approach** for adults you are working with

READ / SHARE / DISCUSS WITH OTHERS:

- guidance on **self neglect**
- guidance to **Assessing Mental Capacity and Making Best Interests Decisions**
- guide to **thresholds and practice for working with people, carers and families in Waltham Forest**
- **Spotlight on escalating concerns**
- **Professional Curiosity resource**
- **Team around the Person spotlight**
- your agency's record-keeping procedures and your own and your teams practice

WATCH the Bitesize Video Guides on:

- **Making safeguarding personal**
- **Professional curiosity**
- **Self-neglect**
- **Adult Thresholds Guidance**

Visit

www.walthamforest.gov.uk/strategicpartnerships

for other useful resources