Safeguarding adults with chaotic lifestyles

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Safeguarding adults is an imperfect art…

- It depends on a clear understanding of how the different 6 SA principles align (and sometimes contest) in each individual case. GOOD PROFESSIONAL UNDERSTANDING.
- It MUST allow people to maintain and exercise their self determination – as long as they have capacity - even if it goes against everything we stand for as professionals in wanting to "cure", "solve" or "eradicate" the problem(s). GOOD PROFESSIONAL JUDGEMENT
- It demands our TIME - if MSP is to be embedded, we need to UNDERSTAND what matters to the person in helping them determine their outcomes and working with them. And, frankly, time is a commodity that so many of us simply do not have. GOOD PROFESSIONAL CAPACITY
- It requires professionals coming together, focussing on the whole person and their surroundings and circumstances and THEN working with that person to determine a plan. GOOD PROFESSIONAL PARTNERSHIPS NOT SILOS.
- It WILL go wrong on occasion – and people will not be safeguarded adequately with people being/continued to be hurt. And when things do go wrong, many people will seek someone/some organisation to blame – with a blurring between what is meant by accountability vs responsibility. This can create a culture of fear – resulting in professional/organisational defensiveness and the individual professionals involved feeling as if they are the "second order" victims. GOOD PROFESSIONAL REFLECTION AND LEARNING and GOOD PROFESSIONAL LEADERSHIP.

And we published a SAR in 2018 that shed light on our imperfections…

HOWARD…….

Howard died aged 53 on 21st March 2017. He had no fixed abode at the time of his death. He was found deceased in a bus shelter on the seafront by a member of the public who contacted the police and ambulance service. The cause of death was found to be cardiac arrest, ischaemic heart disease and coronary heart atheroma, and alcoholic liver disease.

Who was Howard?

Howard was born on the Isle of Wight, where the family can be traced back over 300 years. He grew up with his mother, grandmother, grandfather and half-sister. His father had moved abroad. Howard was happy and flourished academically. He started playing cricket that became one of his life's passions. He was very upset when his grandfather died and when subsequently he had to move house with his mother. Relationships within the family were also difficult, especially with his step-father. This was when family members first noticed obsessional behaviour and expression of paranoid ideas.

Howard went to university to study law. He graduated and began to study to become a barrister. However, he dropped out. He obtained a position in a legal/investigative department. Relationships at work did not go well and he left. He also lost his flat when he could not afford the mortgage repayments.

He then set up his own business, initially dealing with taxation affairs and PAYE. With the success of his business he started flying small planes, was an avid walker, and enjoyed canoeing. He obtained his Day Skipper license and sailed in Greece, The Canaries and the Lofoten Islands where another of his great passions lay. He had developed a love of Norway and returned several times.

When his mother died in 2009 Howard was devastated. This was when things started to unravel at work. He began to drink heavily and to neglect his business. His business was investigated and he was eventually charged with fraud and sentenced to six months in prison of which he served three.

After his release he had fresh ideas for a new venture and formed another company. Unfortunately at its inception, just when he was moderating his drinking and starting to advertise this business, a cuckooing gang moved in on him and from this point forward there was a downhill spiral from which he never escaped and he was soon permanently homeless.

By the time Howard died…..

- Howard had a long history of alcohol abuse. He was considered to be at risk of financial and physical abuse from people he associated with. He had a heart condition for which he took prescribed medication. He had been in and out of hospital and following his hospital discharge on 23 Dec 2016 he had sometimes stayed on the night bus, but mainly sofa-surfed and slept on the streets/in woods.

The SAR about Howard

The Isle of Wight Safeguarding Adults Board received a referral from Adult Social Care for consideration for a Safeguarding Adults Review on 12th May 2017.

The referral form records that, when homeless, Howard could not manage his personal hygiene needs and that he did not have access to facilities to manage his incontinence. When in hospital he was assessed as not having social care needs because it had been judged that he was able to attend to his own care and support needs. His issues were seen to be his ongoing alcohol addiction, associated chaotic lifestyle and homelessness. The referral identifies concerns about how agencies worked together to safeguarding and support him.

It was the wish of Howard's relatives that his first name was used throughout the SAR (discretionary) review - covering the period from 10th April 2015 to Howard's death.

Learning from Howard – the "imperfect science" of adult safeguarding

a. **GOOD PROFESSIONAL UNDERSTANDING.**

There was NEITHER a single, comprehensive, understanding of Howard and his needs NOR a single integrated plan of action. The safeguarding plan was about mitigating risks – NOT "treating" Howard for future abstinence and getting his life back.

In the SAR, no one Internal Management Review was able to articulate Howard's voice. We learned about him in retrospect.

Our safeguarding response reinforced organisational silos – he WAS an adult at risk, but his unwillingness/inability to engage with agencies meant that the actions agreed (e.g., housing to provide him with advice, himself to address his drinking, IRIS to engage with him) REINFORCED the likelihood that he would fall between the gaps.

Learning from Howard – the "imperfect science" of adult safeguarding

b. **GOOD PROFESSIONAL JUDGEMENT**

Howard was deemed not to have housing priority – and no statutory duty towards him. Discretion IS allowed for in the legislation but we did not apply it.

Howard was deemed not to have adult social care needs – his drinking and homelessness were seen as the issues that needed resolving. He did not need "care". But ASC did not undertake a full care act assessment - and so we will never now know.

IRIS removed Howard from their list – as he had failed to engage on three consecutive occasions.

Howard had received medical detox at St May's several times – only to return…and return. The symptoms were treated but not the cause – HOW do people like Howard access residential detox which addresses their psyshological withdrawal as much as their psychological withdrawal.

Learning from Howard – the "imperfect science" of adult safeguarding

c. **GOOD PROFESSIONAL CAPACITY**

- Safeguarding team still continues to receive very large numbers of inappropriate referrals (194 in December 2018) – with less than 1:5 meeting the threshold for a s42 investigation. The system is clogged up – and hence the key importance of the SAB's Threshold Guidance and Decision Making Tool.

- IRIS was experiencing real capacity issues at the time of Howard's death – so much so that they stopped taking any new referrals and the Trust taking the decision to suspend the service in summer 2017.

- There was no "wet" temporary housing provision on island and Howard was informed that he could not access emergency accommodation until he addressed his drinking

- No one professional "held" Howard. Howard had to navigate the different systems separately – and our communication with him was difficult (e.g., our usual letters are simply no good for rough sleepers)

Learning from Howard – the "imperfect science" of adult safeguarding

d. GOOD PROFESSIONAL PARTNERSHIPS NOT SILOS.

- All organisations applied their respective "monocle" organisational lens and Howard fell between services.
- We had, at the time, nothing other than the safeguarding framework to apply in terms of how we worked together around people of concern and complexity – and even then key agencies did not/could not attend safeguarding meetings.
- The epitome of our collective failure to meet Howard's needs is best articulated in three incidents: he was discharged from the hospital in the evening of 23 Dec in his pjyamas – with nowhere to go; the safeguarding action plan advised him to address his drinking; and there is no wet provision on the island for homeless people.

Howard's legacy

e. GOOD PROFESSIONAL REFLECTION AND LEARNING and GOOD PROFESSIONAL LEADERSHIP.

- MARM process established
- Temporary Accommodation Meetings – applying the same discipline to homelessness as we do to DTOC
- Wet provision being developed
- Extension of temporary housing offer being sought
- Bids for additional funding to support rough sleepers
- TO DO: specialist commissioning for people with substance misuse; pathways for homeless people leaving hospital; joint working protocols across ASC and housing
- NB: we currently have other "Howards" we are all aware of and working with. We owe it to Howard not to repeat our mistakes.