7 Minute Briefing – ANTON

1 Background:

A referral was made to Cheshire East Safeguarding Adults Board following the death of Anton who died at home from pneumonia in November 2021. The SAR Panel met in January 2022 and the Safeguarding Board agreed that the criteria for a statutory Safeguarding Adults Review were met. The scope of the SAR covered the period 2019 – 2021, which coincided with COVID restrictions.

Anton was Slovakian. He was 64 when he died. It is understood that he had come to England about 12 years previously. In Slovakia he had been in military or police service and latterly he had worked as a lorry driver. He had no family and appeared to be socially isolated. His understanding of the English language was poor.

Anton had poor physical and mental health and was known to many services.

Anton died of pneumonia in November 2021. He was found on the floor in the foetal position and was wearing a pair of yellow crocs that were filthy and covered in mould. He had engrained dirt under his fingernails, which appeared to show that he neglected his cleanliness and hygiene.

2 The Purpose of a Safeguarding Adults Review:

Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Anton

- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of Anton are heard regarding his experience of accessing care and support in Cheshire East.

3 Key Emerging themes:

Safeguarding practice: The SAR highlighted missed opportunities to raise a Safeguarding Concern. It also highlighted that the Housing Provider had contacted Social Care 17 times, but only 2 Safeguarding episodes were opened.

Mental capacity: Whilst a mental capacity assessment had been completed around Finances, opportunities were missed to explore executive functioning.

Inconsistent responses from services (e.g., failed service provision and short-term working) There were some areas of good practice, but equally some gaps and delays in service provision and home visits – leading to a deterioration in health

Working with difficult to engage clients: Due to Anton's language barriers, he would often miss appointments or disengage, and he lacked trust in Services. This could lead to case closure

Multi-agency management: There were missed opportunities for Multi Agency Information Sharing

Problems with benefits payments: The loss of his settled status and welfare benefits had an impact on Anton's mental health and self-neglect

Working with people with limited English and poor communication skills: The SAR acknowledged good practice where Agencies had used Translation services, but also equally where Agencies sent letters/text messages in English.

The identification of possible alcohol use disorders: This was not sufficiently explored to ascertain whether Anton would have benefitted from Support

Good Practice: The SAR noted key professionals who tried to engage with Anton and improve his quality of life namely the Housing Association and Floating Support

4 Recommendations:

The SAR made the following recommendations:

1. The Board Partners to ensure that vulnerable foreign nationals have access to expert support through the benefit system
2. All Agencies should make information available in native languages and use interpreters
3. The SAB is to provide guidance on how to Engage with Hard-to-Reach people
4. All Partners to utilise escalation procedures, Multi Agency Meetings, and the Complex Safeguarding Forum
5. The ICB to explore how it responds to chaotic and Hard to Reach Individuals
6. All Partners to ensure compliance with Mental Capacity Legislation, including Executive Functioning
7. All agencies to be aware of how to raise a safeguarding concern
8. Public Health to ensure Agencies use robust alcohol/drug screening tools

5 Practice implications:

When anyone is identified with complex needs and poor language skills, it is essential to provide information in an accessible way – both verbally and in written form.
When the person is seen to be Hard to Engage, it is important to understand previous life experiences and to provide consistent support.
Information sharing and accurate record keeping is essential.

6 Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

7 Resources and further information:

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Combined document to Support Adult Safeguarding Referrals_ (003) (002) (stopadultabuse.org.uk)

Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017 | Alcohol Change UK