Salford Safeguarding Adults Board

Discretionary Safeguarding Adult Review (SAR)
In respect of Patrick

Summary Report (to be published)

Review process commenced - April 2021
Completed – November 2021

(For the purpose of the review, the name has changed to anonymise the adult)

1. Introduction – Reason for the Safeguarding Adult Review (SAR)

1.1 The Care Act 2014 Section 44[1] states that a Safeguarding Adult Board (SAB) **must** arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.2 Safeguarding Adult Boards (SABs) **may** arrange for a SAR in any other situation involving an adult in its area with needs for care and support.

1.3 The purpose of a Safeguarding Adult Review (SAR) is therefore to establish whether lessons can be learnt from the circumstances of the adult and to identify areas where there may be a need to improve practice or strengthen the way in which agencies and professionals work together to safeguard adults. The review will also share what worked well and examples of good practice.

1.4 The focus of the share is to ensure a culture of learning **and not blame.**

1.5 Salford Safeguarding Adult Board (SSAB) considers and screens all requests for a Safeguarding Adult Review (SAR) upon receipt of a referral.

1.6 The Salford Safeguarding Adult Board (SSAB) only became aware of Patrick when a SAR referral was received on 17/08/2020; the Board has had no direct involvement with Patrick. The role and responsibility of the Salford Safeguarding Adult Board (SSAB) has been to undertake the review following Patrick's death.

1.7 Upon receipt of the referral, the Salford Safeguarding Adult Board (SSAB) made arrangements to gather the necessary information upon which to make a decision to determine whether or not the criteria for a SAR were met.

1.8 There was a delay in the decision-making process because the Safeguarding Adult Review (SAR) Panel initially felt it should go to Manchester Safeguarding Partnership for consideration given that Patrick had lived and died in Manchester. The decision was made that Salford should be the lead Safeguarding Adult Board to consider whether a review was needed because Patrick was temporarily a Manchester

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resident (this was due to the guidelines during the pandemic that anyone experiencing homeless would be offered temporary accommodation, unfortunately due to lack of properties in Salford, he was offered accommodation in Manchester). Patrick was always planning to return to the Salford area. As a result, he continued to be supported by some Salford services.

1.9 An interagency Safeguarding Adult Review (SAR) Panel met on 21/02/2021 to consider the circumstances of Patrick and it was felt that the criteria for a mandatory SAR was not met because there was insufficient evidence to suggest that Patrick died as a result of abuse or harm but, nevertheless, it felt that further enquiries were needed to understand how agencies worked together and if any additional learning could be identified.

1.10 As a result**, a discretionary Safeguarding Adult Review (SAR) was agreed**.

1.11 The review commenced in April 2021 and the final report was completed in November 2021.

Key dates for the review process	
Safeguarding Adult Review (SAR) referral received/referring agency	17/08/2020
Presented to Safeguarding Adult Review Panel for decision	Sept 2020 – it was agreed that this referral should be passed to Manchester Safeguarding Partnership for consideration
Passed to Manchester Partnership for consideration	Sent 29/09/2020 Returned on 08/01/2021 to say he was temporary resident in Manchester
Decision made by panel for Safeguarding Adult Review (SAR) to be undertaken	21/02/2021
1st Multi Agency Review meeting	28/04/2021
Final Report completed:	November 2021
Date final report was shared with Safeguarding Adult Review (SAR) Panel	Sept 2022 (Delayed due to lack of capacity within the support Team for the SSAB, difficulties getting responses from individual agencies and increase number of discretionary SARs to be managed)

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2. Methodology/Process of the review

- Safeguarding Adult Review referral was screened by Business Manager for the Salford Safeguarding Adult Board
- Single agency involvement was requested by all partner agencies involved with Patrick.
- A combined chronology was created which was presented to the Salford Safeguarding Adult Review panel.
- Decision was made at Salford Safeguarding Adult Review panel for a Discretionary Safeguarding Adult Review.
- Multi-Agency Review Meeting was held for all partner agencies to contribute to the review. Areas of learning and good practice were identified.
- Full report was shared with the review group for wider comment and all representation at the review group have received a copy of the full report.
- Summary report has been prepared for publication.
- Report will be presented to Salford Safeguarding Adult Review Panel for acceptance, comments and sign off.
- Final report to be shared with the Joint Independent Chairs for Salford Safeguarding Adult Board (SSAB).
- Learning from the review is essential so a briefing document will be written which will published on the Salford Safeguarding Adult Board (SSAB) website. The briefing document can be disseminated and enable the learning to be shared across the workforce.
- The action plan will be created, implementation and will be monitored by the support team for the Salford Safeguarding Adult Board.
- Monthly updates will be given to the Salford Safeguarding Adult Review Panel and quarterly updates will be given to the Salford Safeguarding Adult Board (SSAB).

3. Partner agencies who provided information for the multi-agency review

- Greater Manchester Mental Health Trust (GMMH)
- Greater Manchester Police (GMP)
- Achieve (Salford) – commissioned by GMMH
- Northern Care Alliance (NCA) including Salford Community District Nurse Service (SRFT)
- Housing Services for Salford City Council
- Manchester Foundation Trust – Community District Nurse Service
- Greater Manchester NHS Integrated Care – Salford Locality (GP services)
- Greater Manchester NHS Integrated Care – Manchester Locality (GP services)
- Manchester Foundation Trust Adult Safeguarding Team

Salford Safeguarding Adult Board (SSAB) led on the review.

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4. About Patrick

4.1 Patrick was a White/British 52-year-old divorced male and father of adult children who he had no contact with. He had a couple of close friends who he reported he would see four to five times per week.

4.2 Patrick had a diagnosis of mental and behavioural disorder secondary to opioid misuse and dependency syndrome. He had a significant history of substance misuse, as a previous intravenous heroin and crack cocaine user, and was on methadone.

4.3 Just prior to his death, Patrick was experiencing homelessness and sadly passed away in temporary accommodation in Manchester in May 2020.

4.4 He was registered with a Manchester GP but supported by housing services from Salford City Council.

4.5 Patrick was discharged from a Salford Royal Hospital after suffering from Covid (diagnosed 31/03/2020) and he was placed in temporary accommodation in Manchester on the 03/04/2020, as expected per discharge arrangements for patients who are experiencing homelessness and been tested for COVID-19.

4.6 Patrick was readmitted to Manchester Royal Infirmary on 30/04/2020 until 10/05/2020

4.7 Patrick had other complex health conditions relating to his legs and he was due to have a leg amputation on16/06/2020

4.8 Patrick had a number of long-term complex health conditions recorded which needed to be monitored by health professionals. Patrick had reduced mobility and required property that was accessible.

4.9 There were safeguarding concerns raised by probation services because it was felt that people were chasing Patrick for money to pay off his 'drug debts' and concerns were raised regarding possible financial abuse after someone had taken his bank card. Patrick was often asking for food and money. There appears to be some inconsistencies in how these safeguarding concerns were managed.

5. What happened?

5.1 After discharge from Manchester Royal Infirmary, Patrick remained unwell and was believed to still be suffering from the COVID-19 virus (via a swab) but was not symptomatic and not requiring oxygen.

5.2 Patrick was found in his flat (the temporary accommodation in the Manchester area) by the Probation Officer on 12/05/2020 and had sadly passed away.

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6. Views of the family/friend/representative

6.1 GP records have been checked and there was no next of kin or emergency contact which had been recorded which suggested that there isn't anyone to consult with to get the views of family/friends or an identified representative.

6.2 There is no evidence that Patrick was referred to any advocacy services.

6.3 There has been reference to Patrick being supported by a friend, Steven, but there are inconsistencies from the information provided by single agencies regarding the status of their relationship. It appears that their relationship broke down in the latter stages of Patrick's life and the review didn't feel it would be appropriate exploring making contact with this person.

6.4 Unfortunately, there has been no family involvement to act as the voice of Patrick within this review process despite attempts to explore this.

7. Identified themes for the review to consider aligning with the core principles of safeguarding

- **Empowerment**
  Patrick was experiencing ill health and on occasions declining intervention, but the review aimed to explore whether Patrick was given all the right information to make informed choices.

- **Prevention**
  Identified theme - recognising signs of self-neglect

  The review attempted to explore whether Patrick's behaviour impacted on his health and wellbeing and whether professionals recognised his behaviour as being self-neglect and how this was managed to prevent further impact on his health and wellbeing.

- **Proportionality**
  The review aimed to look at whether there was a proportionate and least intrusive approach in response to the risks presented.

- **Protection**
  Identified theme - Duty to Safeguard (Care Act 2014, section 42[3])

  The review aimed to explore whether Patrick experienced abuse or neglect and what support was taken to safeguard him and to reduce any identified risks.

- **Partnership**
  Identified theme - working together

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At the latter stages of his life, Patrick was experiencing homelessness, on discharge from hospital temporary accommodation was needed due to his covid status. The only accommodation available that could meet his needs was in the area of Manchester. This resulted in Patrick being supported by services from both Salford and Manchester. It was the Manchester property where Patrick was found deceased.

The review will focus on how partners worked together across boundaries, and whether there was effective communication and engagement between the services from Salford and Manchester.

- **Accountability**
  Safeguarding is everyone's business and accountability makes sure that everyone plays their part when it comes to safeguarding adults at risk. Everyone is accountable for their actions as individuals, services and organisations.

  The review considered whether all partners involved with Patrick's health and social care were accountable and transparent in their safeguarding practice.

- **Impact Covid-19 had on service delivery**
  The review will explore whether the National and Local restrictions due to COVID-19 impacted on how support and services were provided.

8. Summary of the multi-agency discussion and areas of learning

The timeframe for this review is 01/05/2019 until 12/05/2020.

8.1 Patrick was experiencing homelessness, and due to the pandemic, he was placed in short term accommodation. This ensured people being discharged from hospital who had no fixed abode with a positive result of Covid-19 had a safe place to reside to ensure they reduced the risk of transmission, and they had a safe place to recover.

8.2 Patrick didn't appear to be consistent in accepting support, but the professionals involved at that time remained in contact to ensure Patrick had access to all the support he needed.

8.3 It is important to recognise that the Safeguarding Adult Review (SAR) is about learning and there was evidence of good practice demonstrated through this review which has been provided in section 9 of this report.

Focus areas for the review:

8.5 **Empowerment**

8.5.1 Empowerment and choice need to be the core of safeguarding practice. This means working to enable adults at risk to recognise and protect themselves from abuse. It

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also means taking a risk enabling approach respecting people's rights and wellbeing. This approach is complementary to personalisation and strength-based practice.

8.5.2 The starting point of the Mental Capacity Act is that it should be assumed that anyone (aged 16 or over) had full legal capacity to make decisions. This is known as 'the right to autonomy'[2].

8.5.3 There was no evidence presented to the multi-agency review group that professionals involved with Patrick were given any reason to doubt his capacity. Therefore, the multi-agency review group acknowledged that formal capacity assessments hadn't been required/deemed necessary?

8.5.4 There was evidence provided that even though face to face visits with Patrick were limited due to him having the positive test for Covid and the need to self-isolate, telephone contact remained consistent and it appears that he was given relevant information to make informed choices about his health and wellbeing but at times made decisions that may have been viewed as 'unwise', an example being when he declined medical intervention and declined to go to hospital in an ambulance despite a deterioration in his health. The decision was respected that Patrick did not want to go into hospital.

8.5.5 Patrick was discharged on Discharge 2 Assess Pathway for reablement. He was mobile and self-caring with the ward environment and on the assessment by the Therapy Team. The outcome was for Patrick to have an assessment of needs within the community setting.

8.5.6 It does need to be acknowledged that communication and engagement for Patrick would have been better face to face but due to the Government Guidelines issued at the time, this limited the opportunity for Patrick to see professionals in person.

8.5.7 When Patrick moved to the Manchester area and his health started to deteriorate the review group felt that the appropriate referrals were made to external agencies, with Patrick's consent. Unfortunately, the support from Manchester Adult Social Care didn't come in time before he passed away very suddenly.

8.5.8 It was felt that all Manchester Adult Social Care policies and procedures were followed, and Patrick was going through the reablement process. However, on reflection it was advised that if they had more information about the severity of Patrick's condition then the crisis team could have become involved more quickly.

8.6 **Prevention** - Identified theme - recognising signs of self-neglect

8.6.1 In the last 12 months of Patrick's life, he experienced homelessness and had complex long term health conditions.

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8.6.2 In April 2020, he was discharged from hospital and given temporary accommodation due to having a positive test of Covid. Whilst living in the temporary accommodation which had staff attached for access, and repairs/maintenance and additional support was brought onsite.

8.6.3 Despite being in supported accommodation, due to Covid-19 guidance and his positive test results, face to face visits to Patrick were limited, this naturally brought additional challenges for professionals to be able to undertake comprehensive, holistic, strength-based assessments and they were dependent on Patrick to provide a lot of the information.

8.6.4 It was felt by the multi-agency review group that Patrick may have 'played down' the complexities and his deteriorating health so it would have been difficult to recognise there were signs of self-neglect. This emphasises the importance of practitioners being able to recognise signs of 'disguised compliance' and highlights the value in professionals being able to see adults face to face within their own homes and having the professional curiosity to ask more questions.

8.6.5 The multi-agency review group explored when Patrick started to decline intervention, were 'self-neglect' policies and procedures ever considered. It was agreed by the review group that there may have been missed opportunity for a multi-agency discussion to identify and manage the risks that were being presented and the impact Patrick's decisions were having on his health and wellbeing.

8.6.6 This approach has been supported by the publication of Local Government Association (LGA) publication written by Michael Preston Shoot, 'Adult safeguarding and homelessness experienced informed practice' (Aug 2021) which makes reference to evidence-base for best practice supports a 'team around the adult' approach comprising of the following eight points:

Partner agencies work together to provide integrated care and support (collaboration)

1. Information and assessments are shared
2. Referrals that clearly state what is being requested
3. Multi-agency risk management meeting to plan and review
4. Exploration of all available legal options (legal literacy)
5. Using adult safeguarding enquiries to coordinate an adult's care and support, risk management (safeguarding literacy)
6. Using pathways within policies to address an adult's need
7. Comprehensive recording of practice and decision-making.

8.6.7 Since the period under review, Greater Manchester NHS Integrated Care Manchester Locality) have developed training on assessment of capacity including executive capacity for general practices. They have also developed a non-attendance policy and guidance for general practices to consider how to engage patients, particularly if they are vulnerable to self-neglect. The non-attendance policy and guidance were

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developed into Greater Manchester Non-Attendance Guidance and shared with Greater Manchester colleagues to encourage a consistent approach.

8.7 **Proportionality**

8.7.1 Patrick was supported in the latter stages of his life by several different services. There were additional challenges that the pandemic brought which resulted in support and services being delivered in a different way. Patrick appeared comfortable in his temporary accommodation. It appears from the information provided to the review that individual agencies made every attempt to ensure Patrick had a safe place to live, and the support in place to ensure his daily needs were met.

8.8 **Protection** - Identified theme - Duty to Safeguard (S47 Care Act 2014)[3]

8.8.1 Professionals did report safeguarding concerns to Adult Social Care (both Manchester and Salford) regarding the potential risk of Patrick being financially exploited.

8.8.2 There was recognition by the multi-agency review group that two safeguarding concerns were made, both reported to a different lead agency (1 to Manchester and 1 to Salford) with similar concerns. It was felt by the multi-agency review group that in isolation the professionals' judgements made to take no further action may be deemed appropriate but if both concerns were raised with the same lead agency, then a different approach may have been taken.

8.8.3 The difficulties on this occasion, there was no connectivity between the Manchester and Salford Adult Social Care Teams.

8.8.4 This highlights the importance of detailed screening for safeguarding concerns at the first point of contact because there was a potential trigger for Salford Adult Social Care to liaise with Manchester services due to Patrick having a Manchester address. It also emphasises the important of the screening practitioner having direct contact and discussions with the person who reported the concern.

8.8.5 There appears to be conflicting information between Probation and Adult Social Care with regards to how the safeguarding concern reported to Salford Adult Social Care was managed. The Probation Officer escalated his concerns to his line manager because he didn't feel the information provided by Salford Adult Social Care which had been relayed by Patrick was correct.

8.8.6 It has been acknowledged by Salford Adult Social Care that there could have been potential follow up on 'other needs' under the duties of the Care Act 2014. A section 9 assessment[4] doesn't appear to have been considered when Patrick advised that the concerns regarding his finances had been resolved and he didn't want any further action being taken under safeguarding procedures.

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8.8.7 Due to Patrick being placed by Salford Housing Services at a Manchester address this provided Patrick with a further challenge that support, and services were being provided by two different boroughs.

8.8.8 It highlighted the importance of single agencies working together and sharing information to ensure a holistic approach is embedded and there is clear communication between agencies both within and across different areas.

8.8.9 A Housing Safeguarding Protocol has also been devised as a result of learning from Patrick which strengthens the partnership approach when an adult is experiencing homelessness and supports other workstreams like the development of the Salford High Risk Advisory Panel. (The Salford High Risk Advisory Panel was introduced in March 2021 to support professionals who are working with adult who have complex needs and are high risk of harm.)

8.8.10 From the information provided from Achieve, it was felt there had been some reflection on the circumstances of Patrick and it was advised that there were missed opportunities to implement the Safeguarding Adult Policy and Procedures when concerns were raised regarding his finances and also missed opportunities to implement the Care Act duty of a Section 10 Carers Assessment[5] when Patrick was living in Salford and was being supported by Steven.

8.9 **Partnership** - Identified theme - working together

8.9.1 At times, there was evidence of good partnership working between agencies. Patrick was experiencing homelessness but due to having tested positive for Covid-19, he was given emergency temporary accommodation when he was discharged from hospital. Unfortunately, due to the lack of housing provision it resulted in Patrick having to move to the Manchester area which then meant the support and services for his health care had to be transferred to a new area ie, care from GP and District Nurse Services moved to Manchester. The transfer of care worked well in some areas but not all.

8.9.2 There could have been more effective communication when Patrick was discharged from Manchester Royal Infirmary and Manchester District Nurses took over his care in the community.

8.9.3 The multi-agency review group felt that there was evidence of good practice with agencies sharing information, however the communication with a view to collaboration could have been strengthened, for example Patrick requested codeine for pain, the Salford GP discussed with Patrick the risk relating to his addiction and Patrick stated he was working with addiction services – which the review group now understand wasn't always the case because there is evidence of Patrick did not attend a number of appointments with Achieve. There was evidence of good information sharing between Manchester GP and Salford Drug Services as Patrick was on many addictive medications and the liaison was to ensure safe prescribing.

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8.9.4 Communication does not always contribute to collaboration, but collaboration cannot happen without communication.

8.9.5 Collaboration is working with others towards a common goal to create or problem solve. For Patrick, it was important for agencies to work together in partnership to ensure that information was exchanged, and forward planning and risk management could have been undertaken.

8.9.6 The review recognised that having regular professional meetings would have been beneficial (even held virtually) because it would have given all the professionals involved with Patrick an opportunity to come together not only to share information but to assess and manage identified risks to ensure Patrick had access to all the health and social care he required.

8.10 **Accountability -** Regional learning for across Greater Manchester

8.10.1 To ensure the smooth transition from acute hospital settings to community setting can be difficult and complex but discharge summaries are an invaluable source of information. It supports good practice by providing continuity and coordination of care and ensuring a safe transition to other care providers within the community.

8.10.2 It's really important that when someone leaves hospital there is a detailed summary that supports the discharge arrangements and shared with the appropriate agencies which provides a holistic person-centred overview.

8.10.3 It is important to acknowledge that both acute and community services were under immense pressure at that time due to the increased and high demands relating to the pandemic. There was a lot of unknowns at that time regarding how the virus impacted on individuals.

8.10.4 However, there did appear to be some inconsistencies to whether there was clear communication when Patrick was discharged from Manchester Royal Infirmary to Manchester community services due to limited information being available on the discharge summary.

8.10.5 Information provided by Manchester Foundation Trust advised that the discharge summary covered reasons for admission and treatment regime, oral antibiotics, his covid status and changed regarding his diabetes treatment so it was felt that this construed as adequate.

8.10.6. More detailed information sharing would have ensured appropriate risk assessments could have been undertaken especially since Patrick had had a positive result of Covid whilst being in hospital. The outcome may have been the same but informed risk management for the discharge planning.

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8.10.5 This report will be shared with the Manchester Safeguarding Partnership to ensure they are aware of the learning from this review.

8.10.6 There has been both single and multi-agency learning identified that Manchester Safeguarding Partnership may need to consider whether they wish to seek further assurance from this SAR.

8.10.7 From the information provided, it's apparent that Patrick had no family or friends who could act as a form of additional support for him.

8.10.8 Having family and friends as part of your support network can really have an impact on how an adult manages on a day-to-day basis and it highlights the importance in how assessments are undertaken when a person doesn't have family or friends as that extra protective factor.

8.10.9 It is also important to recognise that there should be a connection between risk factors and isolation/loneliness. For Patrick, not having that support network around him meant that there was no additional 'calls or checks' to ensure he was safe and well or to support him and check he was okay when he declined an ambulance despite feeling unwell. It is potentially an area of learning that all agencies should ensure support networks and identifying when someone is isolated it is included in single agency or multi-agency assessment and risk management.

8.10.10 Therefore, it's a recommendation and learning from this review that all single agencies should ensure support networks and risks associated with social isolation should be a part of all assessments that focus on social care needs and risk management.

8.10.11 Information provided by Manchester Clinical Commissioning Group (MCCG), since the review has commenced (January 2022), Manchester Clinical Commission Group (MCCG) met with Manchester Local Care Organisation to receive further assurance on response to the deteriorating patient/detection of sepsis in the community. Since the incident involving Patrick, a different approach is now being used. An Escalation Policy and process is being put in place across Manchester to standardise practice.

8.11 **Impact Covid-19 had on service delivery**.

8.11.1 It was agreed by the multi-agency review group that the pandemic brought additional challenges and the way Patrick needed to be supported was different due to it being around the time that there was a lot of unknowns about the Covid-19 virus, and the Government rules and guidance changing almost on a daily basis. However, it appears from the information provided to the multi-agency review group that the professionals involved made every attempt to make Patrick's life as comfortable as possible despite the challenges the local and national restrictions brought to service delivery.

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8.11.2 It has been acknowledged that a multi-agency discussion would have been beneficial to ensure Patrick's ability to remain in the community was maximised; but it is also important to acknowledge the additional pressures and demands on all services at that time. Patrick's move into the temporary accommodation came early in the first national lockdown when there was a lot of unknown information regarding Covid and how it impacted on people's health.

8.11.3 The review group did feel there may have been missed opportunities to recognise signs of financial abuse or exploitation. This was a result of the national guidelines at the time because it was felt that the concerns due to a lot of contact by professionals was via telephone rather than face to face.

8.11.3 It was also a time that single agencies were under increased pressure to make changes to their local standard operating procedures with very little notice which resulted in working behaviours having to change very quickly.

8.11.4 Professionals were getting use to virtual working whilst ensuring continuity in service delivery. In addition, there was a large volume of different guidance being published by central government which at times could be confusing.

8.11.4 The pandemic has brought many changes into standard operating procedures across all agencies and has a whole system. There have been many benefits to the new ways of working which enables more efficiency in service delivery; but it is important moving forward that any changes or decisions made to service delivery ensure (where possible) a person-centred approach remains the key focus which supports a strength-based practice within safeguarding practices.

9. What worked well for Patrick

9.1 Focusing on the themes identified in the Terms of Reference, the multi-agency review has identified areas of good practice;

9.2 **Working Together**

9.2.1 When Patrick lived in Salford, he didn't always attend his clinic appointments but often turned up when he wasn't expected, this was a result of his chaotic lifestyle, the nurses did their best to try and ensure Patrick was seen and given the care and treatment he required. Salford Community District Nurses demonstrated good practice by being person centred and having a flexible approach.

9.2.2 A handover took place between Salford Community District Nurses and the Manchester GP when Patrick moved into temporary accommodation in the Manchester area.

9.2.3 There is clear evidence of effective working together from Housing Support Services and Probation. Every effort has been made to support Patrick under the very difficult

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circumstances that was happening from March 2020 relating to the pandemic. There was evidence of regular and good professional sharing of information despite the restrictions that Covid-19 brought to support services and the way professionals worked and had contact with the adult they worked with.

9.2.4 It appears that every attempt was made to support Patrick within the temporary accommodation, and it has been suggested that the workers from housing and probation went above and beyond to keep in contact with Patrick to ensure he had the support he required to manage whilst self-isolating.

9.2.5 The review group has been advised that when Patrick became unreachable there was a very quick response. Communication between the Housing Officer and Probation was very effective which resulted in the practitioners attending Patrick's address to ensure he was safe and well. On reflection, in respect of the Government Guideline and from a health and safety perspective, the allocated worker from probation shouldn't have entered the property when there was a concern for welfare, however, it was recognised that he acted in good faith which resulted in Patrick being found.

9.2.6 The representative for Probation Services advised that the management oversight model has been implemented since Patrick death. Further information regarding this model will be sought through the action plan.

9.3 Impact Covid-19 had on service delivery

9.3.1 Patrick was experiencing homelessness; however, he was found temporary accommodation with staff attached to the property to enable access, undertake repairs/maintenance, but additional support was provided by the Supported Tenancy Service, this enabled Patrick to have a safe place to stay which allowed him to self-isolate to protect himself and others from the spread of Covid 19

9.4 Recognising signs of self-neglect

9.4.1 There was occasion when Patrick did decline support, but the worker from Probation, Housing and District Nurses continued to engage with him to ensure he had a point of contact if additional support was needed.

9.5 Duty to Safeguard (S47 Care Act 2014)

9.5.1. Concerns were reported by single agencies regarding possible financial abuse and/or exploitation.

9.5.2. The probation officer engaged with their line manager to respectfully challenge the decision of Salford Adult Social Care when the decision was made to take no further action.

[1] Care Act 2014, section 44 – Safeguarding Adult Reviews
[2] Mental Capacity Act 2005
[3] Care Act 2014, section 42 – Enquiry by Local Authority
[4] Care Act 2014, section 9 – Assessment of an adult's needs for care and support
[5] Care Act 2014, section 10 – Assessment of a carer's needs for support

9.5.3 Feedback from Achieve, felt that their intervention at times evidenced areas of good practice which included;

- Person centred care and safety planning
- Good assessment of risk i.e. possibility of friend collecting medication when Patrick admitted to Manchester Hospital

9.6 Safeguarding Adult Review (SAR)

9.1 As referenced throughout the report, in the last few months of Patrick's life he was moved to the Manchester area and supported by services from the Salford and Manchester areas. As a result, agencies from both areas have been invited to participate within this Safeguarding Adult Review.

9.2 All partners within both areas have contributed to the review which is appreciated and demonstrates the good partnership working and willingness to learn across Salford and Manchester services. Single agencies have already reflected on the circumstance of Patrick and new processes have been implemented as a result.

10. Author and Date discretionary review was completed

Jane Bowmer – Business Manager – Salford Safeguarding Adult Board

11. Overview and key dates for the governance of the SAR report

Full report was signed off by the September 2022 SAR Panel – SAR panel members accepted the report.

Agreement is that the Summary Report for the SAR report should be published.

[1] Care Act 2014, section 44 – Safeguarding Adult Reviews
[2] Mental Capacity Act 2005
[3] Care Act 2014, section 42 – Enquiry by Local Authority
[4] Care Act 2014, section 9 – Assessment of an adult's needs for care and support
[5] Care Act 2014, section 10 – Assessment of a carer's needs for support