1. Background & Concerns

Tracy was an adult at risk who was known to ReNew (Substance Misuse Service) from April 2019 when she reported daily intravenous use of heroin and crack cocaine. Despite their best efforts she chose not to engage or remain on her methadone prescription. She presented with signs of self-neglect, was homeless and described as 'sofa surfing'.

Tracy was well known to Humberside Police as a suspect, victim and witness, with contact closely associated with her substance misuse.
She was also well known to Hull City Council (HCC) Adult Social Care (ASC), and despite their best efforts she frequently declined support.

During the last months of her life Tracy had several admissions to hospital with a chronic but worsening renal condition – Nephrotic Syndrome and abdominal pain. She was admitted to hospital with bowel obstruction in December 2023 and died shortly after.

2. Safeguarding Adult Review (SAR)

Under S.44 Care Act 2014 a SAR takes place when an adult with care and support needs dies or is seriously harmed, and there is reasonable cause for concern this was due to abuse and/or neglect, and there are concerns about how agencies worked together. The purpose of a SAR is to look at what happened, why, and what action will be taken to improve practice.

In January 2024 Hull Safeguarding Adults Partnership Board (HSAPB) received a referral for a SAR for Tracy. The HSAPB SAR Panel subsequently determined the criteria for a Discretionary SAR was met, a decision later endorsed by the HSAPB Independent Chair. The SAR covered the period December 2021 until December 2023.

A Discretionary SAR `line of sight' learning review was held. This was an in-person meeting attended by relevant agencies where reflective discussions took place focussed on key learning themes and future practice improvement.

Discretionary SAR – Line of Sight - Tracy

Hull Safeguarding Adults Partnership Board

3. What worked well

a) The review identified Tracy was central to the decisions made by those supporting her. Agencies worked proactively, fostering a good relationship in which she had a voice and her preferences were considered. Practitioners showed personal knowledge, and a genuine interest in her welfare, care, and support needs, trying many times and methods to engage with her. Unfortunately, Tracy's substance misuse appears to have been the major influence in her life and contributor to her declining health

b) Multi-agency working was evident, with practitioner meetings and discussions taking place to determine how best to support Tracy. There was particularly good communication and inter-agency cooperation in December 2023 when Tracy suffered 2 suspected drug overdoses whilst in hospital. A Vulnerable Adult Risk Management (VARM) meeting was held with representatives from ReNew, HCC Housing, HCC Safeguarding and the NHS. Despite Actions designed to support Tracy, including a joint home visit, she died 2 weeks later.

4. What could have been done better

a) Greater understanding of S.11 of the Care Act 2014 and the Mental Capacity Act 2005 could have resulted in different choices by professionals.

I. There was a lack of confidence and knowledge of the Mental Capacity Act when assessing Tracy's mental capacity when she was taking drugs. (It was felt this was a general lack of knowledge rather than specific to this case).
II. There here was also lack of understanding of S.11 Care Act, and when Tracy's preferences could have been overruled due to her experiencing, or being at risk of, abuse or neglect. If professionals had overridden Tracy's preference a needs assessment under the Care Act could have been carried out and potential action taken to reduce the risks to her.

b) Accurate record keeping of actions and decisions, alongside the accurate recording of the action taken and when the Action is completed is highlighted as an area for improvement.

c) There did not appear to be a clear pathway and referral process from the hospital Emergency Department to the Homeless Health Team, and onwards to Hull University Teaching Hospitals NHS Trust (HUTH).

d) Despite Tracy being well-known to the police and ambulance services and both services coming into regular contact with her, her known substance misuse and vulnerabilities, her sometimes unkept appearance and evidence of self-neglect, she was not identified as a vulnerable individual and neither service made any safeguarding referrals in the last 12 months of her life.

5. What is the learning (Recommendations)

a) Safeguarding leads review the knowledge and use of the Mental Capacity Act 2005 within their organisation, particularly when assessing a person's capacity when they are taking drugs, and when they are thought to be experiencing, or at risk of, abuse or neglect.

b) Review HCC Adult Safeguarding Teams knowledge and use of Care Act 2014, particularly regarding needs assessments and when an individual's preferences can be overruled.

c) Members of HSAPB cascade the learning from this report through their organisations, including the importance of accurately recording Actions and Recommendations from meetings concerning patients.

d) Continue to promote the adoption of Professional Curiosity, with practitioners being supported to understand what professional curiosity means in the context of risk factors and safeguarding responsibilities.

e) Establish and maintain a clear pathway from the Hull Emergency Department to the Homeless Health Team and onwards to HUTH.

6. Further information - Links

S.11 of the Care Act
https://www.scie.org.uk/mca/
Mental Capacity Act
Professional Curiosity