SAFEGUARDING ADULTS REVIEW

Report in relation to the Death of Mr B.

Found dead in a derelict property in Hull on the 20th January 2016.

Report provided by the Independent Chair and author Rick Proctor.

Acknowledgements - Hull Safeguarding Adults Partnership Board would wish to thank those agencies and staff who provided information in relation to their involvement with Mr B. This information has been used to help shape and inform this report together with identifying recommendations which if implemented should improve safeguarding outcomes for Adults at risk in Hull.

1.0 STATUTORY FRAMEWORK

1. Introduction

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and

c) the adult has died and the board suspects that the death resulted from abuse or neglect. (whether it knew about or suspected the abuse or neglect before the adult died).

The decision to undertake a Safeguarding Adult Review in relation to the tragic death of Mr B. was made in June 2017 by the Hull Safeguarding Adults Partnership Board, this following a recommendation received from the Board's Safeguarding Adults Review panel who were satisfied that the criteria to undertake such a review was met.

2.0 SUMMARY OF SIGNIFICANT EVENTS.

2.1 Mr B. had a history of offending and was well known to the criminal justice, offender management and substance misuse agencies in Hull. For periods of his adult life he required support in relation to substance misuse and was prescribed methadone to manage a heroin addiction.

2.2 On the 20th July 2015 he was sentenced to 16 weeks in custody following a conviction for an offence of theft. This sentence was subsequently served at Her Majesties Prison Hull. (HMP Hull)

2.3 On the 28th August 2015 it was recorded in an exchange of information between HMP Hull and the Renew treatment agency who had previously supported Mr B. prior to his custodial sentence regarding substance misuse issues, that the prison held concerns relating to Mr B., where it was recorded, he was unwell, and not

communicating with anybody. Renew informed HMP Hull that Mr B. had nowhere to live upon release and it would be challenging to find him accommodation.

2.4 On the 19th September 2015 HMP Hull welfare department recorded owing to Mr B.s presenting behaviours that they were seeking him to be assessed under the Mental Health Act 2005 upon his release from custody.

2.5 On the 21st September 2015 it was recorded by HLNY Community Rehabilitation Company (CRC) that prison staff at Hull HMP were concerned that Mr B. was vulnerable in that he had no accommodation provision upon release and at risk of returning to the misuse of illicit substances, if no support was in place. Despite the presenting concerns being known to HMP Hull for some time prior to his release and information being held by several agencies, no multi-agency meeting or discussion was held that may have enabled a multi-agency care plan to be developed to address Mr B.s care and support needs upon release from prison.

2.6 On the 21st September 2015 a Mental Health Act assessment was convened on the day of his release undertaken by Humber Foundation Trust (HFT). The assessment concluded that he was not showing symptoms of a psychosis or mental health problems, resulting in the decision being made that he did not require sectioning under the Mental Health Act. No issues with regards to his overall general physical health were recorded. He was subsequently released from custody at HMP Hull and on this same date without any accommodation was instructed to attend the Wilson Centre managed by Hull City Council, who would identify suitable accommodation for him.
He was transported from prison by taxi to the CRC in Hull where it was suggested he contact one of the local hostels to try to find accommodation. He then left the building unsupervised and it was later confirmed by the hostel, he had not presented at their premises, his whereabouts being unknown.

2.7 On the 25th September 2015 Mr B. was found at the rear of the probation offices in Hull. It was recorded by CRC staff he appeared neglected, thin and cold and had apparently been sleeping “rough” in the container bins at the premises outside. He was described as incoherent, agitated and anxious**.** Concerns relating to Mr B.s mental health were once more highlighted. Following further unsuccessful attempts to find suitable accommodation by CRC staff a further mental health assessment was undertaken by HFT which resulted in him being admitted under Section 2 of the Mental Health Act to HFT hospital admission premises.

Mental Health Act.pdf

2.8 Following admission it was noted by HFT that Mr B. was presenting as agitated, anxious, disorientated, suspicious and possibly responding to unseen stimuli and appeared unkempt and thin. An assessment undertaken identified that Mr B. scored poorly in areas of physical health, self-care, living skills, mental health, addictive behaviour, work and responsibilities.
Whilst on the assessment unit the review has identified evidence of multi-agency communication taking place involving HFT, the CRC and housing providers to

address issues in relation to Mr B.s care and support needs which is identified as good practice.

2.9 On the 30th September 2015 Mr B. was transferred to the HFT hospital treatment unit. Throughout the time he spent on the treatment unit it was recorded he was difficult to engage with and spent long periods of time isolating himself by staying within his room.

2.10 The Model of Human Occupational Screening Tool (MOHOST) and Addenbrookes Cognitive Assessment were utilised which evidenced Mr B. had a low level of functioning. No evident treatment plans or goals to measure improvement were established to monitor progress and whilst records noted slight improvements to his mental health the evidence to support this view were neither clear or apparent from records held by HFT.

Model of Human Occupation Screening Tool

The_Mini_Addenbrooke_s_Cognitive_Examination.pdf

2.11 It was recorded by staff on the unit that Mr B. was not in receipt of benefits and would require support from HFT staff to ensure these could be claimed upon discharge from the unit. However, despite this being identified as an issue of concern, when he was discharged from the unit no such arrangements had been made to ensure Mr B. would be in receipt of his benefits.

2.12 There was good practice identified in relation to Multi Agency working through liaison between HFT and CRC to consider Mr B.s housing needs upon discharge with CRC attending the recovery meetings at the unit.

2.13 Despite the identified concerns regarding Mr Bs history of substance misuse and it being recorded in his notes that treatment agencies would need to be contacted before discharge to ensure his needs were met, no such referral was ever made by HFT, despite there being a high risk of relapse into the misuse of illicit substances if not properly supported upon discharge.

2.14 On the 12th October 2015 Mr B. was referred to HFT Community Mental Health Team although a Care Coordinator (CC1) was not allocated the case until 13th November 2015.

2.15 On the 21st October 2015 HFT recorded Mr B. undertook the Addenbrookes cognitive assessment test. He recorded a low score which was indicative of someone with significant cognitive impairment. On this same date Mr B. was visited by an HFT social worker. They made a request to HFT staff on the ward to assist Mr B. with ensuring benefits he was entitled to upon discharge from hospital could be claimed though nobody took responsibility to do this.

2.16 On the 22nd October 2015 Mr B. was seen by an HFT Occupational Therapist where he confirmed he was able to wash and dress himself and that whilst unable to cook could prepare microwave meals.

2.17 On the 23rd October 2015 Mr B. was visited by a family member who made comment to HFT staff that they had never witnessed him to be so poorly. They found his presentation unusual and they were upset to see him unshaven and wearing dirty clothes.

2.18 On the 25th October 2015 the MOHOST assessment tool was again utilised focusing on a "brunch" group. It was observed he was unable to independently cook an egg on toast and scored low in most of other areas tested. This assessment was never used to benchmark Mr B.s progress since the admission to provide evidence as to whether his condition was improving or deteriorating.

2.19 On the 10th November 2015 it was recorded during a recovery meeting by HFT that Mr B. had an identified risk of self-neglect and the Model of Human Occupational Screening Tool (MOHOST) assessment was completed which assesses several factors including self-care, motivation and productivity. He scored low in several areas.

2.20 On the 13th November 2015 CC1 visited Mr B. on the unit where they observed and recorded, he appeared "flat in mood and was struggling to maintain a conversation". Their professional opinion that was recorded was they did not consider him fit for discharge at this time. This opinion though was not shared with the treatment unit staff or relayed at the later meeting where discharge was recommended. CC1 was unable to attend this meeting and despite good practice dictating they should be present, it proceeded in their absence.

2.21 On the 17th November 2015 a final recovery meeting was held by HFT to discuss Mr B.s case. This meeting was essential in identifying risks, measuring progress, establishing what care and support needs he would have upon discharge, providing an opportunity to establish a coordinated plan which could be activated following his return to a community environment. However, no notes were recorded of this meeting and subsequently no coordinated plan to safeguard Mr B. was established.

2.22 On the 18th November 2015 a Care Programme Approach meeting was held by HFT to discuss Mr B.s case. There was evidence of good practice with multi-agency attendance at the event including HFT clinical staff, CRC case workers and the accommodation provider "Turning Point" the identified housing provider for Mr B. if discharged. At this meeting a decision was made that Mr B. would be discharged from the hospital environment into the community the plan being that he would be supported by a Community Psychiatric nurse (CPN 1). It was recorded Mr B. only had the clothes he was currently wearing, had no money and arrangements for his benefits to be claimed were not in place.

Following Mr B.s death, a Serious Incident investigation was undertaken by HFT which identified the housing provider believed Mr B. was too unwell to be discharged and were shocked by his deterioration. However, they chose not to raise their concerns or challenge the decision for discharge.

2.23 On the 19th November 2015 Mr B. was discharged from the hospital and was provided hostel accommodation by Turning Point in Hull. Turning Point at that time

was an accommodation provider who provided support for ex-offenders and homeless people in the City of Hull. Since the commission of this review it has been established they are no longer in operation, resulting in the review being unable to obtain information and engagement with this agency to inform the review.

2.24 On the 20th November 2015 Mr B. was visited by a Community Psychiatric Nurse (CPN 1) who completed a service and relapse plan in his presence, which he duly refused to sign. CPN 1 recorded that Mr B. appeared brighter in mood then when on the hospital unit, however still displayed poor levels of motivation regarding self-care. No safeguarding concern was raised or considered by CPN 1 despite the emerging presence of factors associated with self-neglect.
CPN 1 agreed with Mr B.s consent to make a referral for support to substance misuse services. It was not recorded as to whether Mr B. had mental capacity to consent to such an intervention at that time. This referral was never completed and subsequently no support was ever provided.

2.25 On the 24th November 2015 Mr B. was visited at his residence by Community Rehabilitation Company worker (CRC 1). It was established that alcohol had been found in Mr B.s room and he was reminded by CRC 1 that the alcohol may affect negatively upon the medication he was prescribed to treat his mental health condition. A risk assessment was undertaken utilising the Offender Assessment System (OASys) framework, which is recognised as expected practice, his overall risk assessed as medium. However, despite this assessment no safeguarding plan was established which included consideration of the potential impact of consuming alcohol in conjunction with his medication, or any mitigation considered through a referral being made to substance misuse services.

2.26 On the 1st December 2015 CRC 1 again visited Mr B. at his residence. It was noted he appeared more talkative though a revisit of the risk assessment still showed his risk to be assessed as medium.

2.27 On the 14th December 2015 CPN 1 visited Mr B. at his residence but found him difficult to communicate or engage with.

2.28 On the 17th December 2015 a concerned member of the public contacted Humberside Police after confronting a male acting suspiciously on Beverley Road, Hull. The male provided his details as those of Mr B.s to the member of the public, stating he had no money and needed to catch a taxi. The member of the public was of the opinion the male was suffering from mental health issues. From the information provided to the review the assumption made is that the male was Mr B.

2.29 In the early hours of the 18th December 2015 Mr B. attended the emergency department at the Hull and East Yorkshire hospital. He reported he had been vomiting and had difficulty breathing. It was noted his speech was slurred. After a short stay in hospital he was assessed by hospital staff to have mental capacity to make his own decisions and self-discharged from hospital.

2.30 On the 22nd December 2015 **"**Turning Point" made a report to Humberside Police that Mr B. was missing and had not been seen since 15th December 2015. It is believed they were unaware of him visiting the hospital as detailed at 2.29 above.

The review has been unable to ascertain why owing to Mr B.s vulnerabilities in relation to mental health, substance misuse and self-neglect, there was such a delay in reporting him as missing.

2.31 On the 22nd December 2015 Humberside Police received the report of Mr B.s missing episode from Turning Point.
Initially his missing report was assessed as high risk but within ten minutes of its receipt downgraded to medium risk by the duty Police Inspector (INSP 1).
Whilst recognised a significant number of persons are reported annually to the police as missing persons, police guidance advises when assessing risk and grading it accordingly that there is a requirement to consider known vulnerabilities, including inclement weather for example cold freezing temperatures, does the person require essential medication and do they have mental health problems. All these factors were pertinent in relation to Mr B.s case, regarding categorisation of risk.

2.32 On the 20th January 2016 despite a multitude of actions taken by the police to locate Mr B., he was tragically found dead in a derelict house in Hull, his cause of death confirmed by the coroner's verdict as death through hyperthermia.

Major Investigation and Public Protection Risk Assessment

What is Hypothermia?

3.0 METHODOLOGY

3.1 SAR methodology is non- prescriptive within the Care Act, with the aims of the review wherever possible being completed in a timely and proportionate manner.

In this case no specific terms of reference were set, the review broadly following a model of significant event analysis. This methodology considers significant events within a case, analyses what went well and what could have been improved. The aim of employing such a methodology is to both identify recommendations for improvement and how these will be implemented.

The process undertaken was as follows.

3.2 Documentary Review.

- Relevant agencies provided chronologies of service involvement within the relevant timeline.
- The chronologies were utilised to create a multi-agency chronology.
- Hull Local Operating guidance for safeguarding adults' concerns and Section 42 enquiries.
- The Care Act 2014

- The Mental Health Act 2007
- The College of Policing Missing Person Investigation Guide (22nd November 2016)

3.3 Family Involvement.

The lead reviewer wrote to Mr B.s family to seek their involvement in contributing their views and opinions to inform this review. Unfortunately, despite these best attempts no response was ever forthcoming.

3.4 Multi Agency Learning Event.

On the 6th February 2018 a Multi-Agency Learning event took place involving all agencies who had supported Mr B. during the timeline of the review except for "Turning Point" who were found to be no longer be in operation in Hull.

A series of questions were posed at this event by the lead reviewer and the answers used to help inform the analysis as detailed at section 4.

4.0 ANALYSIS

In line with the chosen methodology, utilising the information provided by agencies, three significant events as detailed below were selected for analysis, with the aim of identifying future learning and improvement activity.

4.1 The Prison Discharge Process.

As detailed afore that whilst it is recognised that Mr B. only served a relatively short sentence at HMP Hull totalling a period of 63 days, during this time concerns were identified by prison staff and CRC staff that he was vulnerable. These vulnerabilities included concerns regarding homelessness, substance misuse issues and mental health issues.

Whilst there is good practice identified in relation to information exchange taking place between HMP Hull staff and CRC regarding concerns relating to Mr B.s vulnerabilities, at no time prior to his discharge from prison was a multi-agency strategy meeting or discussion held to consider how to address his care and support needs. Such an event would have allowed a multi-agency plan to be established and a comprehensive risk assessment to be undertaken. This would have provided an opportunity to establish a support package which could have been activated upon Mr B.s release to manage or mitigate any known risks.

The Hull Local Operating Guidance is for use by all agencies involved in safeguarding adults with care and support needs in Hull. It explains local

safeguarding practice and supports Chapter 14 of the Care Act 2014 which provides national statutory guidance in relation to adult safeguarding.

Whilst the guidance is detailed in many facets it does not include specifically any reference to when to consider undertaking a multi-agency strategy meeting or discussion and how it may add value in keeping adults safe. The review has identified a requirement for this addition to be made within the local operating guidance, to raise awareness to practitioners of the benefits of undertaking such a multi-agency meeting or discussion.

Recommendation 1. Hull Safeguarding Adults Partnership Board to include within the Hull Local Operating Guidance a section promoting the value and circumstances where it may benefit holding multi agency strategy meetings or discussions to help Safeguard Adults. This should be completed within 3 months.

In the spring of 2015 “Through the Gate” a flagship government policy was introduced within the UK prison establishment with the intention of bringing about a step change in prisoner rehabilitation and by doing so reduce levels of reoffending. The operational delivery of “Through the Gate” was the responsibility of the newly formed Community Rehabilitation Companies (CRC) and was targeted at short term sentence prisoners such as Mr B. who statistically are recognised as having high reoffending rates if their complex needs are not met.

Evidence Reduce Reoffending

The policy vision was for the CRC to provide a seamless service from the beginning to end of sentence, where assessments undertaken within prison would seek to address issues including finance, mental health concerns, housing and substance misuse. Delivery of the “Through the Gate” contract commenced on the 1/05/15 at HMP Hull and was in its early stages of development when Mr B. was admitted into custody. Whilst the review has identified that efforts were made to address some of the known concerns, no coherent or coordinated plan was ever established that would meet his complex needs upon his release from custody. The resulting outcome was that no suitable accommodation was provided, a lack of support was provided in relation to his substance misuse issues which culminated in him resorting to “sleeping rough” within a container bin.

A national review of the “Through the Gate” scheme undertaken by HM Prison and Probation Inspectorates in 2016 identified several issues of concern regarding the delivery model and recommendations for CRCs nationally which included.

1. Develop and implement effective resettlement services to meet the requirements of accommodation, employment, finance, benefit and debt.

2. Utilise other available services within resettlement prisons when undertaking pre-release activities, for example mental health support and education and training provided by other commissioned services

3. Engage meaningfully with the prisoner by involving them in drawing up and reviewing resettlement plans. These should be based upon their individual needs; the actions required to promote resettlement and reduce their likelihood of reoffending and causing harm to others.

Through-the-Gate.pdf

In July 2018 the Government launched the consultation paper - Strengthening probation, building confidence. Proposals for reform include stabilising probation services, improving offender services and through the gate services.

Strengthening Probation, Building Confidence

The proposal for "Through the Gate "provision includes that plans are established before release to meet offenders' basic needs. This includes offenders having somewhere safe to live; securing a job or access to benefits, as well as a bank account; having continued access to substance misuse, health or social care services.

If such a plan had been established in relation to Mr B. upon discharge from prison, his basic needs may have been better provided for.

This government consultation which ends on the 21st September 2018 provides a unique opportunity for Hull Safeguarding Adults Partnership Board to inform the process by sharing the learning from this case.

Recommendation 2. Hull Safeguarding Adults Partnership Board to share the learning from this case regarding the prison discharge process to inform the "Strengthening probation, building confidence" consultation process. This should be completed by 15th September 2018.

4.2 The Residential Mental Health Discharge Process.

As detailed within Section 2 above Mr B. spent several months in the in-patient care of HFT Mental Health Services following admission under Section 2 of the Mental Health Act 2005.This after being found sleeping rough in container bins at the rear of the office premises in Hull.

It was recorded upon admission to the acute admission unit that he was anxious, disorientated, suspicious and potentially responding to unseen stimuli. His appearance was noted as being unkempt and thin.

These were the first signs recorded that Mr B. may be self-neglecting.

Self-Neglect is defined within the Care Act 2014 as "covering a wide range of behaviour, including neglecting to care for one's personal hygiene, health or

surroundings and includes behaviour such as hoarding".

A review of local policy and guidance has identified that there is a deficit of policy, guidance and practitioner toolkits promoted by Hull Safeguarding Adults Partnership Board which may assist practitioners in relation to the identification, management and response by agencies to Self-Neglect.

Recommendation 3. Hull Safeguarding Adults Partnership Board should develop Policy, Guidance and Practitioner toolkits for use across the partnership to help protect adults at risk of Self -Neglect. This should be completed within 3 months.

An assessment utilising the "recovery star" designed for use with adults managing their mental health or recovering from mental illness, identified that Mr B. scored low in the areas of physical health, self-care, living skills, and mental health.

Other assessments were utilised with regards to Mr B.s treatment including MOHOST and the Addenbrookes Cognitive Assessment as detailed in Section 2 above. Both these assessments evidenced a low level of functioning.

Despite these assessments being undertaken no treatment plans and improvement goals were established to monitor Mr B.s progress or provide evidence of improvement before discharge could be considered.

Whilst it was recorded that the opinion was that Mr B.s mental health was improving this was difficult to quantify owing to a lack of further assessments and information recorded.

It was identified throughout Mr B.s stay in the care of HFT that he had a history of substance misuse issues. Despite this being known and dual diagnosis staff attending the recovery meetings, no referral was ever made to substance misuse services by HFT to ensure these services would be in place upon discharge. This placed him at potential risk of relapse into the misuse of illegal substances following discharge.

On the 10th November 2015 an assessment undertaken by HFT at a recovery meeting identified Mr B. as vulnerable and at risk of Self Neglect, however despite little or no improvement in relation to these concerns no Safeguarding Concern was ever raised by HFT in relation to Mr B. prior to or upon discharge. This would have enabled an enquiry under Section 42 of the Care Act to have been undertaken as detailed within the Hull Local Safeguarding Operational Guidance. This would have allowed decisions to have been made as to how to manage the identified risk of self-neglect and consider establishing a coordinated multi-agency safeguarding plan which could have been activated upon Mr B.s discharge.

Recommendation 4. Hull Safeguarding Adults Partnership Board should raise awareness amongst the partnership of the guidance contained within the Local Operating Guidance of when to raise a Safeguarding Concern. This should be completed within one month.

On the 13th November 2015 Mr B. was allocated a Care Coordinator CC1 who visited him on the ward. CC1 observed and recorded in notes that Mr B. was "flat in mood" and struggled to maintain a conversation. The CC1 recorded that in their opinion he did not appear fit to be discharged. This information was never shared at the discharge meeting and neither was CC1 present whose attendance at such events would be seen in normal circumstances as good practice.

On the 18th November 2015 a discharge meeting was held in relation to Mr B., where a decision was made that he was to be discharged from the hospital and be supported within the community, by the community mental health team. Despite the housing provider representative who was present at the discharge meeting holding concerns in relation to Mr B.s unsuitability for discharge, they chose not to raise these concerns in the meeting as detailed within the Serious Incident Investigation commissioned and shared by HFT to help inform this review. Unfortunately owing to the fact the housing providers are no longer in operation the review has been unable to identify the root cause as to why they did not raise their concerns. Learning from this case identifies a requirement for professionals to have the confidence and be supported in challenging decisions they deem may place adults at risk of harm and if necessary, escalate their concerns to their relevant supervisor. Where appropriate such an approach should be championed and promoted by Hull Safeguarding Adults Partnership Board together with establishing an escalation policy to guide practitioners on what action is required to be undertaken on such occasions.

Recommendation 5. Hull Safeguarding Adults Partnership Board should promote a culture of professional challenge within multi-agency safeguarding meetings and using the learning from this case establish a practitioner escalation policy where unresolved differences in professional judgements occur relating to safeguarding adults in Hull. This should be completed within 3 months.

On the 19th November 2015 Mr B. was discharged from HFT and accommodated within "Turning Point" hostel accommodation in Hull. The plan was for him to be supported by CPN1. When discharged he possessed only the clothing he was wearing; his social security benefit payments were not in place or had any referral been made in relation to his substance misuse issues.

Following Mr B.s tragic death HFT as earlier stated commissioned a Serious Incident Investigation to be undertaken. Guidance shows such an investigation is undertaken in health care, when adverse events occur, where the consequences to patients,

families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

Serious Incident Framework.pdf

Following the investigation ,14 recommendations for improvement were identified. Subsequently HFT have used the learning to take forward actions for improvement, which Hull Safeguarding Partnership Board should seek assurance, have been progressed and embedded in practice.

Recommendation 6. Hull Safeguarding Adults Partnership to seek assurance from HFT in relation to the improvement activity undertaken with regards to the 14 identified recommendations. This should be completed within 6 months.

4.3 The Missing Person Investigation.

Upon Mr B.s arrival at hostel accommodation it was noted that he was anxious and very difficult to engage with.

Mr B. was supported by the CPN1 who developed a service and risk relapse plan with him though he refused to endorse this with his signature.

He did agree for CPN1 to make a referral to substance misuse services on his behalf, but this was never completed.

On the 24th November 2015 alcohol was discovered within his room, where CRC staff highlighted the impact alcohol may have upon his prescribed mental health medication.

On the 2nd December 2015 CPN1 did contact the substance misuse services in relation to his Mr B.s needs. Unfortunately owing to a computer malfunction they were unable to receive the referral, and this was not pursued any further by CPN1.

CPN1 continued to provide support to Mr B. and it was noted on the 8th December 2015 his mood appeared brighter and he seemed more settled.

On the 14th December 2015 CPN1 visited Mr B. at the hostel though he refused to engage with the practitioner.

On the 15th December 2015 Mr B. went missing from the hostel and never returned. No report of his absence was made by Turning Point to Humberside Police until the 22nd December 2015, some 7 days later.

It was established that “Turning Point” are no longer operational in Hull. The consequence being the review has been unable to identify why despite the known vulnerabilities in relation to Mr B. it was deemed appropriate not to prioritise reporting him as a missing person to the police. Drawing on learning from this case there is a requirement to review and consider how the multi-agency partnership responds to future incidents in relation to adults at risk, who go missing in Hull. Similar such

arrangements are active in other parts of the country and Hull should seek to identify good practice to help inform the development of future multi agency responses.

Whilst Mr B. was absent from the hostel environment but not reported missing there were missed opportunities to safeguard him.

Humberside Police were contacted by a concerned member of the public regarding a male acting suspiciously who provided his details as those of Mr B.

Hull and East Riding Hospital NHS Trust recorded Mr B. attending at the emergency department.

The review identifies these both as potential missed opportunities to safeguard him.

Principle 3 of the Care Act 2015 sets out that prevention in relation to harm and abuse is a primary objective in relation to safeguarding adults at risk. Consequently, the hostel delaying reporting Mr B. as missing, hindered any preventative action being undertaken to safeguard him, owing to a lack of awareness by the agencies of his absence from the hostel.

Recommendation 7. Hull Safeguarding Adults Partnership Board should work with Humberside Police and the Safeguarding Partnership to develop guidance in relation to Multi-agency responses when adults who are at risk go missing. This should be completed within 6 months.

Following Mr B.s missing person report being provided to Humberside Police it was initially assessed as high risk, the risk status then swiftly reduced to a medium risk by INSP 1.

Whilst the review considers the response by Humberside Police as professional and comprehensive in attempting to locate Mr B., the very nature of the risk categorisation dictates the tactics that are undertaken, the investment of resources and hierarchy of organisational oversight and ownership, in relation to the missing person investigation.

Considering Mr B.s known vulnerabilities, it is unclear why his risk status was reduced from high risk to medium risk without compelling evidence to justify the risk assessment reduction.

Hull Safeguarding Adults Partnership Board should seek assurance from Humberside Police in relation to the training and guidance provided to its staff regarding the risk assessment of missing persons.

Recommendation 8. Hull Safeguarding Adults Partnership Board should seek assurance from Humberside Police in relation to the quality of training and guidance provided to its staff regarding the risk assessment of missing

persons in accordance with College of Policing authorised professional practice. This should be completed within 3 months.

5. RECOMMENDATIONS

Recommendation 1. Hull Safeguarding Adults Partnership Board to include within the Hull Local Operating Guidance a section promoting the value and circumstances where it may benefit holding multi agency strategy meetings or discussions to help Safeguard Adults. This should be completed within 3 months.

Recommendation 2. Hull Safeguarding Adults Partnership Board to share the learning from this case regarding the prison discharge process to inform the "Strengthening probation, building confidence" consultation process. This should be completed by 15th September 2018.

Recommendation 3. Hull Safeguarding Adults Partnership Board should develop Policy, Guidance and Practitioner toolkits for use across the partnership to help protect adults at risk of Self -Neglect. This should be completed within 3 months.

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Rick Proctor

Independent reviewer and author.

Hull Safeguarding Adults Partnership Board

Warehouse 8

Guildhall Road

Hull

HU1 1HJ