Safeguarding Adults Review: Missing Persons Review of 4 Adults with care and support needs that died whilst 'Missing'

What is a Safeguarding Adults Review? A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

(1) *A SAB* ***must*** *arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*
(a) *there is* ***reasonable cause*** *for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***And***
(b) *condition 1* ***or*** *2 is met (see below)*

(2) Condition 1 is met if: -
(a) *the adult has died,* ***and (b)*** *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

(3) Condition 2 is met if: -
(a) *the adult is still alive,* ***and (b)*** *the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

About this briefing – A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of all 4 Adults concerned. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners.

Please take time to reflect on the findings and consider how you can learn, develop, and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

Care Act 2014

Care and support needs are identified in the Care Act 2014 as the following - All 4 Adults that were reported as 'Missing' by the London Metropolitan Police Service (MPS) were adults with care and support needs. Meaning that they had to have two or more of the below -

What are the identified care and support needs as identified in the Care Act 2014?
(a)the adult's needs arise from or are related to a ***physical or mental impairment or illness***; **and**
(b)as a result of the adult's needs the adult is ***unable to achieve two or more*** of the outcomes specified in paragraph (below) **and**
(c)as a consequence ***there is, or is likely to be, a significant impact on the adult's well-being***.

- ☐ Do these needs mean the adult is unable to achieve two or more of the following listed outcomes? -
- ☐ Managing and maintaining nutrition
- ☐ Maintaining personal hygiene
- ☐ Managing toilet needs
- ☐ Being appropriately clothed
- ☐ Being able to make use of the adults home safely
- ☐ Maintaining a habitable home environment
- ☐ Developing and maintaining family or other personal relationship
- ☐ Accessing and engaging in work, training, education, or volunteering
- ☐ Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- ☐ Carrying out any caring responsibilities the adult has for a child

The Pen Picture of all 4 Adults is summarised below –

Adult 1, known as Keith, was reported 'Missing' and was found deceased the following day at the age of 75. At this time, there were a range of care and support services involved with Keith and his family. Keith had worked as a driver for many years prior to his retirement and was living alone with his dog which he cared for. Although, the circumstances around Keith's death were complex; agencies involved did not identify any safeguarding concerns prior to him going 'missing.'

Adult 2, known as Richard, was reported 'Missing' 16 different times in a 12-month period; however, Richard was found deceased a day after the last episode. Richard had deteriorated mobility and a Dementia diagnosis. He was known to Adult Social Care, but the family had declined any support in the home. Sadly, the assistive technology was not switched on and Richard was able to exit the family home leading to his last episode of 'missing.'

Adult 3, known as Lionel, was reported 'Missing' and found deceased after being discharged from a local hospital. Lionel was known to several agencies at the time of his death. Lionel had complex health and social care needs, but also lived as a 'rough sleeper' for over 40 years, but recently was accepting care at home, housing services support and drug/alcohol treatment. Lionel was struggling to cope living inside a property and his behaviours were not seen as a safeguarding concern prior to him going 'missing.'

Adult 4, known as Dan, was reported 'Missing' by his ex-girlfriend due to domestic dispute and was found deceased shortly after. Dan was known to a range of care and support services with a history of other 'missing' episodes; none of the prior episodes were seen as safeguarding concerns.

This is the learning brief on what was found and how you can make a difference to protecting other adults that go 'Missing.'

About the review process – All 4 Adults came to the attention of the Bexley SAB in 2023-2024; where the Bexley SAB identified that there have been several adults with care and support needs in the last 12 months that have gone 'Missing.' The Bexley SAB recommended that a Thematic SAR on Missing Persons with Care and Support Needs should be conducted with the Independent Chair, Andy Rabey, agreeing the SAR Criteria had been met. The SAR followed a Rapid Review methodology in order quickly identify learning to prevent other adults. Anita Eader, Bexley SAB Practice Review & Learning Manager, Chaired the SAR with agencies involved to provide representation at the review panel.

Summary of identified Findings -

1. ***Key Finding*** – there is an immediate need for the Bexley SAB to have an agreed Missing Person's Protocol. Whilst the MPS and others may have agency specific protocols; the Local Authority does not have one for adults at risk. In all cases, it was agreed that had there been a Missing Person's Protocol for Safeguarding of Adults at Risk agencies would have responded differently. Therefore, the Bexley SAB has acted swiftly to initiate a Missing Person's Task & Finish Group to address this Key Finding. Members of the Task & Finish Group are working to address the issues found within this SAR to prevent and protect. The Task & Finish Group is led by the Independent Chair, Andy Rabey, which has overall responsibility for the priorities of the Bexley SAB to ensure the partnership are supported to embed this identified gap in Bexley.

2***. Finding*** - that although MPS were submitting Merlin Reports to the Local Authority, none of their concerns identified led to s.42 enquiries being conducted.

3. ***Finding*** - indicated that the demographics of a 'Missing Person' cannot be categorised as all 4 Adults at Risk had varying backgrounds, health, and social care needs.

4. ***Finding*** - there were missed opportunities by ASC not challenging the decisions by the families and not working with the adult at risk directly.

5. ***Finding*** – there was a misunderstanding by all agencies to understand medical diagnoses given to adults and how their Mental Capacity may have been affected; therefore, no Mental Capacity Assessment conducted on any of the adults at risk.

6. ***Finding*** - there was a missed opportunity by the Local Authority to consider challenging the family with regards to Richard's care and support; particularly around the matter surrounding the family making decisions for Richard without the legal powers to do so. Also, to see Carer's as appropriate to the adult at risk assess the family with a history of Domestic Abuse as appropriate Carers to Keith and Dan.

7. ***Finding*** - there was a missed opportunity by the Local Authority to not consider the severity of the safeguarding concerns being raised by the Police through the numerous Merlin Reports regarding Richard's wandering and unsafe behaviours.

8. ***Finding*** - there was missed opportunities by the Local Authority to risk assess whether or not the family were suitable 'carers' and no challenge to the family when they refused the care suggested for adults concerned.

9. ***Finding*** - there was a missed opportunity by all agencies to hold multi-agency meetings to discuss the cases as concerns were escalating. One agency submitted the following, ''***It appears there is a big gap in the patient's care as he was discharged from district nursing team due to a hospital admission and no referral was sent to them following discharge to restart care.'***

Identified Good Practice –

1. There was Good Practice by the Local Authority by working to identify how Assistive Technology for the home could assist in Richard's case.

2. There was Good Practice with Keith's GP following up on the MH Crisis Line incident to offer support to Keith and seek assurances around his current mental health status.

3. There was Good Practice with hospital teams following through by sharing all A&E attendances with Keith's GP is seen as Good Practice.

Overarching Themes –

1. **Legal Literacy** – Care Act 2014 and Mental Capacity Act 2015 not applied; including: Safeguarding Adults and Care Act duties for s.42(1) Safeguarding Adults, Care Act duties for multi-agency response, and evidencing defensible decision-making.
2. **Think Family** – Carers either overly involved or not involved.
3. **Domestic Abuse** – Family / ex-girlfriends should not be asked to be Carers.
4. **Making Safeguarding Personal -** Silo-working and sharing of information between agencies and not applying the voice of the adults at risk directly.

Recommendations for Partners to consider –

1. It is highly recommended that the Bexley partnership oversee an immediate response to the Key Finding and Themes identified to ensure that adults at risk of going 'Missing' are supported in a multi-agency manner and seen as requiring preventative measures to safeguard them as soon as possible.

Questions for you to consider –

1. How well / confident are you with applying the Mental Capacity Act?
2. How well / confident are you with applying s.42(1) of the Care Act?
3. Did you know Bexley has a 'Joint Think Family Protocol'?
4. How accessible are your services for someone to speak with staff about their care and support needs especially when struggling with psychosis?
5. How well / confident are you with reporting or working with adults at risk of being 'Missing'?
6. What risk management procedures are in place to support in ensuring risk assessments are of a sufficiently high standard and include feedback from key agencies and significant others in the person's life?

Resources to assist you further –

Bexley Safeguarding Adults Board website –
http://www.safeguardingadultsinbexley.com

- The website holds an annual SAR Themed Learning & Development Programme
- Tools and Resources for all Bexley Organisations
- Other SAR published reports
- 7-Minute Briefings
- Other Resources and Links

- Email Bexley SAB at bsab@bexley.gov.uk for any support on embedding this learning.