Philip Safeguarding Adults Review
7- minute briefing

1) **Safeguarding Adults Review (SAR)**

The Safeguarding Adults Review into Philip's death was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in December 2021. Section 44 of the Care Act 2014 requires SABs to undertake a SAR where an adult has i) died or suffered serious harm, ii) it is suspected or known that it was due to abuse or neglect, iii) there is concern that agencies could have worked better to protect the adult from harm.

The SAR relating to Philip raises safeguarding issues regarding the recording and recognition of serious safeguarding concerns, missed opportunities to share information and systems pressures impacting the delivery of services to residents.

2) **Background**

Phillip was found dead in late 2021 having taken his own life whilst living in temporary accommodation. Phillip's children were known to children's social care as 'children in need' in 2021, following disclosures from his wife regarding his emotionally and physically abusive behaviour and alcohol misuse. A children's social worker supported Phillip's wife to evict him from the family home. The following week a family member contacted the children's social worker, complaining about the children being left in his care. During this they raised safeguarding concerns about historic offences. Shortly thereafter, Phillip attempted suicide. Phillip was under the care of East London Foundation Trust where he was admitted informally. He was placed on leave from the ward and placed in B&B accommodation on the basis he would return to the ward for daily support. Phillip subsequently attended the police station to disclose serious historic offences, having initially disclosed this to the children's social worker. The police gave Phillip the opportunity to obtain legal advice before being formally interviewed by them. Phillip was found deceased in his room four days later.

3) **Think Family Approach**

The Think Family approach is the concept that professionals, regardless of whether they are working with children or adults, should be looking at the needs of the whole family. In this case, the children were known to children's services and were well supported by them. Agencies were aware of Phillip's attempts to end his own life and a small number were also aware of allegations of historic offences. Unfortunately this did not trigger a strategy meeting or a referral into adult safeguarding. This was potentially a missed opportunity to risk manage or provide a holistic approach to Phillip's situation. However, it is important to note that Phillip often minimised his mental health and masked any intentions around ending his life.

4) **Raising safeguarding concerns**

When the family member raised concerns about Phillip, specifically that he had assaulted her, a miscommunication meant that these concerns were not acted upon. There appears to have been a lack of sharing of information with police or follow up on the allegations in the form of a complaint or safeguarding referral. This subsequently caused distress to the family member. Whilst this oversight was unintentional, it highlights the importance of ensuring that

any potential safeguarding concerns are reported and acted upon. Furthermore assumptions should not be made with regards to other agencies following up on concerns.

5) System pressures

An overarching theme that was identified in the review was the system pressures that staff working in the health, social and criminal justice sector face. Consequently, the high level of need presenting to services means that professionals are having to balance and manage who is prioritised in terms of support. As a result, some people may fall through the gaps. It is important that there is a shared understanding on the pressures on different systems and the remits of various services, so that professionals can identify how to effectively support residents.

6) Good practice

The review identified a number of positive instances of information sharing and working between agencies. Most notably there were positive and proactive information sharing arrangements between outreach and mental health teams. Phillip was supported to access housing services and there was a collaborative approach in reporting Phillip missing. There are many benefits of multi-agency working and information sharing. This can lead to better support and outcomes for the individual or family as well as an earlier response to safeguarding needs.

7) Recommendations

In total 10 recommendations were made in response to the review:

- Agencies should review complaints procedures to ensure that safeguarding concerns are captured as formal safeguarding referrals.
- There should be formalised procedures for authorising, monitoring and supporting mental health patients who are granted leave during hospital stays.
- Policies should be updated to ensure that the Think Family Approach is incorporated into them.
- Multi-agency meetings should be convened for those with significant vulnerabilities who are placed in temporary accommodation and also in cases where there is significant risk of suicide.