James

James was a 42-year old man who died from cardiac arrest and acute myocardial infarction, that were likely to have resulted from the use of synthetic cannabinoids.

He had a traumatic childhood, which involved spending time in care, in the North West of England. As an adult he moved to Brighton and built a business and bought a flat where he lived with his partner.

In 2010 James suffered a subarachnoid haemorrhage, which led to him suffering an acquired brain injury (ABI). After months in various care settings, and in line with his wishes, he returned home to live independently in his flat with care and support in place.

James' substance misuse dated back to childhood and this continued following his ABI. He could be challenging to work with, with fluctuating levels of engagement and resistance to care and support. Over time the level of this care and support was reduced.

There were ongoing concerns in relation to areas such as substance misuse, anti-social behaviour and exploitation (including cuckooing) but the overall situation began to significantly deteriorate towards the end of 2016.

Despite increased support arrangements the overall situation continued to decline. James continued to use substances, self-neglect, experience exploitation and financial abuse.

James passed away in July 2019 shortly after being admitted to hospital.

Introduction

Safeguarding Adults Reviews are undertaken when an adult in the local authority area with care and support needs either dies, or suffers serious harm, as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a Safeguarding Adults Review is to learn lessons about how professionals and organisations work together and to seek to identify improvement actions.

Learning Briefing

Brighton & Hove SAB Safeguarding Adults Board

A referral was received retrospectively by the Brighton and Hove SAB that was prompted by the Coronial Inquest process. A Safeguarding Adults Review was commissioned to identify learning opportunities in how agencies worked together to support James.

The review focused on James' Acquired Brain Injury and sought to focus on whether there was -

sufficient understanding of this (particularly in relation to mental capacity and decision-making)

the policies, procedures and processes in place at systemic and organisational levels and whether these were followed

whether concerns around exploitation, and cuckooing in particular, were appropriately responded to

understanding and awareness of Safeguarding Adults Reviews processes and pathways

Key Learning Points

1) **Services for people with Acquired Brain Injury to enable them to be safe**

The review identified that the safeguarding system within Brighton & Hove is insufficiently developed to enable people with acquired brain injuries to be safe. Practitioners have insufficient knowledge and understanding of acquired brain injury and there are few specialist services or guidance supporting people who have long-term problems associated with ABI.

This is a national issue and the reviewer states that improving services for people with ABI requires a co-ordinated response across agencies in Health, Social Care, Criminal Justice and the voluntary sector.

2) **Substance misuse services for people with Acquired Brain Injury**

The review noted surprise at the limited involvement from Substance Misuse services as all professionals working with James considered substance misuse the primary issue. Whilst his lack of engagement with services offered was seen as ambivalence towards addressing his drug use an alternative interpretation is that James lacked executive capacity to follow through on previous discussions or behaviour suggesting he did want to cease this.

James wanted to continue living as he had before his ABI and the only way to remove the possibility of drug-related death would have been to place him in a specialist 24-hour care setting, which would have been very difficult. The challenge is to enable existing services to be developed to meet the needs of those with an ABI and substance misuse issues.

3) **Multi-agency working – the role of the lead professional**

The review stated that James would have benefitted from a long-term lead professional who worked with all the provider agencies involved to develop and implement a mutually agreed, coherent care plan with tasks for all that was reviewed and adapted over time and that there was little evidence of this occurring.

The reviewer notes that one individual review cannot provide a full understanding of how services function more widely but the weaknesses in the care planning for James are linked to resource pressures and may reflect wider problems in the system.

4) **Understanding and use of the SAR referral process**

The review has shown that there is limited understanding by frontline staff of the Safeguarding Adults Review (SAR) process. This means that unless there are specific concerns about the nature of a death practitioners are unlikely to make a referral for a SAR.

Over the past year the SAB has undertaken several actions to increase awareness and understanding of Safeguarding Adults Reviews locally. These include the publication of a pan-Sussex SAR Protocol, the development of a BHSAB newsletter (with features on SAR's), a session on reviews at our virtual Safeguarding Conference as well as presentations at a range of forums.

Conclusions

The Independent Reviewer concluded that practitioners did not take sufficient account of James' Acquired Brain Injury (ABI), particularly in relation to assessing capacity, which meant the care provided was ineffective. This was due to a lack of specialist expertise across the system with the procedures and training currently provided considered insufficient as well as substance misuse services felt to need to provide more effective interventions for people with ABI who are also involved in substance misuse.

The Independent Reviewer also concluded that there may be potential issues regarding the functioning of the lead professional role within the adult safeguarding system and that there are limitations in the knowledge and understanding of the SAR process by frontline staff.

The Independent Reviewer made seven recommendations to the Safeguarding Adults Board in relation to the key issues that have been identified. These focus on Health and Social Care commissioners considering how services, processes and specialist guidance pathways can be improved for practitioners working with people with ABI. They also include the Sussex Adult Safeguarding Procedures being updated to ensure there is sufficient reference to ABI and consideration of the effectiveness of the lead professional role.

Questions

Do you feel confident in relation to understanding Mental Capacity?

You can read the full SAR James report here on the BHSAB website and you can become more familiar with the Mental Capacity Act by reading the accompanying Code of Practice here.

How is your understanding in relation to undertaking a multi-agency approach towards adult safeguarding?

A multi-agency importance towards adult safeguarding is crucial. You can read the briefing that was produced by the BHSAB following the audit that was undertaken into multi-agency safeguarding here.

Have you had an opportunity to undertake training recently?

We hope this briefing increases your awareness of some of these issues and contributes to your ongoing professional development. Look out for training opportunities in your own organisations, such as the Mental Capacity Act in Practice briefing through the Brighton and Hove City Council Learning Gateway here.