SAR Craig Learning Briefing

Brighton & Hove SAB Safeguarding Adults Board

Introduction

Safeguarding Adults Reviews (known as SARs) are undertaken when an adult in the local authority area with care and support needs dies or experiences serious harm as a result of abuse and neglect and it is considered agencies could have worked together more effectively. The purpose of Safeguarding Adult Reviews is to learn lessons and identify improvement actions to prevent something similar occurring again in the future.

A SAR referral was received by the Brighton and Hove Safeguarding Adults Board (BHSAB) in respect of a gentleman who is being referred as Craig. The SAR eligibility criteria was felt to be met in this instance with valuable learning opportunities identified in several areas. An Independent Reviewer was commissioned to undertake the review, with a Significant Event Analysis methodology approach used comprising interviews with key professionals involved that was followed by a reflective multi-agency learning event. A review report was then presented to the Board.

Craig

Craig was a 41-year-old white, British man and was a mature student living alone in Brighton. He had a history of mental health issues and had been diagnosed with schizoaffective disorder, depression, and anxiety. He had previously received support from mental health services. Craig was also awaiting an Attention Deficit Hyperactivity Disorder (ADHD) assessment. In addition he had significant physical health issues.

Between 2017 and 2019 Craig was in a relationship in which he experienced domestic abuse. During 2019 his mental health began to deteriorate, with increasing concerns being raised regarding his behaviour. This led to him beginning to receive support from mental health services.

Several safeguarding concerns were raised in relation to Craig's mental health, general wellbeing, substance use, and the state of his home environment. He also had several hospital admissions and was supported by a number of professionals and organisations during this time. However, no safeguarding enquiries were undertaken.

In January 2021 Craig advised mental health services that he was 'stuck in' due to the pandemic as well as due to physical injuries he had recently suffered. He also described generalised anxiety and panic attacks that contributed to him being unable to leave his property.

Craig did not have any further contact with professionals. In March 2021 he did not answer a telephone call and in following-up on this his body was subsequently found by Police at his flat.

Key Learning

Safeguarding Procedures and Pathways

The Independent Reviewer concluded that pathways and screening involved in reporting care needs and safeguarding concerns between statutory partners were not sufficiently clear and robust. There were also gaps in the application of the Care Act around undertaking assessments as well as safeguarding enquiries with missed opportunities to intervene.

Whilst recognising action undertaken since these events took place it is recommended there is assurance processes are clear, with appropriate training programmes, and understanding of protocols already in place. This includes specific focus on the recently reviewed section 75 agreement as well as SCARF's (single combined risk assessment forms).

Section 75 agreements are between health and social care organisations and include the sharing of resources and delegation of tasks. There is a section 75 agreement in place locally between Health and Adult Social Care (HASC) and Sussex Partnership Foundation Trust (SPFT). You can find out more about these here. SCARF's are completed by the Police when they identify concerns in relation to potential care and support needs and then shared with statutory partners.

The BHSAB has recently published an updated version of the pan-Sussex Safeguarding Thresholds Guidance and is updating our Escalation and Resolution Protocol. You can find these Protocols, as well as other pan-Sussex SAB Protocols, here.

Mental Health and Mental Capacity

The Independent Reviewer identified that there was insufficient clinical oversight of Craig's acute mental health needs, the trauma he was experiencing and a real understanding of his lived experiences. There were also assumptions made around his mental capacity and they have recommended assurance is sought that Mental Capacity Act training across partner agencies is at an appropriate level.

They also identified a need for development of a local strategy by health to reduce the waiting time for ADHD assessment and diagnosis, whilst recognising work already undertaken in this area. SPFT undertook an internal review in relation to their work with Craig, which made several recommendations relating to findings in the SAR, with assurance required these have been actioned and are having a positive impact.

The BHSAB have updated the Mental Capacity resources section on our website. This contains guidance in relation to key elements, with specific focus on independent advocacy and Deprivation of Liberty Safeguards (DOLS). There are also links to other resources including external guidance, a toolkit, video, and courses that can all help develop understanding in this area and that you can find here.

A key element of the BHSAB is quality assurance and during 2023 a Self-Assessment and Peer Challenge process will take place to gain assurance around local safeguarding activity. The BHSAB will use this to process to seek assurance from partner agencies in relation to their safeguarding processes that will include training, with a specific focus on mental capacity.

Multi-agency Risk Management

There currently isn't a general multi-agency risk management (MARM) process locally and in the absence of this the Independent Reviewer identified missed opportunities to jointly identify and address escalating risk factors, particularly in the latter months of Craig's life. They recommended the development of a local multi-agency risk management structure that potentially aligns with the MARMs in East and West Sussex.

The development of a local MARM has been recommended in the two most recent reviews published by the BHSAB and there are ongoing discussions as to how to best take this forward.

There are several existing multi-agency processes already in place though that professionals can refer to in specific situations. These include MARAC (Multi-agency Risk Assessment Conferences) in situations where domestic abuse is occurring. You can find out more about MARAC here. There is also MAPPA (Multi-Agency Public Protection Arrangements) in situations where sexual offences have occurred. You can find out more about MAPPA here.

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Good Practice

The Independent Reviewer identified examples of good practice in the review report that it is important to highlight, as well as some of the particular challenges faced during this period.

The examples of good practice included the Lead Practitioner in Mental Health services demonstrating professional autonomy and judgement in continuing to support Craig as he moved across different parts of the service.

They also noted the Police reporting concerns efficiently and having a person-centred and responsive approach, listening to Craig's voice, being sensitive, and seeking to build rapport and trust with him.

The challenges included these events occurring during the pandemic, which reduced face-to-face contact with more contact taking place by telephone. The operational pressure on services led to delays in a number of areas and it was noted there was also reduced staffing and high caseload levels in supporting people with complex mental health needs.

Questions for you to Consider

The Independent Reviewer made seven recommendations in the review report and the BHSAB is working with our partner agencies to develop an Action Plan to take these forward. You can read the full report here.

Below are three questions based on the findings and recommendations that we would ask all professionals to consider in seeking to prevent something similar occurring again in the future.

1) **Do you have a clear understanding of safeguarding processes in your organisation, including how to raise safeguarding concerns, to ensure these are raised in a timely and appropriate manner?**
2) **Does your organisation's training programme include up-to-date training on the Mental Capacity Act and are you clear on your role and responsibilities in assessing mental capacity?**
3) **Are there caseload review processes in place for professionals in your organisation to ensure these are manageable?**