Sam Safeguarding Adult Review (SAR)

Learning Briefing

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Case details

As a child Sam experienced a number of traumas and was accommodated by the Local Authority at the age of 12 years old due to aggression towards his mother. Between the age of 12 and 17 Sam had numerous placements in hospitals, children's residential homes and a residential school including four mental health admissions in his teens.

In 2013 as Sam approached his eighteenth birthday he was discharged from Child and Adolescent Mental Health Services. It was felt that he did not have a 'full mental health disorder', so he was not referred to adult mental health services. An earlier diagnosis of autism had been 'removed' at Sam's request.

Sam's care and support needs were assessed as 'moderate' so he did not meet the eligibility criteria for services for adult social care. However, Sam appeared to have had great difficulty in managing many aspects of everyday life including his own safety and personal relationships. Sam first became involved with the Probation service in June 2015, following his conviction for the offence of Putting People in Fear of Violence. Over the following 2 years Sam's case was discussed at meetings under the Multi-Agency Public Protection Arrangements (MAPPA).

In May 2017 Sam's GP was concerned for his mental health and referred him to the local mental health team. A crisis plan was developed. Clinicians considered the possibility of diagnosing Sam with a personality disorder. In subsequent years Sam was detained under the Mental Health Act 1983 and was also sentenced and imprisoned in February 2018 serving 3 months of a 6-month custodial sentence. Whilst in prison, Sam was accommodated in the health care wing for the duration of his sentence during which time he was placed on suicide watch. Aftercare planning and support (under section 117 of the Mental Health Act 1983) was not adequately utilised and similarly opportunities to provide Sam with advocacy were not taken.

During 2018 Sam's mental health deteriorated further. He reported being bullied by a neighbour who lived above him, which was a major source of stress for him. Sam was identified by the police as a 'high intensity user' of professional agencies, particularly in relation to instances of self-harm, however local services appear to have struggled to plan crisis responses in a co-ordinated way. Sam died in August 2018 (age 22) following an overdose of medication.

Key findings

All organisations who have contributed to this review noted the absence of coordination, of leadership or ownership in Sam's case. This appears compounded by some misunderstanding of others role and responsibility, particularly in terms of which teams and organisations are invited to multiagency discussions, and by an absence of escalation when organisations do not undertake crucial actions. The identification and mitigation of risk was particularly impacted by the lack of a 'lead agency' or collaborative working and risk sharing between organisations.

- **Learning about transitions** - Young people leaving care who have complex mental and emotional health needs must have a person-centred plan informed by the organisations who have and will work with them. Rather than leaving young people and their families to negotiate the complexities of eligibility criteria, the range of different teams in an organisation or the absence of a commissioned service to meet need, we must focus on the person and what support they need to maximise their wellbeing and quality of life. Such holistic plans take time, and they must be informed by the young person (Learning Point 1).
- Whilst a care leaver may not be eligible for adult mental health services, they may be experiencing emotional needs which need a response in order to prevent harm and intensive use of public services (Learning Point 2).
- Any discharge from an MHA section 3 with no agreed discharge plan in place needs timely resolution by the organisations involved once the person is in the community. S117 entitlement should be assessed before the person leaves hospital, but an assessment can still be carried out once they are in the community (Learning Point 3).
- Organisations need an escalation process to use when multiagency arrangements in situations of high risk have broken down. These escalation arrangements need to be timely with clear decision-making pathways. The existing SAB escalation protocol may be suitable for this purpose, but this will need to be made clear within the protocol and with partners (Learning Point 4).
- The evidence from this case indicates that transfer of violent patients to the GP enhanced service is not always timely, well managed and informed by up-to-date information and contact arrangements. These transfers are not frequent, and the GP surgeries involved have taken steps to ask the CCG to clarify the arrangements. Well managed transfers are especially important when GPs are trying to address the health needs of people who mental health services are no longer able to support (Learning Point 5).

- **Learning about Adverse Childhood Experiences (ACEs) -** It is not enough to recognise 'ACEs' in a person's life. We need to understand trauma and re-traumatisation and be confident in using trauma-aware and trauma informed approaches in working with people. These approaches will be supported through the development of professional curiosity in all organisations (Learning Point 6).

- **Learning about legal literacy -** Organisations working with the adult should identify who the carers are in a person's life and the impact that caring responsibilities have on them. This should lead to a referral being made to the local authority (Adult Health and Care) who have a statutory duty to assess carer's needs for support and to advise them or provide support (Learning point 7).
- The statutory right to advocacy is vital, and in cases similar to Sam's can make a real difference in outcomes. Responsible organisations must ensure that there are well understood and used provisions for advocacy, even when a person is away from their local area. Consideration should be given to monitoring the uptake of advocacy by people detained on section (Learning Point 8).
- Organisations need to ensure that all staff are confident and competent in using the provisions of the MCA 2005, in particular those working in Emergency Department settings (Learning Point 9).
- All public authorities have an obligation to uphold Human Rights. This obligation can take many forms, but includes regular review of plans, especially when risk to life is escalating, and understanding what an adult safeguarding concern is, and when to refer to the local authority (Learning Point 10).

- **Learning about barriers to engagement -** Attention should be paid to the effect that the mental health diagnostic process is having on the person and their care and support. The purpose of diagnosis is to determine the most useful treatment approach. The person still needs support whilst this process is on-going (Learning point 11).

- **Learning about family involvement -** Organisations must be aware of the domestic abuse services that exist to support people to reflect on their circumstances and consider how to protect themselves from abuse by a family member (Learning Point 12).

- **Learning about responding to crisis -** It is essential that High Intensity User Plans are developed with the involvement of the person involved who may be able to advise on strategies to reduce risk. Plans should also be made with the collaboration of all organisations involved in order to understand the system around the person and the potential impact of HIU or emergency service deployment plans. Plans must detail who the lead agency is who will review each incident with the person and try to identify triggers to behaviour and what can be done differently in the future. If the person is engaging in harmful behaviours, it is also essential to have a documented regular monitoring and review process to understand the impact of plans and mitigate risk to the person or others (Learning Point 13).

- **Safeguarding and risk management –** Arrangements at the MASH are intended to provide opportunities for early information sharing, analysis and decision making to prevent further harm. Escalating risk from numerous safeguarding concerns and police notifications may need to be identified by the front door team (CART) and thought given as to how escalating risk is identified, particularly when referrals are sent on to locality and care leavers teams (Learning point 14).
- There are a range of arrangements available to enable organisations to collaborate and use collective responsibility to share risk, these need to be understood and confidently used by all organisations, including those who support care leavers. In order for these arrangements to be effective all organisations need to understand and appreciate each other's role and responsibility. Organisations need to commit to attending meetings and to carry out the actions they have agreed (Learning Point 15).

Further reading - useful links for good practice

- Asmussen,K; Fischer, F and McBride, T (2020) **Adverse Childhood Experiences**, what we know, what we don't and what should happen next' Early Intervention Foundation at https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

- **Mental Health Act Code of Practice** (2015) – see chapter 33 in relation to section 117 aftercare at https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

- National Institute for Health and Care Excellence (2020) Organising and planning services for people with a **personality disorder**, Staff training, supervision and support at https://pathways.nice.org.uk/pathways/personality-disorders#content=view-quality-statement%3Aquality-statements-staff-supervision&path=view%3A/pathways/personality-disorders/organising-and-planning-services-for-people-with-a-personality-disorder.xml

- Research in Practice '**Trauma- informed approaches with young people'**. Dartington. At https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Trauma-informed-approaches-with-young-people-Frontline-briefing.pdf