BCSSP – 7 Minute Briefing

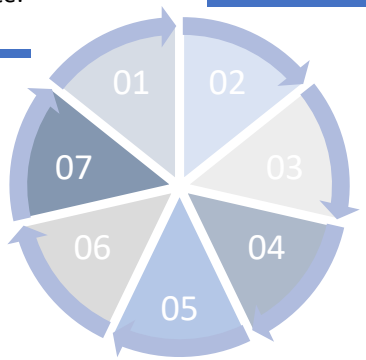
Safeguarding Adult Review (SAR) – Levi Swaby

01. Rationale for a Safeguarding Adult Review (SAR): The BCSSP has a legal duty to review any case it is made aware of where an adult with care and support needs has died, or sustained serious injury, as a result of abuse or neglect (including self-neglect); and there is reasonable cause for concern that partners did not work together effectively to safeguard the individual.

The purpose is to identify lessons learnt so that these can be applied in future safeguarding work. The full report can be found on the BCSSP website: https://bcssp.bathnes.gov.uk/node/112

02. What happened in the case of Levi? Levi died unexpectedly in November 2019 following a cardiac arrest. He was age 36 years old at the time of his death. He left family including his mother, who was involved in his support, and a sister. He also had children with whom contact was variable over the years. He was of Black Caribbean heritage.

Levi had been known to mental health services intermittently since 2007. He had care and support needs arising from his mental health challenges. The Coroner's Report states that the cause of death was accidental overdose, likely triggered by a previously unknown underlying health condition.



03. Learning Point 1: Good Practice

AWP Mental Health Partnership NHS Trust had carried out an extensive internal Patient Safety Review which they shared with the Reviewer, showing a determination to learn from the experience of Levi.

The recent decision by the DWP to include representatives on local SABs meant that the DWP contributed to the SAR and we were informed of the new procedures regarding the management of back payments of benefits to vulnerable adults that might have helped Levi had these procedures been in existence at the time.

04. Learning Point 2: The challenge of delivering services to individuals with long term, chronic mental health problems when there are always more pressing, "urgent" needs or crises means that there need to be mechanisms to stand back, review, and reflect on what is really going on, and to construct strategies for recovery. These procedures include how the CPA framework (or its replacement) is applied, how information is transferred between practitioners, the approach taken in team meetings and supervision, and how services are organised to ensure that individuals with the appropriate professional backgrounds are involved in an individual's care.

The care and support that Levi received was dominated by his periodic relapses, probably caused by a combination of non-compliance with his prescribed medication and his drug taking.

The learning is about how these patterns or cycles are brought into the conversations about patients and service users, how risk is assessed, how care and support it planned and provided.

05. Learning Point 3: Assessing mental capacity is one of the most complex areas of work for practitioners. Whilst there is a growing literature about **mental capacity and impairment through the excessive use of alcohol there is to date little written about impairment through the misuse of substances.** However, this does not mean that the Mental Capacity Act cannot and should not be used to help individuals who misuse substances. Recommended reading: How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales Professor Michael Preston-Shoot and Mike Ward ***Safeguarding-guide-final-August-2021.pdf***

06. Learning Point 4: Action to take to address the learning

- AWP and the Council (ASC) to review professional practice and support of individuals with long term chronic mental health problems
- BCSSP to renew training across the Partnership on self-neglect, and on mental capacity and executive functioning for those who misuse substances.
- Mental Health Services re-invigorate training on culture and race in mental health, and on working with families and carers in the light of this Review
- BCSSP develop a policy on Cuckooing
- DWP hold a workshop to update practitioners on the support that is available for vulnerable adults to safeguard them.

07. Learning Point 5: Changing Practice

- Practitioners and supervisors: think "what is really going on here": the extent in daily practice you think about patterns and cycles. How often you stop, look back, and reflect?
- Take the time to attend training and update your practice
- Take back into your agencies the work needed to deepen understanding of mental capacity in the context of self-neglect and misuse of substances
- Make use of the Safeguarding Adults Multi-Agency Policy