Swindon
Safeguarding
Partnership

SAR Brian

January 2023

How to use this document

The aim of this document is to outline the key themes and learning from SAR Alison. Please share this resource widely. It can be used in conjunction with the SSP Action Plan Proforma

There are also hyperlinks to external resources such as websites which can be accessed by either ctrl+click on the image/icon or hyperlink. Alternatively you can use your mouse to right click and select open link from the options. If you are unable to open a hyperlink please copy the information and paste into your usual internet search engine e.g. Google or Bing.

- Brian was a 43-year-old white British man who had mental health needs and a history of drug use. He lived alone in a flat, where he died in a fire in February 2021.
- From July 2020 until his death, Brian was in contact with several agencies including the police, the ambulance service, mental and physical health services, and specialist drug services in response to self-neglect and drug dependency. Agencies struggled to engage with Brian who spent periods of time away from his flat, staying in hotels.
- In November 2021 a SAR was undertaken following Brian's death and key areas for learning were identified.
- This practice brief sets out these key areas for learning. These areas will be incorporated into the SSP strategic plan and the Learning and Development offer, the outcomes of which will be monitored to ensure they are consistent with the learning to improve frontline practice.

SAR Brian

Trauma Informed Practice

Trauma-Informed Practice is a strengths-based approach, which seeks to understand and respond to the impact of trauma on people's lives. The approach emphasises physical, psychological, and emotional safety for everyone and aims to empower individuals to re-establish control of their lives.

Trauma is common across the entire population, but evidence shows there is an increased likelihood that people using alcohol/drugs have experienced trauma and adversity. If your role or service supports people using alcohol/drugs, realising the increased likelihood of traumatic experiences for the people you support opens up greater opportunities for delivering trauma-informed care and support

NHS Education for Scotland has produced guidance on this theme can be accessed here

Substance dependency and mental capacity

The Mental Capacity Act 2005 (MCA) allows decisions to be made or actions to be taken on behalf of people who are unable to make decisions for themselves, perhaps because of a drug, alcohol or substance addiction or intoxication.

ASD and mental capacity

The impact of autism should be considered when assessing under the Mental Capacity Act 2005 or the Mental Health Act 2007. For example, someone with autism may have good theoretical knowledge about an issue and appear to have capacity, but in fact are not able to retain or weigh up the information. SCIE have produced guidance "Autism: Improving access to social care for Adult's including assessment which can be found here

Stoke and Staffordshire "Andrew" SAR and similarities to this review

Key themes from this review included:

Multi agency approach – communication but not joined up action

Understanding impact of substance dependency on assessing capacity including impact of trauma and life Events.

Lack of escalation processes of concerns and use of legal powers to support adult to make some positive changes such as Environmental Health due to hoarding

Listen to audio overview here

Multi Agency Working

The evidence base for best practice in working with adults highlights the importance of interagency communication and collaboration, coordinated by a lead agency and key worker who oversees this work. A comprehensive approach to information sharing is important to ensure each agency/service has a holistic view of what is happening with an individual.
It is recommended that multi-agency meetings are used to pool information as well as risk and mental capacity assessments, to agree a risk management plan and to consider legal options

Alcohol Change UK 2019 report

This report identifies some common characteristics among the adults whose deaths resulted in the SARs and considers how their alcohol misuse was perceived by the practitioners who were working with them. It reveals the extent to which alcohol is a contributory factor in a number of tragic incidents and highlights some key themes that can inform improved future practice, such as better multiagency working, stronger risk assessments, and improved understanding and training for practitioners to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. It also considers these cases in the context of the law and discusses how practitioners could better apply the relevant legislation to similar situations, as well as how the current guidance could better address the issue of alcohol-related self-neglect.

Learning from Tragedies - An analysis of alcohol-related deaths

Swindon Safeguarding Partnership

Resources for Professionals

SSP training page

Mental Capacity Learning Resource

Professional Curiosity