Learning from OSAB SARs: Jason

Background

A Safeguarding Adult Review (SAR) is a multi-agency process that considers whether serious harm experienced by an adult at risk of abuse or neglect, could have been predicted or prevented. The purpose of the SAR is to promote learning and improvement action to prevent future deaths or serious harm occurring again. It was a unanimous decision of the Oldham Safeguarding Adults Board (OSAB) SAR Subgroup that the criteria for a SAR were met in relation to 'Jason'. The SAR Overview Report is available online. Jason had no contact with his father. From age 3, he was seen by a child psychiatrist due to having developed fire setting behaviours. Records show that Jason was not brought to all his hospital appointments and started school with a degree of learning difficulties. When he was 7, his mother asked the Local Authority to accommodate him as she was struggling to cope; she sadly took her own life when Jason was 9. He spent time living with two different family members, in a foster placement and a short-term respite placement. By age 16, he was reported to be stealing, drinking, driving cars and using cannabis. He went on to become homeless and addicted to class A drugs.

Adulthood

Jason was the victim and perpetrator of crime. He received treatment for substance misuse either side of a custodial sentence. Following release, Jason's engagement with the substance misuse service was poor, he spent time begging and was supported by services into temporary accommodation. He reported frequent accidental overdoses, and experiencing anxiety and depression. Jason was known to be the victim of domestic abuse; most occasions were linked to male family members. He attended A&E 27 times during the review period, requiring treatment for overdoses, assaults, and ongoing infections to a knee injury. Jason was seen by a mental health practitioner due to expressing suicidal thoughts. He did not require assessment under the Mental Health Act. Jason was arrested for possession of a weapon, was found drowsy in a cell and taken to A&E for treatment for a probable overdose. Concealed drugs were found inside his body. Following self discharge he returned to his rented accommodation and was last seen on CCTV talking to another resident. He was found deceased in his flat two days later. He was only 45 when he died.

Bagging

Jason attended A&E on one occasion following being stabbed in the buttocks, a practice known as 'bagging'. This is when a person gets stabbed in the rectum and often leads to the victim having to use colostomy bags for the rest of their life. It is thought this is a form of humiliation. It is a technique being used more often by Organised Crime Groups (OCGs). These injuries are often treated in A&E departments but do not always go on to be reported to police due to fear and intimidation. When Jason received his bagging injury this was an opportunity for practitioners to explore what Jason may have been victim to.

Exploitation

'Cuckooing' is a form of exploitation. It is the term used when an individual or a criminal gang target the home of a vulnerable person for criminal purposes such as drug-dealing, hiding weapons and other criminal activities. There was a missed opportunity for potential cuckooing and financial abuse in respect of theft of Jason's money to be considered before a decision was made to close a safeguarding referral. Jason disclosed to a mental health worker that he had been 'cuckooed' and that police and housing were aware. An opportunity to further explore what was being done about this was missed, good practice would have been to explore a potential safeguarding referral. Jason presented as homeless after experiencing several forms of harassment and abuse at his property from family members and unknown others. Agencies could have considered Jason's ability to manage his own 'front door'. OSAB 'Cuckooing' Guidance makes the link between anti-social behaviour and what this might be an indication of in the wider context. Advice is given about whether this should be reported as a crime.

Self-Neglect

There was a recurring theme in agency records that Jason was self-neglecting and prioritising his substance misuse over his physical and mental health. He frequently missed appointments or was not available over the telephone for consultations which were intended to support his health and wellbeing. The general view by practitioners appeared to be that when not under the influence of drugs Jason did have the mental capacity to understand the risks he was putting himself at, importantly in relation to his physical health, which was significantly poor for the period of the review. He was felt to have the capacity to make an 'unwise decision' in line with the Mental Capacity Act (MCA) 2005. The GP concluded that Jason had capacity however it is not clear which decision he was being assessed against. It is presumed that it was around accessing healthcare but there is no documentation to support this. Opportunities to see Jason in person and assess him holistically were limited due to Covid-19 restrictions and may have reduced the ability of practitioners to appreciate the ongoing state of his self-neglect.

Multi-Agency Risk Management & Record Keeping

A number of the agencies involved in the review reflected that practitioners in their teams did not always escalate the ongoing concerns both within their own agencies or with partners outside their own agency, or if they had this was not able to be evidenced due to poor record keeping. The first reference to a multi-agency risk management meeting was made as a recommendation from the Multi-Agency Safeguarding Hub (MASH) team when a safeguarding referral was closed. The social worker attempted to hold a safeguarding strategy discussion over the telephone although there were no minutes available. A further three meetings were undertaken but no minutes were available. It was also identified that there was a lack of the multi-agency risk assessment being reviewed regularly. Poor record keeping was found to be a contributory factor and did not provide evidence of what was happening to support Jason and mitigate risk where possible. It is essential that robust and appropriate information sharing takes place across agencies and information is added to agency records contemporaneously whenever possible. In Oldham, the Tiered Risk Assessment and Management (TRAM) Protocol has been developed to support practitioners working with adults deemed to have capacity to make their own decisions, but who are at risk of serious harm or death.

OSAB Guidance

The SAR encouraged partner agencies to raise awareness of key OSAB guidance documents produced to support practitioners working with complex cases, including Professional Curiosity Guidance, Cuckooing Guidance, the Practical Guide to Mental Capacity, Guidance Where the Individual or Family are Not Engaging with Services, Trauma Informed Practice Guidance and the Self-Neglect Toolkit. In recognition of the learning from this SAR and other areas of safeguarding work, OSAB offer multi-agency training covering many of these key topics. Find the latest dates available and book your places via eLearning and Training on the OSAB website.

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