

## 2. What happened in the case of GRANT?

Grant was a British Asian Male who was in his forties who sadly took his own life. At the time of his death in June 2020. Grant had been diagnosed with Depression, anxiety, Emotional unstable personality disorder, mental and behavioural disorder due to stimulant abuse, drug induced psychosis paranoid schizophrenia. He was prescribed medications which included Atorvastatin, Clozapine, Folic acid, Omeprazole and Propranolol. He was also believed to have been self-medicating obtaining medication from on-line internet suppliers at the time of his death. At the time of his death Grant had recently returned to his supported living placement following a period of time spent living at the family home address with his mother and father. In the years prior to his death, he was well known to mental health services, had been detained on several occasions under the Mental Health Act (1983) and had spent some time in One of Her Majesty's Prisons.



### 3. Specific issues

#### to be reviewed:

What additional learning can be found using the National Thematic SAR Report, October 2020. [SAR-Mrs BA](#) and [SAR-Sahara](#) cases to be cross-referenced and linking where actions/learning cross. Grant moved to new living spaces in March 2020, lockdown, living with parents; impact and measures due to Covid.

### 4. Involvement of Family and significant others:

The family of Grant were contacted and were made aware of the SAR. They were invited to be involved in the review but declined, making thanks for the contact.



## 1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to GRANT could learn lessons and improve practice. Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight. The overall aim of a SAR is to improve services because of that learning. What do you do? Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR

The full report can be found here –

<https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-GRANT.pdf>

## 6. SAR Assurances & LA Oversight:

BSAB to seek updates from partners regarding the embedding of this learning through the BSAB SAR Sub Group.

## 5. Findings:

It is noted from a number of reports that many organisations involved in this review have already indicated their own internal learning which includes: -

- Refresher risk assessment training and management skills for individuals presenting with risk behaviours to themselves and others,
- Care planning and reviewing of Crisis and Contingency plans,
- Review of staffing in teams where there are large amounts of team sickness
- Record keeping and completion of discharge papers and plans
- Reminders to partners for discharge summaries to be received in a timely manner and notification to the Safeguarding Board

