Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR- Mrs BA

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 Mrs BA 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.

2. What happened?

Mrs BA had been receiving secondary mental health services, for over ten years, since first becoming unwell in 2006. Mrs BA had three children, two of whom who lived at home with her and her husband, they had been the subject of input from Children's Services until shortly before her death. Bexley Safeguarding Adults Board involved key agencies across the partnership so that a Safeguarding Adults Review would seek to learn lessons as to how Mrs BA took her own life whilst services were involved with her and her family.

3. Findings: 1-2 –

I. Concerns regarding a new mother's poor mental health and potential risks to her new born child should be carefully considered with all viable options explored to keep the family together. Where alternative arrangements are made, due to assessed risks to the child, a parent's rights to independent legal advice must be upheld and the child's father Included in any parenting assessments.

II. Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would be responsible for the S42 Enquiry.

4. Findings 3-4 -

III. Lack of availability of local psychiatric inpatient services due to patient flow can be associated with problems caring for people in mental health crisis both in the community and in hospital, with increased risks to them and their families. This puts pressure on local community mental health services to try to manage admissions when there is a clinical need and on the inpatient services to discharge people too quickly. The use of out of area private psychiatric hospitals may ultimately adversely affect the handover of care when patients are discharged back to local community mental health services.

IV. The immigration status of people being deemed unable to remain lawfully in the UK with No Recourse to Public Funds requires complex decisions including appeals to the Home Office. For people who in addition also have mental health problems, this process can be difficult and stressful, with an increased risk to both their mental health and subsequently their safety.

5. Findings 5-6 –

V. The assessment and management of the risk of suicide for people with mental health problems in community mental health services needs to include a structured model incorporating social and psychological stress factors, enabling information sharing by all health and social care professionals, involving families where appropriate. This should include a pathway to access to emergency hospital admissions where people are identified as both experiences mental illness and at high risk of suicide following this assessment.

VI. The use of a standardised and corporate debt recovery process, including automated letters threatening legal action, is not always appropriate. Sending letters to residents with serious mental health problems may cause them harm, including potentially increasing the risk of suicide amongst this group. Interdepartmental systems need to take account of the vulnerability of residents prior to formal debt recovery processes being implemented.

6. Questions to consider:

Where is the full report and action plan? Published here: http://www.safeguardingadultsinbexley.com/wp-content/uploads/Mrs-BA-SAR-FULL-REPORT-FINAL-9v6.pdf

Where do I go if I have more Questions?

Contact - BSAB@bexley.gov.uk

7. What to 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.

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