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**Safeguarding Adults Review - ‘Jonah’**



***What is a Safeguarding Adults Review?*** A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

**(*1)*** *A SAB* ***must*** *arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*

***(a)*** *there is* ***reasonable cause*** *for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***And***

***(b)*** *condition 1* ***or*** *2 is met (see below)*

***(2)******Condition 1******is met if: -***

***(a)*** *the adult has died,* ***and (b)*** *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

***(3)******Condition 2 is met if: -***

***(a)*** *the adult is still alive,* ***and (b)*** *the SAB knows or suspects that the adult has experienced serious abuse or neglect*

*SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.*

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Description automatically generatedAbout this briefing –*** A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of Jonah. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners. Please take time to reflect on the findings and consider how you can learn, develop and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

***A picture containing logo

Description automatically generatedCare and support needs are identified in the Care Act 2014 as the following -***

***Jonah had a diagnosed mental illness –*** *Jonah was in contact with mental health services and had been diagnosed with drug induced psychosis in June 2016 and then with a chronic psychotic illness on 30th August 2021 and struggled until taking his own life in September 2022 following an increase in psychotic episodes. Jonah struggled with audible hallucinations and voices telling him to take his own life. At the time of this incident Jonah as well as Jonah’s family were known by several agencies and were all seeking help.*

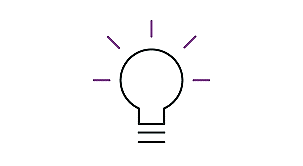
***And* Jonah had 2 care and support unidentified needs: -**

1. *Jonah was unable to maintain personal relationships in a way that contributed to his well-being. Jonah had domestically abusive altercations with both his biological brother and his ex-girlfriend, which contributed towards numerous psychotic events.*
2. *Jonah was unable to make use of services when offered them. Jonah would ring 999 or attend A&E departments when in crisis but would leave before being seen and not attend follow-up appointments. Including to the point where Jonah’s father had to step in and ask for help numerous times. This formed a pattern of behaviours that did not contribute towards his well-being.*

***And Jonah could not protect herself from abuse and harm, including, self-harm.***

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***About the review process –***

BSAB is resolved to consider how reviews can be more effective in terms of balancing the

time that agencies are involved in such reviews, timeliness of reviews and learning.

outcomes that can improve the service provided as partners. The methodology used was

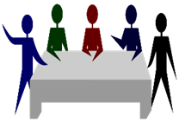
analysis of how agencies worked with Jonah as well as with each other. The way the BSAB captured this

information was through a Chronology of involvement and Individual Management Review from each agency

to form a Joint Chronology of which agency knew what when in relation to Jonah. Jonah was known across

Bexley as well as Kent and Medway SAB areas. They worked together to produce the Report with a Bexley

SAB Commissioned Independent Reviewer who led and wrote the full report.

***Summary of Jonah –*** Jonah was a fibreglass laminator and had built underground fuel storage containers in Malta and carbon fibre seats in high-end sports cars in the Czech Republic. He enjoyed fishing and motorbikes and was brought up as a Christian within the Church of England. Jonah’s father described him as, ‘***very tidy and orderly and as a kindly soul who was always looking out for other people’.*** Jonah’s parents divorced when he was 25 years old, and he lived first with his father in Bexley and then with his mother in Kent. Jonah then bought and moved to his own house in Bexley. Jonah has a brother who lived in Essex and with whom he stayed on at least one occasion during the period covered by this safeguarding adult review. Jonah was 35 years old when he took his own life by hanging in his back garden. There were a number of events that lead to Jonah to take his own life which the full report explores in detail.

Jonah’s use of alcohol and illicit drugs (crystal methamphetamine and cocaine) appears to have caused or exacerbated his mental health needs including intrusive and oppressive thoughts. Jonah may also have used substances as a form of “self-medication” to manage these phenomena. Jonah had attempted suicide on at least one occasion before his death and Jonah came into intermittent contact with physical and mental health services, and the police.

Jonah’s distress increased in August 2021 due to an exacerbation of negative and condemnatory thoughts, he also notified his mother of how he might kill himself. Jonah’s risk to himself was, however, considered by professionals to be low. Jonah was diagnosed with psychosis in August 2021 and prescribed anti-psychotic medication.

Although Jonah was known to services, the review highlighted inconsistencies in approach across the London and SE England regions. For example, Metropolitan Police Service systems do not communicate with Kent Police systems (vice-versa) unless escalated to the National Recording System. The systems issue is also true of NHS Trusts, GP Surgeries and Local Authorities. The lack of information sharing is a key feature in this SAR, as well as, in other SARs Nationally.

**Jonah’s Father reported,** ‘*It is unclear if Jonah started taking illicit drugs due to conflicting thoughts about his sexuality. What is clear, form my observations as his father, is that before Jonah started taking methamphetamines, he was a well-balanced individual; he was rational and peaceful in himself. Jonah was in a heterosexual relationship with his long-term girlfriend from 2009-2014. The relationship began to breakdown from 2012 and finally came to an end in 2014. Since the relationship ended Jonah’s mental health deteriorated due to the misuse of crystal-meths which caused psychotic episodes, paranoia, and confused thinking. For example, Jonah believed that his mind had been hacked like a computer. He was tormented with troubling voices, thoughts, and suggestions of action contrary to his personality. Fearing these voices would make him do something bad or damaging, Jonah took his own life.*’

The review also highlighted the impact of the pandemic on Jonah’s inability to access the right services at the right time and is detailed in the full report.

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| **LEARNING POINT:** Men are also the victims of abuse and of sexual assaults. Do not assume that harm is an acceptable consequence of engaging in what might appear to be high risk activities. Think about how you would respond if they were a woman who had been assaulted in a similar situation and whether your response should be any different just because they are a man. |

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| **LEARNING POINT:** Asking questions about someone’s sexual encounters and sexuality can be uncomfortable, but it essential when they are coming to harm. It is important to recognise that you may have unconscious biases that affect your understanding of someone’s situation and the extent of their responsibility for, or ability to protect themselves in, it. This can especially be the case if drugs or alcohol are involved. |

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| **LEARNING POINT:** Ask questions about domestic abuse, do not wait for someone to disclose it to you. Ask questions routinely, especially where there are warning signs including, injury, anxiety, depression, self-harm, chronic pain, requests for emergency contraception or sexually transmitted disease tests. |

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| **LEARNING POINT:** Remember that name, address, and date of birth have to be included in Merlin reports for a search or entry on the Rio mental health database to be made. If all of this information is not provided, then Rio records cannot be accessed or created. The consequence is that vital information may not be shared or available to protect people’s lives. |

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**Recommendation 1:** The BSAB and KMSAB should measure through the Self-assessment framework that organisations have clear processes in place for working with individuals who are demonstrating suicidal behaviour. The evidence for this includes training, awareness raising, risk assessments, suicide safety plans etc.

**Recommendation 2:** The BSAB and KMSAB should seek assurance from board members that risk assessments involving suicide are clinician led and based upon at least a core set of evidence-based questions.

**Recommendation 3:** Support, rape kits and assistance with reporting incidents to the police should be offered for men and for women who attend A&E reporting about sexual encounters involving the use of drugs. This could include the offer of HIV tests and anti-HIV medication, referral to a sexual health clinic and the offer of contact with an Individual Sexual Violence Advocate.

**Recommendation 4:** The BSAB and KMSAB should seek assurance that guidance is provided to professionals on avoiding the assumption of lifestyle choices as an explanation for engaging in harmful behaviours. Support and guidance should be provided for professionals who feel uncomfortable about, and are uncertain how to respond to, concerns related to sexuality and consent.

**Recommendation 5**: The BSAB and KMSAB should seek assurance that training and awareness raising interventions are used by health and social care services to support professionals to recognise and compensate for unconscious and cultural biases when working with people who engage in drug enabled high risk sexual activities. Specialist training in recreational drug use (including Crystal Methamphetamine and Ketamine) should be included in this.

**Recommendation 6:** KMPT should ensure that processes are in place to prevent paper-based duty systems from missing cases.

**Recommendation 7**: The BSAB and KMSAB should seek assurance from board members that the Department of Health, 2014’s “*Information sharing and suicide prevention consensus statement*” is understood by practitioners who may work with people who are at risk of self-harm or suicide.

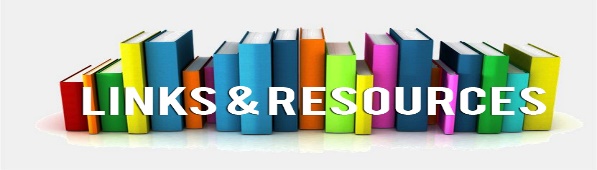
**Recommendation** **8**: The BSAB and KMSAB should seek assurance from board members that “Think Family” approaches are being used to engage with family members.

**Recommendation** **9**: The BSAB and KMSAB should lead an audit of the use of multi-agency information sharing protocols to determine whether or not they promote effective joint working, cooperation, sharing information and prevention when working with people at risk of suicide and to the extent to which they include voluntary and community organisations and families.

**Recommendation 10:** The BSAB should seek assurance from the Metropolitan Police Southeast BCU that name, address, and date of birth will be included in all Merlin reports so that adults coming to notice can be correctly identified in, or their details recorded on, client information systems such as Rio.

***Questions for you to consider -***

1. Do you know what Suicide Prevention Services are available in your area?
2. How familiar are you with training, awareness raising, risk assessments, suicide safety plans?
3. Did you know Bexley has a ‘Joint Think Family Protocol’?
4. Do you see Self-Neglect as an unwise decision instead of a category of abuse as listed in the Care Act 2014?
5. ******How much do you know about Safeguarding Adults and Escalation processes? New Domestic Abuse Bill 2021 duties?
6. How accessible are your services for someone to speak with staff about their care and support needs especially when struggling with psychosis?
7. What risk management procedures are in place to support in ensuring risk assessments are of a sufficiently high standard and include feedback from key agencies and significant others in the person’s life?
8. How does your agency engage with MARAC and other high-risk panels?
9. Anything else to ensure you and your organisation understand Safeguarding is ‘everyone’s responsibility’.

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[SAR-Jonah Full Report](https://lbbexley.sharepoint.com/sites/lgi-adcare-sguard/ASSABOA-AS8.8/Safeguarding%20Adults%20Board/SUB%20GROUPS/SAFEGUARDING%20ADULT%20REVIEW/ACTIVE%20SAR'S/PUBLISHED%20SARs/SAR%20RM%20JONAH/FINAL/www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-JONAH-Final-Report-13-June-2023.pdf)

* Bexley Safeguarding Adults Board website –<http://www.safeguardingadultsinbexley.com>
  + The website holds an annual [SAR Themed Learning & Development Programme](chrome-extension://efaidnbhttps:/www.safeguardingadultsinbexley.com/wp-content/uploads/2023-24-BSAB-Learning-Development-Programme-1.pdf)
  + Tools and Resources for all Bexley Organisations
  + Other SAR published reports
  + 7-Minute Briefings
  + Other Resources and Links
* Email Bexley SAB at [bsab@bexley.gov.uk](mailto:bsab@bexley.gov.uk) for any support on embedding this learning

If you or someone you know is struggling with suicidal thoughts or attempts, please contact: -

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