

Camden Safeguarding Adults Partnership Board

7 minute briefing Re: Mark Safeguarding Adults Review (SAR)



1. Rational for Safeguarding Adults Review

Mark was 24 years old when he was found dead by his uncle in the stairway of the flats in which he lived on 7th May 2020. Mark had stabbed himself in the throat with a pair of scissors. Mark had a history of contact with the police and a childhood of physical and sexual abuse and neglect. These highly traumatic childhood experiences continued to affect Mark who self-harmed, experienced violence as a young adult from gangs, peers and his family and used drugs. Mark had been in intermittent contact with children's service since he was 8 years old and remained in intermittent contact with general practice and mental health services for the rest of his life. During the last three months of his life, Mark does not appear to have been in contact with any services or agencies.

3. Engagement with services...family...

Little is known about Mark's interests, ambitions and his likes and dislikes. Contact with his family was attempted during the process of this review but was unsuccessful and professional records focused on their work with him and the difficulties he faced.

5. Learning Point

Risk management plans require frequent contact with clients so try to maintain their engagement with you. If you are struggling to keep someone engaged, consider other approaches. How can you increase their trust in you and the service you offer? How can you be more flexible? How can you adapt the way you work to make your service more accessible? How can you be more assertive in maintaining contact? Before you close someone to your service because they have not engaged, assess what the risks of doing so are, identify who should you notify and refer on to if before you close your contact?

2. What happened?

The risk of Mark's suicide was not fully understood, and no appropriate risk management plan was created

There was a lack of involvement with Mark's family or friends by services to support Mark

Although several different agencies worked with Mark, there was little inter-agency coordination and opportunities for joint working were not always taken

4. Learning Point

Predicting and preventing suicide is difficult but there can be factors in a person's life which increase the risk of suicide, including life trauma, problems engaging with services, emotional instability, impulsivity and self-harm and previous suicide attempts. Always consider and exploration of these factors to form a clearer picture and consider them in risk assessments. History taking, spotting patterns and identifying escalation are essential activities in managing risks.

6. Learning Point

If you are concerned that someone might attempt suicide or seriously harm themselves, then consider who you should contact, including the person's family members. Do not be restrained by fears of breaking client confidentiality. The *"Information sharing and suicide prevention consensus statement"* (Department of Health, 2014) sets out the circumstances in which concerns about suicide can and should be shared even in situations where permission to do so has not been given by the person at risk.

7. Learning Point

Adult safeguarding enquiries can provide an opportunity to reconsider the extent to which current interventions and approaches are effective. Just because other agencies are involved does not mean that an adult safeguarding meeting should not be used to bring them together to review progress, assess risk and to agree if other approaches should be tried.