Multi-Agency Reflective Review Learning Brief – 'Sam'

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BLACKPOOL SAFEGUARDING ADULTS BOARD

Background

Sam was a vulnerable adult supported by multi-agency services due to complex vulnerabilities and multiple disadvantage. Sam was tragically murdered in 2023. Sam was homeless and had spent much of their adult life in the hostel system. At the time of their death they were street homeless and had been staying with an acquaintance who was charged with their murder.

Sam experienced multiple exclusion homelessness including domestic abuse, substance and alcohol misuse, learning difficulties, and mental health difficulties. Sam would self-neglect and had been assessed as lacking capacity under the Mental Capacity Act, relating specifically to decisions around accommodation, and care and support needs. Sam was described as being vulnerable to exploitation and abuse from others and sought relationships with their peer group.

In the years prior to their death, Sam had been assessed as having Care Act eligible needs. Due to their complex needs, and systemic boundaries, it was not possible to meet all of their identified needs. However, Sam valued the therapeutic relationships they had developed with the professionals who supported them.

A referral for a Safeguarding Adult Review (SAR) was submitted following a Post Incident Review undertaken by Adult Social Care. The SAR consideration panel agreed that the circumstances did not meet criteria for a full review, due to clear multi-agency working to provide *"exemplary care to the individual, adapting as much as possible to meet their needs"*, this was deemed to have been done in a trauma informed way, working as flexibly as possible within statutory, organisational and partnership boundaries.

Whilst the SAR criteria was not met, the panel agreed that there would be benefit in undertaking a Multi-agency Reflective Review to explore potential learning and impact on practice, in the event of similar or identical incidents occurring in the future.

What have we learned?

The multi-disciplinary approach to support Sam has been recognised as good practice, with all agencies working to provide support. Sam was discussed regularly at multi-agency Risk Management Group meetings to ensure risks were managed and appropriate support was in place. There were also referrals to MARRAC and regular multi-agency meetings.

Sam was supported by a homelessness social worker and support worker, alongside the lived experience team in attempts to meet their most basic needs and improve wellbeing.

Sam had accessed a residential detox however left within 24 hours and returned to Blackpool. Additional attempts were made to secure detox placements but despite efforts, this was not achieved in a timely manner. This has been identified as a potential gap in resource to allow for accommodation and care which safely manages necessary alcohol consumption during the process.

There was an occasion where Sam had a brief inpatient hospital stay during which they could have detoxed, however Sam discharged themselves and began drinking. The MARR panel recognised this as a missed opportunity to identify suitable arrangements to support Sam to continue detox in the community.

There were multiple occasions where Sam attended A&E due to intoxication; however, Sam often left before being assessed. Due to the number of incidents like this, the panel agreed that professional curiosity should have been exercised to further explore Sam's needs and potential support available.

Sam had lived in the hostel environment for three years, with multiple challenges around anti-social behaviours. The hostels worked extremely hard to manage behaviours and overcome challenges to keep Sam in safe accommodation, however in the weeks prior to their death Sam was evicted due to extreme anti-social behaviour.

Members of the multi-disciplinary team worked hard to maintain regular contact whilst Sam was homeless, including visits to places they were known to frequent. During this time professionals worked together to secure a placement at a specialist detox facility and secured a placement in a nursing home where care needs could be safely met for when the detox programme ended. Sadly, Sam died days before the detox was due to begin.

What do I need to consider?

If you are supporting an individual with similar circumstances outlined in this briefing, you should consider the following:

→ Guidance for Safeguarding Concerns – guidance and thresholds matrix to support you in responding to safeguarding needs.

→ Changing Futures Programme – supporting people experiencing multiple disadvantages.

→ Risk Management Group – multi-agency approach to safeguard the public, problem solve and reduce risk to those with multiple disadvantages.

→ Mental Capacity Act and impaired executive function.

Ask yourself…

→ Would a s42. Enquiry provide additional support to the individual you are working with? Do you need to consider raising a safeguarding concern?

→ Would a referral to the Risk Management Group help you support the individual you are working with?

→ Is the person you are working with eligible for support via the Changing Futures programme?

→ Does the person you are supporting have capacity? Is their executive function impaired?

→ Are you being professionally curious? Look, Listen, Act, Clarify.

→ Do you need to share information with any other agencies to ensure the individual is safe?

Keep in touch

- For queries or feedback, please contact the Blackpool Safeguarding Partnership's Business Unit: BSAB@blackpool.gov.uk
- Visit the Blackpool Safeguarding Partnerships website for training, information and resources.