July 2023

JAMES, 2023

LEARNING FROM SARs

www.northlincssab.co.uk

BACKGROUND:

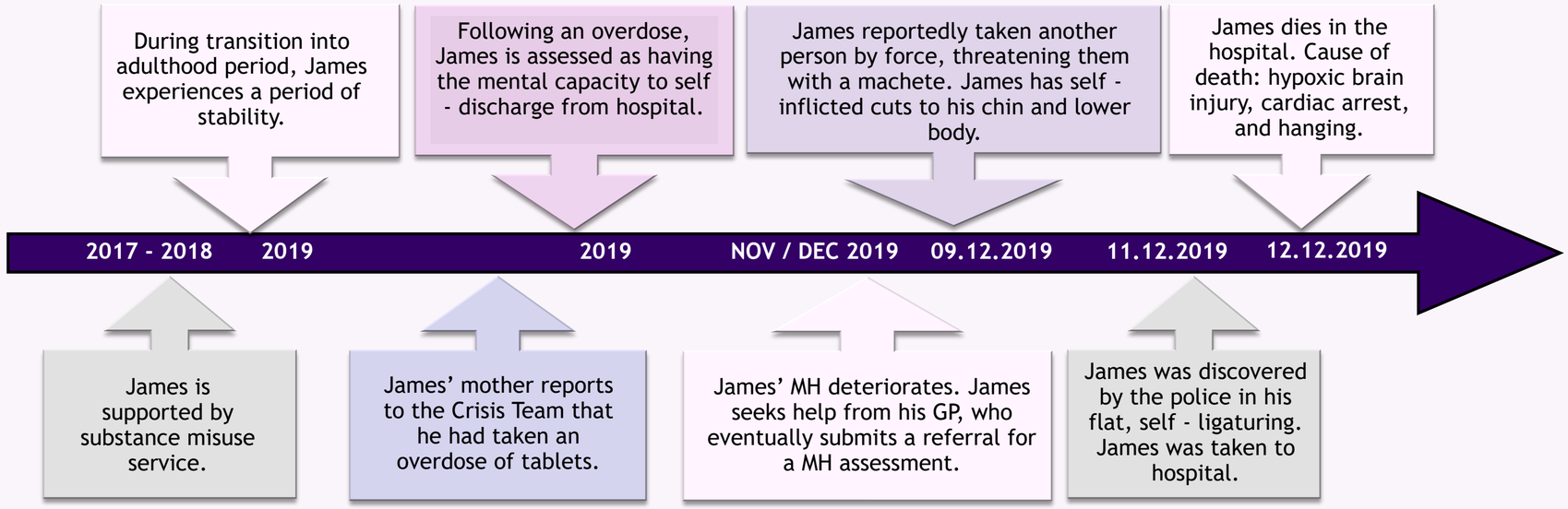
James was 18 - years - old at the time of his death. He lived with his mother, although they had drifted apart, and James spent most of his time with his teenage friends.

James was a vulnerable young person who had support needs in areas of mental health, self - harm, offending behaviour, and substance misuse.

James was supported by several agencies, and professionals described him as funny, likeable, and a kind young man.

James committed suicide by hanging.

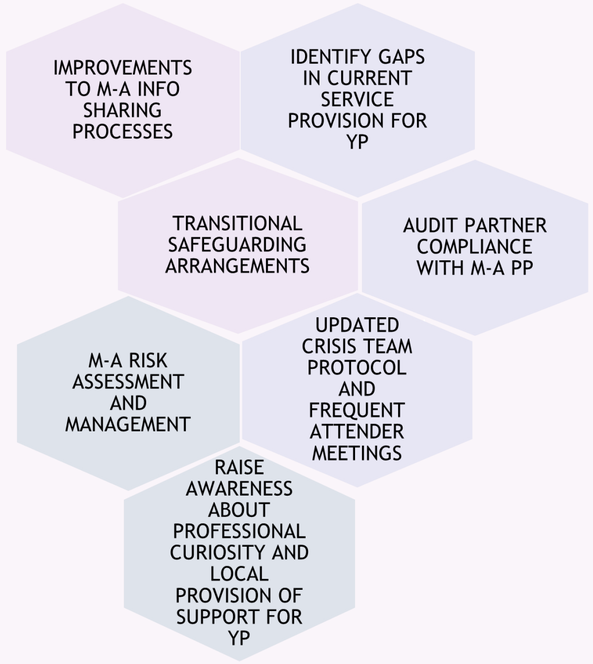
SIGNIFICANT EVENTS IN JAMES' LIFE:



*KEY ISSUES:

- Lack of multi - agency meetings, and missed opportunities to share information, assess, and manage risk.
- James' mum should have received more effective support, she was also James' carer.
- Lack of clarity as to who was responsible for a learning disability assessment.
- No safeguarding concerns were submitted.
- Agencies worked in silos.
- Missed opportunities to provide substance misuse support.
- Transitional safeguarding requires improvements.
- A&E attendances treated in isolation.
- Lack of understanding of the urgent referral pathway for people requiring urgent MH support.
- Insufficient professional curiosity in relation to family relationships, and ACEs not taken into consideration.

KEY LEARNING:



POSITIVE FINDINGS:

Youth Justice Service (YJS) supported James to stay in education, and to attend health appointments.

YJS initiated conversation around a learning disability assessment for James.

YJS and CYPS worked in partnership to plan James' transition into adulthood.

YJS proactively shared briefings among its members, and continued to support James after his transition into adulthood.

GPs referral for a MH assessment included detailed information about James' ACEs.

GP shared information with mother, and she was included in James' safety plans.

ARE WE PREPARED IN NORTH LINCOLNSHIRE?

- Do you actively participate in multi - agency practice when working with vulnerable young people and adults?
- How do you ensure that information sharing is a resource, and not a barrier?
- Are you aware of local service provision for young people who are transitioning into adulthood? How often do you refresh your knowledge about our local offer?
- Do you know what transitional safeguarding is, and how best to support young adults?
- Do you know the differences between the Mental Capacity Act (2005) and Mental Health Act (1983)?
- Are you professionally curious? How do you know?

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ADDITIONAL INFORMATION

*KEY ISSUES:

Multi - agency working:

- There were missed opportunities for holding multi - agency meetings to share information, assess, and manage risk.
- Several agencies held information regarding the risks presented by James, yet this information was not shared.
- There were missed opportunities to assess James' mental health needs.
- Lack of appropriate level of urgency assigned to James' deterioration in mental health.
- There were missed opportunities for substance misuse service to support James.

Support for James' mum:

- There could have been more effective support offered to James' mum, who was also James' unpaid carer.

Current service provision:

- There were challenges in identifying a pathway for an LD assessment - it was not clear which agency was responsible for doing the assessment. The assessment criteria was also unclear.
- There was a gap for a service for LD assessments for 16 to 18 - year - olds, locally.
- James was a 'frequent attender' at the A&E department, yet the incidents of self - harm were treated in isolation. No actions were set following the 'frequent attender' meeting.
- There was a need for greater understanding of the Tees, Esk, Wear Valley NHS Trust's urgent referral pathway for those who require urgent mental health support. Despite the high risk of self - harm, James' referral was treated as a 'routine' referral.

*KEY ISSUES: (CONT'D)

Mental capacity:

- Issues around James' mental capacity. Despite repeated self - harm episodes, with an escalation shortly prior to James' death, James' was assessed as having mental capacity. No mental health assessment took place, and James was not referred to the local authority safeguarding adults team.

Non - engagement:

- James' engagement with support agencies was sporadic. He did not engage with his CIN plan, despite mother's consent. Professionals did not utilise already established relationships (with other professionals and family) to engage James with support.

Transitional safeguarding:

- Although James experienced a period of stability during his transition into adulthood, he would have benefited from a referral into adult safeguarding, due to episodes of chaotic behaviour and increased risks. There were also missed opportunities to signpost James for additional support services during his transition period.

Professional curiosity:

- On occasions, there was a lack of professional curiosity displayed by professionals (in areas such as James' family relationships, and ACEs).

RECOMMENDATIONS:

- Where multiple safeguarding concerns relating to an individual are identified, multi - agency meetings are held to promote info sharing, and assess and respond to the risk posed to the individual.
- When requesting urgent action from a GP, ensure to alert the GP surgery to the urgent nature of the request.
- Highlight the current gap in service delivery for the provision of LD assessments for 16 to 18 - year - olds, and fix the issue.
- When sharing information with GPs regarding 'frequent attender' patients, provide more detailed info with regards to cause and effect of attendance.
- Raise awareness of the circumstances when info is required to be shared to safeguard children and adults at risk.
- Seek assurance from partner agencies as to the effectiveness of their current 0 - 19 offer.
- Partner agencies know of the urgent referral pathway for individuals who require urgent mental health care, and how to access it.
- Audit partner agencies' compliance with the LSAB M - A Policy and Procedure.

FURTHER RESOURCES

SAR report - James NYSAB (safeguardingadults.co.uk)

NLSAB multi - agency police and procedure North-Lincolnshire-MA-PP-FINAL.pdf (northlincssab.co.uk)

NL suicide prevention services, and MH support North Lincs SAB | News and Resources - North Lincs SAB

The MCA (2005) and The MHA (1983) North Lincs SAB | Policies, Procedures and Guidance - North Lincs SAB

Live Well in North Lincolnshire Live well in North Lincolnshire - LiveWell North Lincolnshire

Transitional safeguarding Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk)

NLSAB 7 - minute briefing - information sharing 7-MB-Information-Sharing-FINAL.pdf (northlincssab.co.uk)

NLSAB 7 - minute briefing - MH and suicide 7-Minute-Briefing-MHSP-FINAL.pdf (northlincssab.co.uk)

NLSAB 7 minute - briefing - professional curiosity 7-Minute-Briefing-Professional-Curiosity-FINAL.pdf (northlincssab.co.uk)