East Sussex Safeguarding Adults Board

Response to the Safeguarding Adult Review regarding Finley

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse or neglect is known or suspected, and an adult has died, (including death by suicide), or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult. The purpose of a SAR, as set out in the Care and Support Statutory Guidance, is to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”.

Sadly, in November 2021, Finley died. The cause of his death was drug toxicity. The East Sussex Safeguarding Adults Board (ESSAB) extends our deepest sympathy and our sincere condolences to Finley’s family and also to extend or appreciation and thanks to his mother for her contribution to this review which enabled the panel to view Finley beyond his diagnoses and presenting issues.

The ESSAB commissioned this SAR to understand the circumstances leading up to Finley’s death and to support the identification of strengths and areas for development in how agencies worked together to safeguard Finley.

Finley was in his early 30s when he died.

His mother described him as having a brilliant sense of humour and loving cartoons. He was a loner, only having a couple of friends as a child. His mother said he tended to push people away. When he was well, he was kind and considerate to others. From a very young age Finley had behavioural problems which were evident within the schools he attended. He moved schools when he was at risk of exclusion, but the behavioural issues continued, leading to school exclusions.

When Finley was 16, he was diagnosed with schizophrenia and spent about two years in an adolescent unit. At 19, Finley was placed in supported housing which lasted for several years. Finley was given notice by the home as they could not offer the support, he needed which led to him moving to private accommodation.

Over a period of several years, Finley had a number of inpatient admissions, usually detained under the Mental Health Act (MHA), due to poor compliance with his prescribed medication. Finley would not always accept the support offered by services and had misused illicit drugs for a period of time. During his final year of life, there were key indicators that substance misuse was a high risk to his safety.

His neighbours reported, repeatedly, that the property was being used for drug use, and his mother raised concerns that Finley was getting into debt, spending excessively on unknown items.

The review explored areas of learning specific to Finley’s case:

* The impact of substance misuse on Finley’s capacity to keep himself safe.
* Professionals’ understanding of Lasting Power of Attorney, Appointeeship, in the context of assessment of Finley’s capacity to make his own decisions regarding his care.
* To what extent Finley’s mother, as an informal carer, was included in his care planning.
* To what extent did the discharge planning include an assessment of Finley’s home arrangements, such as amenities needing to be turned on?
* How did agencies assess the suitability of Finley’s accommodation to enable him to live independently?
* What was the impact of Finley not receiving an autism assessment?
* How did professionals hear, and respond, to Finley? Was his voice heard?
* How were potential indicators of cuckooing assessed? How were potential indicators of financial abuse and exploitation responded to?
* To what extent did professionals recognise and respond to Finley’s potential self-neglect?
* What impact did the Covid-19 pandemic have on multi-agency working?

The ESSAB has reflected on the learning from this tragic case, and fully accept the overall findings and recommendations. We remain committed to seeking assurance with regard to evidence- based improvement planning across all relevant organisations involved, with progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

There were a number of emerging issues and learning which came out of this review. The following information represents our formal response to the findings, and learning identified in the SAR.

# **Engagement with families – when someone has fluctuating capacity**

**The review recommended that Sussex Partnership Foundation Trust (SPFT ) and Adult Social Care and Health (ASCH) assure themselves as to the effectiveness of the tools in place to support their staff to understand Lasting Power of Attorney arrangements for property & finance and health & welfare, when they are activated and how their requirements are incorporated into a person's care, treatment, and support.**

**Board response:** This review highlighted situations when someone has fluctuating capacity, as in Finley’s case, and that it would be reasonable to seek their agreement to include their attorney at every point, so that they understand any changes to the individual’s health and treatment. Identification of missed appointments or substance misuse would, potentially, indicate a loss of capacity.

SPFT and ASCH will identify what tools are currently used by staff to support their understanding of Lasting Power of Attorney . We will also develop learning briefings and factsheets for practitioners to support wider learning.

# **Responding to indicators of cuckooing**

In Finley’s case, no specific evidence was found to support the suspicion that he might be at risk from cuckooing. Nevertheless, there were indicators of county lines and previous concerns in relation to cuckooing of an individual known to Finley. Although agencies shared some information assumptions were made about the groups of young people visiting Finley, despite the concerns raised by the local community.

**The review recommended police should consider how information and intelligence, including previous history and at other locations can inform the response to someone who is suspected of being a cuckooing victim (vulnerable to exploitation) but where they are denying they are being cuckooed and that it may be beneficial that these situations are considered in the context of County Lines as well as Anti-Social behaviour.**

**Board response:** We will liaise with police to identify the actions they will be undertaking to meet this recommendation. A recent workshop: Adult exploitation in East Sussex was co-hosted by East Sussex Safer Communities and Sussex police in June to highlight the issue of adult exploitation in East Sussex

# **Dual diagnosis**

Finley was reported to have misused substances over a long period of time. When he was detained in hospital, there were missed opportunities to attempt to find ways to work with him. At the practitioner event, it was expressed that many patients have dual diagnosis who are admitted onto the acute mental health ward. The view expressed at the event was that acute mental health staff are not equipped to deal with substance misuse. Staff signpost to substance misuse services however this requires the individual to be motivated to engage. In Finley’s case, he refused to engage with substance misuse service.

**The review recommended** **substance misuse service commissioners, the commissioned substance misuse service provider, and the Sussex Partnership NHS Foundation Trust to review, agree and implement arrangements for integrated assessment and support planning to support hospital discharges for people with** **both mental health problems and problematic use of substances.**

**Board response:** SPFT, substance misuse service commissioners and the commissioned substance misuse service provider will be requested to update the ESSAB on this recommendation which will be a positive and significant local development in the way people are supported once they leave hospital when they have both mental health problems and problematic use of substances.

# **Multi-agency response to self-neglect**

Finley was known to neglect himself particularly during periods when he was unable to manage his medication and reached a mental health crisis. The multi-agency response to someone who is known to have mental health crises, misuses substances, and is refusing help to support themselves, should be to follow the self-neglect procedures within the Sussex Safeguarding Procedures.

**The review recommended that the ESSAB are asked to seek assurance from commissioners, providers, and partner agencies on arrangements for supporting staff to have the necessary knowledge, experience, and skills to recognise and act upon self-neglect with a specific focus on substance misuse.**

**Board response:** As part of the ESSAB bi-annual safeguarding self-assessment audit 2023 we will be asking for evidence from partners how they ensure their staff have the knowledge, experience, and skills to recognise and respond to self-neglect and, whether substance misuse is currently included within any self-neglect training and awareness.

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