WEST SUSSEX SAFEGUARDING ADULTS BOARD

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Statement from Independent Chair David Cooper on Safeguarding Adult Review of 'Alan'

30 September 2016

Firstly, as the independent chairperson for West Sussex Safeguarding Adults Board, I would like to express my personal condolences, and those of my Board members, to the family and friends of Alan who died far too young in July 2013.

The Serious Case Review report undertaken by Brian Boxall was commissioned by West Sussex Safeguarding Adults Board and commenced work in April 2015, alongside reviews conducted by the Independent Police Complaints Commission and by Health through a Serious Incident Report. In July 2015 the Coroner concluded that "Alan has taken his own life following a prolonged period of abuse and intimidation by a known individual. The statutory agencies failed through a lack of communication".

The purpose of a Serious Case Review is not to apportion blame on individuals or organisations, there are other forums for achieving such outcomes, but to understand what happened and to learn lessons. However, the report does not shy away from highlighting deficiencies by the various agencies charged with supporting Alan.

The report concludes that it is not clear why Alan killed himself. However, "it may be that timely, coordinated and joined up multiagency intervention at an early stage would have reduced the likelihood of this outcome".

The report highlights that whilst professionals from the Police, Southdown Housing, and Sussex Partnership Foundation Trust community mental health team worked with Alan over a number of years and were in touch with each other, work was not undertaken in a coordinated way, in particular the information was not used by his CMHT care coordinator to undertake an appropriate risk assessment; that when Alan did contact the Police in the early hours of the morning of the 23rd July 2013 the Police failed to respond as they should have.

The report has made a number of wide ranging recommendations for improvement across all local agencies, and has also highlighted some key broader issues for learning.

I welcome the report and agree to all its recommendations.

I know that for the family and friends of Alan there is nothing we can do to ease their distress at this sad loss of life. However, my Board will ensure that the recommendations contained in this report are fully implemented by local agencies, and through such action we aim to lessen the risks to other adults at risk of harm.

David Cooper
Independent Chair WSSAB
September 2016