EXECUTIVE SUMMARY

SAFEGUARDING ADULT REVIEW (SAR Case A 2017)

Adult A

Date: January 2021

The Care Act 2014 Statutory Framework for Safeguarding Adult Reviews (SAR):

States that a Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and condition 1 or 2 is met.

- Condition 1 is met if –
  a.) The adult has died, and
  b.) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died.)

- Condition 2 is met if –
  a.) The adult is still alive, and
  b.) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

Contents

1. Introduction

1.1. This document provides an executive summary of the deliberations and recommendations of the Safeguarding Adult Review (SAR) conducted by the Leicestershire and Rutland Safeguarding Adults Board (SAB) in relation to the tragic death of Adult A.

1.2. Adult A, a woman in her thirties, was assaulted by two people in her home. During the assault, it is believed that she fell over a coffee table. On the day of the assault, Adult A was seen by the Police and later East Midlands Ambulance Service (EMAS). She was assessed and treated at home. Five days later, Adult A attended the Emergency Department at Leicester Royal Infirmary. She was given a chest x-ray and CT scan which revealed a left lower rib fracture and small haemothorax. Adult A was found unresponsive by a friend 8 days later and she tragically died.

1.3. A SAR Panel was established, and an Independent Consultant identified. The first Panel was held on 3rd November 2017 and a further five Panel meetings were held.

1.4. Several agencies were in contact with Adult A between the date of the assault and her death and she was known to local statutory and commissioned services prior to the incident. She had input from alcohol services, mental health services and domestic abuse services and was the subject of a Safeguarding Section 42 enquiry. Adult A has a son, born in 2012, who has lived with his maternal grandparents since birth. A Special Guardianship Order (SGO) was put in place after Adult A's death.

1.5. Whilst recognising that the two adults who served custodial sentences are responsible for the assault that preceded Adult A's death, it is important that the SAB ascertained if there were any lessons to be learnt from this case regarding how practitioners work together to safeguard vulnerable adults in the future.

1.6. The full report, on which this executive summary is based, brings together, and draws overall conclusions from, the information and analysis contained in the agency Individual Management Review (IMR) Reports, discussions with family and multi-agency Panel meetings.

1.7. Single Agency Chronologies and Agency Reports were requested from and submitted by:

- Blaby District Council
- East Midlands Ambulance Service NHS Trust (EMAS)
- Leicestershire County Council, Adult Social Care (ASC)
- Leicestershire County Council, Children's Social Care (CSC)
- Leicestershire Partnership NHS Trust (LPT)
- Leicestershire Police
- Local Area Co-ordination (part of Public Health)
- Housing Provider
- Swanswell (Drug & Alcohol Recovery Service)[1]
- Turning Point Leicester & Leicestershire (Drug & Alcohol Recovery Service)
- United Against Violence and Abuse (UAVA)[2]

[1] Swanswell is a registered charity commissioned by local authorities as a third sector provider of alcohol and drug treatment. During most of the scoping period of this review, Swanswell was the provider of integrated alcohol and drug treatment, including the young person's service, for Leicestershire and Rutland. On 1st July 2016, Turning Point became the provider of integrated alcohol and drug service across Leicestershire and Rutland.

[2] UAVA are the commissioned providers of domestic abuse and sexual violence support services for Leicester, Leicestershire & Rutland. It is a consortium of three local specialist providers – Women's Aid Leicestershire (WALL),

- University Hospitals of Leicester NHS Trust (UHL).

A Summary Report was requested from and submitted by:

- A GP Practice.

Further information, via the trawling process, was provided by:

- A second GP Practice.

1.8. Agencies were required to make recommendations within their reports as to how their own performance could be improved.

1.9. A SAR is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adults in the future.

1.10. All the recommendations from the review have been taken forward by the SAB's constituent agencies.

2. Scoping Period and Terms of Reference

2.1. The scoping period for this SAR covered 17 months prior to Adult A's death.The reason for this was that it would focus the Review on a period that was both manageable and likely to contain all relevant information rather than including older, historical information of less relevance to Adult A's care and support needs at the time of the assault.

2.2. Agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of Adult A prior to the scoping period, which would be used to provide the background context.

2.3. The SAR specifically considered the following questions:

- Were the incident and the injuries suffered by Adult A and her subsequent death predictable?
- Were the incident and the injuries suffered by Adult A and her subsequent death preventable?
- Were the care and support needs, including housing, of Adult A identified, assessed and responded to appropriately and effectively?
- Were the links and resulting risks between Adult A and the perpetrators identified, assessed and responded to appropriately and effectively?
- How well were the single and multi-agency safeguarding adult procedures implemented and coordinated?

3. Pen Picture of Adult A

During conversations with Adult A's Mother she provided a pen picture of Adult A.

Adult A was from Leicestershire, was in her thirties and living on her own at the time of her death. Adult A is survived by her son, who was living with her parents and continues to do so.

Free from Violence and Abuse (FreeVA) and Living Without Abuse (LWA) – each delivering a different aspect of support under the UAVA banner. Information was provided by UAVA on behalf of WALL and FreeVa.

Adult A was the middle of three siblings with an older sister and younger brother. She had a happy family life, getting on well with her brother and sister, arguing no more than most families. They had lovely family holidays together, including swimming with dolphins. In adulthood, the children, Adult A and her siblings, continued to holiday with their mum and dad.

She grew up attending local schools, and left school aged 16, having taken her GCSEs. She loved reading, and this continued as an adult.

On leaving school, Adult A worked in an office and left home at 24 years.

She had relationships with several men and had stated that some of these relationships were abusive. Because of one of these relationships, her misuse of alcohol became more pronounced and she eventually became unemployed.

When Adult A discovered she was pregnant she looked forward to becoming a parent and was happy and physically well.

While she recognised that she could not look after him when he was born, she hoped to eventually be able to look after her son. Adult A had supervised contact with her son.

She did not like being alone and at these times she would drink to excess.

Adult A had been the sole tenant of a small number of properties in Leicester and its immediate vicinity. She lived alone in a rented property. She was unemployed and in receipt of state benefits but was actively seeking voluntary work at the time of her death and was hoping to get a job in time. Adult A had particularly enjoyed working with blind people.

4. Relatives and other Relevant Persons

4.1. Adult A's Mother confirmed that the family had agreed that she would speak on their behalf and those views are included in the full report and reflected on in the findings.

4.2. Family Hopes – What Adult A's Mother feels might help for other families:

1. A contact/resource/phone line for parents/carers who support people with alcoholism and offer advice about alcoholism
2. Information for children with parents who have alcohol problems.

5. Perpetrator liaison and involvement

5.1. Two adults were convicted of manslaughter in relation to Adult A's death and have served custodial sentences. Information trawls were completed on the two adults to identify if agencies held information in relation to contact between them and Adult A during the scoping period. Information was provided by the Police and Housing regarding counter accusations of anti-social behaviour (ASB) from May 2016.

5.2. The view of the Probation service was that interviews with the two perpetrators would not yield any further learning due to their views on their culpability and the acrimony between them.

6. Agencies involved during the Scoping Period

There were many contacts between Adult A and services or between services about her, in excess of 384 over the period of just over 17 months. Throughout the period of the Review, Adult A and agencies would engage then disengage as she went through a period of crisis followed by

one of stability: a pattern that would be repeated and which typified her lifestyle, which was described as ‘chaotic’.

6.1. Blaby District Council

Over the period covered in the report, Blaby District Council’s main involvement was twofold. The Housing Options team supported Adult A with her housing application and sourcing emergency accommodation. Adult A's case was also discussed at the People and Places Forum which acted as an oversight meeting to review the actions being undertaken by the individual agencies involved. People and Places Forum is Blaby's version of the Joint Action Group (JAG) and is a monthly multi-agency meeting that reviews vulnerable individuals, assigning action plans to appropriate agencies.

6.2. East Midlands Ambulance Service NHS Trust (EMAS)

EMAS had twelve contacts with Adult A over the scoping period: one for an overdose, two attendances for reported falls, and eight for disclosed assaults. There was one attendance for a non-medical reason following a call from a friend of Adult A’s.

6.3. General Practitioners (Leicester, Leicestershire & Rutland [LLR] Clinical Commissioning Group [CCG] Hosted Safeguarding Team)

During the scoping period, Adult A was registered with two GP Practices, attending Surgery on several occasions each month. The reasons for contact were to discuss her alcohol misuse, mental health, domestic abuse and depression. Some contacts were regarding a review of medication and following up with other agencies.

6.4. Leicestershire County Council, Adults & Communities Department

The role of Adults and Communities was predominantly one of co-ordination – for example, instigating safeguarding investigations, responding to identified risks in the community and aspects of care and support need. Adults and Communities liaised with various services such as Swanswell, Women’s Aid, Local Area Co-ordinators, local Police and intensive community support workers to try and engage Adult A.

6.5. Leicestershire County Council, Children & Family Services

Involvement with Children’s Services started in 2012. There was regular contact with Adult A with a focus on the assessment and monitoring of the concerns about her care of her son. Parenting assessments were undertaken. Her son became a Looked After Child under section 20 of the Children Act 1989 and his grandparents were assessed to care for him on a permanent basis.

6.6. Leicestershire Partnership NHS Trust (LPT)

Adult A received care from six services within Leicestershire Partnership NHS Trust: the Psychiatric Outpatient Service, Community Mental Health Team, Crisis Resolution and Home Treatment Team, Eating Disorders Outpatient Services, Criminal Justice Liaison and Diversion Service and Inpatient Admission for alcohol detoxification. Care from these services was for the following conditions: an eating disorder, alcohol misuse, suicidal thoughts and self-harming behaviours and depression.

6.7. Leicestershire Police

The Police had extensive contact with Adult A, including numerous phone calls with local neighbourhood officers, received direct to their police station, and ad hoc home visits made to

her. Police involvement during the timeframe related to responding to domestic incidents, ASB incidents, assaults and an alleged sexual assault. It also related to ongoing support for Adult A from her neighbourhood officers who built up a good working relationship with her and generally supported her where they could.

6.8. Local Area Co-ordination

The Local Area Co-ordination service was new to Leicestershire, starting in June 2015, when it began supporting Adult A. Its remit is to work in a person-centred way in specific communities to support individuals in achieving their vision for a 'good life' using natural community assets to meet needs and build resilience, preventing crisis and reducing the need for services. Adult A was introduced to the Local Area Co-ordinator for support with finding community activities to maintain her sobriety and to work with her to address some issues relating to her residency, by understanding if she was happy at the address and supporting her if she decided she wanted to move.

6.9. Housing Provider

As a landlord, the Housing Provider's role is to offer suitable accommodation, manage property and estate services and to foster sustainable tenancies. Whilst they do not provide support, they will signpost to support agencies where required and work with external agencies to enable tenants to maintain their tenancy.

6.10. Swanswell (Drug & Alcohol Recovery Service)

During the scoping period, Adult A received support from Swanswell at her GP surgery, community venues and through home visits. She was not prescribed medication for her alcohol use by Swanswell; however, she was known to be prescribed a medication by her GP during this time. Psychosocial interventions delivered by Swanswell Substance Misuse Workers (SMWs) with Adult A looked at ways to safely reduce her alcohol consumption to avoid any dangerous, potentially fatal, withdrawal symptoms and to address the factors that could lead to her relapsing, including identifying triggers and protective factors. Adult A completed several inpatient detoxifications over the course of the treatment episode within the scoping period, both in detoxification units and as emergency detoxifications in hospital following seizures. Adult A was also referred to a Swanswell Recovery Worker, initially for support regarding moving accommodation, and then later for support with appealing a Personal Independence Payment (PIP) decision. The case remained open to the Recovery Worker at the time the service transferred to the new provider as Adult A continued to have support needs around accessing mutual aid groups and mindfulness to support her relapse prevention. Whilst Adult A reported continuing to consume alcohol in a binge/abstinence pattern at the time of the closure of her case to the SMW, the worker had completed several sessions with her around the tools to prevent relapse and Adult A had identified steps she could take when she experienced cravings. The case remained open to a Swanswell Recovery Worker. The decision to close the case to the SMW, with continued support from the Recovery Worker, was supported by the management team with the caveat that Adult A could be re-referred into support from a SMW if she required further psychosocial support or returned to dependent drinking.

6.11. Turning Point Leicester & Leicestershire

Turning Point began working with Adult A in 2016; her case was transferred from Swanswell following a re-commissioning exercise. At point of transfer, Adult A remained with the same Support Worker who was working with her regarding alcohol use. At this time, she self-reported low-level alcohol use and was assessed as being non-dependent. When Adult A's alcohol use

increased, the service responded by reviewing her worker and re-allocating to a Recovery Worker.

6.12. United Against Violence and Abuse (UAVA)

Adult A had a history of being a victim/survivor of domestic abuse receiving services from the Independent Sexual Violence Advisor (ISVA) service and the Independent Domestic Violence Advisor (IDVA) service.[3] DASH Risk Assessments were undertaken on several occasions with many rated as high risk.[4] Adult A took out restraining orders against two ex-partners. She was also the subject of Multi-Agency Risk Assessment Conferences (MARACs).

6.13. University Hospitals of Leicester NHS Trust (UHL)

During the scoping period, Adult A was assessed and treated within the Emergency Department on three occasions (she left prior to assessment on two other occasions). All three attendances lasted for only a few hours.

7. Themed Analysis: Findings and Recommendations

Rather than undertake an analysis on a chronological basis, which would be both lengthy and repetitive, this Report considers the interactions between Adult A and services through themes identified within the chronology and agreed during Panel meetings:

- **A Focus on Presenting Issues (a lack of a holistic coordinated approach)**
- **Assessing the impact of removing a child on the care and support needs of a birth parent**
- **Multi-Agency Meetings and Safeguarding Procedures**
- **Lost in Plain Sight – Making Safeguarding Personal – Where was Adult A?**

7.1. A Focus on Presenting Issues (a lack of a holistic co-ordinated approach)

Finding 1:
The coordination of support services to Adult A was compromised by the number of individuals, agencies and forums involved with her or monitoring her situation.

Finding 2:
Responses to changes in Adult A's situation and behaviour were made to the 'presenting issues' rather than to a holistic and multi-agency assessment of her social and health care needs, situation and desired outcomes.

Finding 3:
Despite meeting the locally agreed criteria for inclusion in the Care Programme Approach, Adult A's care and support was not managed under this framework which would have enabled the coordination of the services offered/provided to her.

Finding 4:

[3] The IDVA remit is short term crisis intervention to mitigate risk.

[4] DASH RIC – Domestic Abuse Stalking & Honour Based Violence Risk Indicator Checklist – the purpose of the DASH risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC in order to manage their risk. DASH RIC includes 24 questions – a score of 14 yes responses or above indicates high risk of serious harm. DASH RIC of 9 indicates medium risk.

There was no formal assessment or consideration of formally investigating Adult A's capacity under the Mental Capacity Act 2005 despite her consistently making "unwise decisions" as to her health and social care needs and failing to learn from experience.

Finding 5:
Adult A was supported by specialist mental health and alcohol misuse services but there was a lack of coordination of both services, despite their responses being to the same issues within her life and situation – see Recommendations 1 and 2.

Recommendation 1:
That the Board, through its governance arrangements, reinforces and promotes that all assessments, including those completed under the Care Act 2014 or the Mental Health Act 1983, are holistic and outcome-focused and that practitioners are encouraged and directed by procedures to demonstrate 'professional curiosity' in looking beyond the 'presenting issues'.

Recommendation 2:
That the Board seeks assurance from LPT that current Care Programme Approach (CPA) training and audit arrangements support clinicians to allocate patients to the correct level within the CPA policy. Assurance should include copies of lesson plans, learning materials, audit reports and audit action plans.

Recommendation 3:
That the Board seeks assurance from all partner agencies that they and the services they commission are appropriately investigating, considering and assessing the capacity of adults who consistently make "unwise decisions" in accordance with 2.11 of the Mental Capacity Act 2005 Code of Practice.

7.2. Assessing the impact of removing a child on the care and support needs of a birth parent

Finding 6:
That Adult A's care and support needs, as a parent with social and health care needs who had a child removed from her care, were not appropriately assessed by Children's Services or ASC. They did not coordinate their assessments of, or responses to, Adult A's social and health care needs.

Recommendation 4:
That the Board seeks assurance from Children's Services and ASC that they have reviewed and revised, as appropriate, the established processes and procedures to coordinate and monitor assessments and service provision where adults with social and health care needs have children who are receiving services from Children's Services.

7.3. Multi-Agency Meetings and Safeguarding Procedures

Finding 7:
There was confusion about the implementation of the multi-agency Safeguarding Adult Procedures that resulted in meetings being held with no clear status and no recognised title, purpose or outcomes were not recorded. There was vague and inconsistent terminology used to refer to the Safeguarding Adult Procedures. There is no such term as "a safeguarding investigation"; since the Care Act 2014 was implemented, the term is a Section 42 Enquiry. Meetings held under the Safeguarding Adults Procedures are either "Strategy Meetings" or "Case Conferences", not "safeguarding meetings" or "professional/professionals' meetings".

Finding 8:
That the lack of linkage between several low-level concern forums and the Safeguarding Adult Procedures resulted in concerns being managed at an inappropriate level rather than escalated to the appropriate procedure.

Finding 9:
There were missed opportunities to raise safeguarding concerns regarding Adult A and instances where concerns were raised but were not recorded as being received by ASC and instances of the procedures being initiated with no recorded concern having been raised.

Finding 10:
There was evidence of safeguarding concerns being raised and appropriate lateral checks not being carried out to ensure effective decision-making within the Safeguarding Adult Procedures or to raise awareness in partner agencies of adults at risk.

Finding 11:
There was little evidence of the Safeguarding Adult Procedures being implemented in accordance with the principles of Making Safeguarding Personal – Adult A not invited to or being made aware of meetings held under the procedures, of her receiving no feedback from them, her desired outcomes from the procedures not being sought.

Finding 12:
That Adult A's housing needs were addressed, often as a result of a crisis caused by her social and health care needs, but that information pertinent to the latter was not consistently disclosed to the housing sector, resulting in poor coordination of services and monitoring of her situation.

Recommendation 5:
That the Board promotes the multi-agency Safeguarding Adult training made available to local agencies, particularly in the voluntary and independent sectors, to ensure it is effective and in accordance with the Care Act 2014 and Making Safeguarding Personal and Multi-Agency Policy and Procedures (escalation, identification of self-neglect).

Recommendation 6:
That the Board seeks assurance that appropriate lateral checks are made to enable effective decisions to be made within the Safeguarding Adult Procedures and that processes are in place to disseminate information proportionately about adults at risk of abuse and neglect.

Recommendation 7:
That the Board, through its audit programme, seeks assurance that adults with social care needs are being effectively safeguarded in accordance with the Care Act 2014 and Making Safeguarding Personal in cases of Self-Neglect.

Recommendation 8:
That the Board promotes consistent terminology to refer to the Safeguarding Adult Procedures – e.g. Section 42 Safeguarding Referral, Strategy, or Conference – and the need for clarity regarding the interface between Safeguarding Adult Procedures and alternative multi-agency procedures, such as MARAC and MAPPA, People and Place Forums and Joint Action Groups.

7.4. Lost in Plain Sight – Making Safeguarding Personal – Where was Adult A?

Finding 13:
The perception of Adult A, as a series of presenting issues rather than as an individual with complex and inter-related care and support needs, prevented her being identified as someone who self-neglected.

Finding 14:
That although Adult A could be difficult to engage with, agencies, except for the Police and the Local Area Co-ordinator, did not demonstrate the commitment to actively seek engagement from her that is essential for working with those who self-neglect. The most positive relationships were and are developed over time.

Recommendation 9:
That the Board, as part of its strategy to respond to self-neglect, seeks assurance that relevant partner agencies have effective policies and procedures in place to enable staff to develop the necessary working relationships to support those who self-neglect.

See also recommendations in relation to Procedures and Multi-Agency Meetings.

8. Reflections on the Terms of Reference

The analysis of the SAR also considered the interactions between Adult A and services and was shaped by the Terms of Reference. It considered the information gained from the Agency Reports and chronologies, and at the SAR Panel meetings. The analysis led to the learning from this Review and recommendations for Leicestershire and Rutland Safeguarding Adults Board.

8.1. Were the incident and the injuries suffered by Adult A and her subsequent death predictable?

8.1.1. Adult A's injuries following the assault were not immediately life threatening. Adult A called EMAS on the day and was assessed both on the day and the day after – she was given worsening advice[5] and was asked to see her GP the following day. There was a period of 13 days between the injury and her death, so it could not have been

[5] Worsening advice is relevant to the circumstances at the time, so usually to visit to your GP / the Emergency Department if symptoms worsen or return (the symptoms of concern will be explained to the person), along with a leaflet in some cases – i.e. if it relates to a specific injury such as a head injury.

expected. It was reported that Adult A was looking to the future and thinking long term but did relapse prior to her death.

8.1.2. The incidents between Adult A and one of the perpetrators were escalating in their nature and that escalation was likely to continue. The likelihood of one of the incidents descending into physical violence was also therefore increasing but, when and if that tipping point was going to be reached, was not predictable.

8.2. Were the incident and the injuries suffered by Adult A and her subsequent death preventable?

8.2.1. It was not preventable, because it was not predictable, and no single action or inaction is identifiable as being a necessary and sufficient cause of it happening.

8.2.2. As Section 1 (1) of Part 1 the Care Act 2014 states, "The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being". Whilst Adult A was in receipt of preventative services it has to be assumed that, had the Local Authority, in cooperation with its partner agencies, exercised its functions appropriately under the Care Act 2014, her wellbeing would have been better promoted. That might not have prevented her death, but it would have maximised the positive impact of services on her life and better enabled her to fulfil her desired outcomes and enhanced her quality of life.

8.2.3. A Care Programme Approach would have brought agencies together in a coordinated way although it probably would not have prevented Adult A's death.

8.3. Were the care and support needs, including housing, of Adult A identified, assessed and responded to appropriately and effectively?

8.3.1. The Blaby District Council Housing Options team were good at responding to changes to risk (by arranging emergency accommodation) and proactive in chasing alternative accommodation for Adult A – for example, asking the Housing Provider to consider a management move to allow Adult A to move. As a service, however, it was found that there is a need to review case recording and information sharing practice.

8.3.2. Adult A was originally nominated in 2015 to one of the Housing Provider's addresses – she was identified as having support needs and had support in place at that time. She was nominated following domestic abuse and the Housing Provider flagged her as vulnerable on their database. At this address, staff understood that Adult A was at risk from further contact from a former partner and that her behaviour and alcohol dependency put her at risk. Once Adult A moved, the Housing Provider was not aware of any link between her and the perpetrator and were not informed of / unaware of any risks in relation to a return to alcohol issues, or antisocial behaviour arising from that or mental health concerns. The move seems to have broken the contacts with the Housing Provider staff from other agencies.

8.3.3. ASB was documented and steps were taken to try and resolve disputes between Adult A and her neighbours. Police records show that Adult A was not always the victim of ASB and was very often a perpetrator; therefore, the risk was not always associated with her. Due to Adult A's issues with drink, it is apparent she had many disputes with those living near her wherever she lived. Unfortunately, she tended to live close to others who in turn had their own issues.

8.3.4. Despite being known to both Children's and Adult Social Care, as well as a range of health services, Adult A's support needs were not appropriately and effectively

assessed. Her needs were considered within their presenting issues and were not overviewed in a holistic fashion, as required by the Care Act 2014. It should be noted that the Care Act 2014, although primarily focused on the assessment of social care needs and the provision of appropriate support services, also places a duty on partner agencies, particularly health agencies of the Local Authority, to co-operate with the Local Authority in its actions to meet its legal responsibilities. This duty is reciprocal on the Local Authority.

8.3.5. Adult A did not appear to Emergency Department staff to be an 'adult with care and support needs'. There were no identifiable triggers which would lead staff to consider a referral to ASC during their involvement with her. There is also no evidence that Adult A lacked the mental capacity to make her own care, treatment and accommodation decisions. Adult A was provided with appropriate medical care and treatment in addition to support by the hospital-based Mental Health team, when relevant.

8.3.6. Other than at low-level community forums, such as the People and Places Forum, Adult A's complex social care needs, and her social context do not appear to have been considered and a multi-agency response agreed. This is despite her clearly meeting the criteria for the Care Programme Approach to manage her mental health issues.

8.3.7. As has been stated, Adult A was known to both Children's and Adult Services, but there is little evidence of joint working between two departments within the same agency. The impact of losing responsibility for the care of her son, albeit to her own parents, should not be underestimated and yet this does not appear to have been recognised let alone addressed by either department.

8.3.8. There was not a coordinated and holistic approach to assess and support Adult A about her social care needs, but it would appear that services, aware of her lifestyle and its cyclical nature, responded only to the presenting issue each time she came to their attention.

8.4. Were the links and resulting risks between Adult A and the perpetrators identified, assessed and responded to appropriately and effectively?

8.4.1. While this Review has been focused primarily on Adult A and her engagement or otherwise with services, information was also requested from agencies relating to the two individuals found guilty of causing her death and any awareness of the relationship between them and her. The information received suggested that either there was no relationship as such or that they chose not to inform services of it.

8.5. How well were the single and multi-agency safeguarding adult procedures implemented and coordinated?

8.5.1. As outlined under the Themed Analysis section, 'Multi-Agency 'Meetings and Safeguarding Procedures' the findings 7-12 indicate that procedures were not always implemented correctly and although agencies were meeting together in a variety of forums to share concerns and plan support the status of these meetings were not clear or follow up coordinated.

9. Examples of what worked well

9.1. There does not appear to be any lack of commitment by workers who had contact with Adult A.

9.2. She was able to form positive working relationships with a small number of professionals, particularly with the local Neighbourhood Officer, Local Area Co-ordinator, Swanswell Support Worker and the IDVA Service.

9.3. One specific Neighbourhood Officer got to know Adult A very well and understood her needs and vulnerabilities. The Officer took ownership of the problem and, for continuity, carried on being involved despite her moving away from their beat. There are examples of this officer going above and beyond what is expected of a Beat Officer to engage with Adult A and trying to resolve the issues she presented. There is also evidence of the local Police Community Support Officer (PCSO), who worked the beat where Adult A lived at the time of her death, being proactively involved in trying to resolve the problems between Adult A and her neighbours. Therefore, the officer's involvement had a positive impact.

10. Sharing the Learning

10.1. The recommendations from the review have been actioned by the Safeguarding Adults Board and the agencies involved in the review.

10.2. The learning/actions from the review have been shared as the review progressed through the Safeguarding Boards Procedures Group, Trainers Network and the publication, Safeguarding Matters.

10.3. A 7-minute briefing 'Alison' was created to be used in training, team meetings and supervision – see Appendix 1.

Appendix 1 - 7 Minute Briefing – Alison

01 Background

Alison died aged 32, she lived alone, her child aged 7 lived with extended family. Alison had a long history of alcohol misuse and mental health issues. Alison and her family were supported by several services. (Mental Health, Children and Adult Social Care, Police, GP, Substance misuse service, Domestic Abuse services). Alison's drinking impacted on her capacity to parent, her relationships with family, friends, neighbours and engagement with agencies.

Alison had periods when her drinking was more manageable and her outlook more positive.

02 Safeguarding Concerns and Risks

- Alcohol misuse
- Domestic Abuse
- Inconsistent engagement with support services

07 Raising your Awareness

All information is found Multi-Agency Policies and Procedures (MAPP)

Mental Capacity Act

Application of the Vulnerable Adults Risk Management (VARM)

Self-Neglect

Children's Safeguarding Procedures

03 Key Learning Themes

Assessments need to demonstrate 'professional curiosity' in looking beyond the 'presenting issues'

Self-Neglect – Consider the use of the Vulnerable Adults Risk Management (VARM) process when the service user has Mental Capacity, refuses services but at risk of significant harm

Mental Capacity (MCA) – Consider application of the MCA where capacity may be compromised by substance misuse or where someone repeatedly makes unwise decisions

Implementation of the Care Programme Approach

06 Reviewing your Practice/Cases

Is Self-Neglect an issue?

Have I looked beyond the presenting issues? What other agencies are involved?

I am clear what the plans are?

I have been invited to a multi-agency meeting, am I clear what the purpose is? Section 42 Strategy, VARM, JAG etc

Are there any children involved?

05 Findings summary

Children's Services and Adult Social Care to review processes and procedures where adults with social and health care needs have children who are receiving services from Children's Services

A met the criteria for inclusion in the Care Programme Approach, management under this framework would have enabled the coordination of the services offered/provided to her.

04 Findings Summary

The coordination of support services to A was compromised by the number of individuals, agencies and forums involved with her or monitoring her situation, lack of linkage, terminology purpose of meeting action review

Responses to changes in A's situation and behaviour were made to the 'presenting issues' rather than to a holistic and multi-agency assessment of her social and health care needs, situation and desired outcomes.