Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND

Safeguarding Adult Review into the death of Adult C

1. Introduction

1.1. This report describes the learning emerging from a Safeguarding Adults Review (SAR) commissioned by the Leicestershire & Rutland Safeguarding Adults Board (SAB). It concerns the tragic death of Adult C who died as a result of severe traumatic head injuries, following a fall from a bridge.

1.2. A Safeguarding Adult Review is a multi-agency review process which seeks to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring. The purpose of a SAR is not to hold any individual or organisation to account as other processes exist for that purpose.

1.3. The SAR panel who oversaw this review extend their sincere and heartfelt condolences to Adult C's family.

2. About Adult C, Her Background and Life

2.1. During her life Adult C experienced difficulties with her mental health and drug and alcohol misuse. In the latter part of her life, Adult C had been known to several services and had experienced personal challenges which caused her to have difficulties being able to fully enjoy and participate in day-to-day life activities. Despite this, in the last year of her life, she had successfully completed a course in sports massage, and it is understood that she had intended to pursue further education in sports science at University in the future.

2.2. Adult C had lived independently on her own for a number of years. The year before her death she began to raise concerns about her neighbours. This coincided with a period of time when she was struggling with her mental health.

2.3. Adult C moved back to her mother's house eleven days before her death following advice to keep her safe by the Police after incidents at the property where she had been living.

2.4. On the day she died, Adult C had attended a session at a counselling service where she expressed thoughts of suicide.

2.5. There were a range of services that were involved with Adult C in the last year of her life, and who had knowledge of her. These were both statutory and voluntary services.

2.6. Adult C's mother actively supported her during the last year of her life, which included accommodating her during periods of acute crisis.

3. The Purpose and methodology of the review

3.1. The purpose of the review was to understand, with the benefit of hindsight, how services worked together to help and support Adult C during the last year of her life, in order to

identify opportunities for learning and improvement in current safeguarding practice . The review aimed to:

- Establish the key agencies who provided care and support to Adult C
- Establish the key agencies' roles and responsibilities in relation to Adult C's care and support needs
- Establish if there were any lapses in service delivery by key agencies that affected the delivery of services for Adult C
- Consider how agencies worked together, and if there were any barriers to effective communication between agencies
- Understand which agencies knew about Adult C and how they engaged with services in the last year of her life
- Identify areas of good practice.

3.2. The SAR was led by a Lead Reviewer from the partnership (from an agency with limited involvement in the case). A Safeguarding Adult Review Panel, which included representatives from key agencies with involvement with Adult C, contributed to the review process.

3.3. The Lead Reviewer collated and analysed information from agencies that had worked with Adult C and consulted with Adult C's family. The reviewer considered this against the purpose and aims of the review and good safeguarding practice and identified four key findings relevant to supporting vulnerable adults and improving adult safeguarding.

4. Findings of the review

4.1. **Finding A** - The review identified that Adult C's mother played a key role in helping her daughter, as an informal carer. Through the review, we found that Adult C's mother struggled at times to support Adult C and there was no formal assessment of her needs.

4.2. **Finding B** - The review found that, although Adult C was known to a number of services, the full extent of the concerns was not fully understood by any single agency. There was evidence that agencies sought assurance that Adult C was taking action in relation to her issues, which was not always the case. There was no evidence of multi-agency working. A key worker, whose role was to coordinate and monitor agencies' response, would have been helpful as both a 'go to' person, but also someone who had oversight of the case. On four occasions, professionals identified safeguarding concerns, but these were never formally referred to the Local Authority Adult Safeguarding Team, meaning that the vulnerability identified was never formally assessed.

4.3. **Finding C** - Individual agencies undertook a range of assessments on Adult C. From the review, it was uncertain how, after the assessments, action plans were developed, and any interventional objectives were met. There were examples that case work was closed with outstanding work to be undertaken.

4.4. **Finding D** – Adult C wanted to continue to see a hospital-based psychiatrist rather than a community-based psychiatrist. Whilst the reviewer accepts that this was Adult C's choice, it meant that she did not have access to the full range of community mental health services. This limited the range of mental health services available to her.

5. Examples of Good Practice

5.1. Throughout the review period, there were examples of where practitioners had demonstrated good practice, which included:

- The Crisis Resolution Team worked persistently and flexibly to engage with Adult C, which included changing appointments times, trying to locate her when they had no response, and being flexible with appointment times and venues.
- The Housing Association were responsive when Adult C raised concerns about her neighbours. They sought prompt legal advice and made many attempts to engage with Adult C in order that they could pursue legal action against her neighbours, albeit, subsequently, Adult C retracted her allegations and the case had to be closed.

5.2. Adult C's mother remained a constant support to her, despite the challenges this caused. Her persistence and commitment during times of crisis were a support and helped see Adult C through some very difficult times.

6. Conclusion

6.1. From undertaking this review, we learnt that Adult C had experienced some significant issues in the last year of her life, associated with her mental health, drug and alcohol misuse, and ongoing problems with her neighbours where she lived. Sadly, although a number of agencies were involved in delivering services to her, the extent of these issues was not fully understood. This impacted on the actions of individual agencies and the support services offered to Adult C and her family. This review makes several recommendations for the Safeguarding Adults Board to consider.

7. Recommendations

i) Awareness is raised across the Safeguarding Adults Board of how carers can request a statutory carer's assessment and how this service is promoted

ii) In cases when safeguarding risks are identified, a referral by the practitioner identifying these must always be made to the Local Authority Adult Safeguarding Service, with the outcome of the referral formally recorded in agency records.

iii) – Practitioners should not withdraw services where there are outstanding safeguarding concerns, unless there is evidence that these concerns have been formally addressed and that a plan is in place for ongoing support.

iv) – Mental Health Service Provider and Local Authority Adult Care Services review caseload supervision arrangements and audit practice to evaluate the effectiveness of individual case work practice, against individual organisational standards.

v) – For the Mental Health Service to review options for patients to access community mental health services, whilst respecting their wish to continue seeing a hospital-based Psychiatrist. To ensure that where there are ongoing mental health concerns, they are able to access a range of community mental health services.