CASE D 2019

Safeguarding Adult Review

Executive Summary

Lead Reviewer: Nicki Walker-Hall

EXECUTIVE SUMMARY

Initiation of the review

This review was initiated by Leicestershire and Rutland Safeguarding Adult Board. A referral had been made as there were concerns Person D's death may have resulted from abuse or neglect. Person D died as a result of a fatal road traffic collision on a busy road. Whilst the Case Review Group (CRG) concluded the criteria were not met for abuse and neglect, it was felt there was a need to understand how agencies worked with Person D and her family prior to her death.

Person D

Person D had siblings. Person D was taken into voluntary foster care; it is reported her mother was physically abusive and her stepfather a violent alcoholic. Person D had witnessed Domestic Abuse (DA). Person D was bright having achieved good grades at school and extra qualifications at college; she had worked in the hospitality sector before moving to Leicestershire.

Person D met her partner when she was a young adult and moved to the Leicestershire area three years after they met. The couple had their only child when Person D was in her mid- 20s. At the time of Person D's death she was estranged from her partner, although they remained in close contact, and Person D had supervised access to their child.

Summary of Case

This review covers a twenty-seven-month period from when Person D presented at the Hospital Emergency Department feeling depressed and anxious with thoughts of self-harm and paranoia, until her death.

During the review period, Person D had five periods of mental health crisis and life for her and her family changed significantly. On two occasions Person D actively sought professional help, on other occasions this was noted by either her partner or professionals. During the first crisis in the summer of 2016, Person D was admitted as a voluntary patient to an out of area hospital where she remained for two weeks. A significant improvement led to her discharge and from this point Person D's mental health was to be managed in the community.

Person D was offered appointments with her psychiatrist on a regular basis but did not receive on-going support via community mental health services, partly due to non-engagement. The treating psychiatrist was caring for both Person D and her partner. Her partner had regular contact with the psychiatrist and would seek increased support as needed. Person D's contact was for routine clinic appointments only which she did not always attend. The psychiatrist, having originally considered Person D might have bi-polar affective disorder, felt it was more likely she had a personality disorder. Person D disclosed historical abuse and was signposted to a counselling support service for women who have suffered childhood abuse.

Person D attended parenting classes and indicated she felt her life was settling down although she remained anxious.

Person D's mental health fluctuated over the next two years and although there were clear points of crisis there was only one further occasion where it was thought admission might be necessary; this was within days of Person D's death. However, a plan was put in place, with Person D's agreement, to increase care and support within the community.

The nature of Person D and her partner's relationship was not well understood but appears to have been complex and lacked stability. There were periods were the family all lived together, at other times either Person D's partner or Person D would move out either staying with friends or family, or

Person D becoming homeless. On occasion this impacted on the services Person D could access, with the need to change her GP and plans to change her psychiatrist.

Person D's use of cannabis and cocaine became increasingly known to professionals over the review period, but despite referrals to the appropriate service, Person D did not access and therefore did not receive any treatment for her addictions. The 'opt-in' nature of the service meant non-attendance led to discharge.

A number of referrals were made to Children's Social Care (CSC) in respect of Person D's child. The first was as a result of Person D indicating she was concerned for her safety due to her partner's worsening behaviours; Person D's partner had known mental health problems. Checks made by CSC with partner agencies led CSC to believe Person D's partner was a protective factor and his mental health was stable. A referral to Early Help was made to support the family. This view remained CSC's view until October 2018. Person D's child alleged that they had experienced physical abuse on two occasions one by Person D and the other by Person D's partner; the latter was not reported to Children's Social Care and neither of the concerns led to a child and family assessment. Person D's fluctuating mental health and Person D's partners concerns regarding the impact of her behaviours on her child led to him applying to the family courts for orders restricting Person D's exercise of parental responsibility in relation to her child. The impact of this on Person D's mental health and her relationship with her child is not fully known however, she did continue to have contact with both her child and her estranged partner.

Early Help were involved for a two-three months period following Person D's first mental health crisis, conducting a signs of Wellbeing assessment, a Family Assessment and supporting Person D. Person D sought support from the Family Outreach Worker (FOW) even after discharge from the service.

During the last week of her life Person D's behaviours caused increasing concern to her estranged partner and professionals. Person D had been found wandering around, disorientated and confused. There were concerns she may have taken an overdose; Person D was experiencing auditory and visual hallucinations. On other occasions Person D was seen running in a busy road went missing, was agitated and disinhibited, and had tried to self-ligature. On each occasion services responded to take Person D to a safe place. Person D had multiple mental health assessments and Person D's behaviours were thought to link to illicit drug use. Person D had fluctuating capacity but when she had her final assessment under the Mental Health Act a decision was made, with Person D's agreement, to go with the least restrictive option – management in the community with home treatment team support. Support commenced immediately, however within hours, Person D was behaving very erratically and had threatened suicide. Before professionals could respond to calls from the public for help, Person D had laid on a busy road resulting in fatal injuries.

Summary of Learning

1. Non-mental health professionals need a greater understanding of mental health conditions, the role of the Mental Health Crisis Team and the interface between the different mental health services in order to understand how they need to engage the individual, manage appropriate support, and understand any emerging risks within families where one or more adults have mental health concerns.

2. Professionals were not sufficiently curious regarding the couples use of illicit substances, leading to a lack of consideration of their reported "recreational" use on their own, and their child's life. Whilst it is impossible to know whether Person D's episodes of psychosis were triggered by the use of illicit substances, her declining mental health or both, it is clear that this

required assessment by a specialist dual diagnosis service or through collaboration between mental health and drug and alcohol treatment specialists.

3. Professionals need to be clear of their responsibilities in relation to the use of the Mental Capacity Act including how decisions are made and recorded. Professionals need to be clear about the basis for a lawful admission of an individual to Hospital. In cases where the individual has capacity and wishes to leave against medical advice, their reason for leaving the Hospital needs to be recorded and shared with partner agencies where relevant and proportionate to do so for the purposes of safeguarding.

4. There is a need for improved coordination between agencies to effectively manage the utilisation of what mental health resources are available locally. This includes a need for professionals to understand the referral routes for individuals who are out of area for county services, and those who are using cross border pathways.

5. The current design and interface of mental health and drug and alcohol services within Leicestershire are not robust. Services are not available within all localities nor flexible enough to meet the needs of individuals who have specific needs.

6. The sharing of information was inconsistent. Information sharing between mental health services was generally good however there was a lack of information sharing with partner agencies who had been supporting one or more members of the family in the community. Lack of multi-agency partnership working meant that services were less responsive than they might have been had they had a full picture of the family's situation.

7. Services were not sufficiently curious to explore the couple's relationship and were not sufficiently sighted on the impact of their behaviours on each other and their child. Although family members and neighbours were often mentioned as places where the couple went when they separated, there was no consideration that a family network meeting might be helpful, nor is there sufficient evidence that all adult workers were 'thinking family' and so opportunities to take a co-ordinated, collective approach to supporting and safeguarding each member of this family were missed.

8. When an individual is reporting historical sexual abuse occurring in childhood, accepted protocols should be followed in response to helping the individual to deal with the abuse.

9. CAFCASS as part of their routine checks request information from CSC to inform their report for Court, they also correspond with parents. When there is limited information from CSC and a parent does not participate, CAFCASS inform the courts who have the power to direct that further enquiries be made. Lack of instruction by the courts to direct further enquiries in such circumstances has the potential to lead to assumptions being made that the applicant is an able parent and the absent parent is not. If CSC are not currently involved with the child but hold information regarding a parents mental health, this information should be relayed to the Court via CAFCASS in order that the Court can consider whether further checks are required to ensure the child's best interests are being represented. Courts should demonstrate full regard for the information and recommendations of CAFCASS.

10. There was a lack of awareness of what social factors can amount to homelessness.

11. The lack of direct work carried out by mental health services in between crises meant opportunities to support and maintain Person D's mental wellbeing were missed.

12. When referrals are received by CSC indicating mental health issues in one or both parents, information should be obtained from mental health services before a decision is made on whether a case meets the threshold for CSC involvement. CSC need to be professionally curious and challenge themselves regarding what it is like for a child living with an adult/adults with mental health issues.

Good practice identified

1. There is evidence that a holistic approach was taken by a number of services including the Children's Centre, the General Practitioner (GP) and the Local Area Coordinator (LAC) service.

2. High levels of consistent support were provided by the Family Outreach Worker (FOW) and LAC.

3. The GP consistently identified Person D's need for support and made appropriate referrals to mental health and drug and alcohol services.

4. Leicestershire Partnership Trust have identified that when the Community Mental Health Team (CMHT) assessed Person D in October 2018 practitioners showed compassion with one staff member paying personally for a locksmith to ensure that Person D could go to her home.

What will the L&RSAB do in response to this?

The Leicestershire &Rutland SAB (Safeguarding Adults Board) and Partner agencies have prepared SMART action plans which describe the actions that are planned to strengthen practice in response to the learning from this safeguarding adult review.