Statement from the Independent Chair of the IOWSAB re: Miss T Case Review

Concerns about the safety of this young woman due to her known drugs misuse, her emotional and mental health needs and the evidence of sexual exploitation meant that this case was managed under adult safeguarding arrangements and professionals persisted in trying to intervene in ways that lessened the risks she faced and to improve her life. Sadly despite the efforts made to help her to reduce the risk of harm Miss T died in August 2015 following a cardiac arrest associated with drug taking.

The Safeguarding Adults Board considered the case against the Care Act 2014's criteria for statutory Safeguarding Adults Reviews. It was agreed that the criteria under section 44 were not met , but that there was sufficient reason to think that valuable learning could be gained from undertaking an alternative case review. A Learning Event was held on 21st June 2016 to enable maximum participation of those directly involved. The event was informed by an analysis by an independent reviewer of the extensive multi-agency record chronology and available agency reports.

As a result of this case review several recommendations were made including :-

- Better use of independent advocates in situations where individuals have capacity to make decisions for themselves, choose not to engage with professionals but face serious risks.
- The production of guidance for all agencies focussed on escalating decisions and taking action when situations require an urgent response.
- Good practice guidance for practitioners on managing risk in cases where an adult's mental capacity is variable or fluctuating.
- Clearer advice on how and when cases are passed from the Local Authority's Safeguarding Team to longer term caseworkers.
- Regular awareness raising for staff focussed on agencies' roles and responsibilities and the legal options available linked to Adult Safeguarding
- Checks in place to ensure that the protection plan process clearly records the different roles and responsibilities of each of the agencies involved in the case.

- Recommendations about improving support for staff who are working to try to safeguard individuals in complex circumstances.

All of the recommendations in this report were agreed by the Safeguarding Adults Board on 25th November 2016. It is imperative that all of these recommendations are enacted in full and as speedily as possible. Accordingly, a detailed action plan will be implemented.