Summary of Learning – SAR Case M 2021

Introduction

A core duty of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area where an adult with needs for care and support (whether or not the Local Authority was meeting these needs):

- has died and the death resulted from abuse and neglect, or
- is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

Importantly, Safeguarding Adults Reviews (SARs) are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be conducted under S.44 (1) of the Care Act 2014, there must be reasonable cause for concern about how the SAB, its members, or others with relevant functions worked together to safeguard the adult.

Angela

Angela was in her early 30's at the time of her tragic death. Her sister said that Angela was the youngest of three children, her older brother also has a learning disability and lives independently. Angela was a ball of energy but could be very stubborn.

Angela could read but did not always understand what the words meant. She could not cook so never prepared meals.

Angela had a long history of mental health problems, a learning disability, alcohol and drug addiction.

Professionals had longstanding concerns regarding Angela's vulnerabilities particularly regarding intimate and peer relationships.

Angela is reported to have had an abusive relationship for some time and had attempted to be open and honest with professionals about this. Angela's alcohol dependency and drug use are reported to have been initiated and facilitated by the people she was involved with.

According to her sister, Angela would not do anything independently as she was anxious and lacked confidence. Angela would not take initiative so for example drugs would be supplied to her, she would never get them herself.

Family involvement

Angela's sister provided a wealth of information to the panel not only about Angela but her reflection on support from agencies. Whilst recognising the complexity of her sister's situation and reluctance to fully accept support, she felt that the impact of her Learning Disability on her decision making had not been fully considered by professionals and opportunities to assess her Mental Capacity had not been taken.

Key events

Under the care of the Psychosis Intervention & Early Recovery (PIER) Team in 2018, Angela discussed extensively the coercive and controlling nature of her relationship with a partner and this was reported as an emotional, and financially abusive relationship during which she was forced to use amphetamines. She later disclosed that this relationship was physically and sexually abusive. Angela fled this relationship to Leicester and engaged well with mental health services.

Angela reported this relationship to and cooperated with police; however, she found this process stressful and eventually changed her telephone number to avoid hearing from them. At one point Angela is reported to have discussed that she felt guilty for reporting her partner to the police. Angela is reported to have commented that she wished that she could reconcile this relationship in summer 2019.

Through the course of her care with the Psychosis Intervention & Early Recovery (PIER) Team, Angela had multiple intimate relationships, and professionals documented concerns. Within her relationships, alcohol use was a significant concern, and it was thought that Angela's dependence on alcohol was facilitated by partners and 'friends'.

Angela's engagement with professionals would fluctuate in line with new and emerging relationships and her levels of alcohol use. It became difficult to engage with Angela due to partners and friends being present at appointments.

There was significant concern regarding Angela's risk of financial exploitation by friends, partners, and neighbours.

Angela was supported and encouraged to participate in domestic abuse education; however, it is not clear if this ever took place.

Angela sustained substantial injuries when she was involved in a road traffic incident as a pedestrian in early 2020, while under the influence of alcohol. During her recovery, Angela's partner was asked *not* to visit her by residential home staff, due to his aggressive behaviours towards professionals, and because staff reported that he was bringing drugs and alcohol into the home for Angela to consume. Records indicate that this was an abusive relationship, and that Social Care were aware of professional concerns regarding Angela's vulnerabilities. There does not appear to have been any specific risk assessments regarding domestic abuse.

Whilst Adult Social Care facilitated a Personal Assistant service (non-regulated), it would appear that the organisation involved did not fully understand why they were being requested to ask Angela questions on behalf of Adult Social Care under Safeguarding guidance.

The GP was also not aware of the Personal Assistant service, and this may have proved to be a positive link.

Angela attempted to self-refer to mental health services in the summer of 2020 and reported that her relationship with her partner was abusive and had recently ended. As a result, he was arrested and placed on bail for assault against Angela, but unfortunately a prosecution was not possible due to evidential difficulties, including Angela subsequently stating her partner had not assaulted her. Mental health services were unable to engage Angela for assessment and care ended.

A multi-agency safeguarding meeting was held in late 2020. Concerns were discussed regarding the reconciliation of the relationship with her partner and professionals and family were aware that this was reported to feature domestic violence.

The question of capacity was discussed during the safeguarding meeting in late 2020; however, there was no plan to arrange a mental capacity assessment.

Angela is reported to have been at home at her time of death, and her partner is reported to have been present.

Methodology

Following the agency request for information, the Case Review Group (CRG) agreed the following methodology:

At the first meeting, a combined information summary and learning from the LeDeR review[1] started to identify the learning, and additional information was needed.

At the second meeting, learning was extracted during discussion to form a summary list of identified learning.

A family visit was made to Angela's sister to share initial findings and how learning had been identified.

At the third meeting, the learning was analysed, and final information agreed upon. It was also agreed that the group felt that all potential learning had been identified.

Learning Review participants

Strategic Service Manager – Mental Health and Safeguarding, Adults and Communities, Leicestershire County Council

Deputy Designated Nurse for Safeguarding, Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB)

Serious Case Review Partnership Manager, Leicestershire Police

Head of Victim Services, FreeVA

Officer, Safeguarding Partnerships Business Office

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Adult Safeguarding Lead, East Midlands Ambulance Service (EMAS)

Head of Safeguarding, University Hospitals of Leicester NHS Trust (UHL)

Lead Practitioner for Safeguarding and Mental Health, Adults & Communities, Leicestershire County Council

[1] https://www.kcl.ac.uk/research/leder

Strategic Lead – Community Delivery, Public Health, Leicestershire County Council

Good practice

The Adult Social Care Social Worker attempted to engage with Angela. They facilitated a Personal Assistant who had established a good relationship with her.

The Social Worker consulted with the Learning Disability team to contact Angela for her Annual Health Check.

Key learning

1 – Understanding and Application of the Mental Capacity Act in complex cases which have multiple factors such as learning disability, substance misuse, physical ill health, and domestic abuse.

Action: the SAB has agreed that MCA and its application is a business priority for 2023/25.

Multi-agency training on MCA is underway. This includes principles of the MCA and additional resources are in development in respect of understanding the role of services that engage with co-existing conditions.

2 – Understanding the person's lived experience, including the impact of a learning disability.

Action: a special issue of the Safeguarding Matters[2] newsletter, focusing on safeguarding adults with a learning disability, was published in April 2023 and shared with Angela's sister.

Oliver McGowan Mandatory Training on Learning Disability and Autism is now mandatory country-wide for Health professionals[3].

3 – Ensuring that multi-agency care and safety planning is discussed at the most appropriate forum e.g., strategy meeting/case conference under S.42 of the Care Act or Vulnerable Adults Risk Management (VARM) as Angela had been deemed to have capacity, living in a way that was significantly harmful, and reluctant to engage.

Action: The Self Neglect/Vulnerable Adults Risk Management (VARM) guidance is being reviewed and re-launched, stressing the importance of ensuring that people understand the purpose of meetings, safety and action planning.

4 – Safeguarding and role of non-regulated services e.g., Personal Assistant service.

Action: Share learning that when agencies become aware of non-regulated services involved with a person using services, they engage with those non-regulated services to ensure they understand their responsibilities to report concerns and follow up on actions agreed and links made with the relevant agencies.

[2] https://lrsb.org.uk/uploads/safeguarding-matters-issue-30-april-2023.pdf?v=1704376426

[3] https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism

An article regarding this was included in the September 2023 issue of the Leicester, Leicestershire & Rutland professionals publication Safeguarding Matters

5 – Family and carers – understanding information sharing and issues of confidentiality and consent to share information with family members.

Action: Article to appear in Safeguarding Matters[4] in September 2023 issue explaining what we can and cannot share with or without consent. The Information Sharing Agreement, updated in April 2023, needs to be championed so staff are aware of issues of consent to share information. Discussions about consent should always be recorded.

An article regarding this was included in the September 2023 issue of the Leicester, Leicestershire & Rutland professionals publication Safeguarding Matters

6 – Multiple risk factors – domestic abuse including coercive and controlling behaviour, exploitation, and substance misuse were present in her life and her relationships. Whilst efforts were made to discuss these issues and concerns with Angela (and at times she was incredibly open), her learning disability and fluctuating capacity affected her understanding of the impact of these issues and risky behaviours.

Action: Linked to learning points 1 & 2

7 – Weight management – Angela, although described as always very slim, had an extremely low body weight. Where there are concerns about low body weight, these need to be monitored and action taken if necessary. Adults with a learning disability should have an Annual Health Check regardless of their capacity.

Action: a special issue of the Safeguarding Matters newsletter, focusing on safeguarding adults with a learning disability, was published in April 2023 and shared with Angela's sister.

[4] https://lrsb.org.uk/uploads/safeguarding-matters-issue-31-september-2023.pdf?v=1694598027
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