Wolverhampton Safeguarding Adults Board (WSAB) Learning Lessons Briefing – Adult B

The Review

This Learning Lessons briefing is created as the result of a Safeguarding Adults Review Committee (SARC) learning review into the death of ADULT B in August 2016.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Background Summary

ADULT B died in hospital on 13/08/16 as a result of attempted hanging. She was in her early sixties. Prior to this final suicide attempt. ADULT B had phoned the Crisis Team informing them of her intentions to harm herself. The ambulance crew had observed that ADULT B had tied a noose round her neck and took her to hospital. At that time she was still conscious but later was pronounced dead.

ADULT B had experienced episodes of depression since 1979 and been exposed to periods of domestic abuse. ADULT B was a Mother but her relationship with her adult child is unclear.

ADULT B was known to a range of services including: Adult Social Care/Mental Health services/Substance Misuse Services /Fire Service/Police, usually at the point of crises.

ADULT B was physically slight and not very tall. She was an artistic and creative person that loved art, painting and crafts; her garden and cat. She was known to be estranged from her family and had very few friends. Practitioners share their experience of ADULT B as someone who wanted the full attention of individuals and would not want to 'share' their time with others. Furthermore, she presented as strong minded that she would live her life in the way that she chose and would not be

told what to do by others. At times, ADULT B presented as quite strong but then 'weak' and vulnerable at others.

ADULT B lived alone in supported accommodation. She had a poor relationship with neighbours that deteriorated due to her nuisance and, at times, anti-social behaviour linked to her alcohol misuse. ADULT Bs behaviour was sporadic with multiple clusters of daily incidents and she was at times aggressive and verbally abusive towards ambulance crew, police, housing and social care staff. Practitioners reported ADULT B sometimes acknowledged the impact of her behaviour on other people and at other times took no responsibility for her actions.

ADULT B's access to services was often linked to her underlying anxiety of being evicted but the services accessed could not address this satisfactorily. It cannot be ignored that the housing situation was as a result of ADULT Bs lifestyle choices.

Self-harm is a critical factor for ADULT B with self-disclosure of multiple suicide and self-harm attempts. The chronology identifies 18 attempts between January 2015 and August 2016; wherein she was admitted to hospital or this was reported to police and/or EDT.

Key learning themes arising from the review

Theme 1

Assessment

The historical context in which ADULT B grew up was a contributing factor to ADULT Bs mental wellbeing and alcohol misuse but, the lack of holistic assessment failed to sufficiently identify this. Historical information had been obtained via initial screening by psychological services in 2007 but the inconsistent engagement by ADULT B with services meant that this was not translated across all agencies or used to inform and fully understand the complexities of ADULT B's life.

The importance of quality assessment cannot be denied for ADULT B as agencies did not understand the underlying issues and trauma that underpinned her presentation, alcohol misuse and associated behaviours. ADULT B had adverse childhood experiences that impacted upon the whole of her life. The lack of context and family history resulted in support being characterised by crisis intervention. There was limited analysis of ADULT B in the context of this history, which resulted in a lack of planning and coordinated multi-agency support.

Theme 2

Multi-Agency Engagement

There is significant evidence of multi-agency involvement in ADULT B's life but little evidence of formal co-ordination and information sharing across all of the services. Multi-agency meetings did not take place. There were referrals and contacts between agencies but no collective oversight and ownership of the issues and challenges of working with ADULT B. All services were not cited on the number of agencies that had been involved with ADULT B and in turn, different agencies were referring ADULT B for a variety of services that were overlapping. This resulted in reactive and crisis intervention rather than planned and focussed intervention with a shared assessment and accountability for the identification and management of presenting risk.Furthermore, this limited the opportunity for agencies to challenge and hold each other to account.

The Care Act 2014 outlines the value of multi-agency working but as ADULT B did not fall within the Care Act criteria consideration was not given, by any of the partners, to initiate a multi-agency meeting. Working more closely may have resulted in clarity regarding roles, responsibilities and responses.

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Theme 3

Dual Diagnosis

Assessments determined that ADULT B did not have a diagnosed mental illness (other than depression) but she did have significant emotional wellbeing needs. In the absence of a formal mental illness diagnosis services struggled to effectively assess mental wellbeing; this highlights the challenge for professionals working with adults where their life choices result in their vulnerability and additional needs.

There is a potential for alcohol misuse to mask mental health needs and can result in individuals' receiving little or no treatment. Aligned to this, is a potential gap in service for those with similar presentations.

Theme 4
Did Not attend/Client Engagement

Across the partnership there were varying responses to DNAs (not attending appointments) leading to unnecessary re-referrals. ADULT B was not routinely

challenged for DNA nor were attempts always made to explore the reasons for her lack of attendance, resulting in agencies 'passing back' responsibility to the originating referrer. This was particularly relevant for the GP as a primary referrer to other services.

It is recognised that each agency has individual DNA policies. However, the lack of a city wide consistent multiagency approach to repeat DNAs as part of a wider 'trigger system' resulted in insufficient efforts to engage ADULT B by some agencies

Recommendations

1. WSAB to publish a Learning Briefing to share the practice learning across the multi-agency partnership
2. Where one or more agencies are actively involved with an individual a multi-agency meeting must be arranged by the statutory agency wherein all partners discuss the level of intervention and determine a solution focus approach to future engagement.
3. WSAB to develop a Dual diagnose pathway which will effectively support in the assessment of mental wellbeing which is often masked by substance misuse.
4. WSAB to develop a Multi-Agency Engagement Pathway to inform good practice across the partnership