LEARNING BRIEFING

Case 3/20 Rapid Review

Teeswide Safeguarding Adults Board

1 Background

Adult F was a young female who had bi-polar, diabetes, was known to self-harm and had a history of substance misuse. She was also known to be a victim of domestic abuse and had been placed in temporary housing several times but always returned to live with her partner.

Adult F attended Accident & Emergency twice during the last 6 months of her life presenting with injuries which were alleged to have been caused by her partner. On the second occasion she received treatment for a head injury but refused treatment for her diabetes against the advice of the consultant as she wanted to return home quickly; she was deemed to have capacity to make this decision.

Adult F sadly passed away just over a week later due to Diabetic Ketoacidosis (shortage of insulin) and Mixed Drug Toxicity.

This review looks at how services worked together to support Adult F and specifically considers the following key issues: safeguarding and self-neglect, mental capacity assessment, engagement with Adult F, understanding her history and the impact of trauma, and how the Covid-19 pandemic may have affected service response.

2 Theme 1: Understanding Trauma

Organisations involved with Adult F had very limited knowledge of her background and knew little about her family situation or any other support networks she may have had. This review highlighted the importance of understanding a person's past, particularly any adverse childhood experiences as this can often present as challenging behaviours in adults. It is important that all workers know as much information as possible to help them make informed choices about signposting, support and choosing the right engagement strategies.

3 Theme 2: Professional Curiosity

The lack of knowledge of Adult F's background, suggested a general lack of professional curiosity to understand why Adult F presented the way that she did. The review highlighted the importance of finding opportunities (no matter how short or limited) to build positive relationships and seizing opportunities for engagement wherever possible.

It was apparent that many organisations were working in silos and did not have an overview of the full circumstances.

4 Theme 3: Safeguarding

There were several opportunities for a safeguarding concern to be raised, however, it was assessed that Adult F had the capacity to make her own decisions and she understood the risks. One example was her decision to leave the temporary accommodation and return to her abusive partner.

The review found that there was a lack of understanding of the legal framework, including the Mental Capacity Act and the Human Rights Act, which can be used by professionals to safeguard adults who are deemed to have capacity but are unable to protect themselves from further risk of abuse and neglect. The impact of coercive control on Adult F's decision making was not fully considered.

This case highlights the complexities of working with adults who self-neglect and also live in a domestic abuse situation; professionals recognised that safeguarding support was needed but did not seem to understand how to raise these concerns to achieve a multi-agency response.

Had a safeguarding concern been raised earlier it would have enabled a person-centred, multi-agency, holistic plan to be developed for Adult F.

5 Theme 4: Communication

The scope of this review took place during the Covid-19 pandemic, where organisations were working under extremely challenging circumstances. One impact of this, was that many services (particularly in the early stages of the pandemic) closed their doors and stopped face to face visits. Although Adult F was known to a number of organisations, she was very rarely seen in person.

Agencies should consider the most appropriate form of contact, for example a letter to the home or a home visit may not be appropriate if a victim lives with an abusive partner. Organisations need to develop/improve effective engagement strategies based on an individual's needs and knowledge of trauma.

It is important that the whole system works together to find opportunities for potential engagement and that policies and procedures are flexible to encourage engagement between agencies and with adults at risk. Discharging from services due to disengagement should be carefully considered and based on individual needs rather than policy.

6 What to do Now

- Reflect on how the above themes link with your direct practice with adults, families and practitioners.
- Think about what changes you can make to your practice in similar cases.
- Share within your team and explore any training needs you may have.

7 What to do Next

Check out this information and share with your team:

- Safeguarding E-Learning Courses—https://www.tsab.org.uk/training/
- Self-Neglect Training Workbook—https://www.tsab.org.uk/training-resources/
- Resources from training events—https://www.tsab.org.uk/training-resources/
- TSAB upcoming training courses - https://www.tsab.org.uk/events-key-dates/
- Human Rights Act—https://www.legislation.gov.uk/ukpga/1998/42/contents

Check www.tsab.org.uk for up to date policies, procedures and guidance, including:

- Self-Neglect Policy and Guidance
- Professional Curiosity Procedure and Briefing
- Team Around the Individual Guidance (under review Feb 23)
- MCA and DoLS Policy
- MCA Guidance
- Police Referral Criteria

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