Derby Safeguarding Adults Board

Executive Summary for Practitioners

Safeguarding Adults Review: Samantha

May 2021

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Safeguarding Adults Review – Executive Summary Report

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A Safeguarding Adults Review is a legal duty under the Care Act (2014), which states that the Safeguarding Adults Board must arrange for a review of a case involving:

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and
c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual

The Derby Safeguarding Adults Board (DSAB) started a Safeguarding Adults Review (SAR) in 2019 to identify learning from a case in which a woman, identified as Samantha (not her real name), who had care and support needs, suffered from serious injuries in 2018. It was agreed by DSAB that the timeframe that would be considered by the review, would be the year prior to when the incident occurred.

The SAR and the final report were completed by an Independent Reviewer with input from those who knew or were involved with Samantha during this timeframe.

It was a priority to allow Samantha and her family to have a voice in helping shape and inform this review. Attempts were made to speak with Samantha via her advocate but unfortunately, this was not possible owing to Samantha feeling unable to contribute and communicate to inform the SAR. The Independent Reviewer ensured that the views of Samantha's family were obtained and included throughout the SAR process and the final report.

In addition, information was gathered from partner agencies that had been involved with Samantha during the review timeframe. A Practitioner and Manager event took place with participation from all the key agencies involved in providing care and support for Samantha. The event was focussed on what were considered some of the significant events, themes that featured during the timeline of the SAR, what was considered to have worked well, what was considered that could have been done better and recommendations for improvement.

The existing SAR Panel consisting of senior managers from lead agencies, with no previous involvement in the case, supported the progression of the SAR. These individuals were

identified to have the authority to effect change in their own agency and have the appropriate level of professional knowledge to support the SAR.

The final SAR report and recommendations were agreed by DSAB in April 2021.

Background

Samantha is described by her parents as the older of two siblings who is caring and driven in setting high standards for achievement. Samantha was a high academic achiever and following secondary education went on to study sports science and psychology at university. She further went on in 2007 to study sports science at a master's level. It was at this time she became unwell psychologically. This deterioration in Samantha's mental health was subsequently followed by involvement with local mental health services which included on occasions her being detained in hospital under Section 2 and 3 of the Mental Health Act 1983.

Samantha was diagnosed with Bipolar Affective Disorder in 2008, Autistic Spectrum Disorder (ASD) in 2012 and Akathisia, a movement disorder, in 2015.

Samantha had a history of self-harm and suicidal ideation which were represented in her actions of self-ligaturing and taking medication overdoses. Samantha had issues in relation to gender identity disorder and it is believed that she had engaged, at some stage, with a gender reassignment clinic.

Leading up to the events of the serious incident, Samantha had been detained for several months as in an inpatient at a Mental Health hospital unit under Section 3 of the Mental Health Act. During her detention there were several occasions when Samantha went Absent Without Leave (A.W.O.L) from the ward, and she also utilised short periods of Section 17 Mental Health Act Leave on a regular basis.

Several Care Treatment Reviews and Multi-Disciplinary Teams meetings were held to plan for Samantha's anticipated discharge from the inpatient unit under the conditions of a Community Treatment Order.

At the time of the tragic incident Samantha was utilising a period of Section 17 Mental Health Act leave to spend time at a transitional service unit to prepare for her eventual discharge. The unit provides alternative discharge routes for mental health service users having difficulty in transitioning back into the wider community, but where continued inpatient treatment is thought no longer to beneficial.

On the day prior to the incident, it was reported that Samantha had informed someone that she was hearing information inside her head and was thinking about significant self-harm.

This report was investigated by the transitional service unit staff. Risk assessments were undertaken, support was provided to Samantha and she denied any intent to self-harm.

Tragically she was found the following day with significant self-inflicted injuries.

Areas of good practice

1. Despite Samantha's case being complex there were elements of case management that worked well, which included family involvement, good documentation and record keeping, and Samantha being consulted with, about decisions made regarding her care and her views were sought to inform future actions.
2. Section 17 Mental Health Act leave was used in Samantha's best interests to protect her dignity and to relieve her of stress.
3. Involvement and communication with Samantha's family about her ongoing care generally worked well.
4. Appropriate professional challenge was applied by a social worker working with Samantha.
5. A disclosure agreement was developed with family to enable information regarding escalating risks to be shared and to receive information from themselves to help inform risk assessment and management.

Recommendations

1) Drawing upon feedback generated at the managers and practitioners learning event, Derby SAB should seek assurance from commissioners that sufficient available ASD specialist support is available to meet the needs of the local population.
2) Derby SAB should seek assurance as to the extent that the Mental Capacity Act 2005 is being applied across the Derby Safeguarding Partnership.
3) Derby SAB should closely monitor the developments of the proposals by the All-Party Parliamentary Group for Runaway and Missing Children and Adults in relation to the multi-agency response to individuals who go missing from hospital and care settings, together with considering the implications for the SAB and Safeguarding partnership should they be implemented.
4) Derby Safeguarding Adults Board should seek assurance from Derby and Derbyshire Clinical Commissioning Group as to how the recommendation to improve the recording of Section 17 Mental Health Act leave by Derbyshire Healthcare NHS Foundation Trust has been embedded and evidenced in current practice.

5) Drawing upon learning from this case and in line with the Care Programme Approach, Derbyshire Healthcare NHS Foundation Trust should ensure a named Care Coordinator is identified to act as the pivotal point of contact for agencies and the family, promoting inter-agency working and information sharing.
6) Derby Safeguarding Adult's Board should develop an escalation policy, where professional differences of opinion exist in relation to proposed courses of action, which may place an "Adult at Risk" as defined in the Care Act 2014 at risk of significant harm, which cannot be resolved through individual agency escalation procedures.
7) Derby SAB should seek assurance from Derby Clinical Commissioning Group as to how the recommendation generated from the Health Serious Incident review regarding contingency and crisis plan formulation, has been embedded in practice and evidenced in current operational practice by Derbyshire Healthcare NHS Foundation Trust.
8) Drawing upon learning from this case Derby Safeguarding Adults Board should promote the value of Multi Agency working, information sharing and joint decision making to protect Adults at risk of abuse and neglect as detailed in the Derbyshire and Derby Safeguarding Adults Policy and Procedures.

Next steps

All agencies are encouraged to reflect on the findings and identified recommendations to improve future practice.

These recommendations will be monitored by DSAB's Quality Assurance (QA) Subgroup who will seek assurances from the agencies named in the above report that these recommendations are being acted upon and will inform and improve practice for the future.