Learning Report in respect of the death of R

Date prepared 26th July 2022

Introduction

The death of R has been discussed on a number of occasions by the Ealing Safeguarding Adult Board and while the case was not considered to meet the criteria for a Safeguarding Adult Review, it was considered to be a case from which learning could be extracted to assist in improving the safeguarding system.

R was found deceased by her former partner, suspended from a door frame with a ligature around her neck. She had taken her own life and there were no suspicious circumstances. However, in the course of local discussion a number of areas emerged that it was considered might benefit from further exploration and from which learning could be extracted.

Accordingly, all agencies involved in care were asked to consider the following key issues and to identify potential leaning, both for their agencies and for the wider system.

Key issues and methodology

The following concerns were raised by the Board during discussion of this case

- Concerns regarding R's mental health provision in the community.
- Confusion regarding the address that was held on agency records, as it differed from the address where R died.
- How could a vulnerable individual reside in a house that had received multiple police reports?
- Concerns regarding any assessment of R's mental health as part of the care proceedings for her children.
- How do multiple Merlin's translate into overall assessment of risk?
- Multi-agency communication, where the needs of adult and children conflict.
- Concerns regarding the use of agency staff within teams/services.

All agencies were asked to complete a case template and the outcome of that is collated at Appendix 1.

What went well in this case?

This case is a complex case, with involvement from many services and with social care in another Borough involved in removing the children from R's care. The impact of covid and the pressures in the workforce highlight some clear concerns in this case relating to oversight of vulnerable adults in the community. There were some positives:

1. The community safety service recognised wider issues beyond anti-social behaviour and tried hard to coordinate a coherent response.
2. Appropriate referrals made by a locum in the GP practice.
3. All services are positive in undertaking reviews of this kind, even in circumstances where the threshold of a Safeguarding Adult Review under the care act is not met. This approach to system learning is a positive strength of the system.

What can we learn?

Although there was no suggestion of abuse or neglect in this case, there was a long-standing history of complex needs and the involvement of multiple agencies with the care of R and the wider family including children albeit in a different Borough. There is some key learning to pick up.

General learning for all agencies.

1. In cases where there are safeguarding issues relating to children consideration should be given to the care of the adult when critical statutory interventions are made.
2. Communication between agencies for the purpose of safeguarding vulnerable individuals is vital to ensure effective assessment of risk, and effective planning.
3. It must be recognised that when in crisis adults may not always be truthful or may withhold information from agencies.
4. Professional curiosity is important to probe and put a picture together.
5. Use of agency staffing creates challenges in consistency of approach and practice, immediate action needs to be taken if they do not turn up for work and their caseload needs to be reallocated.
6. Risk assessment planning needs to be complemented with effective safety planning and this needs to be produced with the adult.
7. Assessments need to include the view of wider family and friends and incorporate and value their contribution to risk and safety.
8. All agencies need to remind practitioners that consent might be difficult to obtain when an individual is in crisis, but that safeguarding concerns may override the need for consent in information sharing.

Specific Learning

1. Further work needs to be undertaken to ensure the Mental Health Integrated Network Team (MINT) team is offering the service expectations set.
2. Current risk in relation to MINT needs to be logged appropriately.
3. All agencies need to consider routes for case escalation when there are serious concerns.
4. Agencies need to consider how high-risk cases are considered collectively.
5. There is a need for effective communication channels to be established between mental health and housing and this must include clarity on suitability.
6. Further work is needed to consider the collective nature of repeat MERLINS and these need to be translated into effective risk assessment.