Safeguarding Adult Review: Adult Q - Learning brief

Bracknell Forest
SAFEGUARDING BOARD

What was this review about?

Q was 46 years old when she died from an overdose of prescription medication. This review looked in detail at the events during the three years before her death. She had been the victim of domestic abuse and a serious sexual assault. She also had to cope with the sudden loss of her mother and the end of a personal relationship. Although she had two children, they did not live with her and she was quite isolated. In the last six months of her life, there was an escalating pattern of overdoses involving alcohol and prescribed medication. Q did not engage with any of the community-based services on offer for addiction or support with her mental health. While Q died after the eighth serious overdose, it is not possible to know if she wanted to end her own life, as sometimes she seemed determined to die and other times she quickly rang for help after she had taken an overdose

Q as a person.

Family members believe Q always had problems with her mental health. They vividly describe a type of bipolar behaviour, sometimes full of energy and exuberance and other times quietly despairing and not wanting to talk to anyone, including her own children. Q increasingly struggled to maintain adult relationships and was dependent on her mother for practical and emotional support. She loved her job as a lunchtime supervisor in a primary school but had to leave as a result of the changes in her behaviour that appear to have followed a serious sexual assault.

Q's family do not want her only to be remembered as being defined by her problems, as she had a funny and witty personality and loved to spend her free time gaming and listening to music. When she was well, Q was described as a loving and fun mother who enjoyed not only spending time with her family but also with her close group of friends.

Key learning/themes

Self-neglect: There was an inconsistent approach to recognising self-neglect. Q lived in neglectful surroundings and was not able to take care of herself. The indicators of self-neglect in the home were very obvious. Despite these conditions being observed by ambulance crews and police officers, as well as being reported to hospital staff when Q was admitted, a safeguarding concern about self-neglect was not raised by any agency. Any of these concerns could have been the trigger to a multiagency Risk Framework meeting. Multi-agency training should be considered.

Understanding of the concept of consent:

It is important not to confuse consent to engage in therapy with consent to safeguarding activity. While Q did not consent to safeguarding referrals being made for her daughter, this was not her consent to give or withhold. Likewise safeguarding concerns (due to self-neglect and dangerous home conditions) should have been made regarding Q, regardless of her stated willingness to engage with particular services.

Key learning/themes ctd.

Impact of domestic abuse:

The impact of domestic abuse on Q was significant but has only come to light in the course of this review. She had been traumatised as a child by witnessing severe domestic abuse between her parents. She was a victim of abuse herself in her last relationship.

This SAR report, including the recommendations, can be found on the Board's website, with other SARs and learning briefs.

Challenges of working with alcohol dependency:

- There may have been elements of case fatigue; the same offers were met with the same rejection. Q made the same undertakings to control her drinking – and suffered the predictable relapse once she was discharged from hospital. It is only when a specific worker or agency takes responsibility that this pattern becomes apparent. This apparent cycle of behaviour masked the issue – both in frequency and drugs/ alcohol consumed.
- Working with Q could be frustrating because at times she was hard to contact and she would usually change her mind and go back on things she had previously agreed. It is important to think through and reflect with colleagues on what the bigger picture might be. Is there any way we can find out more about this person? Could family or friends help? What do we think the barriers are to Q working with us?

Recognising the wider family as a resource:

Q had a concerned family who felt frustrated in their attempts to find help for her. As a family, they had resources of persuasion, direct care and knowledge of Q and were willing to be engaged in a support package and to work alongside professionals to offer support. The procedural guidance and case supervision should consider ways of creatively involving families when they are willing and have the potential to be supportive.

Engagement :

- Missed opportunities to use the multiagency Risk Framework tool; this may have enabled agencies to pool their information, consider different approaches, and develop a better understanding of the barriers to engaging Adult Q. This approach could also have helped coordinate Q's family who were involved in trying to support her and had made referrals to both social care and the hospital. Such an approach could have explored a family group conference style response that further promoted resources located within the family.
- Adult social care could have engaged with this case more proactively. For too long they saw their role as signposting to other services and could have played a key role in assessing Q's vulnerability and coordinating services.
- Adult Q's mother's employment as a member of staff at BFC may have inhibited Q's engagement and offered false assurance to professionals. It appears that assumptions were made which may have been unhelpful. A more objective consideration of Q's needs could have resulted in a better appreciation of the actual risk to her wellbeing and the impact of this on her children.