Kirklees Safeguarding Adults Board
Partners in preventing abuse and neglect

Cumbria Safeguarding Adults Board

Learning from a Safeguarding Adults Review Donna

This learning report summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB) in relation to Donna. Donna moved between two areas and therefore this SAR identified important learning for both Cumbria Safeguarding Adults Board and Kirklees Safeguarding Adults Board. The implementation of the learning from this review will be jointly overseen by both partnerships.

1. What is a Safeguarding Adults Review?

A SAR takes place where there is reasonable concern about how members of the Safeguarding Adults Board or other agencies worked together to safeguard the adult, the adult has died, and the Safeguarding Adult Board knows or suspects the death resulted from abuse or neglect. The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve safeguarding practice and the wellbeing of adults at risk in the future.

2. Background

Donna was born in 1999 and was 23 years of age when she died. Her death was reviewed at an Inquest in January 2023, where it was found that the cause of death was hypoxic brain damage and cardiac arrest, caused by hanging in December 2022. She had taken illicit drugs when she ended her own life in her flat, which may have affected her cognition.

The SAR was undertaken alongside a Domestic Homicide Review (DHR), which reviewed practice from 2011 involving both Children's and Adults Services. The SAR focussed on the period from March 2020 to December 2022 and so not to duplicate learning from the DHR has had specific remit to explore Safeguarding Adults and related practice issues. The SAR process brought together reports and chronologies from agencies who had contact with Donna, in addition to a learning event for practitioners who had been directly involved with Donna.

Donna's family were also offered the opportunity to contribute to the review and her mother was spoken to as part of the process. Her mother described a "rough relationship" with Donna, and how she was not very involved in Donna's life as she was in Foster Care out of the area from the age of 10. Donna's mother and father split up when Donna was in her early teens and her mother described this as a very nasty break up. Donna was brought up by her grandparents after Foster Care. Donna had an extremely traumatic life, with multiple experiences of rejection, physical and sexual abuse, substance misuse and domestic violence.

At the beginning of the review period Donna had been supported to move out of the Cumbria area to escape violence and was housed in supported accommodation in Kirklees, before moving into her own flat. She had been discharged from mental health services in Carlisle and was referred to local mental health services by her GP. However, she only had some brief contacts before being discharged again. She experienced violence from others, including a relationship with a man who was known to mental health services. She alleged he was coercively controlling, physically violent and had started a fire in her flat. Police were involved, as were local domestic abuse services, but no charges were brought against him.

Donna was then groomed and sexually exploited by another man, along with two of his relatives and several associates, she was held against her will, given drugs and alcohol. She called police from the street, having escaped them. She was violent and abusive to police who attended, for which she was later prosecuted. None of the men she raised allegations about were prosecuted. During this time Donna also became increasingly mentally unwell and expressed suicidal thoughts, presenting to A&E on a number of occasions, but then not being able to engage with follow up services. She continued to see one of the men, whom she had feelings for, despite his ongoing abuse and violence.

Donna then left her flat in Kirklees and returned to the Carlisle area in September 2021, staying with her grandparents after presenting as homeless and being offered emergency accommodation. She was discussed at Carlisle MARAC, after a transfer from Kirklees. She began a new relationship which again became violent, and she was assessed by local Adult Social Care, with safeguarding involvement on two occasions. She was supported with her alcohol issues and subject to probation, following her conviction for earlier assaulting the police officer. She was allocated a temporary property, she experienced another violent relationship and had further sporadic contact with mental health support. She was in frequent touch with a local voluntary service for homeless young people, with whom she had maintained contact even when previously out of the area. She became increasingly paranoid and depressed, making several further crisis calls to emergency services following overdoses, resulting in mental health assessments at A&E, prior to her death in December 2022.

3. Findings

1. There was a misunderstanding or underestimating the impact of trauma in safeguarding adults work when assessing statutory duties with women who have mental health problems and face barriers to their engagement with services.
2. Underestimating the complexity, severity and long-term nature of the risks arising from sexual, domestic abuse and recognising that sexual exploitation can amount to Modern Slavery, for women who experience multiple areas of disadvantage, including care leavers.
3. Assessing the risks of suicide is a complex process requiring careful consideration of both relevant risk and protective factors. These are always problematic, especially for adults who present to mental health services in Crisis but subsequently minimise those risks and are not followed up effectively afterwards, following a suicide attempt. Where these factors are not collated and adults are discharged home alone without a suitable safety plan being formulated and agreed with relevant agencies, the adult may be left at high risk of suicide.

4. Information sharing is potentially compromised when an adult moves between local authority areas, especially when an adult is unable to consistently engage with statutory services, and this negatively effects subsequent contextualised assessments of the ongoing risk of harm from abuse for the new host area.

5. It is problematic recognising duties as set out under the Care Act 2014 for adults with mental health problems, especially for people with personality disorders. This may mean that eligibility decisions for Safeguarding Adults are deemed not to be met, either on the basis that the adult does not have Care and Support needs arising from their personality disorder, or that despite this any needs they do have don't prevent them from protecting themselves from abuse.

6. Formal assessments under the Mental Health Act 1983 or under the Mental Capacity Act 2005 are rarely undertaken for adults with borderline personality disorders, even when they may pose a risk to themselves. Where less restrictive alternatives are repeatedly offered, but the adult is unable to engage with these, this can raise doubt about the suitability/viability of these alternatives to assessment/admission. It may also raise doubt about the decision-making ability of these adults.

4. Recommendations

1. As part of improving safeguarding services with an understanding of the impact of abuse on how adults may present to services, all agencies commit to ensure their responses to referrals for domestic, sexual abuse, or sexual exploitation reflect a sufficient and trauma informed approach. This should specifically include consideration of the decision making or engagement difficulties for adults subject to coercive control and how this may impact on an adult's ability to protect themselves.

2. Awareness of Modern Slavery is improved to ensure systematic sexual exploitation is recognised as being within the definition and ensure that suitable referrals are made to the National Referral Mechanism, including the subsequent provision of appropriate support and protective services.

3. For services to develop sufficient guidance for their staff on the links between Domestic Abuse, Sexual exploitation/Modern Slavery and Safeguarding Adults to review the current models of multi-agency service provision relating to these areas, to improve coordination and the accessibility of their services.

4. To ensure that the local authority meet the requirement to offer all Care Leavers the support of a Personal Advisor up to their 25th birthday and the duty to notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24.

5. CSAB to receive assurance from partner agencies that their clinical suicide risk and prevention strategies include a commitment to develop suicide risk and safety plans with adults and their families where appropriate, in line with NICE guidelines on self-harm 2022, these should be undertaken by a lead professional, following a serious incident of self-harm or a suspected suicide attempt and that this is shared with other agencies, who can then take a proactive role in reducing the risk.

6. For Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust to undertake an audit of the quality of any narrative biopsychosocial suicide safety plans that are in use. The audit should include a review of how well professionals when working with adults and, where relevant other agencies, document all the known risk factors for suicide (such as substance misuse and domestic abuse/coercive control/modern slavery) and what action was taken in response to these, such as plans for engagement and suitable onward referrals as necessary.
7. Cumbria Safeguarding Adults Board and Kirklees Safeguarding Adults Board to consider reviewing and updating current operational guidance for staff regarding lawful and best practice for multi-agency information sharing agreements as part of safeguarding adults responsibilities, including when an adult moves between local authority areas, in order to escape abuse, whether or not these are part of formal safeguarding adults plans.
8. Cumbria Safeguarding Adults Board and Kirklees Safeguarding Adults Board to receive assurance from relevant services that staff can demonstrate an understanding of the relationship between borderline personality disorders, abusive relationships (where domestic abuse and sexual abuse/exploitation occurs) and subsequent safeguarding adults duties, where an adult is unable to protect themselves as set out in s42 the Care Act 2014, to ensure sufficient action is taken to identify and meet this duty.
9. Agencies should provide assurance that there is a process for managing complex cases, such as adults with mental health diagnosis including those with personality disorders where there has been patterns of suicidal and / or high-risk behaviours. The process should include adherence to evidence base practice identified in the NICE guidance and clearly demonstrate assessment of capacity through a trauma informed lens.

Cumbria Safeguarding Adults Board in collaboration with Kirklees Safeguarding Adults Board will continue to work with partners to ensure learning and recommendations from the SAR are embedded.

Practitioners from across the system are invited to attend a SAR lunch & learn session facilitated by the independent reviewer on 7th November 2024. For more information and to book your place click here.

Cumbria and Kirklees Safeguarding Adults Board will continue to work with partners to develop actions and improvements in response to the recommendations the report makes.