Summary report: Adult G SAR

Brief circumstances of the case.

Adult G was admitted to Calderdale Royal Hospital in February 2023 and sadly died in hospital 11 days later, in the presence of her mother. Her cause of death was pneumonia secondary to liver disease.

Adult G was 45 years of age when she died. She was a working professional and a mother (as a family they had support from Childrens Social Care), and was a victim of domestic abuse, experienced mental illness and became dependent upon alcohol. Her alcohol use is likely to have contributed to both malnutrition and self-neglect and ultimately decompensated liver disease.

Adult G was known to several agencies over a number of years. She was first discussed at MARAC in 2016 and was last discussed at the Domestic Abuse (DA) Daily Risk Assessment Management Meeting (DRAMM) in February 2023, the day she was admitted to hospital. She was assessed as a High-Risk victim of domestic abuse from 2 of her partners.

Methodology

On receipt of the SAR referral from Calderdale & Huddersfield Foundation Trust (CHFT) all agencies were asked to complete scoping documents detailing their involvement with Adult G, submit details and analysis of their involvement with Adult G.

The scoping information was shared, and the case was discussed in detail at a SAR consideration meeting held on the 17th April 2023. It was determined that the case did meet the criteria to conduct a SAR, and the key themes identified. There was recognition that learning was or had already happened in cases with full reviews, so there was a desire to have timely learning cross referenced with other reviews.

It was agreed that a Multi-Agency Reflective Practice Session, facilitated by the SAB Independent Chair would be the most appropriate way to draw out the learning from this case. The Reflective Practice Event took place on 10th November 2023. The agencies who attended were:

- Calderdale Recovery Steps
- Adult Services & Wellbeing, Calderdale Council
- General Practice
- Calderdale and Huddersfield Foundation Trust
- Children's Social Care, Calderdale Council
- South West Yorkshire Partnership Foundation Trust
- West Yorkshire Police
- West Yorkshire Integrated Care Board

Analysis of how Single and Multi-Agency working helped to safeguard Adult G.

Taking a strength-based approach, the key learning points gathered through the initial SAR consideration meeting and the more detailed Reflective Practice Session to identify what worked well, what are we worried about and any learning or areas for improvement.

What Worked Well?

- Attendance at Accident and Emergency Department did trigger a DA enquiry and Adult G was seen by the hospital Independent Domestic Violence Advocate (IDVA).
- Police always attended at calls to Adult G's address even when she called to say everything was fine. Police also undertook daily visits to check on the welfare of Adult G as part of the Domestic Violence Intervention Programme.
- Persistence of several individual workers to engage Adult G in services, despite being unsuccessful to engage her with Calderdale Recovery Steps and IDVA.
- GP referred to Recovery Steps for help with alcohol issues.
- Policy in place at GP surgery that all patients discussed at DRAMM/MARAC invited in for face-to-face appointment within 7 days.

Learning:

- Remote appointments together with a lack of professional curiosity may not have adequately assessed the risk or identified the reasons behind her reluctance to engage with services. (Learning points from MR C and Burnt Bridges SARs).
- There was a reflection that there might have been unconscious bias around exploring risk and a lack of challenge as Adult G was a professional and understood triggers for concern.
- MARAC Tags and Flags that inform professionals of a heightened risk of DA may have provided false reassurance that someone else is managing the risk.
- Agencies said that it was not known how well Domestic Violence Protection Orders (DVPO's) and Domestic Violence Protection Notices (DVPN's) were understood by partner agencies.

What needs to happen?

- Routine DA enquiry on presentation at Accident & Emergency
- Assurance from CSP/MARAC Steering Group that the changes made following the recent review of MARAC would ensure that the issues raised in this SAR are no longer a concern.
- Review attendance at MARAC/DRAMM to ensure all relevant agencies are represented and contingency arrangements in place for absence.
- Review of the effectiveness of risk management at DRAMM/MARAC including who is holding the risk and ensuring all required actions are taken.
- Raise awareness of flagging process in each organisation
- Awareness raising and training re DVPO's, DVPN's and how they can be enforced.
- Seek assurance that PIPOT and LADO processes are being adhered to.

Next Steps

1. This report to be considered by the SAR Adult G Panel initially and the SAR Subgroup and an action plan and / or briefing agreed. COMPLETE
2. Nominated Senior Manager at agencies involved quality assure, agree to recommendations and sign off the report. COMPLETE
3. Report to be signed off at the Safeguarding Adult Board. COMPLETE
4. The report and actions to be fed back to the front-line practitioners and managers who took part in the Reflective Learning Session.
5. The report, agreed actions and briefing to go to the Domestic Abuse Operational or Strategic Group (on the direction of the DA coordinator and Chairs of each group) to inform Domestic Abuse Action Planning.
6. The report and agreed actions will be presented to members and the Chairs of the MARAC, and also to the MARAC Steering Group.
7. Actions monitored by the CSAB SAR sub group. Once actions have been completed, this should be reported to the SAB.
8. Learning from this case should feature in the 2023-2024 Annual Report.
9. The anonymous Briefing should be published on the SAB website and learning events considered with the wider partnership.

Marianne Huison
Independent Chair
Calderdale Safeguarding Adults Board
March 2024