South Gloucestershire Council
Practitioner Learning Brief
Adult B July 2020

Background

Adult B died in November 2019. In March 2020 a meeting was held to determine whether her death met the criteria of a Domestic Homicide Review (DHR). While it did not meet the criteria a learning review was undertaken. This briefing summarises learning identified.

Police data showed a long history of domestic abuse towards Adult B from her family, mainly from her son. There is also a history in the police reports of alcohol misuse by Adult B and family members.

Adult B was working with DHI for support around her alcohol use and had just completed a detox prior to her death. Although she had been referred to NextLink, and they had made some contact with her both through hospital attendances and via the telephone, she was not an open case at the time of her death.

There had been referrals to MARAC and Adult Social Care but nothing had progressed past initial investigation stage.

Theme One: Information Sharing and Multi Agency Working

- Agencies were too concerned with gaining consent to escalate concerns and did not work together to share information around risk or find solutions
- Where a case does not meet the threshold for safeguarding, but there are legitimate concerns, there needs to be a mechanism where professionals can discuss risk and share information
- Agencies tended to work in silo, in isolation the risks didn't look high. Need to bring information together to see whole picture
- Agencies too quick to accept Adult B's downplaying of the situation and her lack of consent. Need to work in more creative ways
- Opportunity to discuss in a multi agency way at MARAC, but this was not maximised and risks not fully considered
- Different agencies saw different risk levels. Police saw Adult B as high risk, Next Link never rated as high.

Theme Two: Creative Working

- No conversations exploring reasons for Adult B refusing consent, potentially her work history or her culture may have been a factor but no one asked her
- Records document that some of Adult B's family posed a risk to her, but no attempts were made to speak to family members Adult B named as supportive
- Adult B's reluctance to engage was accepted too readily. Assertive outreach not attempted

There were some concerns About quality of record keeping and follow up of referrals

Good Practice identified included multiple referrals to Next Link, info sharing between GP and DHI

Follow Up:

- There was no documented after care plan for Adult B after detox
- Strategy Discussion held by Children's Social Care, Section 17 assessment agreed as outcome but this was refused by the family and case closed

It is difficult to support someone who continually refuses to engage, there is evidence Adult B did want help but the traditional options did not support her adequately

Recommendations

1. That agencies need to be flexible and work creatively where consent is not given and find other ways, outside of safeguarding procedures, to escalate concerns and share information. Consent should be asked of the service user to discuss their situation at a professionals meeting for example. Alternatively an anonymised case discussion could take place. Practitioners also need to be clear when their concern for someone's safety over rides their lack of consent and act accordingly. In addition, consent to share information/make referrals etc should continue to be asked of the service user, rather than it being a one off question.

2. That practitioners should explore the barriers to people accepting support in full. They should directly ask service users about their reluctance to accept help, the reasons for their lack of engagement with services and actively look at whether there is someone in the professional and/or support network who has a good relationship with the service user and could access help, advice and guidance on that person's behalf.

3. That the MARAC process be reviewed to ensure that actions are robust, comprehensive and include all agencies that might be involved and that there is follow up to those actions.

4. That a person's supportive network should be included in safety planning rather than just the risks they are subject to.

5. That where possible assertive outreach and creative ways of engaging people be employed. Examples here include the NextLink worker attending DHI as a drop in or the DHI worker and the NextLink worker discussing how they may support the service user together, rather than as individual practitioners.

6. That work takes place to improve working links and relationships between NextLink, Adult Safeguarding and DHI.

7. For all agencies to ensure improved record keeping of DVA cases and discuss with other involved practitioners to ensure that all agencies have the same level of risk recorded.

8. That DHI and AWP ensure there is a documented procedure on aftercare post detox, to include handover between AWP and DHI and that an aftercare plan is discussed with the individual and documented in their file so that it is clear who is responsible for their aftercare.

9. That Children's social care look into actions that could be taken where consent for Section 17 assessment is refused but there are still concerns.

10. For Adult Safeguarding to explore their response to DVA referrals, taking into account issues of consent, discussion with referrers, history of referrals.

11. That the Safeguarding Adults Board, Safe and Stronger Communities Partnership and Children's Partnership to develop a process whereby organisations can raise concerns about the management of a particular case, whilst understanding it doesn't meet the criteria for a SAR/DHR/CSPR.