Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR -Ms AB

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Ms AB could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

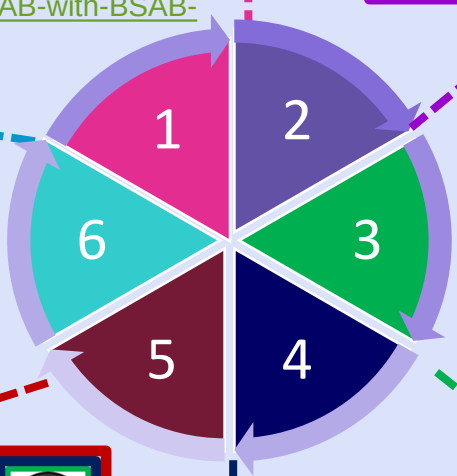
The full report can be found here –

https://www.safeguardingadultsinbexley.com/wp-content/uploads/BSAB-SAR-AB-Ms-AB-with-BSAB-Action-Plan.pdf

2. What happened in the case of Ms AB?

AB was a 45 year old woman who died in her housing association flat from a drug overdose. Her partner (XY) of 10 years had recently been released from prison following a prison sentence for Grievous Bodily Harm (GBH) against AB in August 2017. Cause of death confirmed by the Coroner: Methadone Toxicity, found to have taken diazepam, cocaine, dihydrocodeine and a significant amount of methadone. A Coroner's inquest classed her death as 'accidental overdose' and not suicide.

The methodology for this SAR was agreed to be an Internal Management Review (IMR) – chronology based, highlighting identified key learning themes.



3. Involvement of Family Members:

Attempts were made to contact the sisters of AB prior to starting the review. One sister made contact and made a decision not to meet and discuss the report but received a copy of the report once it was published.

A decision was made not to contact XY, the ex-partner of AB, as he was the perpetrator of the domestic abuse towards the deceased and is also vulnerable due to drug and alcohol addiction.

AB's adult daughter was not contacted due to lack of contact information.

4. Background/Summary:

AB was described as a drug addict living a chaotic life. AB has a daughter who was removed from AB's care when she was a baby. In 2006 AB's partner died, soon after this it was reported that AB tried to take her own life. AB was known to the current provider of drug and alcohol services since 2007. AB was prescribed methadone given by the pharmacy on a daily basis. Physically she was frail – just over 36kgs at the time of her death. AB lived with her partner XY in Thamesmead and then Sidcup. AB became homeless following the domestic abuse incident. AB was estranged from her family for 3 years prior to her death. AB did not receive any psychological support and did not qualify for rehabilitation services due to the fact that she was unable to remain drug free long enough to qualify for this. She had some mental health input in the past for depression but at the time of the Domestic Abuse Incident was assessed as not requiring secondary mental health support. She did however have ongoing support from drug and alcohol services. AB is reported as often purchasing drugs over the counter and off the street, she would take these drugs in addition to the prescribed methadone, which was administered daily due to the risks of overdose.

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5. Recommendations 1-8:

Recommendation 1: Ensure the DASH process is in place to assess risk to clients prior to making contact with them.

Recommendation 2: To review and revise a Borough wide process for agreement of the most appropriate process to use, and a timescale requirement, for a multiagency conference to identify and address risk for high risk.

Recommendation 3: IDVA services to give recommendations to the Courts when Domestic Abuse is known to have occurred – e.g. Injunctions.

Recommendation 4: (linked to 3) MARAC to include a Safety Plan for all risks to the victim, always including provision to keep the victim safe following the release of the perpetrator, housing and health risks.

Recommendation 5: Safety Plans for High Risk cases to be mandatory and shared across all agencies, unless sharing with a particular agency would be unlawful.

Recommendation 6 – All agencies to include in their procedures the process for escalating risks to high risk panels.

Recommendation 7: A system to be agreed to ensure that victims of domestic abuse are supported to find accommodation in a safe place including consideration of placing in safer areas when at risk of other key factors (e.g. recovering drug addict).

Recommendation 8: Consideration to be given to whether there is a national need for supported accommodation for people who want to recover from drug and alcohol abuse.

6. Recommendations 9-10:

Recommendation 9 – Housing services to complete an audit and feedback to BSAB to provide assurance on reports given to private housing providers.

Recommendation 10: All agencies to ensure that they have a process in place to ensure that they are aware of which agencies are involved with their clients and that information is shared in a timely way.