Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

EXTENDED ADULT PRACTICE REVIEW

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1 Background

CTMSB undertook an Extended Adult Practice Review after a young woman was tragically found deceased. Her death was unexpected, and the cause of her death remains unclear as she was not found for some time. This young woman had complex needs arising from past trauma, mental illness and polysubstance misuse. She had a diagnosis of Emotionally Unstable Personality Disorder and was dependent on alcohol and benzodiazepines. She was depressed, self-harmed and sometimes had suicidal thoughts. Her physical health was poor. She was supported by a network of agencies and services.

2 Context

The year before her death was turbulent. Contact with her young son ceased, she began a relationship with someone who also had mental health issues and misused substances. Their relationship was characterized by serious domestic violence, and he was also coercively controlling of her. Over the year eleven 999 calls were made either by this young woman or by someone who had found her. Four were for physical health issues; two because she had tried to take her own life and two because of domestic violence. She had six hospital admissions. She also had financial problems and had been served with notice to leave her accommodation.

3 Key Learning Points

Working with someone who is difficult to engage: it is important to distinguish between contact and real engagement. This young woman was difficult to engage and selective about which services she communicated with. Professionals felt they were, always 'fire-fighting,' always reacting to crises rather than working with clear and positive plans

Domestic violence and coercive control: it is insidious, powerful, far-reaching and difficult to challenge. Victims of coercive control often do not realise they are victims even when there is clear evidence. In this situation she described her abuser as her carer.

4 Key Learning Points

Inter-agency collaboration and communication: it is important to think about wider implications when submitting a PPN and which agencies should be informed when a carer can no longer enter a house.

What was missing in this situation was an opportunity for all professionals and services to come together to share information; to plan strategies and to coordinate actions. A MARAC was held but mental health professionals were not invited and so their information and perspectives were missing from discussions.

5 Key Learning Points

Trauma informed practice, which is a strengths-based approach, would have been helpful in understanding this young woman's mental health and polysubstance misuse.

Connecting with the wider family: the challenge for professionals is how to work in partnership with families, who may be sources of support, whilst respecting the individual's right to confidentiality.

Was there delay in finding her? She had been deceased for some time when she was found. However, various professionals did make attempts to contact her and her elusiveness was not unusual. What might have alerted professionals is that she had not collected her prescriptions for some time. This was not her usual pattern of behaviour.

6 Effective practice:

- Communication and the exchange of information between services and agencies was good and systems were followed appropriately
- The Police did as much as they could in terms of making a Clare's Law disclosure, commencing 'Police watch' at critical junctures and overriding the withholding of consent to share information when they submitted PPNs
- Handwritten prescriptions were replaced by printed ones to remove the risk of them being tampered with
- The professional network were committed and persistent

7 Developing Systems and Practice

-When working with complex cases consider referrals to the Complex Case Panel which provides a multi-agency opportunity to review individuals who present with a significant level of risk
-MARACs – review attendance to ensure the appropriate people are present. Also Chairs of MARACs to be reminded to routinely ascertain when a person was last sighted.
-Setting up a protocol with pharmacists to flag up when those at risk and vulnerable fail to collect their prescription
-A thematic feedback event to be organised to disseminate learning from recent reviews about coercive control
-All agencies to review current training to ensure it includes trauma informed practice.