Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

7 Minute Briefing

SAFEGUARDING ADULTS REVIEW AMANDA

THE ADULT

Amanda was a white woman who was born and grew up in southeast London. She died in May 2019 at age 57. At a young age, doctors had diagnosed Amanda with paranoid schizophrenia. Amanda developed a dependence on drugs and alcohol and used different substances at different times in her adult life.

Amanda was regularly drinking large amounts, mainly vodka. She was making efforts to reduce her alcohol intake, and she was achieving this intermittently. She hoped to attend a residential detox placement to begin further rehabilitation.

BACKGROUND TO THE REVIEW

The Care Home where Amanda lived provided her with 24-hour care and support. As someone who had both schizophrenia and substance misuse, she was treated for her dual diagnoses. Amanda had previously been detained under the Mental Health Act and her ongoing care and support was funded under the s.117 aftercare provisions of that Act.

In 2018-2019 some of Amanda 's social life revolved around street drinking. When she was intoxicated Amanda was susceptible to falling and sustaining injuries, including head injuries. The police were often involved in responding to incidents in public places and she was regularly transferred to hospital Emergency Departments by ambulance.

WHAT HAPPENED

On 15 May 2019 Amanda did not return to The Care Home. Care Home staff informed the police that she was missing. Amanda did sometimes go missing for short periods of time. On this occasion, when she didn't return quickly, family members began their own enquiries. The family enquiries led to new information about what might have happened to Amanda. This information was provided to the police Missing Persons Unit. The police responded by searching an unused garage in the borough.

The garage was derelict and along with adjacent garages was due to be demolished as part of a redevelopment programme. It had been used by street people to leave or dispose of belongings. It had also been used as a rough sleeping site. To stop this activity, the entrance to the garage was boarded up in May 2019.

On 5 July 2019 the police found Amanda 's body in the back of the garage. She had been missing for just under two months. At the time of the completion of the review, the cause of Amanda's death had not yet been established.

KEY LEARNING

A legal and expert practitioner review of the circumstances of Amanda's fluctuating capacity should have been commissioned. This may have determined whether there were options available to practitioners to detain her under either the Deprivation of Liberty Safeguards, or through an application to the Court of Protection.

Training on Professional Curiosity should focus on the subjects of 'normalisation' and 'desensitisation'. Professionals did not fully recognise the 73 visits Amanda had to the Emergency Department (in 17 months) as a very significant risk trend in her life, as they became too accustomed to these episodes as 'normal' for her.

QUESTIONS FOR YOU TO CONSIDER

1. If an adult with care and support needs is sustaining multiple and frequent injuries, do you ensure that this provokes a determined safeguarding assessment and plan?
2. Do you follow local safeguarding pathways consistently and fully in relation to adults with care and support needs who have alcohol misuse problems?
3. When working with an adult with long-term and persistent problems, do you take a step back to find new and creative ways of working, that may open new avenues to best support the person?
4. Do you escalate persistent risks about an adult in an appropriate and multi-agency way, making use of available panels and systems?
5. Do you initiate Domestic Abuse protocols when interviewing individuals who have sustained personal injuries, even if there may appear to be other explanations for these, such as falls due to intoxication?
6. When reporting a missing person do you ensure that a full risk profile is provided to police?

WHAT YOU CAN DO TO PREVENT A REOCCURRENCE

Ensure your continuous professional learning and development has a focus on Professional Curiosity, and in particular find out more about 'normalisation' and 'desensitisation'.

Look for risk patterns in attendances at Emergency Departments (A&E) and hospital admissions.

Ensure that you and your colleagues are up to speed with local safeguarding pathways, and that you take a multi-agency approach, which recognises the need to appropriately share information with the local authority as the lead agency.

Take a multi-agency approach in assessing fluctuating mental capacity in the most complex cases, and consider seeking appropriate legal advice, which considers the needs of people who are dependent on alcohol and are vulnerable.

When developing a strategy to support someone who is dependent on substances, think about progressing with a detox placement in parallel with a plan for post-detox care and support, which focuses on relapse prevention.

Lewisham Adult Safeguarding Pathway
https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

London Multi-Agency Adult Safeguarding Policy & Procedures (April 2019)
https://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf

Mental Capacity Act 2005
https://www.legislation.gov.uk/ukpga/2005/9/contents

NICE Guideline CG115 (2011a) - Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, (London)
https://www.nice.org.uk/guidance/cg115

NICE Guideline CG120 (2011b) - Psychosis with coexisting substance misuse, (London)
https://www.nice.org.uk/guidance/cg120

NlCE Guideline NG58 (2016) – Co-existing severe mental illness and substance misuse, (London)
https://www.nice.org.uk/guidance/ng58

NICE Guideline NG108 (2018) Decision-making and mental capacity (London)
https://www.nice.org.uk/guidance/ng108

Preston-Shoot, M. and Ward, M. (2021) How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales. (Alcohol Change UK)
https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers

Public Health England/National Health Service England (2017) – Better care for people with co-occurring mental health and alcohol and drug use conditions (London)
https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services