North Tyneside and Northumberland Safeguarding Adults Board

Safeguarding Adults Review in Respect of Leanne Patterson

Executive Summary Report

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Executive Summary

This report provides the outcome of a review undertaken, in accordance with Section 44 of the 2014 Care Act, into the death of Leanne Patterson. For the purposes of this report, Leanne's full name has been used, at the request of her family. Leanne was a 36 year old woman who died in hospital on 18th April 2018. Three months prior to her death, she had moved to a multi-occupancy hostel, having suffered domestic abuse at the hands of her previous partner. At the time of her arrival she was known to have a history of substance misuse, and associated physical health problems. During her stay at the project Leanne's alcohol use increased, and she became involved in a relationship with another resident who was later evicted due to his abusive behaviour towards her. Following this Leanne was assaulted by other residents on both 25th and 29th March, which resulted in her being admitted to hospital and then discharged. On 05th April 2018 her condition deteriorated and she was readmitted and died less than two weeks later from her ongoing longstanding physical health problems. A number of people were charged with Assault offences against Leanne in relation to the events leading up to her death.

In learning from the tragic death of Leanne, the following key themes were outlined:

Lack of an earlier robust and coordinated multi-agency approach to the managing of risk and Safeguarding.

This review identified that a significant number of appropriate referrals or notifications were made to both MARAC and Safeguarding procedures. However, there were also occasions when such referrals or notifications were missed. Two primary reasons emerged from agencies' analysis of practice as to why these omissions occurred.

Firstly, there were a number of incidences where staff believed that processes were already ongoing, or that other agencies had already made referrals, and therefore no further referral was felt necessary. It was identified that reliance on other agencies to make referrals inherently results in a greater risk of such referrals being missed, and can fail to build up a more holistic and robust picture that shows the extent of concerns from a number of sources and potentially highlights differing perspectives and information available.

Secondly, while there was substantial evidence throughout the review period of MARAC referrals being made from most agencies, these appear to have taken precedence over the Safeguarding process, instead of these processes having been considered in parallel. While it was positive to see evidence that domestic abuse was recognised and referred appropriately, the limitations of the MARAC procedure become apparent in this case. MARAC meetings are focused specifically on the risk presented within a domestic abuse context to high risk victims; with a number of cases being discussed at each meeting by a Panel of representatives from a variety of agencies. In contrast, a Safeguarding meeting is designed to discuss one case at a time, that of the Adult at Risk, with those attending normally involved directly in the case; the focus is the broader 'vulnerability' of the Adult at Risk, including that relating to others outside of domestic abuse, as well as elements of risk such as self-neglect. While it was not clear that this procedure would have necessarily been able to identify the risk by specific individuals to Leanne, as such information did not come to light until later; it would have encouraged a wider consideration of concerns. This could

potentially have allowed for a more robust plan to be put in place at an earlier stage, in order to address Leanne's overall vulnerability and consider measures to decrease this.

Working with individuals with multiple complex needs and vulnerabilities, and the impact on overall perceptions of risk, including the role of choice and Mental Capacity.

A number of agencies identified in their contact with Leanne that she was 'making choices' around lifestyle that were increasing her risk and made her difficult to engage; such references were mostly seen in relation to her experience of domestic abuse and her substance misuse. A number of agencies referred to her choice to return or remain in an abusive relationship, and her lack of consistent engagement with services. What was less apparent however was consideration of the interplay between these factors. This is particularly relevant in light of the fact that, when viewed in its entirety, information around Leanne's circumstances has highlighted that her partner may have been physically abusing her, that she may have been exploited to finance her drug use, and that her lack of stable accommodation made her vulnerable to returning to abusive relationships or to being exploited. In addition, the emotional impact of having been subject to such high levels of abuse and the impact of this on her decision making processes, as well as the impact of the associated health conditions, do not appear to have been explicitly considered as part of a wider picture.

In specific relation to the issue of choice, Adult Social Care also highlighted that Leanne's mental capacity should have been considered. This was not undertaken although a number of agencies reference Capacity and the belief that Leanne was making a capacitated decision, without any evidence of this having been assessed. It was identified that Leanne's long-standing history of substance misuse, domestic violence, reported coercion, mental health concern, physical health concern, and reported exploitation gave reasonable and sufficient evidence for capacity assessments to have been considered.

Managing risks for those with complex needs and risks within a multiple occupancy accommodation environment.

One of the significant features that emerged within this review was the difficulties in fully assessing and managing the risks that occur when individuals with entrenched problems, that limit their access to certain services, are subsequently housed together with others facing similar issues. This can result in increased difficulties for individuals to move away from certain behaviours and social networks, as well as increasing risk around potential opportunities for exploitation. The Accommodation Provider starkly highlighted this in recognising that they originally accepted Leanne in to their accommodation due to awareness of the limited options available to her, and the greater risks that would exist should they have refused her access.

While this continues to support the compelling need for a robust multi agency approach for managing such risk, it also highlights the gaps in existing systems for such multi-agency approaches, as they would not necessarily have identified the interplay of risks between the number of individuals involved. However, had agencies working with all individuals met to consider the risks and vulnerabilities of each, this may have led to a more comprehensive

assessment of the potential interactions within the project and the dynamics of the possible risk. The importance of this was highlighted during compilation of this overview report, when it was at times difficult to ascertain who held what information in relation to whom, and therefore what risk information was available to each agency in undertaking their risk assessment and management. It was apparent that this often relied on individual practitioners to actively seek information, or to identify that their information needed to be shared and with whom. Such reliance leaves agencies open to gaps in information that impede the effective management of risk.

In considering the findings and conclusions of this report the following recommendations were made:

Recommendation 1:
North Tyneside and Northumberland Safeguarding Adults Board to identify an assurance framework that evidences that all actions identified within individual agencies IMRs as undertaken, or ongoing, have been fully completed.

Recommendation 2:
North Tyneside and Northumberland Safeguarding Adults Board to seek assurances that all agencies have sufficiently addressed within policies/procedures, and associated training and awareness among staff:

- The need to ensure that notifications/referrals to multi-agency procedures are made in all cases, regardless of whether processes are believed to be ongoing or whether other agencies are also raising concerns.
- The need to consider referrals to all appropriate multi-agency procedures (in line with agency role), and that referral to one of these should not substitute or be given preference over another.

Recommendation 3:
North Tyneside and Northumberland Safeguarding Adults Board to seek assurances that all agencies have sufficiently addressed within policies/procedures, and associated training and awareness among staff that:
While capacity should be assumed, in complex situations when capacity has been considered by staff, it should be recorded whether **or not** a capacity assessment has been undertaken and on what rationale this decision was based on.

Recommendation 4:
North Tyneside and Northumberland Safeguarding Adults Board to review current risk assessment/management requirements and information sharing protocols in place for commissioned supported/temporary accommodation services. This should include consideration of the need for:

- A specific interpersonal risk assessment tool to be commissioned/developed for use by commissioned supported/temporary accommodation services.
- A multi-agency information sharing protocol to aid the timely completion of any such assessment.

A Northumberland multi agency meeting/group to consider the wider dynamics of interaction and risk relating to those living within the transient community, drawing on similar practices within the Newcastle and North Tyneside areas.

Recommendation 5:
North Tyneside and Northumberland Safeguarding Adults Board should ensure feedback is given to the family of Leanne within 2 weeks of approval of this report; should the family wish to be involved. In addition, learning from the review should be effectively disseminated to all agencies involved in Safeguarding Adults within 3 months of the SAB approval meeting.