APR GWASB 3 / 2019

Recommendations

*The Regional Safeguarding Boards should provide multi-agency guidance on working with antagonistic & uncooperative carers and families of adults at risk.
*The Regional Safeguarding Boards should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.
*Agencies to consider how they manage the sharing of information when patients/clients nominate someone else to co-ordinate their care.
*Awareness and understanding of coercion and control, including how to provide the detail of information required for a criminal case, and use of the DASH risk assessment would be beneficial for front line staff.
*The Regional Safeguarding Board should consider how to raise the awareness and understanding of when to consider the inherent jurisdiction of the court in complex and serious cases.
* The Regional Safeguarding Board should consider how to raise awareness and use of the MCA and capacity assessments.
*Safeguarding training should include complex case examples to illustrate the importance of considering all the factors affecting an adults at risk and how this relates to the relevant legislation.
* The Regional Safeguarding Board should share this APR with the local VAWDASV Partnership Board.

Learning Opportunity

Reflect on the case discussed & think of how this situation could have presented in your work with vulnerable individuals?
Ask are there any similarities in cases you have worked or situations you have encountered?
What would you have done in a similar situation when working with vulnerable individuals & what are the barriers to practice in your organisation?
Identify key support for yourself in your team.

Context

An extended Adult Practice Review was commissioned by the Chair of the Gwent Wide Adult Safeguarding Board on the recommendation of the Joint Case Review Group in accordance with 'Working Together to Safeguard People: Volume 3, Adult Practice Reviews, Social Services and Well-being (Wales) Act 2014

The review concerns the death of a 48 year old woman with a learning disability, who will be known hereafter as 'Ann' in accordance with her family's wishes.

Key Learning Themes

•Working with antagonistic and uncooperative carers/families
- Adult B prevented access to Ann for services and acted as a point of contact.
•Primary Care Issues
- A practice wrote to Adult B about his behaviour and he then moved Ann to another surgery.
•Use of Legislation, specifically: Social Services and Well-being (Wales) Act 2014, Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and the Mental Capacity Act 2005.
- Practitioners used Safeguarding processes, & recognised coercion and control but did not consider how this could have been used. The impact of his behaviour on her ability to make decisions could have been considered.

Background

Ann was adopted at 3 months old. She attended a special school & college courses. Ann never lived independently. She met & married her husband, & they moved to Wales to take on a business there. They had one daughter. Her marriage ended, due to domestic abuse & Ann was unable to care for her daughter so she went to live with her maternal grandparents in England. Ann enjoyed social activities, craft work & going to clubs, she enjoyed being with people. Ann enjoyed family gatherings, & when she was able she visited her family & daughter in England.

Coercion and control

Practitioners recognised that Adult B's behaviour was coercive and controlling. He prevented practitioners from gaining access & used aggression & complaints to services as a way of controlling access. The family revealed a long history of controlling behaviour by making access increasingly difficult. When they first started their relationship Ann would visit her family in England with Adult B. Over time they reported that contact became more limited and that the visits ceased. Ann's daughter continued to visit her but Adult B made her feel uncomfortable, and would follow her and prevent Ann from leaving the property. This pattern of behaviour meant that contact between Ann & her daughter was reduced to occasional phone calls, and at the point of her hospitalisation Ann had not seen her daughter for 4 years. Her Learning Disability diagnosis got lost to services over time. There were concerns about the decisions she was making. This should be a reason to question a person's capacity & to undertake an assessment.

Ann's life with Adult B

All contact with Ann was via Adult B. In June 2017 the GP made a referral noting Adult B's influence and control.
Contact with services was patchy and a joint Police and Social Services visit took place in March 2018. Adult B was very aggressive towards Local Authority staff and only allowed the Police Officer into the property. The Police Officer briefly met Ann before Adult B became agitated and aggressive and demanded the Police Officer leave the property. Following this, further safeguarding measures were discussed and in April 2018 access was gained under an Adult Protection Support Order (APSO) under the Social Services and Well-being Act 2014. The APSO was used on the 10th April 2018 to gain entry to Ann. On this date a visit was made by Social Services and the Police. Social Services staff were able to speak to Ann to assess her welfare and her wishes, and following a visit from the G.P. later the same day she agreed to be admitted to hospital. Ann remained in hospital from the date the APSO was served, until she sadly passed away on 28th April 2018.

NST would like to thank Manchester Safeguarding Board and Lancashire Safeguarding Children and Adult Boards for their help with the template and original guidance on 7 minute briefings.

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