Diana - 6 Step Briefing

The Background

Diana was a 50-year-old lady with a long history of physical and mental health issues, having received treatment from mental health services for over 30 years. When Diana's mother died in 2013, Diana struggled to grieve and became depressed, leading to hospital admission. Diana's siblings tried to support her, but she was unable to regulate her behaviour, causing her to become estranged from her family. Alongside complex health problems and a diagnosis of EUPD, Diana had a long-term volatile relationship until 2017. Diana subsequently reported being harassed and fearful of her ex-partner throughout 2018 and required a housing management move. In the days before her death, Diana reported problems with her "new" neighbours, which required police involvement.

The Incident

In June 2019, Diana's ex-partner raised concerns that they had not heard from Diana for a few days and asked a mutual friend to check the flat. Unable to access the property, the police were called. Upon entering, they found Diana deceased. Diana's death was thought to be by suicide, but, at the current time, is awaiting a coroner's inquest. Diana's sister described her as being "alone, nobody cared, abandoned" when she died.

Safeguarding Concerns

Diana was described as being "institutionalised" by the mental health services after 30 years of receiving treatment. Diana was a product of the old mental health system which did create dependency on services; it is difficult for someone to become independent after spending most of their life in that structure.

Diana had identified care and support needs. She might not have required intensive mental health treatment but did need support in maintaining her daily living. This might have been more due to her physical needs but there has been no clear evidence of how the services monitoring her physical needs were informed about the changes to her circumstances.

Diana would give the impression she could cope when she became angry with professionals trying to help, her but needed a significant amount of support to attend to her daily life due to her physical problems and did not always make sound decisions about who to ask for help, which made her vulnerable to exploitation.

The Review

This Safeguarding Adult Review (SAR)/ Multi Agency Review concerns the effectiveness of inter-agency practice in relation to engagement and care of a vulnerable adult. The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory SAR and this was agreed by the Southampton Safeguarding Adults Board (SSAB). The timeframe for the period under review was 1st January 2018 to 10th June 2019.

Findings

There were several examples of professionals going above and beyond to help Diana have a successful housing move, but there was no joined-up thinking about the impact that losing those who knew her well - at a time when she had not established safe relationships to enable her to access support – may have had.

There were missed opportunities to explore the risks to Diana from a multi-agency partnership perspective. This is partly due to an over-reliance on CHMT to address safeguarding concerns - Diana had made multiple disclosures that indicated she was at risk of exploitation, and the workers in direct contact should have considered safeguarding referrals at these points.

The housing team offered support to Diana but recognised her dependence on the CMHT. This did not prevent the housing team from providing advice and support for Diana but was limited to addressing the incidents with her neighbours rather than advocating for a multi-agency response to how to develop a safe network of support for her.

Police call handlers dealt with 14 calls from Diana shortly before her death and treated them as neighbourhood dispute and antisocial behaviour issues, without consideration for why these problems were occurring or what help Diana was receiving.

Following Diana's housing move, help from individual workers appears to have diminished too rapidly. This meant that Diana was left without clear support because services interpreted her behaviour as meaning she was resourceful enough to access the help she needed.

Diana had experienced problems with her ex-partner and another neighbour prior to the move and so it was wrong to assume that she would cope within a new community, especially knowing that she was being obstructive to workers who tried to help her following her move.

Good Practice

Prior to the move the CMHT tried to work with Diana to support her in the move and in general home management. The CMHT continued to support Diana in raising concerns about the ex-partner receiving Carer's Allowance. This team included Community Mental Health Nurses (CMHN), one of whom acted as her Care Coordinator, Social Worker and Support Workers.

There was good liaison between the CMHT and the housing association which was responsive in organising a management move for Diana. Following the move, arrangements were made to provide help in preparing the flat. There was also the involvement of a Welfare Benefits Officer.

The PCSOs who visited Diana's flat in May 2019, following the altercation with neighbours, showed kindness, spent time listening to Diana's concerns and even moved some of the stacked boxes as they recognised that there was a risk of injury. These PCSOs spent time listening to Diana and appropriately identified the need for support and referred to Adult Social Care via a PPN1.

Useful links for Best Practice

- Diana full SAR report
- 7 Minute Briefing Mental Capacity
- Gaining access to an adult suspected to be at risk of neglect or abuse
- Mental Capacity Guidance – Bournemouth University
- One Minute Guide to Self-Neglect
- 4LSAB Multi-Agency Safeguarding Adults Escalation Policy
- Care Act factsheets - GOV.UK (www.gov.uk)