Safeguarding Adults Review

“Mrs Moyo”
Executive Summary

September 2021

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Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

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1.Introduction

1.1. The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[1]

1.2. This Safeguarding Adult Review (SAR) concerns inter-familial domestic abuse to an adult, 'Mrs Moyo' who had care and support needs. It considers learning surrounding an assault to Mrs Moyo by her son, 'Joseph.'

1.3. Both Mrs Moyo and Joseph were known to partner agencies of the Safeguarding Adult Board. The review explores whether there were opportunities for agencies to have worked together at an earlier stage to reduce risk of harm arising. The review also considers how effectively agencies responded to Mrs Moyo's family's concerns that she was at risk of harm from her son.

1.4. Leicester City Safeguarding Adults Board (LCSAB) commissioned an independent author, Sylvia Manson for the review. The author is independent of LCSAB and its partner agencies.

2. Mrs Moyo and the Background for this Review

2.1. Mrs Moyo is a black woman of African heritage. She was in her sixties at the time of the incident and lived in a council property with her son Joseph.

2.2. Mrs Moyo was supported through Leicester City Council Adult Social Care (ASC) due to her physical health needs. She was provided with domiciliary calls twice daily. Mrs Moyo has another son, Aaron and she also received support from him and his wife, Jasmin.

2.3. Mrs Moyo's son Joseph had a history of psychotic episodes that were induced by his use of illicit substances. Historically, Joseph had been compulsory detained under the Mental Health Act[2] on two occasions. On both these occasions, he had been paranoid and aggressive, requiring intervention by police. On both occasions, his family had identified his relapse and alerted services. Joseph was supported by Adult Mental Health Services (AMHS) on his discharge in 2014 and his mental health recovered.

2.4. In 2015, Joseph was sentenced to prison for six years for class A drug offences. In 2018, he was due to be released on license to probation. Probation assessed his risks as low, based on information from his offending history and the minimal

[1] Department of Health, (updated 2020) *Care and Support Statutory Guidance Issued under the Care Act 2014* https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance *[Accessed December 2020]*

[2] Section 2 Mental Health Act 1983 (as revised 2007)

information about Joseph's mental health history, that was available for his pre-sentencing report.

2.5. Joseph was also provided with prison in-reach from AMHS in preparation for his release. Joseph's mental health had been stable whilst in prison**.** He had been without anti-psychotic medication for the last five months of his prison term and shown no symptoms of mental disorder.

2.6. Joseph was supported well by AMHS for a fifteen-month period. AMHS was aware that he had an offender manager but there was no contact between the services. The offended manager was not aware of AMHS or of Joseph's history of violence when his mental health relapsed.

2.7. Joseph did not have a GP although AMHS had encouraged him to register. Joseph had told AMHS that he had had difficulty registering with a GP and that his offender manager was helping him with this. This was not the case – the offender manager was unaware that Joseph had no GP and assumed there were no difficulties with his mental health.

2.8. As Joseph had sustained stable mental health, AMHS ended their involvement. Seven months later, Mrs Moyo's other son and daughter-in-law, began to contact different agencies, concerned that Joseph's mental health was relapsing. They worried as he was becoming aggressive and were concerned for Mrs Moyo's safety.

2.9. In the six-week period leading up to the assault, Mrs Moyo's son and daughter in law, had been in contact on nine occasions with Adult Social Care; Probation; NHS 111; ambulance service; police and mental health services, concerned about Joseph's deteriorating behaviour and of Mrs Moyo's wellbeing.

2.10. They requested ASC carry out an assessment under the Mental Health Act but were advised that Mrs Moyo, as Joseph's Nearest Relative,[3] would need to request this. Mrs Moyo, when contacted by agencies, provided different accounts of Joseph's behaviour. She gave assurance that all was well, but her family told agencies that this was because Joseph was influencing her, and she feared his behaviour.

2.11. On the day of the assault, Joseph began a prolonged and sustained assault to his mother, punching, kicking and trying to strangle her. Mrs Moyo managed to call the police. Mrs Moyo was taken to hospital where she received treatment for soft tissue injury and a nasal fracture. Joseph was arrested and subsequently detained for psychiatric assessment under the Mental Health Act 1983 and then recalled to prison.

[3] Mental Health Act 1983 (as revised 2007) section 13(4) states that a nearest relative has a right to request to an assessment of their relative i.e. to consider the patient's case with a view to making an application for his admission to hospital

3. Summary of Learning Points

- Opportunities for Preventative Intervention

3.1. The review identified important factors for earlier intervention that may have made a difference to the events that followed. In summary:

1. Importance of a shared understanding across agencies of Joseph's mental health needs; relapse indicators and risk assessment when well and when in relapse

2. For agencies to understand the nature of carer roles and 'significant others' and incorporate this into assessments of assets, protective factors, stress factors and risks.

3. The need to improve communication between probation and AMHS in working with offenders, pre-sentence, in release planning and post release support and monitoring.

4. The importance of GP registration to support step-down from secondary mental health services and to coordinate response to relapse.

5. Where a person is not registered with a GP, the need to consider the impact of this within discharge planning and communications with others involved.

- Responses to the escalating concerns

3.2. Learning from Domestic Homicide Reviews highlights the need for improved recognition and understanding of risk factors. The analysis of risk factors most prevalent in the DHRs found the single largest category was previous violent behaviour (70%), followed by mental health problems (64%). Drug problems were prevalent in 37% of the reviews.[4] These factors were common to Joseph and presented the combined 'trilogy of risks' that Leicester City Safeguarding Children and Adult Boards have been raising awareness of.[5]

3.3. The chronology of events demonstrated:

1. There was a high volume of calls from family within a short period.
2. Concerns about Joseph's presentation mirrored features of past relapse.

[4] Chantler K, Robbins R, Baker V, Stanley N. Learning from domestic homicide reviews in England and Wales. Health Soc Care Community. 2020;28:485–493. https://doi.org/10.1111/hsc.12881 [Accessed May 2021]
[5] Leicester, Leicestershire and Rutland Safeguarding Children and Adult Boards Trilogy of Risk: Awareness Raising Resources https://lrsb.org.uk/trilogy-of-risk [Accessed May 2021]

3. There were unexplained inconsistencies: Mrs Moyo's assertions that all was well did not fit with Aaron and Jasmin's recurrent concerns and their description that she was fearful of Joseph.

3.4. At the time, all these factors were not known to any single agency. The question for the review was whether there were opportunities for agencies to have seen this picture.

3.5. There were pockets of inter-agency communication – between AMHS and police; LCC and AMHS; ambulance service and police. However, without a GP there was no central coordination point.

3.6. There were missed opportunities to conduct an assessment that may have revealed the wider picture. ASC highlighted the need for improved risk assessment and safeguarding minded practice by their Contact and Response team. There was a need to make further enquiry, following concerns raised by family. ASC recognised key omissions in not checking Mrs Moyo's levels of vulnerability or whether she was known to their service. They also highlighted errors in forwarding the referral through to their Approved Mental Health Professionals[6] for their decision regarding the request for an assessment under the Mental Health Act.

3.7. Whilst it is not known what the outcome of this assessment would have been, the information gathering would have improved understanding of the whole circumstances and the severity of risk. It would also have sighted all agencies on the nature of concerns.

3.8. The review recognised there are many well founded reasons why people at risk of, or experiencing domestic abuse, may chose not to disclose. For example, coercion; fear for future safety; emotional attachment towards the abuser and the hope that their family member will change; feelings of shame or failure; religious or cultural expectations; previous experience and/or fear that the issues and concerns of people from their community will be poorly understood or ignored.[7]

3.9. The review highlighted the need to undertake safe enquiry and build relationships to give the person trust and confidence in how agencies could support their safety. The review recognised some good practice examples of responsiveness by agencies and making safe enquiry. There were also some areas of learning.

3.10. Practitioners need to be vigilant to signs of inter-familial domestic abuse, recognising the additional vulnerabilities that being in a caring role can bring.

3.11. Following the assault to Mrs Moyo, agencies were responsive and demonstrated effective multi-agency practice that was in line with Making Safeguarding Personal.

3.12. There have been some national and local changes since the scope period that are relevant to the learning. In summary:

[6] Approved Mental Health Professionals carry out assessments under the Mental Health Act.

[7] Local Government Association Adult safeguarding and domestic abuse A guide to support practitioners and managers 2015 https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf [Accessed May 2021]

- National development between NHS and National Offender Management Service to improve support and monitoring of offenders on release.
- National reforms of the Probation service through the reunification programme. Probation practitioners will work in both HM Prisons and in community settings which should aide continuity of care plans and the flow of information.
- Locally, the Strategic Offender Management MAPPA Board is working to improve partnership working between probation and mental health services.
- LPT has opened a Crisis Mental Health Hub at the Mental Health Unit where people and their families can self-refer for urgent mental health support to a central access point by telephone.
- ASC is strengthening processes and training for staff within their Contact and Response team.

4. Conclusion

4.1. This review arose following a serious assault to Mrs Moyo by her son. The review has considered whether there were earlier opportunities for preventative, risk reduction measures by agencies involved. The review also considered the responsiveness of agencies to the family's mounting concerns. In both these aspects, there were elements of good practice but also learning for agencies.

4.2. There were missed opportunities for agencies to collaborate at an earlier stage. Although there were no concerns of domestic abuse at that time, this would have developed a fuller understanding of risks and vulnerabilities and established key components of care. Registration with a GP was an important element of this. Had these foundations been in place, it would have provided a contact point for family concerns and aided communication between agencies.

4.3. There were some effective responses by individual agencies to the concerns raised by the family. However, the family's concerns should have triggered consideration of a Mental Health Act assessment and a Safeguarding Adult Enquiry. Had these assessments taken place, this would have revealed an escalating picture and the opportunity to agree safety measures.

4.4. Ultimately, it is not possible to say whether agencies could have prevented the assault to Mrs Moyo. The review recognised the multiple barriers that people may face in disclosing domestic abuse, many of which may have been faced by Mrs Moyo. Agencies have a responsibility to work together to try and reduce those barriers, supporting the adult to reduce risks of harm.

4.5. The recommendations aim to address these learning points from the review.

5. Recommendations

Recommendation 1: Procedural Development, Monitoring and Review

5.1. Leicester's Strategic Offender Management MAPPA Board should use learning from this review to inform their strategic plan for 2021-2022, specifically, the action to improve publicity, pathways and gateways into mental health services.

5.2. The Strategic Offender Management MAPPA Board should seek to develop mechanisms to strengthen partnership working between AMHS and Probation pre-sentence, pre-release, and post-release. This Board should also seek assurance on the quality of the release plans and that registration with a community GP is a component within the release plan.

Recommendation 2: Procedural Development, Monitoring and Review

5.3. Learning from this review should be shared with the relevant Ministry of Justice and Home Office departments (Her Majesty's Prison and Probation Service, and Domestic Abuse). The learning should be used to influence national policy and guidance on the need for information sharing and joint work between AMHS and Probation at key junctures in the offender pathway: pre-sentence (including Fast Delivery Reports), pre-release, and post-release.

Recommendation 3: Procedural Development

5.4. LPT need to assure that their policies (and application of those policies) for Did Not Attend and Discharge, take adequate account of circumstances when a patient is not registered with a GP i.e.

- Reasonable attempts are made to support service users to register with a GP.
- Lack of GP registration is factored into risk assessment and,
- Risk assessment is used to inform proportionate communications with other agencies, family and carers, in line with information sharing guidance.

5.5. It is important that all agencies play a role in encouraging people to register with a GP. The contribution of the Leicester City CCG in providing guidance and raising awareness of access routes to register with GPs, will assist in this.

Recommendation 4: Staff Support

5.6. LCSAB and its constituent agencies, should use learning from this SAR to inform training and supervision, in relation to safeguarding and domestic abuse:

i) Reinforcing the value of multi-agency collaboration

ii) Recognition of carers and significant others within assessments, including consideration of assets, protective factors, stress factors and risks.

iii) Fundamentals of a robust risk assessment; understanding and working with barriers to disclosure (including safe enquiry).

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Date: September 2021

6. References

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7. About the reviewer

7.1 The review report was written by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance. Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.