Walsall Safeguarding Partnership

Safeguarding Adult Review – SAR11

Review in Rapid Time Report

'AB'

1. Details of initial referral

'AB' was a 41 year old British Asian woman who had learning difficulties and mental ill-health. She was found in cardiac arrest, taken to hospital where she died on 3 October 2022.

2. Review in Rapid Time

Reporting agency: Black Country Integrated Care Board
Date submitted to WSP: 18 November 2022

Short summary of rationale for referral:

'AB' was found in the bathroom by family in cardiac arrest due to choking on Pizza. They called 999 but were unable to perform CPR; this is thought to be because of language barriers preventing understanding of instructions being given.

Ambulance crew stated they were having trouble maintaining her airways, and when inspecting her airways found her teeth lodged in her throat with lots of blood.

The crew managed successful resuscitation. However, 'AB' then went into arrest again and was handed over to the hospital A&E Dept.

They found more teeth lodged in her throat - then managed successful resuscitation again and she was transferred to ITU but sadly passed away a few days later.

The attending WMAS crew stated they had a number of concerns and the hospital treated it as suspicious for a number of reasons:

- appeared to be bruising around the mouth,
- crew found a soiled pair of trousers on the floor next to subject (she was fully clothed)
- lots of what appeared to be chewed up food around the floor.
- crew are unsure exactly how subject's teeth have managed to get lodged in her throat
- young child in the house and it wasn't clear who was looking after him.

Concerns were reported to the Police but three hours after the Ambulance crew left the scene. Police have investigated and closed the case.

Coroner has given a verdict of "misadventure".

There are previous safeguarding concerns raised 2-3 years ago.

There were concerns that there are other vulnerable adults in the household and a young child. Children's Social care confirmed there were no safeguarding concerns regarding her child.

3. Family context

At the time of the incident 'AB' was living at home with her husband, their child aged 2 years, her mother and brother.

She had a history of mental ill-health and attended Dorothy Pattison hospital for injections relating to her mental health.

She also had a diagnosis of a Learning Disability.

It was noted that there were concerns as to the mental health of both 'AB's brother and mother.

4. Initial scoping discussion

The initial referral had been submitted by the Black Country Integrated Care Board as a result of concerns regarding both the response on the day of the incident and from interactions between agencies and 'AB' and her family prior to this.

On further examination at the subsequent Review in Rapid Time some of those concerns were identified as issues of single-agency procedure and not safeguarding.

This allowed proper emphasis to be given to the safeguarding concerns on the day of the incident, and from before.

The WMAS crew who attended the incident had expressed concern about the difficulty that had experienced in attempting resuscitation due to food and dislodged teeth stuck in her airway.

Enquiries had indicated previous concerns about her dental health, her ability to chew food and risks of choking. It was unclear whether this had been adequately addressed.

There had been two previous safeguarding concerns recorded;

i) Found in street at night having escaped locked room in home (*it was later ascertained there was no lock on the room and that her family had tried to keep her at home for her own safety. Deprivation of Liberty Safeguards (DoLS) had been under consideration at the time*),

ii) Suggestion of financial abuse by a sister. (*Enquiries showed that the family had taken responsibility for subject's financial affairs and she had retracted an allegation of financial abuse. It had been assessed as not meeting the threshold to progress to a Section 42 Care Act enquiry*).

Further background information was also provided that 'AB' had been open to secondary mental health services, that her mental health fluctuated in terms of capacity but at the time of her last visit, she had capacity.

There were concerns regarding other adults in the home; her brother has mental health difficulties and mother has physical difficulties. It was unclear how much subject's husband understands due to language barrier. It was confirmed that a MARF had been completed for child.

The single-agency issues relating to procedure or compliance issues discussed at the scoping meeting and again at the Review in Rapid Time will be addressed directly with the agencies concerned.

The criteria for a Safeguarding Adult Review was discussed and it was agreed this matter should go forward for consideration of a SAR.

5. Review in Rapid Time

Attendees:

- West Midlands Police
- Black Country Integrated Care Board (Black Country ICB)
- Black Country Healthcare NHS Foundation Trust (BCHFT) – Dorothy Pattison Hospital
- Walsall Council – Adults Social Care (ASC)
- Walsall Council – Children's Services
- Walsall Healthcare Trust (WHT)
- Walsall Safeguarding Partnership Interim Case Review Coordinator
- Walsall Safeguarding Partnership Interim Chair

This case was the first to be considered under Walsall Safeguarding Partnership's recently introduced Review in Rapid Time process.

The Interim Chair of the WSP Safeguarding Adult Board chaired the meeting and began by explaining the process. The first issue to be addressed was to determine whether the criteria for a SAR as laid out under Section 44 of the Care Act 2014 had been met.

It was agreed that 'AB':

- had care and support needs,
- there was reasonable concern how partnership agencies had worked together to safeguard her,
- Condition 1 was met as subject had died,
- There were unresolved concerns as to whether her death resulted from abuse or neglect.

It was further noted that there are a range of SAR methodologies available, and that a Review in Rapid Time was one option. At the conclusion of the meeting it would be determined whether all relevant learning had been identified via the Review in Rapid Time process or an alternative form of review was required, and this could include a traditional SAR methodology.

It was confirmed that a Learning Disabilities Mortality Review (LeDeR) had been commenced and then paused pending consideration of a Safeguarding Adult Review (*this report will be shared with the LeDeR author)*.

Further detail on the LeDeR process was provided:

- LeDeR looks at whole life of person but not in detail of a SAR
- It would be a focused review with a panel to consider the information.
- It seeks to include as many agencies as possible

- Info from SAR can feed into LeDeR
- Currently on hold due to SAR taking place
- Family have opportunity to contribute

There was a discussion as to the extent or otherwise of abuse or neglect being present, and it was acknowledged that there were elements of self-neglect present. It was further noted that whilst self-neglect is not mentioned in Section 44 of the Care Act, it is a strategic priority in Walsall and should be taken into consideration within this review.

Following consideration of the initial submission by the Black Country ICB there was discussion around subject's history and circumstances:

- She had been under mental health services for around twenty years.
- There were other vulnerabilities in the household.
- There was an overreliance on the family supporting subject.
- Her lived experience had not been properly established with issues such as her keys being taken away by her family, the placing of CCTV in her room and her calls to the ambulance service.
- There was minimal evidence that subject had been seen on her own when meeting with professionals and that this had potentially diminished her voice. Her feelings and thoughts were not clear.
- She was usually accompanied by her late father who was seen as a protective factor, or by her sister.
- There had been assumptions that her family were generally a protective factor but with hindsight there were concerns as to whether it was control or protection.
- Subject had travelled to Pakistan to marry soon after being released from a mental health facility; it was not established at the time whether she fully understood what was happening.
- When pregnant the focus from partner agencies appeared to have been on the pregnancy and the unborn child rather than her.
- There were occasions when subject may have benefited from having an advocate outside of family members.
- There was discussion as to whether the Subject may have benefitted from a referral to Speech and Language Therapy (SALT) but there was no indication that this had happened.

Other issues:

The vulnerabilities of her mother and brother had been recognised. Both were arrested following the incident and had Appropriate Adult support at interview (*It has been confirmed that there were no suspicious circumstances regarding her death and no further action was taken).*

There were discussions about speaking to the family, but it was agreed that it was unlikely this would significantly add any relevant information.

Although there was an incomplete picture of her life story and experiences, it was agreed not to explore further back as there had been limited agency involvement and it was also felt that any additional information would cover similar issues to those already discussed.

Concern had been raised in the initial referral regarding her risk of choking and associated issues around her dental health. It was confirmed that she had Pierre Robin syndrome (a congenital birth defect) and would be prone to choking through having the syndrome.

It was also noted that 'AB' had been under an orthodontist in 2018 but had missed several appointments to have teeth removed. This prompted a discussion as to whether this was viewed as 'Was Not Brought' or 'Did Not Attend'?

The issue of teeth having been dislodged was discussed and was explained due as likely being due her dental history and pre-existing medical conditions. Attempts at resuscitation may also have been a contributory factor, and it was agreed that this was not a cause for concern. The police investigation had concluded that this was non-suspicious.

Recognition of good work:

There had been good interaction with the Community Psychiatric Nurse service prior to subject's death.

The Health Visiting Service had asked for a PAMS assessment (Parent Assessment Module) which is used where a parent has a learning disability.

Learning identified:

- Interconnectivity between adult's & children and communication sharing.
- In future such reviews more attention needs to be paid to the culture and heritage of those we seek to better understand, and the application of an Equity, Diversity and Inclusion lens should be incorporated into such as carer assessments and SAR submissions.
- When presented with similar circumstances of mental ill-health or learning disabilities, there should be consideration of independent advocacy.
- Acknowledging differences in every case, there should be consideration as to engagement with individuals such as subject as well as with their carers.
- There was considerable scope for more collaborative working and information sharing.
- There had been a lack or professional curiosity about the family dynamics and subject's place within this.
- The WSP Self-Neglect pathway needs to be promoted (*already in progress)*.
- Greater clarity is required across the WSP regarding Learning Difficulty, Learning Disability, mental health & where there is a diagnosis or not.
- 'AB' had a diagnosed Learning Disability and may have benefitted from being referred to the Promoting Access to Mainstream Health Services (PAMHS) facility. This was potentially a missed opportunity.
- It was also noted that as 'AB' suffered from Pierre Robin Syndrome, a referral to Speech and Language Therapy, and there was no information to suggest this had been done.
- The need to give particular consideration to people with a Learning Difficulty or Disability when providing or discussing access to family planning services.
- When dealing with a person with mental ill-health or a Learning Difficulty or Disability, careful consideration should be given as to how missed medical appointments are viewed.
- **All professionals to 'look' at the person in front of them**.

Recommendations:

- WSP to review information sharing protocols between the Adult and Children's partnerships.

- All future Reviews in Rapid Time to explicitly detail how issues of Equity, Diversity and Inclusion were considered.
- Safeguarding Adult Reviews, regardless of methodology and all agency submissions must include an assessment of 'Equality Diversity and Inclusion'.
- WSP to review awareness of, and accessibility of pathways to advocacy services.
- WSP to disseminate a series of learning briefs that address: i) the need to ensure individual people are given a 'voice' (which may incorporate independent advocacy), ii) that professional curiosity is key to establishing a more complete understanding of need, and iii) a reminder of the principles behind Making Safeguarding Personal.
- WSP to gain assurance from Health partners that health staff receive mandatory training on learning disability and autism. This may include awareness raising around PAMHS and would need to be designed and delivered for a targeted audience. Further guidance will be sought from Health Partners as to the relevant audience.
- The report will be shared with the West Midlands Ambulance Service with regards to the suggested issue of language difficulties faced by the family of 'AB' when they called '999'.

Conclusion

In summarising the discussions, it was the consensus view that the criteria for a SAR had been met and that the Review in Rapid Time process had identified all the likely relevant learning and that it was not necessary to commission a traditional SAR.

An Action Plan to address the learning points will be produced.