Thematic Learning Review Learning Briefing

Introduction

Safeguarding Adults Reviews (known as SARs) are undertaken when an adult in the local authority area with care and support needs either dies, or experiences serious harm, as a result of abuse and neglect and it is also considered that agencies could have worked together more effectively to prevent this. The purpose of Safeguarding Adult Reviews is to learn lessons and identify improvement actions to avoid something similar occurring again in the future.

This Safeguarding Adult Review, in the form of a Thematic Learning Review, was commissioned by the Brighton and Hove Safeguarding Adults Board as it was identified there were several similar themes in two referrals received where young women had died in Brighton and Hove. These themes were also reflected in a SAR recently published by a neighbouring SAB so learning from this was also incorporated into the review.

The Women

Mairead

Mairead was a 24-year-old woman who experienced a traumatic childhood, spending many years in care. She had previously been diagnosed with emotional instability, anxiety, and depression, as well as substance misuse.

After moving to the city she and her partner were initially placed in emergency accommodation due to being pregnant. She had previously given birth to two children who had been immediately taken into care and adopted.

Concerns were identified by agencies in relation to domestic violence (particularly coercion and control), suicidal thoughts, and their housing environment. Mairead took two separate drug overdoses that both led to hospital admission in the months before her death. Mairead died after suffering a cardiac arrest following a drugs overdose.

Amy

Amy was a 41-year-old woman who had experienced significant trauma. She had previously been diagnosed with schizophrenia, borderline learning difficulties, and had a history of substance misuse.

She had previously had a child adopted and had high-level care and support needs. She was evicted from two hostels she lived in with her partner, whilst pregnant, with concerns identified in relation to several areas including domestic abuse (particularly coercion and control).

Emergency accommodation was arranged but Amy returned to her partner before further alternative accommodation was found. Amy was found deceased at this accommodation following a drugs overdose.

Miss C

Miss C was a 41-year-old woman who had experienced trauma, mental health issues, substance misuse, domestic abuse (particularly coercion and control) from her partner, and where alternative placements for her children had been arranged. Miss C died following a drugs overdose.

Key Learning

Language and Terminology

The Independent Reviewers identified a need for all professionals and agencies to change the language and terminology used in engaging with women who have multiple and compound needs. They noted that all three women were frequently described as having a 'chaotic lifestyle' or as being difficult to engage with but what they all had in common was that they had been exploited, mostly by men. They state that simple changes of language can have a substantial effect upon thinking – if we refer to them as 'women who have been exploited' then the fact that they have a chaotic lifestyle, or may be difficult to engage with, comes into the correct context or disappears altogether. This then changes the way in which we view the support they need.

Language changes will positively alter mindsets and below is the example used in the review.

Changing Language from	To
She keeps changing her accounts to services, so we don't know what actually happened.	**There is a risk of coercive control due to the variety of accounts given by the victim/survivor to agencies.**
There is no evidence to corroborate her account	**There is insufficient evidence against the perpetrator for further action to be taken**
These are just allegations	**The victim/survivor has disclosed abuse**
The onus is on the victim/survivor to engage with us	**Does anyone have any suggestions on how to safely engage with the victim/survivor?**
She let him in, despite there being bail conditions in place	**The perpetrator broke his bail conditions by attending the address**
The victim/survivor failed to engage	**Our agency was unable to engage with the victim/survivor**
The victim/survivor is continuing to have contact with the perpetrator despite the risks	**There is a risk due to the perpetrator continuing to have contact with the victim/survivor.**
She has placed herself at serious risk of abuse because of her substance use	**The victim/survivor has substance use issues which increases her vulnerability**

Trauma-Informed Practice

The Independent Reviewers identified that Mairead, Amy and Miss C all experienced significant trauma in their lives and that there is a need to improve the local understanding of, and response to, trauma across all services so that the system becomes truly trauma-informed.

Trauma results from an event, series of events, or circumstances, which are harmful or life threatening and impact on a person's ability to function. Trauma-informed practice is a strengths-based approach that aims to empower people to re-establish control of their lives. It means recognising and understanding that exposure to trauma can impact on someone's neurological, biological, psychological, and social development. This will lead to an increased understanding of the impact of trauma across the life span and on areas such as engagement. You can learn more about trauma-informed practice here.

Whilst recognising improved understanding across the system will take time there are a range of resources that professionals can utilise to develop their own knowledge and understanding of trauma-informed practice. This video from Sowing Seeds on trauma-informed practice focuses on children and adolescents but contains helpful guidance in working with all those who have experienced trauma. This video from NHS Scotland is also helpful in focusing on trauma-informed practice for workforces.

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Domestic Abuse

Mairead, Amy, and Miss C all experienced domestic abuse that included coercion and control, and the Independent Reviewers have identified that whilst there were examples of good practice in how agencies responded to this issue there were also missed opportunities. They stated how important it is in situations of domestic abuse that opportunities to intervene are clearly understood by agencies and noted that the impact of trauma, substance misuse, and coercion and control on decision-making can often be overlooked.

The implementation of the Domestic Abuse Act in 2021 has established a raft of changes to how domestic abuse is identified and responded to. These changes include the statutory definition of domestic abuse, setting out new response powers, new offences (that include coercive and controlling behaviour), and increased protection for victims and witnesses. You can find further information in relation to the Domestic Abuse Act **here** as well as where to access help and support **here.**

Agencies and relevant departments need to have up-to-date domestic abuse policies, procedures, and training that reflect these changes and support the increased identification of domestic abuse, with processes in place in raising this. Pan-Sussex SAB Safeguarding Threshold guidance has been produced to help support professionals in identifying and reporting domestic abuse and you can find these thresholds **here**.

Multiple and Compound Needs

Mairead, Amy, and Miss C all experienced a range of needs that included mental health issues, substance misuse, unstable housing or homelessness, and domestic abuse or violence. People who experience a combination of these needs are considered to have multiple and compound need, which can also be referred to as multiple and complex needs, multiple and intersecting needs, or simply as multiple needs. They frequently also experience other issues that include physical ill-health, learning difficulties or disabilities, poverty, or have had children removed from their care.

The Independent Reviewers identified that Mairead, Amy, and Miss C at times presented to agencies as problematic, or difficult. They noted the findings from a study on women with complex needs seeking to access services being described as non-compliant, and that whilst these women were non-compliant there were underlying reasons for this. You can learn more about identifying and working with people who have multiple and compound needs through the social work guidance produced by the National Institute for Clinical Excellence (NICE) **here.**

There is an increase being seen in people with multiple and compound needs and as such the Independent Reviewers also identified the need for a preventative approach, with sufficient multi-agency risk management processes in place to respond to significant or increasing risk. There is a range of work being taken forward in relation to the increase in multiple and compound need and you can find more about the work being undertaken locally by Sussex Health and Care **here.** Changing Futures is part of this approach and has a programme specifically focused on improving systems and services across Sussex. You can find out more about Changing Futures **here.**

Good Practice

The Independent Reviewers identified examples of good practice throughout the review and highlighted that they found an uplifting desire to make a difference amongst those who contributed to the review, coupled with compassion and a recognition of the 'real world' pressures upon all agencies.

Some of the examples of good practice in the review -

- **Health professionals displaying awareness of domestic abuse, in particular coercion and control, by identifying suspicious bruising and later asking Mairead's partner to leave so they could speak to her alone about her safety and wellbeing.**
- **The inter-agency communication, and flexible and sustained engagement efforts, demonstrated by Housing professionals in supporting Mairead to move into temporary accommodation.**
- **The recognition by the Police of Mairead and Amy's vulnerability, ensuring a flexible approach was adopted and concerns were shared with multi-agency colleagues at any point and then on a regular basis.**
- **The preventative, multi-agency processes (such as the Cuckooing Panel and Complex Risk Management meeting) that are already in place locally.**

Questions for you to Consider

The Thematic Learning Review identifies twelve learning points and makes ten recommendations based on the key areas of learning. You can read the full review report where these are contained here. The BHSAB will be working with our partner agencies to develop an Action Plan in response to the findings in the review but below are five questions based on these learning points and recommendations that we would ask all professionals to consider in seeking to prevent something similar occurring again in the future.

1. **Do you have at least one point of contact within your team, or organisation, for other organisations to be able to request access to specific information or records?**
2. **Does your training programme include up-to-date training on domestic abuse, including on coercive and controlling behaviour, following the implementation of the Domestic Abuse Act?**
3. **How do you identify increasing risk within your own organisation and are you aware of the policies and processes in place organisationally, and across the wider system, to respond to increasing risk?**
4. **Do professionals in your organisations have the necessary knowledge, skills, and experience to support women with multiple and compound needs and how is your organisation responding to this area of increasing need?**
5. **Have the supervision and support arrangements in place for professionals in your organisation working directly with people with multiple and compound needs been reviewed to ensure there is regular advice and guidance provided, as well additional support processes in place?**