01

Process:

Under the Care Act 2014, Safeguarding Adult Boards are required to commission Safeguarding Adult Reviews of cases that meet set criteria.

Lian's (not the individual's name) case did not meet the statutory criteria for a Safeguarding Adult Review, as there was no evidence that her death resulted from abuse or neglect. The RBSAB instead commissioned a "discretionary" Safeguarding Adult Review and appointed an independent person to Chair of the review.

The report of the Review was concluded in December 2019. The report will be published following conclusion of other processes, this will be available on Rochdale Safeguarding Partnership Board - Safeguarding Adult Reviews and Audits for a period of 12 months.

Background:

02

Lian was in her early 20's at the time of her death. She had a complex history that included behaviours, which put her at risk of serious harm including self-harm, overdoses, attempts to commit suicide and excessive consumption of alcohol. Lian had also made disclosures that she had been sexually abused when she was a child.

Lian was involved with a number of agencies, both in Rochdale and another area. Children's Social Care in Rochdale had been involved when she was a child. Lian's IQ was only just above the level generally considered to indicate a learning disability and had a personality disorder. She died as a result of taking a mix of drugs shortly after her return to Rochdale.

07

What does this mean for me?

- Do I understand the multi-risk management (MRM) process?
- Am I appropriately utilising MDT's? Am I ensuring actions are completed?
- Do I understand personality disorder?
- Am I formulating risk assessments and putting actions in place to address those risks?
- Am I reviewing risk assessments?
- Am I considering whether family and friends can be a protective factor? Am I recording this?

Findings 1 & 2:

03

Although Lian's vulnerabilities were recognised on her return to Rochdale, the evidence of risk being evaluated was weak.

The identification of risk and the development of risk management plans is important in the provision of help and support that reduce or remove risks faced.

Finding 3

Lian was appropriately referred to drugs service but did not attend at the appointed time. When she did go to the venue, she was given a later appointment, which, again, she did not keep.

She was known to have a chaotic life and to be impulsive. There was evidence that a multi-agency disciplinary team (MDT) approach was not always used which might have resulted in a more coordinated approach

Finding 4

When the MDT approach was used it lacked rigour and although it identified the need for a protection plan there is no evidence one was ever created.

When actions are identified these need to be documented and actions allocated to a named professional with tracking to ensure completion.

05

04

Finding 5

Lian had friends and family. They may have been difficult to engage but agencies should seek to identify possible sources of support and individuals who might serve as a protective factor (including family and friends).

Finding 6

Lian's needs for support under the Care Act were deemed low and there was some difference in understanding regarding her cognition and learning disability.

Care needs to be taken to ensure professionals understand terminology.

It is also important to recognise that ability may fluctuate above and below a threshold for services, depending on the individuals' circumstances.

06

RBSAB ROCHDALE BOROUGH SAFEGUARDING ADULTS BOARD

RBSCP ROCHDALE BOROUGH SAFEGUARDING CHILDREN PARTNERSHIP