Derbyshire Safeguarding Adults Board

Derby and Derbyshire Safeguarding Children Partnership

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Learning Brief: Multi Agency Learning Review19A: Aaron

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@DerbyshireSAB

@DerbyshireSAB

www.derbyshiresab.org.uk

DerbyshireSAB@derbyshire.gov.uk

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The aim of a Multi-Agency Learning Review (MALR) is to learn from serious incidents and deaths in relation to adults with care and support needs. The focus is to look at the practice of agencies involved and the systems in place to see if any learning can be identified about the way we work together to support adults in Derbyshire. The review also identifies and highlights positive practice. The purpose of a MALR is not to apportion blame on any individual practitioners or agencies.

Derbyshire Safeguarding Adults Board (DSAB) conducted a MALR in 2019 with support from Derbyshire Safeguarding Children Board representatives to identify learning from a case in which a young man, referred to as Aaron (not his real name), sadly and unexpectedly died at the age of 19 after taking an illegal drug at a social event. Aaron was not a known or regular drug user. He died less than a year after leaving care and three months after leaving semi-supported accommodation in Derbyshire.

Aaron's foster carer between the ages of 15-18 had a positive relationship with him and was a key figure of support in his life. The foster carer contacted the DSAB following Aaron's death to request this review and contributed significantly to the process. Contact was made with Aaron's Mum who decided not to take part in the review. The DSAB is grateful to the professionals who worked closely with Aaron who attended a practitioner learning event to share their experiences and stories about Aaron, which provided valuable information for the review.

Background:

During Aaron's childhood, Children's Social Care were involved with his family. There had been concerns raised regarding Aaron's delayed speech and language skills and his behaviour during this time. Aaron spent some time living out of area during his childhood and then moved back to Derbyshire where support was provided for Aaron by the Multi Agency team within Children's services. In 2013, Aaron moved into voluntary foster care at the age of 13.

Aaron spent time in three foster placements, one of which was a long-term foster placement between the ages of 15-18. During his time in foster care he had involvement with the Child and Adolescent Mental Health Services (CAMHS) and was tested for conditions, including Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder (ADHD), but he was not diagnosed. Aaron's foster carer had noticed that he required a great deal of prompting with activities of

daily living including when to wash, eat and go to bed. He was a victim of sexual exploitation, control and abuse in his relationships and there were episodes where he went missing and the Police had to be notified. Aaron was described as having very complex needs, including possible learning needs/difficulties. A referral from the Children's Social Worker was made to Barnardo's shortly before Aaron's 17th birthday.

Aaron's foster carer took part in some training, which made her recognise that his behaviours could be linked to Foetal Alcohol Spectrum Disorder (FASD); Aaron was assessed and diagnosed at the age of 18. The FASD helped to explain why Aaron needed very basic language to help him understand as he tended to takes things literally. The FASD meant he had an increased vulnerability to exploitation. The foster carer reported Aaron was happy with the FASD diagnosis as he always felt there was something different about him.

Aaron's vulnerabilities and his use of alcohol increased once he turned 18 years of age. He left the foster carer's address for a period of time in 2017 when he went to live with his partner, however this relationship broke down when Aaron was a victim of domestic abuse and violence; he then returned to the foster carer's address. Agencies tried to keep Aaron safe regarding possible sexual exploitation, and discussions, referrals and risk assessments with other agencies including the Police took place. Social Care tried to identify the appropriate service for Aaron to have a psychological assessment around this time.

A decision was made for Aaron to leave his foster placement when he was aged 18 years and 6 months but unfortunately, an incident at the foster carer's home meant a placement needed to be found quickly and he was referred to an adult provider placement. This semi-independent accommodation provision was not the ideal place for Aaron and did not meet his needs. Concerns were raised about his behaviour and his ability to cope while he was in this accommodation. This was exacerbated by his alcohol use and his tenancy was ended when he damaged his room after consuming alcohol. Moving into the accommodation affected Aaron's mood, lack of boundaries and motivation. This was a significant change for Aaron with an adult placement being very different from what he had been used to.

Leaving the foster placement was a time of increased concern for both the foster carer and professionals regarding Aaron's mental health and self-harm behaviours, and referrals to other services were made, including drug and alcohol services, the Barnardo's counselling service and an appointment with his GP regarding his emotional wellbeing was arranged. Aaron was seen by the Drug and Alcohol service briefly and also saw his GP, but there were a number of appointments not attended to review his mental health when he did not want to go. The adult Social Worker continued to engage with the GP and tried to encourage Aaron to

attend his appointments. A Vulnerable Adult Risk Management (VARM) meeting was held in April 2018. Aaron attended the VARM meeting along with his foster carer who he had chosen to be his advocate. It was agreed that Aaron was high risk in all the areas of concern discussed at the VARM, however when capacity to make decisions around keeping himself safe became a concern no decision specific capacity assessments were completed in accordance with the Mental Capacity Act 2005.

At the time of his death, Aaron was staying with friends following eviction from his housing placement. There is no evidence or indication that Aaron meant to take his own life, even though there had been periods when he was low and felt depressed.

Aaron was a young man who had suffered adverse childhood experiences and was extremely vulnerable to abuse and exploitation. However, he was described by his foster carer and professionals who worked with him as being kind and funny with a variety of interests and aspirations.

Findings:

Foetal Alcohol Spectrum Disorder (FASD)

At the age of 18 Aaron was diagnosed with FASD, but further recommended tests were never undertaken due to a lack of understanding and pathway of where the referrals needed to go. It was evident from the learning event that agencies had a limited knowledge of FASD. The following recommendations were therefore made as part of the review.

- The DSAB and DDSCP should consider providing training on FASD, ideally for agencies working in both adults and children's services, and to have clarification regarding referral pathways for requested tests. Training should focus on how best to work with children, young people and adults who have been diagnosed with FASD.
- Commissioning services across Derby and Derbyshire for children and adults should consider the introduction of a pathway of services to undertake the professionally recommended tests – currently these include an Executive Test, Adaptive Function Test and Speech and Language tests – once a diagnosis of FASD has been made.

- The Health and Wellbeing Board in Derbyshire, in conjunction with Public Health, should continue to raise the profile of the dangers and effects of both alcohol and drug use, to increase the knowledge and understanding for professionals, young people and the general public of these dangers, and should include the potential dangers of alcohol misuse during pregnancy. The messages to the general public would need to be communicated sensitively and in context.

Adult Exploitation

Individuals who are extremely vulnerable up to the age of 18 years do not suddenly become less vulnerable when they turn 18 years of age.

- The DSAB should consider the development of a risk assessment for young adults where there are concerns about additional vulnerabilities, including sexual exploitation and adults at risk of other forms of exploitation and abuse. Risks should be balanced against Making Safeguarding Personal and documented and shared with agencies involved. Risk assessment forms should be available for those over 18 years where there are concerns and additional vulnerabilities.

Mental Capacity Assessments

In Aaron's case, presumption of capacity was applied. No MCA assessments were undertaken in relation to whether he was able to decide where to live and receive care and support, around contact with specific people who had presented a risk to him, and around his use of social media and internet. Therefore the following recommendation was made:

- Mental Capacity Act assessments for specific decisions need to be understood, considered, documented and shared with those involved. Where it is evidenced that there is capacity, and the VARM criteria are met, to promote the use of the VARM process. If in key decisions, capacity is not present, decisions about keeping the person safe needs discussing with the Social Worker, manager and key agencies involved, with a focus on a safety plan and a best interest decision would be required.

Accommodation
Agencies looked at alternative accommodation options to offer more support to Aaron, but he wanted to stay local to his friends and some family members and it was difficult to find appropriate accommodation locally.

With better transition planning and even an urgent planning meeting, young people like Aaron should in the future be placed in more suitable accommodation. However, there is recognition that finding the right accommodation to meet complex needs of young people is difficult, especially when trying to avoid moving young people out of area. Contingency planning and multi-agency planning meetings involving both adults and children's services should be held to ensure the right accommodation is sought to meet the young person's needs to avoid them having to move if placements break down.

Positive Practice

- All the agencies involved with Aaron tried really hard to engage with him, to understand his needs and work with him. Aaron had consistent workers from Children's Social Care, Adult Care and Barnardo's, and joint visits were often undertaken between professionals, and the complexities of working across border did not affect the quality of the relationships of information sharing.

- There is evidence of strategy meetings and high risk management meetings between Social Care and the Police following significant events and rationale for decisions made. Consistent advice from professionals around risk-taking behaviour, including drug and alcohol misuse, was given and a referral to alcohol services was made.

- The foster carer identified the Social Workers and Barnardo's workers as professionals who really worked hard in understanding Aaron's needs.

- The foster carer shared a lot of information and concerns with the allocated workers and worked really hard to try to keep Aaron safe, despite significant challenges at times. She provided stability and good understanding of Aaron's needs and was persistent in getting the right support for Aaron.

- The Police worked closely with Aaron following allegations he made. They took his allegations seriously and sought evidence to build a case; however, Aaron then withdrew the allegation and so Police were unable to prosecute through lack of evidence.

- The Social Worker sought advice about how best to work with individuals diagnosed with FASD and spoke to support services that provide training on FASD to enhance understanding of the condition.

- Workers tried to empower Aaron and encouraged him to become more independent and be involved in the decisions made about him. They explained risks and shared the concerns about the relationships that he was engaging with.

- The use of a VARM meeting was helpful in agencies getting together and having a shared understanding of the level of risks; it was also really positive that Aaron attended the meeting along with his foster carer.

Next Steps:

All agencies and professionals are encouraged to reflect on the findings and learning themes and discuss the implications for their service and future practice.

Practitioners who feel they are dealing with similar cases should escalate or discuss with their line manager or safeguarding lead, to ensure that they are supported. Front-line staff need time for safeguarding supervision or a suitable alternative meeting to allow reflection, as well as protected time with the children, young people and adults they work with.

The DSAB and DDSCP will track the recommendations made via an action plan and will seek assurance that the learning is embedded.