SAR 'Valentina' Case Summary

Nottingham City Safeguarding Adults Board

BACKGROUND: Valentina was a white British woman in her twenties when she died in 2019. Valentina was found unconscious in her home following a deliberate overdose of insulin. She died in hospital having been in a coma for ten weeks. The coroner was unable to determine whether Valentina intended to die.

Valentina's family describe her as a vibrant, bubbly person who once met, would not be forgotten. Sadly, Valentina had been troubled by her mental health for most of her life and had a diagnosis of Emotionally Unstable Personality Disorder. She had experienced trauma as a child, and this affected her psychological wellbeing into adult life. Valentina also had type 1 diabetes, diagnosed as a young child. This impacted on her physical and psychological wellbeing. Valentina had used her insulin as a means of self-harm from a very early age and she had been supported by Child and Adolescent Mental Health Services.

At the time of taking the overdose, Valentina felt overwhelmed by stressful life events. Valentina had been the victim of sustained domestic abuse from her ex-partner. In the months leading up to her death, Valentina had also been attempting to claim Personal Independence Payment (PIP) through the Department for Work and Pensions (DWP). Problems within this process caused her extreme anxiety and distress. This additional stress significantly increased her risk of self-harm and suicide.

Valentina received a high level of support from her family and from agencies. The Nottingham City Safeguarding Adult Board (NCSAB) believed that there was learning about how agencies had worked together in relation to supporting Valentina and reducing the risks of harm arising from stressful events.

PRACTITIONER KEY LEARNING:

Responding to people in distress requires personal qualities of empathy, care and compassion. In addition, practitioners may need:

i) Training and guidance to understand the impact of mental health needs and
ii) Skills and time to offer effective responses to people in mental health distress.

Although Valentina wanted to manage her substance misuse, **she was not ready, or able, to engage in drug and alcohol services**. Valentina relied on substances as a coping mechanism. This made it difficult for her to control, while pressures such as domestic abuse continued to dominate her life. **Research highlights the dichotomy where women may use alcohol and substances to cope with abusive situations. However, the use of drugs and alcohol, may increase their vulnerability to domestic abuse as well as create other problems in their lives.** This was evident in Valentina's experience.

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✉ ncsafeguardingadultsboard@nottinghamcity.gov.uk

Research highlights the correlation between domestic abuse and suicide, **where those trapped by domestic abuse may see suicide as the only way out.** The risk of suicide should always be considered by those working with survivors of domestic abuse. All agencies involved with Valentina were aware of her domestic abuse and the impact it had on her mental health, including her risk of self-harm and suicide.

Adults need to provide protective factors to the child; **a child should never be described or viewed as a protective factor for the parent**. This risks a child viewing themselves as responsible for their parent's wellbeing and safety – a responsibility no child or young person should have.

Practitioners need to be mindful of the prevalence of domestic abuse in the post-separation period. Child contact arrangements are a point of vulnerability and increased risk to the victim of domestic violence, and to children and young people involved. This must be factored into multi-agency safety planning.

AGENCY KEY LEARNING:

Referrals were made to MARAC appropriately and in a timely way, including use of professional judgement regarding level of risk. All agencies contributed good quality research to the MARACs and the MARAC was effective in bringing this information together. However, there were limitations in the quality of action planning that followed**. The MARAC action plans would have benefitted from greater structure in terms of addressing the key issues arising from the discussion; detailing the different aspects of risk, and then setting out each parties' role in a protection plan linked to those risks**. There was a tendency for generalised 'feeding back' or 'continued support.' There was limited evidence of measurable or timed outcomes and not all agencies reported back on outcomes from previous actions.

Multi-agency working in domestic abuse, needs to extend beyond information sharing at the MARAC. Agencies also recognised the need for multi-agency working beyond the MARAC. The author of the Women's Aid report referenced the danger that the MARAC is seen as a panacea for domestic abuse. **The MARAC can only be as effective as the quality of the protection plan and the ongoing collaboration between professionals that occurs within and out with the MARAC to follow through on that protection plan.**

There was a missed opportunity for agencies to collate information about all incidents. This may have built evidence for a Stalking or Controlling/Coercive Behaviour offence, offering more extensive legal sanctions.

A person may be defined as having a disability within the meaning of the Equality Act 2010, if they have physical or mental impairment that has a substantial, and long-term adverse effect on their ability to carry out normal day-to-day activities. **This definition applies to people with a mental health need, such as a personality disorder.** Public authorities must have due regard to the need to eliminate discrimination, harassment and victimisation and advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

The review highlighted the importance of accessing knowledge and expertise held by multi-agency partners when carrying out assessments. Where there are differences of professional opinion, all practitioners need to feel confident to make professional challenge and understand the escalation routes to do so.

Robust record keeping is essential to facilitating well-reasoned decisions and safeguarding people with additional vulnerabilities. Records must accurately reflect interactions and provide sufficient detail to enable evidenced based decisions that take due account of risk factors. **All organisations need to set standards for record keeping, as relevant to role, and make these competence requirements for staff explicit.**

ACTION TO BE TAKEN: Please share this briefing and discuss the learning from it to inform future practice. If you have concerns about someone who is experiencing domestic abuse and are unsure how to proceed, please speak to your agency safeguarding lead, even if the individual may not meet the criteria for a referral to social care.

HOW TO USE THIS BRIEFING: As with all Safeguarding Adults Reviews, there is learning for all practitioners and services, even if they were not involved in the original case. Here are some ideas on how you can take this learning forward:

- **Include reading this briefing in your personal development time and check whether you are familiar with the policies and procedures detailed within**
- **Discuss in your supervision/ 1:1 sessions – are the themes in this case familiar with what you see in your day to day work?**
- **Share with your comms team to put on your own agency intranet**
- **Add it to your agency internal newsletter**
- **Use it in your weekly team meeting to start a conversation – are there themes in this case that your team may struggle with? Would they know where to seek support if they were faced with the situation within the briefing? Is there a training need to ensure staff are well informed and confident in dealing with self-neglect and raising a safeguarding concern?**
- **Do you know where to find the Safeguarding Adults Board resources in your agency? If not, raise this with your manager**

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