Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Adult: Sasha

Adult Sasha:

Sasha was 20 years old and had a long history of mental health illness and missing episodes since the age of 15. Before her death, she was under the care of several health services and as a child had been supported by the Child and Adolescent Mental Health Team (CAMHS). On the evening she died, Sasha was found in a serious condition by a lake in a country park close to where she lived. She died shortly afterwards in hospital from a suspected overdose of propranolol. The Coroner confirmed that Sasha died as a result of suicide following a deliberate fatal overdose of propranolol tablets.

The Review:

Sasha had a longstanding difficulty with her mental health and well-being that led to several diagnoses from childhood into adulthood. She found transition from children's services into adult services particularly difficult appearing to trigger an escalation of stresses and self-harm behaviours. Efforts to contain her stresses with various therapies and medications did not appear to alleviate her self-harm with overdoses and self-laceration. It cannot be underestimated how Sasha's extensive and very controlling OCD rituals and behaviours impacted on all efforts by professionals and her parents to find treatments and therapies that would be successful.

Several safeguarding referrals were made by ambulance services, police, and other organisations and were dealt with by either Area A social care or Area B social care, none of the referrals resulted in safeguarding enquiries under Section 42 The Care Act.

On the day of her death, Sasha became very anxious and had left the house stating that she was going to kill herself. Sasha had been found in a car park by an Area A police officer, it was ascertained that she had not taken excess medication at that stage. Sasha's mother took her back to the Mental Health Hospital herself. Sasha's mother became concerned for her daughter as she was not acting normally and made the decision to divert to Area B Acute Hospital 2. Sasha refused treatment, then absconded from the emergency department. In line with the inter-agency care plan, police were not informed by the Emergency department staff. Less than an hour later police were notified that Sasha had posted a video on social media that was a suicide note. There were then officers from Area A and B police forces deployed to try and locate Sasha. After several phone calls to Sasha, police ascertained her exact whereabouts. Sasha was in a serious condition when found and continued to deteriorate. Paramedics were called but despite all attempts, resuscitation was not successful, and Sasha died.

The SAR identified that there were complexities of cross border working and a large number of agencies who touched the life of Sasha. It is apparent that there have been lessons learnt regarding how agencies worked together to keep Sasha safe and therefore lead to learning and recommendations for future practice.

Key findings:

1)Young people benefit from clarity and flexibility in the transition process that is person centred but that work underway in the NHS 10-year plan could provide local solutions to improve practice.

2) Early recognition and diagnosis of Autism Spectrum disorders is vital to ensure right approaches and treatment.

3) There can be confusion regarding the status of a person subject to detention under the Mental Health Act as well as appropriate application of the Mental Capacity Act where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment.

4)Professionals may benefit from guidance to support them with understanding advanced decisions and high risk and complex cases that they do not face very often. Single and multi-agency action plans and communication.

5) Multi agency plans need to have clear ownership, be outcome focussed, reviewed and shared widely. Single agency plans should be shared where appropriate.

6) Care Programme Approach can be a vehicle for effective multi-agency working and information sharing.

7) Newer processes to manage high intensity users will provide support for professionals if concerns and risk are shared with senior managers.

8) Using a safeguarding lens can offer an alternative view on the risk posed by an individual's behaviour if it can be identified as a form of self-neglect.

9) Working with parents and carers who appear to be adding to risk of a young person may provide insights into parental actions that may be perceived a safeguarding concern.

10)Multi-agency risk panels should be used for sharing information and developing a multi-agency plan to help mitigate the risks identified.

Questions for Surrey

How does the SSAB receive assurance of the quality of handovers between Children's and Adult services for those with care & support needs and their management during transition

How does the SSAB gain assurance that behaviour of this type would be recognised and dealt with appropriately. Do staff have the skills and knowledge to understand high risk and complex cases?

How does the SSAB receive assurance that the providers of services are effective in the application of the Mental Health Act and Mental Capacity Act?

How does the SSAB gain assurance that on cross border cases communication is effective and shared appropriately so that information and actions are consistent?

How does the SSAB receive assurance that Multi Agency plans always have clear ownership and are outcome focussed.

How does the SSAB receive assurance that with high intensity / frequent users that there are appropriate processes in place to ensure effective coordinated response and risk management?

Full Report