Safeguarding Adults Review Learning Summary

West of Berkshire Safeguarding Adults Board
Reading, West Berkshire & Wokingham

Bree

Bree died in February 2022 after falling from a bridge, she was 24 years old. An inquest held in June 2023 recorded a conclusion of suicide. Bree was a White British female who had learning difficulties and may have had undiagnosed autism spectrum condition. Bree had been living in supported accommodation since 2019. The placement was within one local authority boundary but commissioned by another local authority. Bree received support from a care agency which specialises in providing support to people with learning disabilities and autism.

In January 2022 Bree's presentation deteriorated markedly. Her self-harming behaviours intensified as did her suicidal ideation. The Crisis Resolution and Home Treatment Team (CRHTT) supported her for a period and discharged Bree when her presentation appeared to have stabilised and at a time when her unhappiness in her supported accommodation was shortly to be addressed by a placement move. However, the SAR has identified that Bree was living with complex trauma and a placement move would not have solved the underlying issues that led to Bree's her self-harming and suicidal ideation.

The incident in which Bree fell from the bridge took place on the day after she presented at her GP practice expressing suicidal thoughts and was seen by a specialist mental health practitioner within primary care who considered referring her back to the CRHTT, but after consulting with the latter service, provided Bree with reassurance that her placement move was imminent.

Learning from this SAR identified that Bree had experienced traumatic events, including those that would fall under the category of abuse and neglect, throughout her life; which would have attributed to her self-harming behaviours and suicidal ideation, therefore consideration of the safeguarding pathway would have been appropriate. This would have equipped all professionals working with Bree to understand the reasons why Bree's presentation had deteriorated significantly and to agree an appropriate risk management plan.

Findings

- Stakeholders across the West of Berkshire are not clear about when suicidal ideation and/or self-harm requires a safeguarding concern under Section 42 of the Care Act or when other pathways should be used. Safeguarding concerns were raised but these did not go onto enquiry.
- Management of Bree's disclosure of rape;
    - There was confusion on which Local Authority had the legal duty to manage the safeguarding response.
    - A safeguarding enquiry was not iniated.
    - During Bree's police interview, Bree was not offered an advocate and was asked leading questions.
    - The focus of follow up work by professionals seemed to be dealing with practical issues such as pregnancy, sexually transmitted infections and safeguarding her from future contact with the males as opposed to considering how the event may have made her feel.
    - It is unclear whether work on relationships, consent, sex and sexual boundaries was done with Bree at that time and whether it was emphasised that she had the right to a safe, loving relationship.
- Many of the agencies with whom Bree came into contact believed her to have a diagnosis of mild learning disability. However, a diagnostic assessment completed in 2019 that concluded, given Bree's level of ability, any future psychological work could be met by mainstream services. This confusion led to inappropriate assumptions of services that Bree would have access to.
- Bree was 'really upset' that she was not considered to have a learning disability and was 'frightened' that she would get 'thrown out' as professionals no longer needed to support her.
- Although there was evidence of information sharing and joint working between professionals during the period in which Bree was presenting in crisis in January and February 2022, no multi-agency meeting was held – which would have been a valuable opportunity to take stock of Bree's circumstances and ensure that all partner agencies had a shared awareness of Bree's relevant history.
- Bree presented with at least 5 out of the 12 identified as possible risk factor identified in the Berkshire Suicide Prevention Strategy 2021-26.
- Professionals could have requested clinical advice or a consultation from the Berkshire Health Foundation Trust Learning Disability Service even in the absence of a diagnosed Learning Disability
- A referral to the Community Mental Health Team (CMHT) was considered but it was not made as the CRHTT felt it would not be accepted.
- A referral to the Community Mental Health Team was not considered.
- Bree could have benefitted from an advocate when presenting in crisis.
- Reasonable adjustments were not always made for Bree's learning difficulty, for example in providing her with support to fully understand her safety plan.
- There is a need for a robust supported living approach for young women who have complex trauma

The full SAR report and the agreed action plan can be found here.

Thankyou for taking the time to read this practice note. If you would like to provide any feedback or have any questions regarding the Board please contact: Lynne.Mason@Reading.gov.uk

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When does concerns regarding suicidal ideation and/or self-harm require a safeguarding concern?

Self-harm including attempted suicide and suicide is often a way of dealing with difficult feelings and memories of overwhelming situations and experiences. Support is available for anyone who self-harms and thinks about self-harming. Safety of the person is paramount and in a mental crisis or emergency, call a mental health crisis line or 999.

A safeguarding concern may be appropriate when there is reasonable cause to suspect that the individual has need for care and support and because conversations have uncovered reasonable cause to suspect abuse and/or neglect as a factor in suicidal thoughts/threats.

The SAR identified that Bree may have experienced abuse or neglect through: Financial, Domestic, Psychological and Sexual Abuse/Exploitation and therefore a safeguarding intervention would have been appropriate.

It may be that the situation is believed initially not to constitute a safeguarding concern, but later new information indicates that it does. This should be monitored and there should be a preparedness to change approach where necessary in the light of new information.

The Board have produced the following guidance to support professionals in their decision making.

Trauma-informed practice

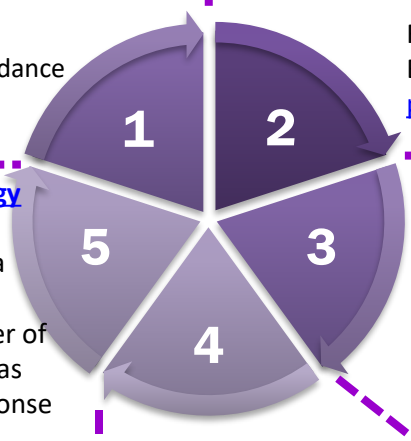
Is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. An understanding of the persons relevant history is key.

Relevant history is something that is relevant to a situation or person that is **important** or **significant** in that situation or to that person. For example, a past trauma effecting the individual and/or their loved ones that may impact on their engagement with services.

Learning from this SAR identified that Bree had experienced traumatic events, including those that would fall under the category of abuse and neglect, throughout her life; which would have attributed to her self-harming behaviours and suicidal ideation.

Individual practitioners did not know Bree's relevant history and therefore a trauma informed approach to supporting Bree was not possible. A multi-agency meeting should have taken place, this would have equipped all professionals working with Bree to understand the reasons why Bree's presentation had deteriorated significantly and to agree an appropriate risk management plan.

For Safeguarding Adults Week 2023 the Board created a Trauma-Informed practice briefing note



The Berkshire Suicide Prevention Strategy 2021-26

Female Suicide Deaths was identified as a Priority Area after the Berkshire Suicide Prevention Group agreed that the number of female suspected suicides in Berkshire was sufficiently unusual and convened a response group to look at cases in more depth. Although the numbers are too small to identify statistically significant themes, several themes were identified for more than one of the women who died, namely:

a) A mental ill-health diagnosis and /or history of contact with mental health services;
b) Adverse Childhood Experiences
c) History of self-harm;
d) History of alcohol or substance abuse;
e) Parenting / carer stress;
f) Financial stress;
g) Domestic abuse;
h) Workplace stresses and adjustment challenges, particularly for those in a health, care or other frontline role (including childcare and police);
i) Neurodiversity;
j) Bereavement and grief;
k) History of disordered eating and
l) Denial of suicidal intent at the time of last contact with services

Of the themes listed above, a, b, c, i (undiagnosed) and k were present in Bree's case. Domestic abuse from a former partner may also have been present although this may also have taken the form of sexual exploitation. Financial stress may have been apparent in the form of financial abuse which Bree reported on two occasions.

Berkshire Health Foundation Trust Learning Disability Service

The Learning Disability Service will be promoting awareness of how and when, an offer of clinical advice or consultation is available to relevant partner agencies, where a person doesn't have a confirmed learning disability diagnosis.

Disclosure of Sexual Abuse and/or Sexual Exploitation

When an adult makes a disclosure of this nature and they appear to me to have care and support needs, a safeguarding concern must be raised to the Local Authority where the alleged abuse took place, as they the legal duty to undertake a safeguarding enquiry under S42 of the Care Act.

The Local Authority did not initiate a safeguarding enquiry in response to Bree's disclosure of rape, a key determinant of decision making appeared to be the Police. This decision was incorrect and a S42 enquiry should have been iniated and run alongside the police investigation.

When working with Bree after the disclosure the focus of follow up work with professionals dealt with practical issues such as: pregnancy and safeguarding her from future contact with the men. There was a missed opportunity to work with Bree on consent, sex and sexual boundaries, how the incident had made her feel and to emphasis Bree's rights to a safe loving relationship.

In response to learning from a previous SARs the Board has created: Supporting Agencies in the Management of Complex Multi-Agency Enquiries - Joint Safeguarding and Criminal Investigations Protocol and Resolving Professional Disagreements In cases that meet the statutory criteria for Safeguarding Adults Escalation Policy