Safeguarding Adult Review (SAR) about Ms A

Background

Ms A was a 20-year-old woman who had very complex needs and who died after falling from the window of her flat. She had been a looked-after child due to abuse and severe neglect and had received support from Children's Social Care services for many years when younger. Her needs included mental health and special educational needs, as well as behavioural issues. At the time of her death, she was receiving support from a Young Person's Adviser (YPA), who was very committed to Ms A, visiting her and helping her to clear her rent arrears. As well as Children's Services, Ms A had been known to NHS Trusts providing treatment for mental and physical health needs, paramedic services, the police, Community MARAC services and the Adult Safeguarding Team within Adult Social Care in Havering Council.

Key finding

Eligibility criteria and specialised support. Thresholds for care and support assessments for people transitioning past the age of 18 require clarification, as do thresholds for acceptance of an adult safeguarding alert relating to a vulnerable adult, with clarity for professionals about who should raise such alerts. Eligibility criteria for young adult mental health services should be regularly reviewed to ensure it is responsive to complex needs. Professionals working with vulnerable young adults should be supported with expertise in areas such as the law and mental health provision. Also, management must recognise the challenging and lengthy nature of complex cases and provide support accordingly.

Further reading

If you would like more information on the SAR about Ms A, please refer to the published executive summary and overview report.

Background

At the time of her death in mid-December 2015, Ms A had a boyfriend and had previously experienced losing a baby through stillbirth. The Coroner's inquest recorded a narrative verdict and noted that Ms A had been under the influence of alcohol at the time of her death. The inquest concluded that there was not enough evidence to fully establish that she had intended take her own life at this point. Following the inquest info Ms A's death, the Adult Social Care Safeguarding Team requested the establishment of a multi-agency learning review to determine whether a robust safeguarding plan, including more collaborative working across agencies, would have reduced the likelihood of Ms A's death.

Review

The Havering Safeguarding Adults Board (SAB) commissioned a SAR, as key criteria had been met. It was agreed that the review should focus on the process of transition from Children's Services to adulthood for individuals with very complex needs and in vulnerable circumstances, and also include eligibility for services. There was also a desire to learn and understand how services might be co-ordinated and delivered in a different way to improve outcomes for such vulnerable individuals. The SAR was led by an independent reviewer and involved many agencies represented on the SAB, including practitioners who had worked directly with Ms A. The review reported in January 2017, identifying a number of recommendations for improvements to transitional processes and systems.

Key finding

Professional practice. Training for staff needs to improve in key areas such as mental capacity (relating to young people aged 16-18), working with young people with mental health needs (including attachment disorders, behavioural and emotional problems), leaving care and accommodation. Questions relating to capacity should appear and be used in all assessments and screening tools for young people. Provision of training in transition processes and information-sharing obligations, including those legally mandated and required, is crucial. Good systems of supervision and support, particularly for frontline staff working in such cases, should be reinforced. Also, staff need to be more confident and better able to communicate professional curiosity with concern, and to establish the nature of an individual's lived experience.

Key finding

Information sharing and record keeping within and between agencies at key points such as transition between services and transfers of an individual's care and support are key to effective multi-agency safeguarding systems. This includes the timely transfer of medical or health records and using information and knowledge of an individual's case history to inform risk assessments (including on a multi-agency basis), which are also critical for transition processes to be successful. Case management should be multi-agency, take a long-term perspective, and take into account the views of practitioners working most closely with the person, such as the YPA who worked with Ms A but felt excluded from mental health assessments undertaken with her, did not have a consistent contact in Adult Adult Mental Health Services with whom they could liaise, and often found the wider professional network to be unresponsive to their concerns unless Ms A was presenting high-risk behaviours.

Key finding

Management of complex cases relating to young adults needs to improve, with greater oversight and fewer placement disruptions for vulnerable individuals where possible. Stability of placements can be enhanced by additional support to carers where necessary. Transition processes between Children's and Adults' Social Care and Mental Health services should be streamlined to work as smoothly as possible. Young people should be engaged in co-producing strategies for self-protection before and beyond transition points, and care-leaver champions established within agencies to promote better understanding of transitional issues. Multi-agency care pathways for young adults with complex needs should be developed, should not rely on strict eligibility criteria, and should attend to issues of non-engagement. Likewise, establishing well-defined agency responses when individuals appear not to meet thresholds or eligibility criteria will promote joint working and flexible approaches.

Havering Safeguarding Adults Board

7-minute briefing