Safeguarding Adults Review: Adult M

Overview Report

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A Local Authority Safeguarding Board Commission

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1. **Introduction**

1.1 On the 25th October 2021, M[1] was on holiday with her mother and her mother's partner when it was alleged that a disagreement between M and her mother's partner resulted in a cup of coffee being thrown over her. M then appears to have travelled back to the Berkshire area, alone.

1.2 On 27th October 2021, M was admitted to the Royal Berkshire Hospital having taken an overdose of some 220 separate prescribed pills. Following a transfer to the ICU, M died due to multi-organ failure on 28th October 2021.

1.3 On the 30th November 2021, members of the Local authority Rapid Review Panel acting under delignated powers of the Safeguarding Board, unanimously agreed that the death of M met the criteria for a Safeguarding Adult Review (SAR).

1.4 The Safeguarding Board's Safeguarding Adults Review Framework reflects the requirements of the Care Act 2014 (s44) and suggests the purpose of a SAR is:

> "to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again."

1.5 The Board appointed an independent reviewer to compile a report on what happened to M and what lessons could be learned for the future. The reviewer has worked closely with a multi-agency panel which has directed the work of the review.

1.6 The time period for this review was agreed as 11th March 2020 to 28th October 2021.

2. Review methodology

2.1 The Safeguarding Board's policy in respect to case reviews requires the SAR panel to give careful consideration as to the appropriate methodology and to apply its decision-making matrix.

2.2 This matrix suggested that the review should follow the *Option D Significant Event analysis* SAR model, as the appropriate methodology for this case. The framework suggests this approach provides a structured process to help identify what happened, why, what is the learning and what could be done differently.

2.3 Key features of this model are set out below:

- Group led (via panel), with facilitator
- Staff/adult/family involved via panel
- No chronology
- No single agency management reports
- One workshop: quick, cost effect

[1] To ensure anonymity the subject of this report will be known as M.

- Aims to understand what happened and why, encourages reflection and change.

2.4 At the first panel meeting it was agreed to adapt this approach by creating a combined chronology derived from management review data related to M's involvement with key agencies, and an appreciative enquiry once a first draft report was produced to enable panel members to explore positive recommendations.

2.5 A practitioner workshop was held on 2nd September 2022 which enabled the reviewer to check the accuracy of the data informing the report and explore key events in more detail.

3. Terms of reference

3.1 The learning for those agencies involved with M during her short life, initially focused on:

- whether there was sufficient realization of her life trajectory amongst multi agency partners
- what mechanisms or processes would have helped to generate that realization, and
- what services or combination of services would have made more of a difference to improve her life chances.

4. Background info

4.1 M had a complex family history including substantial involvement with Children's Social Care services from her early childhood to after she turned 18. A significant event was the death, by suicide, of her father in May 2009. M would have been 9 years old. A paternal uncle and aunt both died by suicide following M's father's death.

4.2 Later, in September 2009, M was reported to struggle with peer relations at school. She made threats to fellow pupils. In October, she stayed with her paternal family in south Wales for a week. She was reported to be close to them and was exceptionally angry about her father's death. Later, viability assessments were undertaken to establish whether she might stay permanently with her paternal family. The outcome of these assessments is not known, however. That same year, a police record indicated that she wanted to kill herself. This would be the first of many such instances.

4.3 On 17th February 2010, M was accommodated under s20[2] following a breakdown in her relationship with her mother. Significant problems within the household were revealed with many reports to police about assaults between M's sister and her mother and between M and her siblings. Six child protections referrals were also created in the year mostly centred around M. These related to her aggressive behaviour and running from the family home five times.

4.4 When 11 she alleged the first of several sexual assaults. When 13, she was self-harming and said she heard voices. At 14 she was detained by police under s136[3]. Before she died, she

[2] Children Act 1989

[3] Mental Health Act 1983

was detained a further 6 times and three times under s2. From 16 onwards, she reported having several physical health complaints requiring medical/hospital treatment including for seizures and a heart problem, she experienced at least 9 changes of placement/address (post 16 years but 35 placement changes in her life before transition). She took overdoses four times and attempted to end her own life on five other occasions via different methods. She also had Covid and was reported to have symptoms of long Covid.

5. What led to M's death?

5.1 In 2020 six key episodes occurred and serve to illustrate M's daily lived experience.

5.2 On 11th March 2020, M took an overdose at her supported accommodation. The police were called as was South Central Ambulance Service (SCAS). M was noted to be drowsy, and she stated that she wanted to kill herself. She blamed her mother for her father's suicide and expressed that she wanted to be with him. A referral was made to the CRISIS team and to Adult Social Care. M was taken to A&E.

5.3 18th June 2020, the Local authority's Leaving Care Services prepared to end their service to M on her 21st birthday. M had expressed a desire for independence, and she was reported to be engaging well with the Community Mental Health Team (CMHT) and with her GP. M wrote in her care plan:

> The time I have been at (supported accommodation) has been the most settled that I have been in a long time. I have been in plenty foster placements throughout my life that have fallen through but I am proud that I managed to stay my two years at (supported accommodation). I am looking forward instead of backwards. I have had struggles with my mental health and dealing with the trauma of my dad's death, but I have worked to be in a place where I can have therapy to talk about my dad's suicide and I am now engaged in weekly sessions. I also have learnt to engage well with the mental health team.

5.4 27th August 2020: M moved to her own accommodation.

5.5 12th September 2020: M's grandmother rang the police to report M missing from her address where she had been staying temporarily. Her grandmother told police that M had been picking fights all day and then told her that she had taken an overdose of her beta-blockers and she wanted to be with her father who had died by suicide. After telling her grandmother this she left the address. SCAS was called and M was taken to A&E via ambulance. GP follows up on 15th. The CRISIS team was involved.

5.6 27th September 2020: M stabbed herself in the abdomen with a kitchen knife. She had previously called her mother to say she was going to kill herself. Her mum phoned 999. M was detained under s136 of the MHA & taken to A&E for treatment. She told police she was hearing voices that were telling her to kill herself. She was discharged from hospital two days later with a care plan.

5.7 22nd October 2020: M took a drug overdose. The previous day she had threated to stab her mum. She was arrested and deemed fit for interview, but no charges were pursued. She

was initially detained under s136 MHA. M was discharged home but the next day emergency accommodation was requested after M smashed her mother's flat. The day after she tries to jump off a bridge. A week later she takes another overdose.

5.8 Following these occurrences M was admitted to hospital with acute pericarditis in November 2020. It is thought likely that she would have been able to hear her own heart beating, and this may well have been very frightening for her. In February 2021, she said she wants to stab herself. She was taken to hospital under s136. In the same month she alleges that she was being stalked. There are concerns she was pregnant. In addition, her brother threatens her with violence.

5.9 In June 2021 she is prescribed Colchicine after being admitted to hospital with chest pains. In August 2021 she is detained under s2 MHA. In September 2021 she threatened to jump off a bridge and was again detained under s136. Later that month her prescription for Colchicine is changed to Prednisolone.

5.10 In early October 2021 M self refers to CRUSE for bereavement counselling. Following the holiday in Devon later that month, M died after taking approximately 220 pills including several Colchicine.

6. Analysis – relevance of history

6.1 M's untimely death is tragic. Perhaps given the number of times she seemingly tried to end her own life, her early death by accident was highly likely, but this review has learned that it was unpreventable. M clearly didn't realise that the cocktail of medication that she took was not survivable. Previously, when she had taken an overdose of medication, she had survived. It is likely she thought the same thing would happen when she took her last and lethal overdose. Unfortunately, by including Colchicine in the cocktail of drugs she ingested, her chances of survival diminished dramatically. M told the health staff who were treating her that she did not want to die.

6.2 M's history is littered with periods of calm followed by breakdown. As a teenager she would frequently run away particularly when the relationship with her mother broke down. She self-harmed regularly and would exhibit self-destructive behaviours. She was exploited by others particularly some men with whom she thought she was in a romantic relationship. Her self-destructive behaviours and running away frequently brought her into contact with emergency services. It is extraordinary for a young person under eighteen to be subject to s136 police powers several times. In 2021, SCAS were called for M eighteen times.

6.3 On the one hand practitioners recognised that M frequently presented with a positive frame of mind, she was "full of life", and she clearly desired to live more independently and seek employment. But M also remained very vulnerable and despite her feedback to professionals, there was evidence of her increased isolation and limited capacity to achieve her ambitions when faced with the ongoing significant family dysfunction that often appeared to result in conflict with her mother and M's subsequent significant self-harm.

6.4 Whilst the death of her father, when she was 9, was a catalyst for increasing problems, M's earlier adversities at home meant she was very vulnerable. Earlier interventions with M

by Children's Social Care services had resulted in her engagement – although these were often challenging for staff due to her initial resistance/frustration. But the accumulation of traumatic and disturbing events for M were increasingly harmful leading to her diminished coping skills. There was also likely to have been a family narrative relating to suicide in which members verbalised this as an option relating to stressful events. The impact of this trauma may have been easily underestimated.

6.5 While safeguarding services had responded to the perceived inter-familial risks in M's life it was felt that the impact of separation (including her siblings' reception into care/adoption), loss and frequent changes in placement had not been fully appreciated and may have reflected the lack of appropriate local services that were sufficiently robust to contain M in the moments when she became challenging and on occasions could be violent. As a result, M was repeatedly moved and was placed in residential care which was not ideal for a young person with her needs.

6.6 Once M had turned 18, the agencies involved with her no longer had a whole picture of what was happening to her. During the latter part of her life the focus may have been on the presenting problems/crisis situations, and it is unlikely that the judgements of those responding would have been informed by a full appreciation of her past and how that affected her day to day.

6.7 Colleagues involved in providing health care for M have reflected on her presentations at A&E and questioned whether these were M communicating her distress and whether her physical ill-health manifestations resulted from the accumulative trauma that was well documented. It remains unclear whether M's seizures resulted from an underlying physical medical condition or whether they reflected her experience of trauma and/or substance misuse.

6.8 Those supporting M more latterly reflected how her decision-making abilities appeared to have been eroded and often conceptualised as her being involved in 'risk taking behaviours' and how this had culminated in her becoming vulnerable to being exploited. At times this made caring for M a significant challenge, but on reflection, it is suggested it demonstrated the importance of professionals being flexible, tolerant and tenacious in the face of her fluctuating mindset that often was initially rejecting / challenging but frequently gave way to an appreciation of the support being offered. Examples of M being collected from the local authority area and abandoned in other areas of the country were potential indicators of her being trafficked. On reflection it appears there was little appreciation of the risk of child sexual exploitation and therefore indicators that in hindsight appear to have been clear were not known and understood by all those involved.

6.9 From a CMHT perspective, it was clear that while "no one had given up on M", the focus had been one of responding to the various crises and a reliance on her reaching out, rather than one of maintenance. Several agencies have highlighted the number of similar cases currently being managed with a large proportion with a history of adverse childhood experiences that result in enduring mental health difficulties, already well-established during childhood.

7. Analysis - Leaving care services, transitions and mental health

7.1 The challenge of supporting vulnerable children transitioning into adulthood is well recognised but these challenges amplify when there is a need to respond to young adults with enduring mental health problems for whom there has been insufficient planning or preparation. This is especially challenging for young people with a long history of trauma, many of whom are care experienced and are often experiencing a range of significant problems including self-harm or substance misuse, with some also becoming well known to local policing due to their vulnerability and victimisation but also being arrested for criminal offences related to drug use and / or their inability to regulate their emotions during conflict situations.

7.2 From an adult social care / mental health perspective it is suggested that while some young people's experience of transitioning services when they become 18 may be positive, the approach for M was piecemeal, it lacked a sufficient understanding of her needs and proper preparation.

7.3 Colleagues in the practitioners' event acknowledged there was wider learning needed about fully understanding the reality of young people's experiences particularly involving complex trauma and abandonment which transcends labels such as emotionally unstable personality disorder (EUPD). Similarly, it is recognised there is a 'cliff edge' experience for some young people approaching eighteen as they try to access adult mental health services and that while prior trauma may have resulted in a child and adolescent mental health service, often these did not meet the threshold criteria for those over eighteen years.

7.4 Adult Social Care services do not appear to invite early referrals of young people approaching transition. Young people are often very near their 18th birthday before referrals are made by Children's Social Care. This inevitably leaves vulnerable young people/adults at significant risk.

8. Analysis - Access to medication

8.1 M had been prescribed most of her medication via her GP, but she was also prescribed medication by a cardiology consultant. It is unlikely that a secondary care consultant would have appreciated the extent of M's vulnerabilities and therefore was unaware of her previous self-harm/suicidal ideation and previous overdoses. The current NHS systems do not easily enable prescribers in secondary care to see the extent of the medications a patient might have prescribed for them in other parts of the health system.

8.2 What is clear is M's GP and other clinicians in the same Practice were fully aware of M's mental health issues and history. There were clear problem codes on her records relating to mental health, overdoses, suicide attempts and for being a previous Looked After Child.

8.3 M's medication was on a repeat prescription as monthly supplies but in December 2020 following a review with M's Consultant Psychiatrist, new medication (sertraline) was put on 7-day prescriptions upon their advice. The medications on M's repeat prescription at the time of her death were Aripiprazole, an anti-psychotic (started by CMHT), Folic acid, Lansoprazole and Prednisolone which are commonly prescribed medications for physical health conditions.

Codeine phosphate was on a variable repeat but only a one-off supply had been issued in August 2021.

8.4 The medication used in the fatal overdose, Colchicine, was prescribed by the hospital cardiology team and not continued by the GP. Given the time when the Colchicine was prescribed and how much she should have taken per day, M should have completed the Colchicine course well before she died. It appears likely that she took fewer than was prescribed leaving several available.

8.5 Colleagues involved in assessing mental capacity have provided clarification in respect of the legal framework associated with formally determining mental capacity. Further discussion at the Practitioners' Event considered other conceptualisations of how long-term trauma might impact on decision-making and the merits of viewing such vulnerability as accumulating over time.

9. Recommendations

9.1 The Safeguarding Board is recommended to improve its policy and practice in relation to managing risk of harm and safeguarding young people who are moving into adulthood. This improvement work should strive to create a more integrated system of inter-agency effort to support young adults at risk of harm.

9.2 Children's Social Care Services is invited to develop foster placements which can provide a comprehensive and tenacious service to children and young people who have experienced complex trauma.

9.3 The procedures for the Approaching Adult Panel should be amended so that the needs of young people with complex trauma histories can be prioritised and given greater consideration.

9.4 The Safeguarding Board is invited to establish a task and finish group to develop alternative practice approaches to adults at risk of harm where there are concerns about the adult's ability to make decisions when they have experienced complex trauma.

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