Safeguarding Adults Review Learning Summary – Enya

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What is a Safeguarding Adult Review (SAR)

Under the 2014 Care Act, Safeguarding Adults Boards (SABs), are responsible for Safeguarding Adults Reviews (SARs). SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

Statutory guidance (updated in 2018) to support implementation sets out the purpose of SARs, and principles for their conduct.[1]

Action to safeguard adults should include:

- Promoting well-being and preventing abuse and neglect from happening in the first place.
- Ensuring the safety and wellbeing of anyone who has been subject to abuse or neglect.
- Involving all those who can offer support and impact on reducing risk.
- Taking action against those responsible for abuse or neglect taking place.
- Learning lessons and making changes that could prevent similar abuse or neglect happening to other people.

Enya

Enya as a person

Enya was a mother to two children; she was a nurse who met the children's father, Tom, at their place of work. She was a white British citizen, aged 35 years at the time of her death. Enya had siblings, two sisters and a brother; her relationship with her father had been difficult prior to her parent's divorce.

The events leading up to Enya's Death

Enya had experienced post-natal depression with her first child and when she was pregnant with her second child, her relationship with Tom was breaking down and her mental health began deteriorating again. Early on in her second pregnancy, Enya experienced suicidal ideation and following that, she was in contact with the police, Surrey Children's Services, Surrey and Borders NHS Partnership. Tom reported to the police that Enya was a domestic abuse perpetrator. Enya accepted this.
Soon after this Enya was detained under the Mental Health Act, and she was detained in hospital. Whilst there, Enya disclosed to professionals that Tom was/had been subjecting her to controlling coercive behaviour. Enya was diagnosed with type two bipolar disorder and Emotional Unstable Personality Disorder (a diagnosis in which genetics interacts with adverse childhood experiences and includes feelings of emptiness and fear of abandonment; and is strongly linked to suicidal behaviours[2]).

Tom commenced private proceedings to care for the couples' child and the unborn baby. Following the birth of the baby, Enya returned to the family home, but she struggled with her mental health, the breakdown of her relationship with Tom. She took an overdose six months prior to her death, and was detained again under the Mental Health Act, and was admitted to a specialist hospital. Enya tried to continue to feed her newborn baby whilst she was in hospital; this would not have been easy as she could only see the children under supervision and Tom continued to progress the private proceedings for their care.

When Enya left the specialist hospital, she was homeless and placed in temporary accommodation. Her mental health deteriorated further. She also made further disclosures to professionals that she had experienced and continued to experience coercion and control from Tom. Two weeks prior to her death,

[1] SARs guidance https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-

[2] Leichsenring, F. et al. (2024). Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. World Psychiatry 23:1.

Enya took another overdose. She was found dead in a wood near the family home and Enya had a note on her saying,

> *"I'm sorry I can't live in a world I don't understand I really have tried; child and baby they tore you both from me and it tore me apart. All I ever wanted was to be a good mum, but they did not think I was good for you. Loving you with all my heart was not enough. I am always in your heart. Your mummy"*

Key Themes highlighted from the review

An understanding by all professionals that an adult with care and support needs, who may be at risk of abuse or neglect should be referred to Adult Social Care.

Enya had care and support needs, and all agencies should be reminding professionals about the Adult Social Care levels of Need including how to make a referral[3].

Professionals to understand the impact of the loss of access to their children and the link to death by suicide.

Enya had a combination of factors which may have contributed to her unexpected death including mental health, homelessness, alleged victim of controlling coercive behaviour and the loss of her being able to care for her children. The children meant everything to Enya and research has identified that the grief a person can experience following separation from their child can be compared and considered equal to the grief when someone loses a child as a result of death. Professional need to understand the impact that child separation can have on a vulnerable person and assess the potential increase of risk of harm, professionals need to be suicide alert.

Reinforce Think Family Model with Health and Social Care Professionals.

It was not clear whether the health and wellbeing of Enya was fully considered by all agencies, and this review highlights the need to Think Family [4] [5] and consider the needs of the wider family by coordinating services focusing on the strength and challenges of the family.

The Importance of Advocacy for a Vulnerable Adult.

Enya needed an advocate to help support her and give Enya a voice in trying to navigate all the complex issues she was facing. The review highlighted that professionals and the community were not always aware of what advocacy support is available in Surrey.

Agencies, Professionals and Practitioners to Embed a Trauma Informed Approach to Better Support Vulnerable Adults.

Enya experienced traumas in her life including adverse childhood experiences. There were examples within the review that identifies that not all the traumas that Enya was experiencing were considered, Enya lived experience was never fully explored which meant that Enya's voice was never fully heard. Although agencies should have trauma informed policies and culture withing their organisation, this review highlights the need to ensure that trauma informed practice is embedded within the culture of the agency and to remind professionals to ask, "what does this person need" and "not what is wrong with this person".

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[2] www.legislation.gov.uk-Section 42 of the Care Act 2014-An enquiry where a local authority has reasonable cause to suspect that an adult in their area has:

a) Has a need for care and support
b) Is experiencing, or is at risk of abuse or neglect and
c) As a result of those needs is unable to protect himself/herself against abuse or neglect or the risk of it.

[4] www.surreycc.gov.uk Think Family

[5] www.nhsthinkfamily.uk

Agencies to embed training and practice on their organisation to ensure professionals understand the concept of unconscious bias and that there are systems in place to challenge unconscious bias.

The review highlighted unconscious bias by some professionals who focused on Enya's mental health diagnosis which does have a stigma, and this impacted on information provided about Enya and how professionals engaged with Enya. Agencies need to ensure that professionals understand the concept of unconscious bias and through supervision and reflective practice, professionals are challenged appropriately.

Professionals to Understand the Complex Dynamics of Controlling Coercive Behaviour.

Enya was always viewed by professionals as the perpetrator of domestic abuse, despite disclosing to professionals that she felt that Tom was controlling and coercive. This review identifies the complex nature of domestic abuse and that professionals need to be curious and be neutral in their reporting of domestic abuse in all its forms and to understand how unconscious bias may impact on their views.

Professionals Working with Families to Understand the Impact of Ante and Post-Natal Depression on a Person's Wellbeing.

Enya was pregnant and gave birth during the period of this review. Enya experienced post-natal depression following the birth of her first child. Not all professionals supporting Enya and the family considered what Enya was experiencing following the birth of the baby.

Professionals to have Knowledge on the Impact of Lack of Housing on a Vulnerable Adult.

Enya was homeless following her discharge from the specialist hospital. The local housing authority provided good support to enable Enya to access temporary accommodation, but Enya struggled to accommodate seeing the children in the accommodation and as she was a joint homeowner her options for gaining access to housing were limited. What became clear as part of the review, is the lack of understanding of the supply and demand of housing in Surrey and the housing options available.

Recommendations

Recommendation 1

Surrey Adult Social Care and Surrey Children Social Care.

a) To embed the adult social care referral process for adults who may have care and support needs within the practice of children's social workers in SCSC. Once embedded, to monitor the implementation of the referral process by SCSC and provide further training/guidance as required
b) ASC and SCSC to work together to ensure robust understanding and implementation of service remits, eligibility and referral pathways into each other's directorates.
c) Once embedded, to monitor the implementation of the referral process by SCSC and provide further training/guidance as required.

Recommendation 2

a) **Surrey County Council, Adult Social Care**; should take whatever steps it identifies as needed so that it can assure itself that it is consistently meets its Care Act 2014 duties towards adults with Care and Support needs, who are at risk of abuse and neglect, including those under s9, s11(2)(b) and s42 Care Act 2014.
b) ASC to ensure there are robust audit and review processes in place to assure it is consistently meeting its Care Act duties.

Recommendation 3

Surrey Safeguarding Adults Board to seek assurance that all relevant agencies involved in this SAR (health/mental health NHS trusts and specialist hospital /SASC/SCSC) that all policies are trauma informed and are embedded within their agency and this to include staff at all levels including consultants to ensure that patients are treated with respect and in a non-judgmental manner.

Recommendation 4

All agencies involved in this review ensure that through their own training provision that professionals are suicide alert and are able to respond. This to include factors which may impact on risk of an individual, i.e. loss of caring for child/children, domestic abuse, mental health, homelessness and multiple traumas.

a) All agencies in involved in this review ensure that suicide prevention training is implemented consistently within relevant professional teams.
b) Surrey Safeguarding Adult Board to request that Surrey Suicide Prevention training includes risk relating to loss of ability to care for children and perinatal mental health.

Recommendation 5

Surrey Safeguarding Adults Board seek assurance that the following agencies involved in this Safeguarding Adult Review (Surrey Children Social Care, Surrey Adults Social Care, Surrey and Border NHS Partnership) have professional curiosity embedded within professional practice, including monitoring of professional curiosity through supervision and reflective practice.

a) Through training and practice for practitioners to have the skills to identify dual allegations of domestic abuse and therefore to offer support to both individuals without bias.

Recommendation 6

Surrey Safeguarding Adults Board seek assurance that the following agencies involved in this Safeguarding Adult Review (Surrey Children Social Care, Surrey Adults Social Care, Surrey and Border NHS Partnership and specialist hospital) that training includes the concept of unconscious bias and how to challenge a professional's bias as appropriate.

Recommendation 7

Surrey Safeguarding Adults Board to raise awareness of domestic abuse in all its forms through a focus on training/campaigns, in SSAB's 2025/2026 work programme. This to include the complex dynamics of domestic abuse e.g. controlling coercive behaviour.

Recommendation 8

Surrey Safeguarding Adults Board to raise awareness and understanding with professionals in Surrey on the impact of the loss of a child/children through the care process/private proceedings, including appropriate support (grief counselling) which is available in the community.

Recommendation 9

Surrey Safeguarding Adults Board to raise awareness with professionals and the wider community about Advocacy services in Surrey for those who need it including how to access advocacy services.

Recommendation 10

Surrey Chief Housing Officers to provide guidance for, Surrey Children Social Care/Surrey Adults Social Care and Surrey and Borders NHS Partnership professionals on housing options in Surrey, the role of the housing authority and how to refer.

Recommendation 11

Surrey Safeguarding Adults Board to raise awareness and remind professionals /practitioners of the Think Family model when supporting vulnerable adults and their family

Recommendation 12

A workshop to be organised for professionals and practitioners which will focus on the key learning from this SAR, including risk relating to mental health/loss of caring for a child/professional curiosity around allegations of domestic abuse and trauma informed practice.

What Can You Do?

- Ensure you know how to make a referral if you have concerns about a vulnerable adult in Surrey.
- Ensure that you treat vulnerable adults with empathy and understanding, do not be judgemental.
- Consider all the trauma's that a vulnerable adult has experienced and remember to think "what support does this person need" and "not what's wrong with this person. "

- Remember to be suicide aware when supporting a vulnerable adult who has experienced suicide ideations and actions.
- Consider the impact/risks on a vulnerable adult when caring responsibilities are removed from the vulnerable adult.
- Ensure you understand the complex dynamics of domestic abuse and remember to be professionally curious if someone discloses concerns that they may be emotionally abused.
- Remember to Think Family.
- Have knowledge about Advocacy Services in Surrey.

Useful Links

- **Advocacy Services -** www.surreycc.gov.uk/adultadvocacy
- **Domestic Abuse Services**
  - Covering Reigate and Banstead, Mole Valley and Tandridge - www.esdas.org.uk
  - Covering Epsom and Ewell, Spelthorne, Elmbridge, Runnymede - www.nsdas.org.uk
  - Covering Woking - www.yoursanctuary.org.uk
  - Covering Guildford and Waverley - www.swsda.org.uk
- **Surrey Domestic Abuse -** www.healthysurrey.org.uk - Helpline 01483 776822
- Making a **Safeguarding Referral for Adults** - www.adultsocialcareportal.surreycc.gov.uk-
- Useful Support Groups for adults who may no longer be caring for children - www.matchmothers.org.uk

Support organisations for adults who may be experiencing suicide ideations.

- **Samaritans** - www.samaritans.org
- **Safe Haven** Epsom, Guildford, Redhill, Woking - www.sabp.nhs.uk
- **Mental Health Crisis Helpline** – 0800 9154644

This summary is one of the ways in which the Safeguarding Adults Board aims to share learning as widely as possible to support practice across Surrey. The briefing aims to pull together key messages from the review and the lessons learnt to enable you and your organisation to reflect and challenge the ways in which we work to safeguard adults from abuse and neglect.

Thank you for taking the time to read this learning summary. If you would like to provide any feedback or have any questions, please email: surreysafeguarding.adultsboard@surreycc.gov.uk