Ms L Summary for publication

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1. Background to the review and why this summary has been produced

1.1 In 2015 the Tower Hamlets Safeguarding Adults Board commissioned a Safeguarding Adults Review into the circumstances leading to a young adult committing suicide. Many agencies, including both adults' and children's services, were involved over a period of time, and the circumstances meant that under statute - the Care Act 2014 - the criteria were met to review the those circumstances and consider what lessons could be learnt that would improve multi agency practise.

1.2 The immediate family did not want a review to take place, or publication of a report, and out of respect for their wishes the SAB has agreed to publish only the key facts and learning for all agencies involved. The TH SAB is obliged under data protection legislation to protect the identities of the family and not reveal identifiable information. This summary has been written to try and ensure confidentiality.

1.3 An independent reviewer was commissioned to review the IMRs, challenge the findings and ensure that recommendations based on the SAB sub panel discussions were made to be robust and achievable.

2. **Agencies involved**

Accident and Emergency Departments at two local hospitals
Metropolitan Police
London Ambulance Service
Two counselling services in Tower Hamlets
Former London Probation Service
The local Magistrates Court
A specialist support service commissioned by the former London Probation Service
An NHS mental health trust
An education setting

3.Summary of findings

3.1 The period covered by the review is now some years in the past, and so it is important to stress that the way services work together has changed for the better in all the areas below, and examples of these improvements have been reported to the Safeguarding Adults' Board and the Safeguarding Children's Board. For example, cooperation between organisations is now significantly more constructive than it was during the period under review, and in September 2017, Police and Children's Social Care gave an update to the

review, drawing on information already provided to the Office for Standards in Education (Ofsted).

3.2 However, for the period in time that the review covered, the key issues it drew out were

- Responses to individuals who do not meet thresholds for intervention;
- Children's and adults' social care not working together when referrals come in by adopting a Think Family Approach or responding in line with best practice;.
- The sharing and coordination of information at key points;
- Appropriate responses to feelings of self-harm and actual self-harm.

3.3 Whilst education involvement and support was of a high standard the response of the local authority teams who were contacted for support and advice were not adequate and did not recognise the seriousness of the situation.

3.4 A key finding was the absence of a self-harm and suicide prevention strategy, translated into a framework for frontline staff to use when assessing these risks and deciding how to respond. The absence of this was immediately noted following Ms L's death and the SAB influenced its development.

3.5 All agencies made some immediate changes to policies and procedures after the event and have accepted in full all the learning, recommendations and actions, which will be overseen by the SAB with the LSCB.

4. Recommendations for Tower Hamlets Safeguarding Adults' Board

4.1 Until late 2017, professionals in some services operated in the absence of local guidance about how to respond to the risk of suicide and also in the absence of a suicide prevention strategy for the borough. The Board has influenced the development of both of these but should continue to seek assurance about how adults at risk of suicide are responded to.

Recommendations for the Safeguarding Adults Board:

- The Borough's Suicide Prevention Strategy was developed during 2017. The SAB has influenced the development of the Strategy so that it addresses the issues raised in this review but should seek regular assurances about the impact of the Strategy.
- There is a training programme for agencies in Tower Hamlets based on the Suicide Prevention Strategy. The SAB should assess and seek assurance on the impact of this training, including asking for data about agencies' attendance.
- The SAB and LSCB should build on existing joint work to create and support guidance and training for professionals about responding to suicide and self-harm across families.

4.1 Professionals did not understand the significance of the individual's history, and the Board should seek assurance about how well professionals gather and analyse the histories of adults at risk more generally.

Recommendations for the Safeguarding Adults Board (and Safeguarding Children's Board):

- Both Boards could seek assurance on the current standards and triggers to "Think Family", and agree if any additions need to be made in response to this Safeguarding Adults' Review.
- The Multi Agency Safeguarding Hub is improving the screening of whole families - as part of the scoping of an adult MASH, the SAB should test out whether such screening will be enhanced by adult MASH proposals and work with the LSCB to draw on experience from the MASH so far.

4.2 The Board could use the case to build on existing work about adults at risk who are perceived as not engaging with services in order to test out the impact of professional responses to those adults.

Recommendations for the Safeguarding Adults Board:

- The Board should confirm its approach, policy, and procedures, for all agencies working in situations where the adult at the centre of multi-agency concerns does not give consent for involvement or wish to engage.
- As a further piece of assurance in relation to adults who do not wish to engage with services but who are at risk, the Board should establish the prevalence of instances where multiple agencies are involved with an adult at risk, with a particular focus on if, and how, co-ordination of these agencies takes place.
- As part of its work on prevention and early intervention, the Board should assure itself of the options available for agencies to offer to adults at risk who are reluctant to engage with services.

4.3 Professionals did not see domestic abuse as trauma and respond accordingly, and with the Care Act bringing domestic abuse into scope for adults at risk, it is timely for the Safeguarding Adults Board to explore this further

Recommendations for the Safeguarding Adults Board:

- The Board should carry out a piece of work to inform local understanding of how domestic abuse features in adult safeguarding cases.
- As part of this work, the Board should consider how gender, ethnicity, religion and culture, as well as any other factors that are particular to Tower Hamlets, show themselves in domestic abuse cases involving adults at risk - and what the implications are.
- Based on its own analysis, the Board should set out to influence the work that is starting in the borough to develop a strategy around abuse.

4.4 The Safeguarding Adults Board could consider what kind of assurance it needs in the future to be more confident that there is effective internal cooperation in the local authority to identify and respond to adults at risk whichever 'front door' they come in through.

Recommendations for the Safeguarding Adults Board:

- Ofsted inspectors were recently assured about co-operation and information sharing in the Multi Agency Safeguarding Hub for children, and about joint working between the police and children's social care. The SAB should use similar lines of enquiry to assure itself about joint working at the front door between adults' and children's services, and with the Metropolitan Police.