East Sussex Safeguarding Adults Board
Response to the Safeguarding Adults **Thematic Review**

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse or neglect is known or suspected and an adult has died (including death by suicide) or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult.

The SAR Subgroup considered that these four cases did not meet the statutory criteria for a SAR, but that there were areas of multi-agency learning to be taken forward. A recommendation was made to undertake a thematic review and this decision was endorsed by the SAB Independent Chair in March 2021.

The SAB commissioned this Thematic Review to understand the circumstances of four women aged between 19 to 51 years old who died between May and November 2020, either from suicide or from causes linked to drug overdoses. Whilst these four women lived in East Sussex, they did not know each other but did have contact with a number of the same health and social care services.

Whilst the four women all had different individual circumstances, a number of parallel themes were present including:

- Experience of trauma in childhood, involving domestic abuse, physical and sexual abuse.
- Poor mental health, including self-harm / known suicide risks / depression / anxiety.
- Domestic violence and abuse.
- Substance misuse.
- Homelessness.
- Having difficulty engaging with services and support.
- The impact of Covid-19 on service delivery as well as people's mental health and wellbeing.

Amy was a 51-year-old woman who was found deceased in her home after taking her own life through hanging. Amy had complex mental and physical health needs, used drugs and alcohol and was highly vulnerable to abuse and neglect. Amy had experienced trauma in childhood, which is thought to have contributed to her fragile mental health and she experienced frequent episodes of depression and self-harm. Amy was known to a number of statutory and non-statutory services

Bridget was 19 years old when she took her own life through hanging whilst residing in temporary accommodation. Bridget was a care leaver, who survived physical and sexual abuse as a child and had a long history of mental health difficulties (including known risks of suicide and self-harm) and drug and alcohol use. Bridget had been known to Child and Adolescent Mental Health Services (CAMHS) since 2012 and

had extensive involvement with Children's Services, latterly provided through the Through Care Team.

Christine was 37 years old when she died from an intracerebral haemorrhage with amphetamine use. At the time of her death, Christine was living in temporary accommodation. Christine had a longstanding history of mental health difficulties, and experienced significant sexual abuse and domestic violence during childhood. Christine was known to be at risk of self-harm and had made previous suicide attempts.

Denise was 39 years old when she was found deceased in the bath following a drug overdose. Denise had experienced domestic violence and abuse over a number of years, and her case had been presented to the Multi-Agency Risk Assessment Conference (MARAC) on numerous occasions particularly during the last two years of her life.

This review had a particular focus on specific areas including:

- To consider how well services identify and respond to women with multiple complex needs who have a history of trauma and difficulties engaging with support, and whether professionals and agencies have the knowledge, skills and experience to effectively support this cohort of people.

- To explore the areas of lifestyle choices and mental capacity / human rights and how issues of coercion and control affect decision making.

- To consider how well agencies work in partnership, in relation to sharing information, the co-ordination of responses and maintaining oversight within and across agencies.

- To consider whether the current systems, policies and processes that are in place to assess and manage risk presented to women with complex and multiple needs are effective and embedded in systems.

We extend our deepest condolences to their families. All the families were invited to take part in the review and one of the families took part.

The East Sussex Safeguarding Adults Board (ESSAB) has reflected on the lessons arising from these tragic cases. We accept the overall findings of this Thematic Review and are committed to taking the learning forward as far as is possible within existing statutory frameworks. The role of the ESSAB is to seek assurance from organisations in East Sussex about changes they have made since the death of these four women.

This report sets out the formal response of the ESSAB to the findings and learning identified in the review. The actions arising from this review will be monitored by the SAR Subgroup with progress reported to the Board.

Suicide prediction and prevention requires consideration of multiple factors including background, events and stressors.

As set out in the recommendations the SAB will consider inviting a representative from the Royal College of Psychiatrists to attend a safeguarding adults board meeting to present the report in collaboration with the East Sussex Suicide Prevention Group. The SAB will also recommend ss outlined in the Royal College of Psychiatrist's report, agencies in East Sussex should use Suicide Safety Plans, completed with the person at risk of suicide or self-ham who has thoughts of suicide and self-harm or who has attempted suicide and self-harm.

East Sussex County Council Public Health Department are responsible for co-ordinating suicide prevention work across East Sussex. Suicide prevention initiatives are geared towards addressing the overall suicide rate in East Sussex and also addressing issues specifically related to a high-frequency location. The structures for delivering suicide prevention work are the East Sussex Suicide Prevention Group (ESSPG); a multi- agency working group responsible for developing and implementing a comprehensive suicide prevention programme and a multi-agency working group, focusing on reducing suicide at a high-frequency location, the latter reports to the ESSPG. Both of these groups are chaired by an ESCC consultant in Public Health.

Organisational policies and practices will need to change to support hard to engage people who have traumatic life histories.

The SAB will research the use of local outreach and flexible approaches to meet the needs of individuals over the age of 18 years old who find it hard to engage with services and who services consider have multiple-complex needs and/ or have experienced adverse childhood experiences.

Changing Futures is a £64 million programme aiming to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system. The programme aims to deliver improvements at the individual, service and system level including to stabilise and improve the life situation of adults who face multiple disadvantages. Sussex is one of the 15 local partnerships across England and the SAB will share updates with partners on the progress of this invaluable work taking place locally.

We will ensure positive practice taking place with the Foundations Project and Community Link Workers supporting adults with Multiple Complex Needs are promoted and highlighted to all agencies showing how a lead practitioner approach might operate and the skills and methods used to assertively engage, motivate and work with multiple vulnerabilities.

Think Family approaches may be useful to support engagement and harm prevention

The SAB will seek assurance that transitional safeguarding processes are meeting the needs of people who have had adverse childhood experiences but are struggling to engage with services, are met after they reach the age of 18 years old.

The SAB will work with the East Sussex Safeguarding Children's Partnership (ESSCP) to develop a strategy to ensure there is adequate transition provision to support criminally exploited children as they move to adulthood.

Deborah Stuart-Angus

Independent Chair, East Sussex Safeguarding Adults Board