East Sussex Safeguarding Adults Board

Response to the Safeguarding Adult Review regarding Charlie

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 purpose of a SAR, as set out in the Care and Support Statutory Guidance, is to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”.

Tragically, in April 2021, Charlie died aged 18 in Brighton. The East Sussex Safeguarding Adults Board (ESSAB) extends our deepest sympathy and our sincere condolences to Charlie’s family.

ESSAB and Brighton and Hove Safeguarding Adults Board (BHSAB) commissioned this SAR to understand the circumstances leading up to Charlie’s death and to support the identification of strengths and weaknesses in how agencies worked together to safeguard Charlie.

Charlie had a short and complex life, yet he was described as funny, with an excellent sense of humour, good company, polite and clever. Charlie never believed that about himself and he struggled with poor mental health, alcohol misuse and significant self-harming episodes.

Charlie had a substantial history with Children’s Social Care (CSC) and was known from shortly after his birth and was on a child protection plan twice. Charlie was also a looked after child under Section 20 of the Children Act 1989. He had lived with his step-grandparents, in foster care, supported lodgings arrangements and care and supported housing between the ages of 15 and 18.

Charlie started identifying as transgender in 2019. His protected characteristics were considered in the review and whether there was evidence of any direct or indirect discrimination because of those characteristics and no evidence was found.

He was the subject of two periods in hospital under Section 2 of the Mental Health Act 1983 (as amended) due to his repeated self-harm and the refusal of medical assistance to treat the wounds. Charlie was assessed by a consultant psychiatrist who made a provisional diagnosis of ‘mixed personality disorder’.

Following the second period in hospital and violent assaults on hospital ward staff, Charlie was discharged with no care arrangements in place. He was found a self-contained flat in Brighton and was the best accommodation option available at that time. There was a gap in any professional visiting Charlie in the first few weeks of this arrangement.

Two visits took place before he died. Charlie’s physical and emotional presentation was poor, and he had continued to self-harm and drink significant amounts of alcohol daily. Despite his presentation and the conditions of his living environment, the threshold was not considered met for formal safeguarding procedures to be instigated. Charlie was aged 18 years and four months old when he died. It is believed that Charlie took his own life.

The family were invited to take part in the review and did contribute to the review. The review explored areas of learning specific to Charlie’s case to include:

* The effectiveness of case coordination, inter-agency communication including across geographical boundaries, the effectiveness of information sharing, including risk management structures and interplay between agencies.
* The use of Mental Capacity Act (MCA) assessments when adults decline input from specialist mental health services.
* How a diagnosis of Mixed Personality Disorder is managed and understood by professionals and the impact this may have on assessment and decision making.
* How ‘lived’ experience of an individual is considered in agency risk management planning to help mitigate risk and reduce loneliness and isolation.
* The impact changing gender could have had and what level of support was provided around this.
* The impact of Covid-19 on service provision (including the effectiveness of safeguarding responses) and the impact this could have had on the case.
* What agency service developments have taken place/are taking place which relate to services he was engaged with at the time of his death.
* How agencies communicate, share information, and manage risk when an individual is transferred following a period of time spent with inpatient services into the community.
* The management and coordination of the transfer of a child to adult services

.

ESSAB has reflected on lessons learnt from this tragic case, and fully accept the overall findings. We remain committed to seeking assurance with regard to evidence- based improvement planning across all relevant organisations involved, with progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

There were a number of emerging issues and learning which came out of this review. The following information represents our formal response to the findings, and learning identified in the SAR.

# **Training, awareness, and support for operational staff**

**The review recommended that both the ESSAB and East Sussex Safeguarding Children’s Partnership (ESSCP) encourage a partnership wide approach to trauma informed practice, which should be supported by training. Both should work with partners to ensure practitioners are able to access awareness training on the use of social media and its significance in the safeguarding of children and adults and to undertake some joint learning events to assist children’s services colleagues understand adult safeguarding procedures and differences.**

**Adult Social Care and Health need to assure themselves through practice learning events, that practitioners are aware of the need to ensure Education, Health, and Care (EHC) Plans are factored into young adult care planning.**

**Agencies involved with adults who significantly self-harm should ensure the right support is in place for practitioners to reflect on their practice, and a multi-agency critical incident de-briefing process could be developed with partners, to support staff subject to vicarious trauma, when people self-harm; or threaten to or take, their own lives.**

**Board response:** This review has highlighted the need for both children’s and adults services to be better aligned at the point of transition for young people approaching 18. We will work with our partners in the Children’s Safeguarding Partnership to raise awareness, support staff and improve on the areas for learning highlighted in this review.

A young person who has educational needs may also have additional health and social care needs and those can be included in the EHC plan so long as they relate to education. You cannot have a freestanding EHCP for health or social care reasons alone. However, where there is an EHC plan it will include some valuable information such as the views, interests, and aspirations of the young person to consider and factor into any adult care planning. This would enhance the already strengths-based approaches used in adult assessment/care planning processes.

# **Effective safeguarding arrangements**

**The ESSAB to review the Summary of Involvement/Individual Management Review documents to ensure clarity of agency understanding and what information is being requested.**

**The ESSCP Quality Assurance Subgroup should consider how best to undertake a multi-agency audit of selected young people aged between 16 and 18 subject to child protection plans in the last two years to assure themselves that effective safeguarding arrangements were in place**

**Both Safeguarding Adults Boards in East Sussex and in Brighton should assure themselves through shared multi-agency audit that adults moving between borders in Sussex and local authorities are supported and safeguarded with clarity of case responsibility and accountability.**

**Board response:** The ESSAB have already reviewed and amended the current administrative document we use to capture agency involvement and learning to make it clearer for agencies when receiving requests for information relating to safeguarding adult reviews.

The ESSAB will work with our partners in Brighton and Hove to assure ourselves that agencies have consistent safeguarding processes in place when adults move between our border and specifically in terms of case responsibility.

# **Transition between children and adult services**

The review recommended that Sussex Partnership Foundation Trust (SPFT) should:

a) review arrangements for transition between children’s and adult mental health services and

b) assure itself that children and adults do not fall through operational gaps at the point of transition and

c) ensure that the transition process is defined and understood by practitioners.

The ESSAB and ESCCP should update and assure partners that the current work being undertaken between both Boards to develop a Transitions Protocol for East Sussex reflects the needs of vulnerable young people reaching 18 and assurance should be provided that the Protocol will be shared with practitioners to inform and promote the current pathways and arrangements in place locally.

**Board response:** Recommendations that relate to a single agency will be monitored through a specific ESSAB action plan relating to this review. SPFT will be requested to update on any specific recommendations that have arisen from this review and the ESSAB will seek assurance that arrangements are in place.

The Transitions Task and Finish Group will be in operation during 2023 with the purpose of developing a multi-agency Transitions Protocol for adoption by all ESSAB agencies. This work will also be monitored through the action plan and progress will be monitored and reported to the ESSAB.

# **Multi-agency risk assessment and care planning**

It was recommended that SPFT review the current arrangements for CAMHS support across Sussex and ensure that any inconsistency of practice in local teams is addressed including the lead practitioner role for hospital discharge. To also assure itself that systems and processes are in place to trigger multi-agency risk assessment and care planning where this is required to support hospital discharge

Further promotion of the [Multi-Agency Risk Management Protocol](https://www.eastsussexsab.org.uk/documents/multi-agency-risk-management-marm-protocol/) (MARM), which was launched in January 2022, and supports partners of the East Sussex Safeguarding Adults Board (SAB), including Children’s Safeguarding Partners, to achieve successful outcomes when working with adults (18 years and over) with multiple and complex needs who remain at high risk of harm despite previous interventions and who may not be willing to engage with agencies.

ESSAB partners should ensure that care and risk management plans clearly identify the visiting patterns and escalation arrangements if agencies struggle to engage in services and support with adults who are considered at significant risk.

**Board response:** The Multi-Agency Risk Management Protocol has been in operation for 12 months and will be further promoted to children’s safeguarding partners as recommended in this review. Current risk management processes are outlined clearly in the [Pan Sussex Safeguarding Adults Policies & Procedures](https://sussexsafeguardingadults.procedures.org.uk/pkotq/sussex-safeguarding-adults-procedures/recognising-and-reporting-abuse-and-neglect/#s2808) and the [Sussex Multi-agency Procedures to Support Adults who Self-neglect](https://sussexsafeguardingadults.procedures.org.uk/pkoox/sussex-safeguarding-adults-procedures/sussex-multi-agency-procedures-to-support-adults-who-self-neglect) and identifying what further promotion is required will be considered.

The bi-annual ESSAB self -assessment process will take place in 2023 which is a safeguarding assurance activity undertaken by all Safeguarding Adult Boards. This year we will include the need to request escalation and risk management processes from partners to identify if current processes are robust enough.

Sussex Partnership Foundation Trust (SPFT) have made the following changes:

* Minimum clinical standards for the CAMHS ( Children and Adolescent Mental Health Services) duty teams in order to have consistent practice.
* More resource into CAMHS duty to avoid the use of answer phone responses.
* Clinical standards clearly now state the need for Lead Practitioner if a young person is discharged from hospital.
* A Personality Disorder Pathway and a Pathway Lead for 16- to 25-year-olds is now in place.

# **Commissioning (gender identity and advocacy)**

The Integrated Care Board (ICB) responsible for commissioning alongside ESSCP should consider use of the [CASS review](https://cass.independent-review.uk/) ( independent review of gender identity services for children and young people) to develop a local framework for support services to children and young people who are gender dysphoric.

Children’s and Adults services in ESCC should review their commissioned advocacy arrangements for young people post 18. They should better promote the role of advocacy in care planning, particularly where agencies struggle to engage young people.

**Board response:** NHS England has identified the need for innovative and ambitious gender services pilots, in a bid to ensure equity of access across the country, and to help reduce the long waits experienced by individuals. Sussex Partnership Foundation Trust (SPFT) are working in a multi-agency collaboration to draw up a proposal for the provision of a Sussex based gender identify clinic pilot and updates will be provided through the action plan relating to this review.

Local adult advocacy arrangements are quite extensive in East Sussex and can be found on the [ESSAB website](https://www.eastsussexsab.org.uk/publications/guidance-and-resources/#accordion-efgif0) and discussions will take place to see how these can be promoted further in care planning.

East Sussex Safeguarding Adults Board

May 2023