**Safeguarding Adults Review (SAR)**

**Executive Summary**

**Charlie**

# Charlie’s Story

* + Charlie[[1]](#footnote-1) was white British and did not follow a particular religion or faith. He 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 in himself and he struggled with mental health, alcohol misuse and significant self-harming episodes[[2]](#footnote-2). He was described as having beautiful blue eyes and was small in stature. He loved animals, particularly cats and liked playing pool, card games and watching birds. He described himself as a ‘total maniac’ and hated talking to new people. He needed others to give him ‘space’ and would react negatively if they didn’t. Charlie was estranged from his family, and he had had no contact with his mother, stepfather, and younger sibling since May 2019.
	+ 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 in care and supported housing between the ages of 15 and 18. The last period being up to his 18th birthday.
	+ Charlie came out as transgender in 2019. This decision has been a significant challenge for his mother and stepfather who have continued to refer to him as female. Charlie’s protected characteristics were considered in the review and whether there was evidence of any direct or indirect discrimination because of those characteristics.
	+ Charlie had suicidal thoughts in adolescence and significantly self-harmed on many occasions and regularly refused hospital treatment. Charlie also began to go missing regularly and was temporarily excluded from school. He was referred to the Child and Adolescent Mental Health Service (CAMHS) but professionals struggled to engage him in any therapeutic work. The decision was made to close his case to CAMHS as his behaviour was deemed ‘social and emotional’ and not caused by mental ill health. Charlie was also referred by his school for an Education, Health, and Care Plan (EHCP)[[3]](#footnote-3). Charlie was referred to the Multi-Agency Child Exploitation[[4]](#footnote-4) (MACE) meeting and was rated at significant risk of harm. The care plan noted that a suitable therapeutic resource should be identified. This never materialised and he moved to semi-supported living accommodation.
	+ There were serious concerns about Charlie’s social media accounts including a secret Twitter account showing sadomasochistic fantasies about satanic rituals, torture, cannibalism, and murder. There was also a consultation with Prevent[[5]](#footnote-5) as he had talked about terrorism and Syria.
	+ Charlie was the subject of two periods in hospital under Section 2 of the Mental Health Act 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’. They conceded that Charlie’s behaviour was a result of historic abuse and not a diagnosis of Autistic Spectrum Disorder.
	+ Charlie moved to supported housing in West Sussex with support via 1:1 staffing arrangements following his first discharge from hospital. He was discharged under the care of CAMHS and was offered one follow up appointment with mental health services. CAMHS discharged Charlie from their service quoting his ‘non engagement’.
	+ Charlie continued to present with a very low mood and regularly left the supported housing placement and was found significantly drunk in the community. He had threatened and assaulted staff on several occasions. There was a lack of support for Charlie from mental health services and whilst Charlie was referred to adult mental health services, they failed to engage him in any proactive interventions.
	+ Following the second period in hospital and violent assaults on hospital ward staff, Charlie was discharged with no care arrangements in place. The consultant psychiatrist at the hospital confirmed that Charlie had capacity to make his own decisions and his behaviour should be addressed through criminal justice routes.
	+ Charlie was found a self-contained flat in Brighton. This was the best accommodation option available at very short notice. He was consulted on the placement options and chose the self-contained flat as he did not want restrictive 1:1 staffing being offered at any alternative placement. He was informed that the flat was only a temporary arrangement.
	+ There was a gap in any professional visiting Charlie in the first few weeks of this arrangement and there remained confusion about who was responsible for his mental health support.
	+ 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.

# Emerging Issues and Learning

## Risk Management and Planning

* Supported accommodation providers are not always set up to manage and support individuals who have complex needs and at high risk of harming themselves or others. The commissioning of these resources needs to be carefully considered. The placing of young people in semi-supported accommodation at a young age with limited or no experiences of living alone or semi-independently needs to be carefully risk assessed especially if there are no support mechanisms including visiting patterns in place.
* Effective planning and risk management needs to be in place following discharge from hospital under Section 2.
* The management of harm and risk of young people and adults needs to be shared across the multi-agency partnership and the appropriate use of the child safeguarding system to assess risks and needs for young people post 16 needs to be considered, particularly where self-harm is evident.
* The awareness and use of the recent Multi-Agency Risk Management (MARM) protocol and guidance needs to be encouraged and also better understood by child safeguarding professionals.

## Self-Harm

* Practitioners who work with young people and adults who significantly self-harm need ongoing support from their line managers alongside opportunities to reflect on their practice with other professionals involved with the adult.
* Assessments of capacity under the Mental Capacity Act 2005 should be considered when young people or adults who are significantly self-harming are unable to make effective decisions for themselves whilst under the influence of drugs or alcohol. Opportunities or a necessity to undertake an assessment under the Mental Capacity Act and needs to be included in forward care planning.
* Up to date awareness sessions are needed for professionals about the use of social media platforms and the role they play in young people’s lives. Non suicidal self-injury and suicidal ideation in adolescents with mental health problems and their sharing on social media platforms are an indicator for suicide.
* Young people’s use of alcohol should be risk assessed, particularly if this is a trigger for self-harming behaviours. Alcohol use is as significant as self-harming behaviours and needs to be given equal weight in terms of risk to health.
* Practitioners need to understand the operational expectations of the recently published Sussex Suicide Prevention Strategy.

## Transition to Adult Services

* Unchallenged perceptions of child and adulthood and vulnerability and capacity can lead to young people falling through the ‘safeguarding net’. The safeguarding systems for children and adults are based on different legal and procedural frameworks and this has the potential to create gaps in operational practice. Basing safeguarding decisions on chronological age is fraught with challenges ignoring the developmental and behavioural challenges of becoming an adult. The model of transitional safeguarding requires whole system change and a shared accountability by children’s safeguarding partners and strategic leads in adults’ services.
* Effective transfer and joint working post 18 between Children’s Social Care and Adult Social Care and Health (ASCH) can have a significant positive impact on care planning.
* CAMHS need to ensure effective transfer to adult mental health services after the age of 18.
* Social workers and other professionals working with young people and adults should have up to date knowledge regarding the legal use of Deprivation of Liberty Safeguards (DOLs) and the forthcoming changes to legislation including the implications for 16 and 17-year-olds regarding the introduction of Liberty Protection Safeguards (LPS).
* Learning from the experiences of young people post Covid-19 should be considered in future care planning and Education, Health, and Care Plans (EHCP) need to be referenced in ongoing support plans for young people pre and post 18.

## Gender Identity

* Local support and care pathways need to be developed for those young people who are questioning their identity. Focusing on the presenting behaviour of self-harm does risk other complex needs and issues being missed.

## Trauma Informed Practice

* Trauma informed practice needs to be embedded across children and adult services, including the impact on staff of managing high risk and complex case work.

## Mental Health

* The Mental Health Act 1983 does not distinguish between different forms of mental disorder and therefore the Act applies to personality disorders in the same way it applies to mental illness and other mental disorders. It is likely that the treatment options will be different and this needs to be fully explained to the professional network working with young people and adults.
* There appears to be a lack of professional understanding between the agencies about what constitutes mental ill health and the respective responsibilities of agencies. This leads to professional disagreement, challenge, and frustration. There needs to be a mechanism in place to avoid this consistent feature and ensure multi-agency shared understanding, training, and risk assessment.
* Unplanned discharge from hospital, places local authorities under significant pressure and unintentional heightened risk for patients. The decision to discharge should be the subject of multi-agency agreement and decision making.
* Child and Adolescent Mental Health Services (CAMHS) need to provide consistent and coherent support to young people regardless of geographical location and work together to ensure consistency of practice.

## Making Safeguarding Personal

* The inability to access services should result in further enquiry or assessment. Agencies need to ensure a more person centred, flexible and relationship-based approach to support and services. The non-engagement of young people and adults should encourage professionals to work harder in meeting their specific needs rather than withdrawing support. Independent advocacy and assertive outreach, needs to be encouraged where agencies struggle to engage with professionals.
* NHS Providers should ensure that the services offered to young people and adults are consistent regardless of geographical location.

# Conclusion

* + Charlie’s death has been devastating for his family and they seek answers to the reasons why. They have truly struggled with his refusal to seek contact with them, particularly when he was at his lowest and were unable to accept his decision to transition.
	+ Professionals found it challenging to engage with Charlie. Professionals’ ability to get alongside him was difficult. This masked a person with a wicked sense of humour whose sad and untimely death has impacted on individual professionals who were able to see through the presenting angry and overt non-compliance. His story reflects how childhood experiences and trauma can significantly impact on adolescence and early adulthood.

* + Sadly, the analysis in the learning from safeguarding adult reviews regarding transitional safeguarding replicates the experiences of Charlie. These include the interface between systems, played out through inter-agency and multi-professional’s relationships or lack of them. Differing attitudes to risk from agencies and no shared understanding or accountability for that risk, leaving one or two professionals holding that risk or making decisions based on sole observations and presentations. The lack of communication and accountability between agencies when people are placed out of area and where professionals are working across borders. Unplanned and swift discharge from hospital or residential placements leaving people vulnerable and at risk of harm. The perceived inability to engage people in support and services resulting in case closure or withdrawal of support. The clear differences in professional opinion regarding mental health support to people with substance misuse issues and presenting behaviour and how this is not the subject of professional debate and understanding.

# Recommendations

1. The East Sussex Safeguarding Adults Board (ESSAB) to review the Summary of Involvement Forms/Individual Management Review’ to create two separate documents to ensure clarity of agency understanding and to fulfil ESSAB expectations.
2. ESSAB and East Sussex Safeguarding Children Partnership (ESSCP) should encourage a partnership wide approach to trauma informed practice, which should be supported by training.
3. 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.
4. The Integrated Care Board (ICB) responsible for commissioning alongside ESSCP should consider use of the CASS review to develop a local framework for support services to children and young people who are gender dysphoric.
5. ESSAB and ESSCP 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.
6. ASCH need to assure themselves through practice learning events, that practitioners are aware of the need to ensure Education, Health, and Care Plans are factored into young adult care planning.
7. The 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.
8. CSC and ASCH 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.
9. SPFT should review the current arrangements for CAMHS support across Sussex and ensure that inconsistency of practice in local teams is addressed including the lead practitioner role for hospital discharge.
10. ASCH to promote the Multi-Agency Risk Management Protocol (MARM) ,launched in January 2022, which 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.
11. SPFT should 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.
12. 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.
13. ESSAB and ESSCP are encouraged to undertake some joint learning events to assist children’s services to better understand adult safeguarding principles, processes, and lawful differences.
14. 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 deemed at significant risk.
15. ESSAB and BHSAB 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.
16. 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. Assurance should be provided that the Transitions Protocol will be shared with practitioners to inform and promote the current pathways and arrangements in place locally.

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1. Not his real name. [↑](#footnote-ref-1)
2. The term self-harm is often used as an all-encompassing term referring to suicidal thoughts and attempted suicide (Mental Health Foundation 2006) [↑](#footnote-ref-2)
3. An education, health and care (EHC) plans are for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs. [↑](#footnote-ref-3)
4. https://www.esscp.org.uk/about-us/subgroups/multi-agency-child-exploitation-mace/ [↑](#footnote-ref-4)
5. The Prevent strategy, published by the Government in 2011, is part of our overall counter-terrorism strategy, CONTEST. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Act this has simply been expressed as the need to “prevent people from being drawn into terrorism”. [↑](#footnote-ref-5)