EXECUTIVE SUMMARY

SAFEGUARDING ADULT REVIEW
OF THE CIRCUMSTANCES CONCERNING

SASHA

Hampshire safeguarding Adults Board

May 2020

Executive Summary

The aim of this review

Hampshire Safeguarding Adult Board (HSAB) commissioned this Safeguarding Adults Review (SAR) after the death in 2017 of Sasha, a young person. The circumstances of Sasha's death and her history of contact with a wide range of agencies, gave rise to serious concerns. In response, the HSAB commissioned an independently led Safeguarding Adult Review to establish any learning about the way in which local professionals and agencies worked together to safeguard Sasha. HSAB accepts in full the recommendations in the report.

Who was Sasha?

Sasha was 20 years old and had a long history of mental health illness and missing episodes since the age of 15. Before her death, she was under the care of several health services and as a child had been supported by the Child and Adolescent Mental Health Team (CAMHS). On the evening she died, Sasha was found in a serious condition by a lake in a country park close to where she lived. She died shortly afterwards in hospital from a suspected overdose of propranolol. The Coroner confirmed that Sasha died as a result of suicide following a deliberate fatal overdose of propranolol tablets.

What went well?

The following was identified as good practice:

- There was a good level of communication between a number of organisations.
- Obvious effort to offer person centred care, offering Sasha care that professionals felt she would be more likely to engage in.
- There was a commitment to working together.
- There was a good level of involvement from the GP.
- There was good continuity of care offered by teams.
- There were attempts by professionals to build a good relationship with Sasha and her family.
- The existence of inter-agency care plan did show an effort to support professionals coming into contact with Sasha, a consistent response.
- Professionals did not give up.
- There was good information sharing between some agencies.
- There was a willingness of agencies to come together.
- The review process evidenced a lot of care and compassion from those that worked closely with Sasha

What did we find?

Sasha had a longstanding difficulty with her mental health and well-being that led to several diagnoses from childhood into adulthood. She found transition from children's services into adult services particularly difficult appearing to trigger an escalation of stresses and self-harm behaviours.

Efforts to contain her stresses with various therapies and medications did not appear to alleviate her self-harm with overdoses and self-laceration. It cannot be underestimated how Sasha's extensive and very controlling OCD rituals and behaviours impacted on all efforts by professionals and her parents to find treatments and therapies that would be successful.

The SAR identified that there were complexities of cross border working and a large number of agencies who touched the life of Sasha.

It is apparent that there have been lessons learnt regarding how agencies worked together to keep Sasha safe and therefore lead to learning and recommendations for future practice.

What did we Learn?

The SAR identified important learning and key areas for further improvement resulting in recommendations around the following themes:

Mental health: transition, diagnosis and the Mental Health Act

- Young people benefit from clarity and flexibility in the transition process that is person centred but that work underway in the NHS 10-year plan could provide local solutions to improve practice.
- Early recognition and diagnosis of Autism Spectrum disorders is vital to ensure right approaches and treatment.
- There can be confusion regarding the status of a person subject to detention under the Mental Health Act as well as appropriate application of the Mental Capacity Act where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment.
- Professionals may benefit from guidance to support them with understanding advanced decisions and high risk and complex cases that they do not face very often.

Single and multi-agency action plans and communication

- Multi agency plans need to have clear ownership, be outcome focussed, reviewed and shared widely. Single agency plans should be shared where appropriate.
- Care Programme Approach can be a vehicle for effective multi-agency working and information sharing.
- Newer processes to manage high intensity users will provide support for professionals if concerns and risk are shared with senior managers.

Safeguarding

- Using a safeguarding lens can offer an alternative view on the risk posed by an individual's behaviour if it can be identified as a form of self-neglect.
- Working with parents and carers who appear to be adding to risk of a young person may provide insights into parental actions that may be perceived a safeguarding concern,

- Multi-agency risk panels should be used for sharing information and developing a multi-agency plan to help mitigate the risks identified.

What are we doing about it?

We will now be working with partner agencies to share and embed this learning within respective organisations and to deliver improvements in the key areas identified in the recommendations. We expect the learning from this SAR to bring about positive change and improvements in:

- Management of cross border working.
- Transition pathways to ensure these are person centred and provide clear transition plans.
- Early recognition and diagnosis of Autism Spectrum disorders to ensure right approaches and treatment.
- Protocols for managing people who access services on a frequent basis.
- Use of multi-agency risk panels to share information to inform the formulation of multi-agency plans to help mitigate identified risks.
- Guidance to support professionals with understanding advanced decisions and high risk and complex cases that they do not face very often.
- Understanding and application of the Mental Health Act and the Mental Capacity Act where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment.