Safeguarding Adults Review (SAR)

SASHA

Overview Report

FINAL

Author: Karen Rees

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1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. 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[1].

1.2. An inquest into Sasha's death was concluded two years later. The Coroner undertook an Article 2 (refers to Article 2 of the Human Rights Act) hearing i.e. there was consideration that there was some evidence that one or more public bodies involved with her may have breached her right to life under the Human Rights Act. As such there was a jury inquest. The Coroner confirmed that Sasha died as a result of suicide following a deliberate fatal overdose of propranolol tablets.

2. METHODOLOGY AND SCOPE

2.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR). Full terms of reference, rationale for the scope and methodology of the review etc. for this SAR can be found in Appendix 1.

2.2. As the methodology for this review included collaboration with professionals from key agencies, a decision was made to delay the review process until the conclusion of the inquest to allow full participation. This was at the request of managers within those agencies that were involved with the inquest.

2.3. This review takes into account interagency involvement covering the four months prior to the date that Sasha died. This is the period that covers identification that risk was escalating. Key background information has also formed part of the review that sets the context and informs the more contemporary elements of Sasha's life.

2.4. Sasha attended hospitals in several counties, was known to numerous services within those counties and also due to commissioning arrangements, she received services from

[1] Propranolol belongs to a group of medicines called beta blockers. It's used to treat heart problems, help with anxiety and prevent migraines. https://www.nhs.uk/medicines/propranolol/. Propranolol has also been used to treat treating emotional, behavioural, autonomic dysregulation in children and adolescents with autism spectrum disorders SagarOuriaghli et al. (2018) Propranolol for treating emotional, behavioural, autonomic dysregulation in children and adolescents with autism spectrum disorders. J Psychopharmacol. 2018 Jun;32(6):641653.doi: 10.1177/0269881118756245.

organisations based in different areas. In order to maintain confidentiality of those organisations whilst still able to understand the complexities that these arrangements created, those organisations will be known in the way identified in Appendix Two.

2.5. For ease, the areas are denoted as follows:

Area A	Sasha's area of residence
Area B	County in close proximity
Area C	Further county involved in offering services to Sasha

3. FAMILY ENGAGEMENT

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The author made and maintained contact with the parents of Sasha and met with them on conclusion of the inquest. Their views have been incorporated throughout this report as appropriate. Sasha's parents shared with the author and the board manager, some of their thoughts about the person that Sasha was. Sasha's parents talked about Sasha pre and post illness. Pre illness Sasha was described as feisty, challenging, passionate and very artistic. Sasha would do anything for anyone, she loved scuba diving, skiing, snorkelling, cooking and being creative. Sasha's parents stated that she had a beaming smile and an amazing inner strength. Sasha was incredibly intelligent and when she could no longer attend college due to her illness, she taught herself degree level physics. These traits meant that she was able to understand elements such as the Mental Capacity Act, The Mental Health Act and her legal rights; these areas will be included in this review.

4. RELEVANT BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Sasha was the youngest of two children, she had an older sister and lived at home with her parents. The CAMHs report for this review indicated that that Sasha was reported to have presented with obsessive compulsive disorder (OCD)[2] type behaviours type behaviours from as young as seven years of age. Mother identified that Sasha had symptoms from being a toddler but that it was not brought to the attention of CAMHS until she was 14/15 years old. The family relationships were often difficult. Sasha was bullied at school and therapists concluded that this resulted in Sasha presenting with patterns of behaviour indicating an insecure attachment style which led to Sasha's fear of abandonment. This was not a formal

[2] **Obsessive compulsive disorder** (**OCD**) is a common form of anxiety disorder involving distressing, repetitive thoughts. That makes **OCD** particularly difficult to make sense of or to explain to other people.

diagnosis, but a professional view. The impact of diagnosis and changes in diagnostic processes will be subject to analysis.

4.2. Sasha's parents sought help from their GP and had several consultations in this early period, but Sasha always refused to speak to the GP. Sasha did not meet her GP until she was 18. At the age of 15, Sasha was seen by a private psychologist. It is recorded that Sasha did not engage and therefore support was given by the private psychologist to her parents to help them to manage Sasha's behaviours. A few months later Sasha was referred to CAMHS by the GP. At the first CAMHS home visit, Sasha was noted to have some autistic type behaviours. These traits were also noted by visiting private professionals in a report shared with CAMHs. It was of note that Sasha displayed behaviours associated with eating disorders and had a very low Body Mass Index[3] (BMI).

4.3. As assessments continued and parents were struggling more to cope with supporting their daughter, Sasha was assessed under the Mental Health Act (1983). She was assessed and detained under Section 2 then 3[4], during her admission to Adolescent Mental Health Unit for a period of more intense assessment. Progress was slow as Sasha refused to engage with her treatment plan. Sasha absconded from the unit on several occasions leading to extensive searches to locate her.

4.4. Sasha was discharged four months later with a view to offering intensive support at home. The CAMHS report for this review indicated that Sasha continued to be supported by the CAMHS team with multiple home visits by the home treatment team. During the next few months and years, Sasha had several periods of inpatient care and there were notable highs and lows in her moods and behaviours. Sasha had begun to self-harm and be found in public places either indicating that she was about to or having already self-harmed.

4.5. At 16 and a half Sasha had a further emergency admission to a mental health unit provided through specialist commissioning services. She remained on a section 3 within that unit until she moved into adult services at 18. Towards the end of that admission Sasha had several periods of Section 17[5] leave home with various elements of success at rehabilitating back to the home. As Sasha was approaching 17 and a half, preparations started to transfer her care

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[3] The **body mass index** (**BMI**) is a value derived from the mass (weight) and height of an individual. The BMI is an attempt to quantify the amount of tissue mass (muscle, fat, and bone) in an individual, and then categorize that person as *underweight*, *normal weight*, *overweight*, or *obese* based on that value.

[4] **Section 2** is part of the civil **sections** under the **Mental Health Act (1983)**. It provides for someone to be detained in hospital under a legal framework for an assessment and treatment of their **mental disorder**. **Section 3** of the **Mental Health Act** is commonly known as "treatment order" it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met.

[5] **Section 17 Leave** is any **leave** of absence that is authorised by the Responsible Clinician which enables a detained patient to go outside the hospital grounds for any period of time

to adult mental health services in readiness for her reaching her 18th Birthday. It was hoped that she would be discharged home before transition took place so that she would have her care transferred to a community mental health team. Unfortunately, this did not happen as Sasha was not well enough for discharge, finding it difficult to spend more than three days at home. It is recorded that Sasha was not adhering to the discharge plan; Sasha's family have disputed this, but the author, despite research and questions of agencies, has not been able to find any other recorded reason for the change of plan. Sasha remained under section 3, transfer was brought forward and Sasha transferred to an adult mental health ward within Area B NHS Partnership Trust.

4.6. It appears that this was significant event for Sasha. Both Sasha and her family found the difference between the CAMHs and adult mental health services difficult to comprehend. Sasha's parents told the author that Sasha's sister found it incredibly difficult to live in the family home with so many complexities regarding Sasha's OCD; she moved to live in London.

4.7. In the time period before the scope of this review, following this transition, Sasha's self-harm with overdoses of paracetamol and absences from home and various care settings to take further overdoses, were prolific. She was taken to numerous hospitals based on locations where she was found and there were searches undertaken by police forces in Areas A, B & C as well as British Transport Police and others. The out of hours GP service also had numerous interactions with Sasha and her family. It is clear from information provided to this review that there had been extensive efforts to find solutions and provide the right care and support for Sasha.

4.8. Various systems and issues that crossed from before the scoping period are included within the next section to provide for complete analysis in section 6 of this report.

5. THE FOUR MONTHS BEFORE SASHA DIED

5.1. It was a feature of this period that Sasha presented to the services listed in Appendix Two on numerous occasions, sometimes on more than one occasion in a day. In order to inform later analysis, it has not been found necessary to take an in-depth view of each occasion. It is important that from the aspect of learning, that the systems and processes in place to support Sasha, her family and professionals to manage her presentations are analysed for effectiveness. This will lead to recognising what worked well, identifying gaps in systems and leading to recommendations for practice.

5.2. Sasha had complex presentations, was very intelligent, articulate in expressing her needs and wants and understood the systems that were there to support her. She was

knowledgeable about travel and was able to present at various locations when self-harming, in an apparent attempt to evade services or to access medication via various means. Sasha also appeared to have a preference for some services over others.

5.3. Sasha's ritualistic behaviours made treating and providing care for her very difficult. For example, she did not like to be touched, would not handle a telephone and would not eat food prepared by anyone else in order that she could control the calorie content of foods that she ate, as dictated by her OCD. It is also of note that Sasha's rituals would sometimes change, which is consistent with severe OCD. Sasha also presented with behaviours associated with eating patterns leading to her low BMI. Some of Sasha's rituals took several hours of a day e.g. dressing. Home life was complicated by this as there were certain rules that the family needed to observe in order to prevent distress to Sasha. Sasha's parents told the author that it was incredibly difficult and tiring for the family. Parents played 'good cop/bad cop' with Father being firmer and her mother being the one that would try to ensure that Sasha remained stress free. Sasha's mother described the 'meltdown' that happened if Sasha's rituals could not be observed which was distressing for everyone. Sasha's parents felt that this was the best way to maintain a balance between boundaries and managing her illness. It is notable that Sasha had significant concerns related to some hours of the day and specifically with the end of each month when her fears would increase.

5.4. During the beginning of this period Sasha's main presentations were due to paracetamol overdoses of varying amounts. Sasha stated that most often the amount taken was related to specific numbers that were part of her rituals. On occasion she would stage these to take several every few hours. Sasha also self-lacerated on several occasions. She stated that this self-harming behaviour was a way of dealing with her stressors as the effect protected her from the emotional responses she experienced from flashbacks and other traumas. It was also part of her OCD behaviours, as an attempt to protect her loved ones. On some occasions she presented at emergency departments mainly at Acute Hospital 1 and 2, sometimes because her mother alerted emergency services and sometimes because mental health services alerted the emergency services. Sasha never ever initiated a call to the emergency services. She often refused treatment and was deemed to have mental capacity to do so on many of those occasions. Sasha also engaged in some other self-harming behaviours such as cutting herself.

5.5. Often these presentations were when Sasha was subject to detention under the Mental Health Act and had absconded and taken overdoses or had been on Section 17 leave and taken overdoses. Due to the number of attendances and having taken the advice of mental health colleagues, there was an inter-agency care plan in place that advised emergency departments and police forces how best to deal with Sasha's presentations and absconsions based on the different scenarios that may be present.

5.6. Sasha's mother became very used to Sasha's method of self-harming and would often recognise that the level of paracetamol was unlikely to present a life-threatening emergency. On those occasions, if Sasha refused to go to hospital, Sasha's mother would call the NHS 111 service to seek a visit from an out of hours GP for a prescription of anti-sickness medication. On one occasion Mother requested more suture kits from the GP and out of hours GP as the ones that Sasha had obtained in London to suture herself had run out; this request was refused.

5.7. Circumstances escalated when Sasha changed her self-harming to overdoses of propranolol, initially this was with paracetamol but progressed to more and more propranolol being used. Sasha agreed that this was a deliberate move to suicide attempts and away from deliberate self-harm. Propranolol had originally been prescribed to Sasha to manage anxiety symptoms but following initial overdoses of this medication the prescription was stopped. There were occasions where Sasha's mother requested propranolol from the GP, before Sasha and her family were aware that Sasha's clinical psychologist had stopped prescribing propranolol, but this was refused based on the knowledge of Sasha's overdoses. As Sasha continued to take overdoses of this medication questions were asked as to how this was being obtained. Professionals thought that it may have been gained from private GPs via private clinics in London and was confirmed by the Coroner at inquest and addressed through the coronial proceedings. Family stated that they believed that professionals only realised it might have been obtained through a private GP via a private clinic when one of those private GPs contacted CAMHS. Sasha had refused consent for the private doctors to have contact with her own GP or family and therefore contact was not made. Her own GP, therefore, was not aware of how Sasha was obtaining Propranolol so could not alert those clinics and the wider care team of the risk that this presented. Parents believe medication would not have been obtained elsewhere as Sasha would have feared contamination.

5.8. Sasha often presented to professionals seeking mental health help, concerned that she would overdose and, if was not able to get any appropriate help that she felt she needed at the time that she needed it, she would then re-present, with pressure from her mother, having overdosed or self-harmed in other ways.

5.9. Sasha's behaviour, despite all care and therapies offered, led professionals and her parents to believe that Sasha was very likely to die. Sasha continually stated that she could not cope with life and that she would one day die. 11 weeks before her death, Sasha took an overdose of propranolol that was so significant that she suffered a cardiac arrest with hospital records showing that she was without a heartbeat for 35 minutes. As was often the case, Sasha originally refused treatment and was deemed to have capacity to do so therefore the ambulance service did not convey her to hospital until she became drowsy

and was deemed to no longer have capacity. On this occasion Sasha was not subject to Mental Health Act detention but was assessed and detained following this incident.

5.10. These types of presentations were very complex; Sasha was on section 17 leave and subject to section three of the Mental Health Act for most of the period but was deemed to have capacity to decide not to be treated. Sasha's care was managed in mental health services using the Care Programme Approach (CPA)[6]. Her CPA care plan was updated regularly and was shared with her and her family. The family have argued that the plan was not updated regularly or that it was shared with Sasha or her family. There were several differing opinions as to whether being a detained inpatient on an adult mental health ward was beneficial or whether she was likely to be better at home with a package of support. In the last few weeks of Sasha's life there was also an assessment that indicated that she required specialist therapy in a secure locked environment.

5.11. Sasha presented advance decisions (discussed in 6.34) about how she wanted to be treated or not treated when she had self-harmed. Organisations sought legal advice on these, and they were deemed not to be legally binding.

5.12. Several safeguarding referrals were made by ambulance services, police, and other organisations and were dealt with by either Area A social care or Area B social care, none of the referrals resulted in safeguarding enquiries under Section 42 The Care Act.

5.13. There were disagreements between family and professionals regarding the nature of Sasha's needs and what services were required to meet those needs. Sasha's parents had managed Sasha's behaviours and issues for many years and reiterated on several occasions that they were trying to get the care that they needed for their daughter. Sasha's relationship with her parents was complicated by some of her rituals. This often led to conflicting opinions between parents and professionals.

5.14. Of the numerous assessments that were undertaken with Sasha, there was an ongoing debate as to whether Sasha had an autistic spectrum disorder (ASD)[7]. Sasha and her family were of the view that she had ASD and her father was actively pressurising services for further assessment. Diagnosis of these conditions have improved and changed significantly

[6] The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx.

[7] Autistic Spectrum Disorder (**ASD**) is a term used to describe a number of symptoms and behaviours which affect the way in which a group of people understand and react to the world around them. It's an umbrella term which includes autism, Asperger syndrome and pervasive developmental disorders

over the years with diagnostic services for adults now commissioned. Previous assessments recorded in the CAMHS report for this review, when Sasha was younger, had not identified ASD; Sasha was finally diagnosed with the disorder in the weeks before she died.

5.15. On the day before and the day of Sasha's death there were several contacts made with professionals by Sasha and her parents. Sasha had not been able to see the liaison psychiatry team at Area B Acute Hospital 1, which was what she wanted. The plan that had been agreed and offered by professionals was for Sasha to go to the ward or to be seen by home treatment team; Sasha's parents were not happy about this, telling the author that this amounted to a refusal of the psychiatric liaison team to see Sasha on this day. The psychiatric liaison nurse discussed the plan with their service manager and the Area B High Intensity User Lead who agreed with it. This was also agreed the following day with the ward's Advanced Nurse Practitioner. Sasha's parents remained unhappy with this decision.

5.16. Sasha became very anxious and had left the house stating that she was going to kill herself. Sasha had been found in a car park by an Area A police officer, it was ascertained that she had not taken excess medication at that stage. Sasha's mother took her back to the Mental Health Hospital herself. Sasha's mother became concerned for her daughter as she was not acting normally and made the decision to divert to Area B Acute Hospital 2. Sasha refused to enter the department, refused treatment, then absconded from the emergency department. In line with the inter-agency care plan, police were not informed by the Emergency department staff. Less than an hour later police were notified that Sasha had posted a video on social media that was a suicide note. There were then officers from Area A and B police forces deployed to try and locate Sasha. It was at first thought that she had travelled away from the area. By tracking Sasha's mobile phone signal, she was eventually located back in her area of residence but her precise location was not known. After several phone calls to Sasha, police ascertained her exact whereabouts. Sasha was in a serious condition when found and continued to deteriorate. Paramedics were called but despite all attempts, resuscitation was not successful, and Sasha died.

6. THEMATIC ANALYSIS

6.1. It can be seen from the account above that there were several systems that professionals used in order to support Sasha in the care that was being offered. These are broken down into sections for analysis and learning. There is inevitably some crossover as systems often run in parallel to each other. Where there were positive or negative impacts of the crossover of systems, these will by highlighted. It is notable that, as Sasha died over two years ago, there have already been some changes made to systems, some as a direct result of this case and others as there are natural improvements made resulting from changes in

policy, practice and research.

MENTAL HEALTH: TRANSITION, DIAGNOSIS AND THE MENTAL HEALTH ACT

Transition

6.2. Albeit that Sasha transitioned to adult mental health services before the time period that this review is focussed on, it is important to recognise the impact that transition had on Sasha. It appeared to have been a possible trigger for increasing self-harming actions.

6.3. The review heard from professionals at the workshop that there have been cases of issues related to the transition experienced by young people moving from child to adult mental health services. The thresholds for acceptance into the adult service differ and different types of services are delivered.

6.4. Plans were in place for Sasha's rehabilitation back to home and to then be transferred to an adult mental health community team. As Sasha was making good progress, but needed more time for more supervised home visits, funding had been agreed to extend her placement in the adolescent unit by three months past her 18th birthday to give more time for the transition home. This was good practice and was a positive aspect showing a person-centred approach and understanding Sasha's needs at transition. Professionals during the review indicated that, due to an incident on the adolescent unit that it was felt would have a negative impact on Sasha, plans were suddenly changed. Records show however, that as Sasha was not adhering to plans and was not making progress in the transition home, she was moved to an adult mental health inpatient unit. The plan was for Sasha to continue with rehabilitation home. This was a move that was made by the mental health team as it was thought to be the best option at the time. Sasha was discharged from the adult mental health ward and the Section 3, ten days after her transition to adult services. As detailed in section 5, Sasha's parents do not agree that this is an accurate description of why plans changed; the author has not been able to clarify anything regarding this issue.

6.5. The sudden change in plan had a negative impact on Sasha as she felt let down. Sasha told her parents that she felt like she had been dumped into a landscape where there was no structure. Sasha's parents felt that the transition had been badly managed and made a formal complaint about how transition had been handled. The parents of Sasha told the author that they did not have clarity regarding this sudden change and believed it was because of wider concerns with the unit. It cannot be known if the original plan had gone ahead whether Sasha and her family would have found the process to have been a better experience. Despite seeking information, the author has not been able to understand why the transition plan changed suddenly so is unable to provide comment on whether there is

learning on this aspect.

6.6. There is recognition that transition is a very difficult time for young people and their families. In order to support Sasha through transition there were several meetings over the last few months where Sasha met with CAMHS and her new worker from adult mental health who would be her care coordinator. This is recognised as practice that would be expected and follows protocols in place to support transition. Professionals involved in the review questioned whether 17 and a half years is too late to start transition, especially for those young people who had a high level of need, are current inpatients or are accessing mental health services on nearly a daily basis.

6.7. Current work being undertaken nationally evidences that there are several issues with the way that transition is managed. The UK Government has prioritised this in the NHS 10-year plan[8] published in January 2019. There are concerns, however, that the 10-year plan is only advisory to commissioners, with local areas determining how far they will go to meet the advisory elements regarding transitions.

6.8. One of the biggest issues reported to be faced by young people going through transition is regarding the differences in thresholds for services between CAMHS and Adult Mental Health Services (AMHS). This was not the case for Sasha in that her referral was accepted as she met the criteria for the adult service.

6.9. The Healthcare Safety Investigation Branch (HSIB)[9], undertook an investigation into a case where a young person took their life after transition. When reviewing their findings in that case, it can be seen that in the case of Sasha, transition was handled well in that it had been planned for some time, she had been accepted into AMHS and that CAMHS and AMHS had met together on several occasions. These had not happened in the case investigated, further evidencing the good practice elements of Sasha's transition. There are, however, findings and recommendations within that report that would have benefitted Sasha.

[8] The 10-year plan includes measures to prevent 150,000 heart attacks, strokes and dementia cases, and better access to mental health services for adults and children. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[9] Healthcare Safety Investigation Branch (2018) Investigation into the transition from child and adolescent mental health services to adult mental health serviceshttps://www.hsib.org.uk/investigations-cases/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/

- Flexible transition that starts even earlier and can be extended until the 25th birthday if necessary.
- Flexibility of services that have no strict cut off points; this is especially important for those with emotional problems complex needs and autistic spectrum disorders.

6.10. Recommendations from that report were made to NHS England and NHS Improvement where they related to the 10-year plan. These were regarding:

- movement from age-based transition criteria towards a more flexible criteria based on an individual's needs.
- ensuring that the care of a young person before, during and after transition is shared in line with best practice, including joint agency working.

6.11. These two recommendations in particular will be helpful to support young people like Sasha. The author would hope that these recommendations hold more weight and have more teeth than the 10-year plan on its own.

6.12. Currently in Hampshire, there is a transition panel reviewing the whole transition process to ensure that the process is a better experience for young people. This review will recommend that the learning from the HSIB investigation and this SAR is used to inform its decisions.

Learning Point 1: Transition from CAMHS to AMHS can have a significant impact on the well-being of young people; young people benefit from clarity and flexibility in the transition process that is person centred. **(Recommendation 1)**

Learning Point 2 The NHS 10-year plan should provide local solutions to be considered to improve the experience of young people. **(Recommendation 1)**

Diagnosis

6.13. The review considered how important diagnosis was in the treatment and understanding of Sasha. It is often the case that consideration is given to meeting individual needs regardless of diagnosis of a specific condition i.e. treating the symptoms. In the case of mental health conditions, it can be argued that diagnosis is important in understanding what medication and treatment will help. E.g. psychotic illnesses can be treated with medication, personality disorders are best managed using therapies.

6.14. In Sasha's early and teen years there was consideration that Sasha's OCD type behaviours may have been indicative of pervasive development disorders. This is an umbrella term for a

group of conditions that includes conditions on the autistic spectrum. As Sasha moved into adult services, her confirmed diagnoses were of OCD, complex post-traumatic stress disorder (PTSD) and emotionally unstable personality disorder (EUPD). Sasha did not agree with these diagnoses and believed that she had ASD.

6.15. The importance of understanding diagnosis for Sasha was considered in depth by the review alongside a discussion regarding why diagnosis was particularly difficult. Sasha was not officially diagnosed with ASD until the weeks before she died. Although early thoughts were one of ASD, assessment at the time did not confirm this.

6.16. OCD behaviours particularly in girls are often misconstrued as being OCD when in fact they could be indicative of ASD. Diagnostic methods and understanding of ASD have changed significantly in recent years. It is also the case that male and female children with an eventual diagnosis of ASD present quite differently in earlier years. Research suggests that the diagnosis of males to females with ASD is 10:1 but that that it should be more akin to 4:1[10]. The reasons for this difference are multi-facetted and appear to be due to the differences in how boys and girls socialise as they develop and how they are regarded by their peers[11].

6.17. As time progressed, the complexities of post-traumatic stress caused by some of Sasha's experiences added to the difficulty in recognising ASD. It therefore appears that although there was a delay in the diagnosis of ASD, this was actually not a simple case of delay. As more was understood about Sasha, alongside a growing awareness of how autism presents particularly in females, a further referral for diagnosis was made. Sasha was assessed and diagnosed quickly. The usual waiting time for ASD panels is 12-14 months; Sasha received the diagnosis in two months as the requirement for this was seen as very important by some members of the mental health ward who chased and requested cancellation slots for Sasha to be assessed.

6.18. There is an issue of associated stigma that can be applied to personality disorders as they are often viewed as being untreatable conditions. There is limited understanding of the interrelationship between personality disorder and autism and the possibility of dual diagnoses[12].

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[10] The Pattern of Abilities and Development of Girls with Asperger's Syndrome available at http://www.tonyattwood.com.au/books-by-tony-m/archived-papers/80-the-pattern-of-abilities-and-development-of-girls-with-aspergers-syndrome Accessed 27 June 2019

[11] Gould, J. and Ashton-smith, J. (2011) 'Missed diagnosis or misdiagnosis? Girls and women on the autism spectrum', Good Autism Practice (GAP), vol 12, pp. 34–41 available at https://journals.sagepub.com/doi/abs/10.1177/1362361317706174 . Accessed 10 September 2019

[12] Dudas, R. B., et al. (2017). The overlap between autistic spectrum conditions and borderline personality disorder. *PloS one*, *12*(9), e0184447. doi:10.1371/journal.pone.0184447. Available at

Learning Point 3: OCD behaviours in young children may be indicative of an ASD (**Recommendation 2)**

Learning Point 4: Prompt diagnosis is vital in ensuring the right service is delivered and to underpin the ethos of care delivered. (**Recommendation 2)**

Learning Point 5: Changes to diagnoses need to lead to prompt changes to care plans and service delivery (**Recommendation 3a)**

6.19. Professionals involved in the review identified that an earlier diagnosis may have made a difference in way treatment and support was offered for Sasha:

- There are specific support and information services for people with ASD.
- Understanding mental capacity for someone with ASD may have been different (discussed in the relevant section below).
- In line with the Equality Act (2010), the need for reasonable adjustments would need to have been made to enable Sasha to access services that were cognisant of her needs as a person with ASD.
- There would have needed to have been a change in the inter-agency care plan to ensure that managing Sasha on presentation in crises took account of her ASD.

6.20. It can be seen in hindsight, why so many of Sasha's admissions and placements did not get the heart of what she needed. Understanding and diagnosing ASD was not as developed as it was in the latter years of Sasha's life and indeed has continued to improve. Again, the NHS long term plan has detailed further developments regarding diagnosis and treatment for autistic spectrum disorders.

Mental Health Act

6.21. Sasha was subject to the provisions of the Mental Health Act (1983) both section 2 and section 3 (and others) during the timeframe for this review. As needs arose, Sasha was admitted for assessment and then treatment under the Act. During the timeframe of the review, it is recognised that there were disagreements between professionals as to whether detention in hospital was in her best interests and whether she fared better at home. It was of note that the ward environment and changes caused anxieties and difficulties with Sasha's rituals and OCD behaviours but that on some occasions, Sasha appeared to prefer to be in hospital as she sometimes felt safer there. Sasha was subject to Section 3 when she

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5590952/ Accessed 10 September 2019

died.

6.22. Whether detained in hospital (Section 2 or 3) or on home leave (Section 17) Sasha was still able to abscond or not return to hospital when she should and often did so. Sometimes Sasha was discharged from A and E even though she was subject to MHA Section. On occasions where Sasha did abscond there were differences of opinion between professionals, and between her parents and professionals whether she should be returned to hospital and how this should happen. Absconsions from emergency departments followed refusal of treatment for self-harm.

6.23. The Mental Health Trust's Absent Without Leave (AWOL) policy clarifies procedures and, recognises that risk must be assessed in order to make the most appropriate action for return when a person subject to Mental Health Act section is not in the place where they are supposed to be.

6.24. Sasha presented differently with different risks. On occasions she was brought back to hospital by police, sometimes it was her mother who returned her and sometimes it was agreed that she could stay at home and return later or the next day. In answer to why there were these differences, professionals had taken an approach of offering flexibility to Sasha, based on what it was believed it would be best for her in each of the circumstances. This then caused confusion as to if and when Sasha should return to hospital and who's responsibility it was to ensure she returned. This was not specifically addressed in the inter-agency care plan (see later section). What transpired on occasion were delays in searching and returning Sasha due to disagreements. On one occasion in particular, the mental health trust staff were asking police to return Sasha when it should have been mental health staff (according to policy). The Mental Health Trust did not have the resources to return her on that day.

6.25. This review has also found evidence that some services were not always aware of her Mental Health Act status, and therefore did not act accordingly. Sasha's parents told the author that she would sit on her bed and laughing and saying, 'they will not come and get me' This indicated that Sasha knew that there were disagreements between professionals, and she was able to exploit this.

6.26. Issues regarding the use of Section 17 leave, roles and responsibilities have been addressed by The Coroner by use of requests for action in order to prevent risk of future deaths. Therefore, although there is learning from this review, it will not be necessary to make further recommendations.

6.27. The Mental Health Act Code of Practice[13] is clear:

> *(Unless there is a required need for Police to support) Responsibility for the safe return of patients rests with the detaining hospital. If the absconding patient is initially taken to another hospital, that hospital may, with the written authorisation of the managers of the detaining hospital, detain the patient while arrangements are made for their return. In these (and similar) cases people may take a faxed or scanned copy of a written authorisation as evidence that they have the necessary authority without waiting for the original. P.325*

6.28. Accurate recordings and management oversight of absconsions when subject to Mental Health Act section can track patterns and inform risk management. Area B Hospital 1 has made recommendations regarding the internal incident reporting of patients who have absconded whilst subject to Mental Health Act detention. It is suggested to the Safeguarding Adults Board in Area B that it considers seeking similar assurances from Area B Hospital 2.

6.29. A recently published report by the Care Quality Commission[14] identified that the Mental Health Act Code of Practice is not being used as intended and makes recommendations to ensure that providers understand how the application of the code of practice can have an impact on the guiding principles of the Act being adhered to. This, therefore, is not only a localised issue but a national one.

6.30. Amongst the discussions regarding what would be appropriate options for Sasha's treatment, was an assessment by two psychiatrists that she may benefit from a period in secure accommodation, in order to contain Sasha in a safe environment from where she was less likely to be able to abscond or self-harm with access to the therapy she needed. These placements are very difficult to access as they are so few in number and this had been suggested as an option only a few weeks before Sasha died. It is not known if this would have had a beneficial effect. When Sasha's parents met with the author, they identified that this would have been a difficult arrangement. Her parents stated however, that they would have supported an appropriate placement if it was the right one for Sasha, as would Sasha herself, as they felt totally exhausted and that every other avenue had been explored, with no identified or sustained improvement. Her parents talked about trying to

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[13] Department of Health (2015) Mental Health Act (1983) Code of Practice TSO Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF Accessed 10 September 2019

[14] Dr Paul Lelliott, Deputy Chief Inspector of Hospitals (lead for mental health) Mental Health Act Code of Practice 2015 – An evaluation of how the code is being used CQC June 2019 https://www.cqc.org.uk/news/releases/cqc-finds-mental-health-act-code-practice-not-being-used-intended Accessed 10 September 2019

keep her alive long enough for a placement to be found.

6.31. Regarding treatment for self-harm actions, if an individual is detained under the Mental Health Act physical healthcare can be administered only if it is part of the treatment for the mental disorder and its manifestations. Treatment can only be given against someone's consent in the hospital to which they are detained. Sasha may have, on occasion, fitted that criteria. She was not treated for her presentations in this way and was assessed as being able to make decisions herself under the Mental Capacity Act (See section below). Case law regarding this element of the Mental Health Act and its interface with the Metal Capacity Act is extremely complex and each case must be judged individually. It is therefore necessary, especially in cases where self-harm/suicide attempts are becoming increasingly risky and likely to lead to death, to escalate to senior managers and ensure that specialist legal advice is sought.

6.32. The Mental Health Act sections were applied with various successes, but due to her spasmodic engagement, they did not ensure that Sasha was always able to undertake the suggested treatments and therapies that may have improved her circumstances. It appeared that most success was gained from those that she had good relationships with. Some of those relationships and positive responses appeared to be from those who gave very clear boundaries e.g. police, British Transport Police and some mental health staff. As a detained patient, Sasha was entitled to the support of an Independent Mental Health Advocate (IMHA) who may also have been able to build a relationship with Sasha. This service was offered and always declined by Sasha. For Sasha it was her mother that was her spokesperson and advocate.

6.33. If there had been a knowledge of her ASD diagnosis, professionals agree that there may have been a better understanding of how best to approach and manage Sasha under the Mental Health Act and to build relationships.

Learning Point 6: The Provisions of the Mental Health Act should be applied robustly in order to ensure safety and treatment. This will prevent confusion as to the status of a detained person as well as clarity regarding use of the Mental Health Act and/or Mental Capacity Act. **(Recommendation 4)**

MENTAL CAPACITY ACT

6.34. The provisions of assessing mental capacity are covered by the Mental Capacity Act (2005). It is an element of the legislation that if a person appears to be making unwise decisions, that they are not automatically assumed to lack capacity. Mental capacity to make decisions should be assessed where a person has a disturbance of the mind or brain that may impact

on their ability to make specific decisions.

6.35. Throughout the timeframe of the review and despite, on occasions, being subject to Mental Health Act provisions, Sasha was more often than not assessed as having Mental Capacity to refuse treatment for her self-harm episodes. It was clear to professionals that she had an in-depth knowledge of overdosing with paracetamol and then propranolol. The only occasions where she was deemed to not have capacity was when she became drowsy or unconscious as a result of her actions or when, on occasions, she refused to speak to assessing staff.

6.36. There were considerable differences in how well the Mental Capacity Act was applied and how well assessments were recorded. Acute Hospitals recorded that Sasha had capacity to refuse treatment, and she was allowed to leave emergency departments. This has been discussed in the section above. It may have been that Sasha demonstrated capacity to refuse treatment, but this should not have resulted in her being allowed to leave the hospital if she was subject to Mental Health Act detention as she could be recalled to the detaining hospital. Several organisations have made single agency recommendations regarding improvement of recording of Mental Capacity Assessments and of discussions regarding assessments.

6.37. There were occasions where it was not possible to assess mental capacity as Sasha refused to communicate with clinicians. As communication is key to be able to assess capacity, then it can be seen that by choosing not to communicate, Sasha could not be assessed to have or not have capacity to decide on treatment. On these occasions it is important to seek legal advice. In some cases, the Court of Protection may need to be approached for an interim declaration[15]. Informing Sasha that there were other options open to professionals to resolve issues of Sasha's refusal to be assessed may have encouraged her to be assessed. This would be in line with the Code of Practice as well as providing clarity each time as to the consequences of refusal of treatment. Sasha's parents reflected that when Sasha refused to communicate for an assessment, that some clinicians deemed her not to have capacity.

6.38. There were also occasions when attending appointments and emergency departments, when Sasha reminded staff that they needed to assess her capacity. Her knowledge of the Mental Capacity Act was used by her to ensure that her wishes and feelings and refusal of treatment were assessed and recorded. It is acknowledged, however, that the full application of the provisions of the Act that could have led to Court of Protection

[15] Keene. AR, (2016) Mental Capacity Law Guidance Note; A brief guide to carrying out capacity assessments. 39 Essex chambers http://www.39essex.com/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf

involvement were not applied. It is known that Sasha responded to clear boundaries and this could have been another occasion where those boundaries may have been put in place as is the case for people with autism, who find it reassuring.

6.39. The out of hours GP service also made efforts to ensure Sasha was seen so that capacity could be assessed. At no time was Sasha assessed as not having capacity in face to face contacts with the service. Mental Capacity assessment was not always well recorded by the service.

6.40. The Mental Capacity Act Code of Practice[16] confirms that people have the right to make decisions that others might think are unwise. It also states, however, there is cause for concern if someone repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character. The code states that this does not necessarily mean that a person lacks capacity. They may need more information to be able to help them understand the consequences of the decision they are making or there may need to be further investigation as to whether the person has developed a condition that is affecting decision making.

6.41. One of the main reasons for not having applied the Mental Capacity Act effectively was an element of understanding and fully assessing capacity. The Act states that if someone has a disturbance of the mind or brain and appears unable to make a specific decision then they should be supported to make that decision. The Act also states that a person is not able to make a decision if they are unable to do one or more of the following:

- Understand information given to them.
- Retain that information long enough to be able to make the decision.
- Weigh up the information available to make the decision.
- Communicate their decision.

6.42. It was clear that Sasha was very able to articulate her needs and knew and understood the information relevant to her self-harm. What was not clear to professionals, however, is that she could use and weigh up that information in her decision making. Sasha stated that her paracetamol overdoses were to alleviate difficult situations and stressors related to her OCD and PTSD. Her intent to die was not stated clearly on each occasion she self-harmed. Her intent was to take her out of the situation, which was why on many occasions on leave, her CPA care plan was that she would attend to see a mental health team member when she felt she was about to self-harm. She often used that provision to attend an emergency

[16] Department of Constitutional Affairs, (2007) Mental Capacity Act Code of Practice available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf accessed 27 June 2019

department and ask to see the psychiatric liaison team. It can be argued therefore that the decision to take an overdose without the intention to end her life was not congruent with refusing treatment. This did change when overdoses moved to propranolol, as the intent changed.

6.43. Sasha also made an advance decision in writing. Advance Decisions are further provisions under the Mental Capacity Act to refuse specified medical treatment at a time in the future, even if this might result in death. Advance Decisions should specify which treatment is to be refused and include as much detail as possible regarding the circumstances under which the advance decision will apply. They will only come into force once an individual has lost capacity. The Mental Capacity Act Code of Practice indicates that advance decisions can be overruled if the person is detained under the Mental Health Act and the advance decision is to refuse treatment for an order related to that detention. The Code also indicates that if a person is suicidal, mental capacity to have made the advance decision should be questioned and carefully assessed.

6.44. An advance decision in suicidal behaviour is a complex issue[17]. Any Advance Decision could be argued will not be valid if evidence is provided that the Advance Decision was made whilst someone is suffering emotional distress that is likely to be impairing their decision making. Advance Decisions to Refuse Treatment made by service users following episodes of suicidal behaviour raise a number of specific issues particularly if subject to detention under the Mental Health Act. It is suggested that clinicians should proceed especially cautiously, in view of the acute distress, ambivalence and changeability that often characterise suicidal thoughts and behaviour.[18]

6.45. In the case of Sasha, the advance decision was rightly challenged, and legal advice was sought. It was found not to be legally binding as it was not written in the way that the Mental Capacity Act Code of Practice says it should. It is of note that albeit the Advance Decision Sasha wrote was not binding, it did cause anxiety for professionals. Professionals felt that it would be helpful to have more specific guidance as they are not used to seeing Advance Decisions in someone so young or in relation to self-harm and suicide. Professionals also felt that there would have been benefit from including a response to this in the inter-agency care plan and in multi-agency forums so that there was clarity if Sasha raised the existence of an advance decision.

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[17] **SELF-HARM: LONGER-TERM MANAGEMENT**; (2012) National Clinical Guideline Number 133, National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence published by The British Psychological Society and The Royal College of Psychiatrists

[18] Kapur, N et al. (2010) **Advance directives and suicidal behaviour**. British Medical Journal, 341, c4557.

6.46. It can be argued that assessments made regarding the decisions to refuse therapies and mental health treatments were different than those faced by the emergency departments. In those acute and crisis situations, being able to give Sasha time to use and weigh information was not possible and staff assessing capacity in those situations had to make decisions based on what they were actually seeing and hearing from Sasha. On occasions where she was assessed as not having capacity she was treated in her best interests. Her clinical care plans and inter-agency care plan covered these circumstances.

6.47. Sasha had not been recognised as a person with ASD. This is another area that may have made a difference in how professionals approached assessment of Sasha's mental capacity. The Social Care Institute for Excellence notes for people being assessed who have autism:

"The impact of autism should be considered when assessing under the Mental Capacity Act 2005 or the Mental Health Act 2007. For example, someone with autism may have good theoretical knowledge about an issue and appear to have capacity, but in fact are not able to retain or weigh up the information"[19].

6.48. Following Sasha's significant cardiac arrest, she complained of some memory issues. She had been referred to neurology, but it was not possible to identify if there was any cognitive deficit following the cardiac arrest. It takes several weeks and months before it becomes apparent if there is a long-term issue that can be properly diagnosed that would identify if her mental capacity had been affected. Health professionals involved and working with Sasha at the time suggested that they did not see a change in Sasha so did not apply the suggested memory loss issue to application of the mental capacity assessments. Sasha's parents have indicated that, to them, the issues were obvious, and that it would have made a huge difference for Sasha to know if the issues were temporary or not. For the reasons given above, it was not possible to know this immediately.

6.49. Where Sasha was subject to detention under the Mental Health Act professionals at times appeared confused as to which Act took precedence or how the two acts work alongside each other.

6.50. It is of note that the Mental Capacity Act Code of Practice is currently under review. It is not clear at this point whether there will be updates that will be relevant to the learning from this review.

[19] **Assessment for people with autism** https://www.scie.org.uk/autism/assessment-accessibility/assessment Accessed 27 June 2019.

See Learning Point 6 Above
Learning Point 7: Mental Capacity needs careful and robust assessment where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment. (**Recommendation 6a)**

Learning Point 8: Advance decisions should always attract questions and seeking of legal advice in cases of self-harm and suicidal behaviour. **(Recommendation 6a)**

Learning Point 9: Professionals benefit from guidance to support them with high risk and complex cases that they do not face very often. (**Recommendation 3c,5a,6a)**

SINGLE AND MULTI AGENCY ACTION PLANS & COMMUNICATION

6.51. There were several types of care plan in place some of which were multi agency and some were single agency. Communication and understanding of who was involved in the care of Sasha and who was undertaking which specific elements of care and support was managed using these plans.

6.52. The single agency plans varied from agency to agency e.g. emergency departments in Area B had clinical management plans in place, Police in Area B had a 'trigger plan', Ambulance Service 2 had a implemented their frequent caller policy. The Area B Mental Health Trust had various care, crisis, contingency and out of hours plans and these were developed as the need arose and reviewed as necessary. Sasha was involved in all of the plans that were created to support her crisis and recovery plans as well as risk assessments. Her parents have indicated that they do not think that they or Sasha were always involved. Sasha sporadically and inconsistently engaged with the requirements of any plans.

6.53. Those that were involved with Sasha on a regular basis, identified that those individual single agency plans had their place in the individualised care that each organisation was delivering, but it was felt that a multi-agency plan was needed. These were first created before the timeframe for the review in a meeting that took place around the time of Sasha's 19th birthday. This was attended by a large number of professionals from emergency departments, mental health services, police forces in Area A and B. This meeting agreed that Sasha needed strong boundaries and that she should be arrested if she broke the law. It was also agreed that Sasha would be seen by the GP for support every two weeks. This was set up so that it fitted around her college attendance. Sasha attended two of these appointments but then disengaged and was not seen by the GP again despite follow up

letters pointing out that the appointment was part of an agreed plan.

6.54. Sasha's parents told the author that a care plan was written by them in the first instance with a police officer who visited them at home to support them. This was an attempt to try and resolve confusion regarding options for treating her so that it would be clear what parents could do and what police would do when Sasha self-harmed and/or absconded. This was clearly later developed further when other professionals became involved.

6.55. The nature of the inter-agency care plan was to provide background and specific responses to varying scenarios of presentations. The plan was to advise how to respond when Sasha went missing and also to provide emergency department staff with a plan of care when she attended, and either refused treatment of absconded. The theory behind the plans showed very good attempts at multi agency working and generally worked well for some of the agencies that were involved. There is evidence that when Sasha attended the emergency department in Area C, that the Area C psychiatric liaison team were informed of the nature of the plan by Area B mental health staff, it was sent to them and uploaded onto the record system.

6.56. Both Area A and Area B police forces were involved in the plan, but both responded differently when Sasha went missing. Area A police force applied a response based on the scenarios within the inter-agency care plan which dictated a no response from police in some circumstances but did elicit a response in others, based on assessment of risk. E.g. On Sasha's last day, for both incidents the control room deployed officers. In the case of the first incident, it does not appear that this was in line with the inter-agency plan or that the plan was known about or considered. In the case of the second incident, the plan is considered, and police were deployed as expected by the plan.

6.57. Area B police force, more often than not, commenced investigations and dispatched resources to deal with most missing episodes, based on perceived risk. It can be seen that risk and interpretation of the inter-agency care plan was viewed differently by each force.

6.58. The plan was intended to allow for positive risk taking in line with current thinking on management of risk. It also provided clarity as to what services were available and what they could and could not provide for Sasha. Her family were included and requested changes, some of these were responded to and other requested changes were deemed not possible from the professionals' perspectives.

6.59. Whilst this generally worked well and covered both Area A and B professionals, there were some issues that could have made the plan more cohesive and cognisant of other processes.

- The title of the plan was not consistent in all agencies, the author found many references to the plan, all identified with different titles. This meant that communication about the plan may have been confusing.
- No agency, in their reports, identified the same dates for the plan meetings, outcomes and how updates differed from the previous ones.
- The dates on the plans were not updated when a plan was reviewed. This was due to the same plan being used and amended but dates not being amended.
- The plan was entitled *inter-agency care plan* but in essence it was an agency action plan i.e. how agencies would respond to Sasha in various circumstances.
- The plan was lengthy (6 pages of text) and was therefore not easy to navigate in an urgent or emergency situation by those that may not have been familiar with it.
- The plan was not shared, nor did its formulation involve, all the agencies that were dealing with Sasha in an emergency. Although the NHS 111 out of hours GP service were aware of the Hospital 1 emergency department Plan it is not clear if this was the inter-agency care plan or something else. Neither of the ambulance services had copies of the plan.
- The plan did not detail treatment for self-lacerations with advice regarding self-suturing and requests for suture kits.
- It was not clear who owned the plan, how and when it would be updated, and was not outcome focussed.
- There were no minutes from the meetings, therefore it was not clear how and who the plan was circulated to and who had received it.

6.60. If the above points had been considered, then the author would suggest that the plan would have been more inclusive and effective. Most importantly the plan needed set review dates that people could have diarised in advance, getting together professionals to review the plan was difficult. The plan should have been reviewed at set intervals as well as if there was a change in Sasha's presentations.

6.61. Other issues with the plan was that it was not clear to all, if the circumstances would be different if Sasha absconded when subject to Mental Health Act detention (it refers to formal or informal patient, but that terminology would not be clear to all services). The plan was not specific about what actions would be taken or which polices should be followed in those circumstances. The plan would also have benefitted from inclusion of a flow chart style as the text was lengthy to read in an emergency situation.

6.62. In the latter weeks of Sasha's life, there was a recognition that the plan needed to change, and these conversations were taking place verbally. Discussions were recognising that the situation had changed with the addition of propranolol being used in overdoses and the diagnosis of ASD. The previous plans were related to the response to paracetamol overdoses and other self-harm. A reviewed and updated plan had not been circulated before Sasha died.

6.63. Professionals involved in the review recognised the learning regarding the inter-agency plan and also added information regarding new processes. Since the time that Sasha died, both Area A and Area B have improved processes in place for managing those that come to the attention of mental health and emergency services on a regular basis.

6.64. They are titled differently, but both relate to the same population and meet on a regular basis to review all plans related to those high intensity users. Attendance can be problematic and therefore this review makes recommendations related to ensuring that the processes can be effective and robust in managing situations, that they are person centred and outcome focussed. The process must also have organisational senior manager oversight in particularly complex cases to support for professionals as well as an escalation process for highlighting increasing risk. Non-attendance of any professional group that is deemed essential to the plan should also be highlighted and escalated.

6.65. Other plans in place that could have had more involvement from other agencies was the Care Programme Approach (CPA). The essence of the CPA is coordinated care by a care coordinator to identify all aspects of assessed care needed. The plan should state who will be undertaking different aspects of care delivery including what the person and their family and carers will do. The plan can draw in all agencies who are involved in care. A section of this care plan will include a crisis plan and therefore that could have been the vehicle for an inter-agency plan without the need for a separate process. CPA meetings are held regularly for those high-risk patients and are minuted.

6.66. The author would suggest that where there are so many plans, keeping documentation and plans to a minimum but sharing them widely may prevent confusion and provide clarity of roles. Sharing of plans and information more widely would have ensured that all knowable information would become known to a wider group of professionals. It is also important to recognise that any high intensity user plans should form part of the CPA plan rather than be separate to it.

Learning Point 10: Inter agency plans are more effective when they have clarity of ownership, review dates, are outcome focussed, are shared widely and are easy to follow in urgent and crisis situations. (**Recommendation 3b)**

Learning Point 11: Single agency plans should be considered for sharing where there may be a benefit and it is relevant to share. (**Recommendation 3d)**

Learning Point 12: Where a person is subject to CPA and there are several agencies involved, this should provide a vehicle for effective multi-agency working and information sharing. Plans shared widely can be of benefit to the professionals involved and the person they concern. (**Recommendation 3e)**

Learning Point 13: Newer processes to manage high intensity users will provide support for professionals if concerns and risk are shared with senior managers. (**Recommendation 3c)**

SAFEGUARDING

6.67. There are several issues that appeared within this review that can be considered under the safeguarding umbrella. This section will not only cover statutory safeguarding considerations but also management of the family issues and influences as it relates to keeping Sasha safe and ensuring access to treatment. Using a safeguarding lens would have offered a further opportunity to apply a multi-agency approach to supporting and caring for Sasha and brought in organisational safeguarding leads who may have offered a different approach.

6.68. Sasha's parents, and in particular her mother, had been managing Sasha's intensive rituals and behaviours for many years. It is fair to say that for the most part that this review covers and in the more recent years prior to that, family relationships between Sasha and her parents were strained and under intense pressure. Her parents reported to the author that they were totally exhausted. At one point, when Sasha was in a distant placement, they both gave up their jobs in order to be able to travel to see her. Her parents also told the author that hotels were expensive and that on one occasion Sasha's mother slept in the car overnight. In reading the reports for this review, it is clear that her parents often complained about the services that Sasha was receiving in her adult years. Despite the difficulties that Sasha posed, it does appear that they always had her best interests at heart. They were widely read on the subject and services and had a good understanding of their rights and those of their daughter and they exercised those rights.

6.69. There were occasions where Sasha took overdoses and her mother was unable to intervene due to Sasha's rituals meaning that her mother was unable to cross a certain line, enter her

bedroom or touch her. This was seen by professionals as a safeguarding issue and in some respects, it could be argued that it may have been. It was, however, an intensely difficult situation for her parents who were fearful of her reactions if her rituals and rules were not followed by them. This pattern had emerged over many years. It also came to light later in the review process that Sasha had obtained suture kits when in London and that she self-sutured on occasions. Sasha's mother knew of this and although she did not agree with this action, she felt that if she was encouraged to go to hospital for suturing against her wishes, that the effect on her was that she would return home and cause further self-harm because of her OCD behaviours. It can be seen therefore that self-suturing appeared the least stressful option. It is of note that albeit that Sasha's mother requested further suture kits when the first ones had run out, local services i.e. GP and out of hours GP service refused to give these therefore the self-suturing stopped.

6.70. Sasha's mother agreed that although that she knew she should not pander to Sasha's behaviour that she was treading a fine line between protecting her daughter and preventing a complete 'meltdown' and further self-harm. This, seeking anti sickness medication for overdoses of paracetamol and accessing a variety of hospitals based on how Sasha's mother and Sasha felt that they would be treated, are evidence of trying to seek self-support for Sasha's presentations in a way that kept her out of hospital if possible and thereby preventing triggering further self-harm by having had to go to hospital

6.71. This issue needed further exploration with Sasha and her parents to understand to what extent they were able to safeguard her. At times the issues that Sasha's parents had with professionals in not agreeing to plans of care for her should have been discussed as a safeguarding issue. Sasha's parents believed that they were acting in her best interests and this could have been subject to a challenge from professionals if there was a difference of opinion.

6.72. Understanding Sasha's parents' perspective should have been seen in the context of them being parents of a young adult. When a young person turns 18, the view from professionals is that they are now an adult and they are treated quite differently. Parents, however, do not suddenly change their care and support of their child; the transition to adulthood from a parental perspective takes much longer. One could argue that in a case of a person with such significant needs, it is likely that the role does not ever really change.

6.73. The author asked professionals why they did not feel able to challenge Sasha's parents. It was argued that they found parental actions of complaints and threats of litigation intimidating. The ability of the parents to follow these actions, the use of paying for private practitioners if they did not feel they were getting the services that they felt Sasha needed was unusual and ones that professionals stated they were not skilled in dealing with.

Sasha's parents told the author, that there were occasions where they did lose their temper with professionals. They were tired and extremely stressed at times feeling helpless and frustrated that they could not see any improvement in their daughter despite many attempts at interventions.

6.74. Sasha's mother reflected on this and gave an example of a CPN that did challenge her behaviour and she did apologise, and they talked it through. Sasha's parents recognised that their actions could have been seen as collusive and that motivations could have been misconstrued but argued that professionals should have discussed this with them. Sasha's parents commented that they were aware that some professionals felt that they were able to engineer actions quicker because of their standing in the community. This review has not found evidence of this. Sasha's parents also reported that when assessments could not be accessed quickly, that they offered to pay privately but that they were told that this would not be accepted for NHS diagnosis.

6.75. None of this confrontation between family and professionals was in Sasha's interests; a resolution to these difficulties would have been beneficial. As parents with knowledge, there were assumptions made that Sasha's parents understood more than they actually did regarding the way in which services could be delivered. There were often therefore limited explanations and rationale given to parents about decisions.

6.76. It was also a feature that Sasha often refused to speak to professionals using her mother as spokesperson. In that role, Sasha's mother felt that she had to maintain the wishes and feelings of Sasha and explain those even if she did not agree with what she felt she had to say. Sasha's mother felt that professionals should have spoken to her on her own, but they didn't. This is possibly that after 18, professionals felt that they could not speak to Sasha's mother on her own, without the consent of Sasha.

6.77. The author suggested to professionals that they were more used to dealing with families where responses were very different and where there was limited understanding of services and wherewithal to pay for additional services. The connectedness that Sasha's parents had to those in local positions of power and their own standing in the community meant that professionals became disempowered and intimidated. In these circumstances organisations can become concerned about reputational issues and the system does not respond well to such issues. Professionals did not challenge and assess motivation to identify if there were any safeguarding issues. On the whole professionals agreed; Sasha's parents also agreed with this.

6.78. Exploration of these issues may not have led to a safeguarding enquiry but may have helped all understand the impact that the intense routines had on relationships and family life and why Sasha's parents presented in the way that they did.

6.79. A further complexity in this case was the different roles and responsibilities of the two-county council Multi Agency Safeguarding Hubs[20]. If Sasha went missing or absconded from hospital or there were safeguarding issues within an Area B site, then it was Area B social care who referrals were sent to. Area A social care are responsible for the residents within their area and therefore general safeguarding concerns related to Sasha were the responsibility of Area A social care. Whilst Area B Informed Area A social care if they had a referral, it meant that two areas were dealing with safeguarding concerns expressed about Sasha. This is in line with the ADASS protocol for out of area safeguarding arrangements[21]. What is key in complex cases, like Sasha's, with two areas are in receipt of concerns, is good communication and sharing of information. There is evidence that Area B forwarded concerns and information that was in Area A's jurisdiction, there is no evidence of Area A feeding back any outcomes of such information sharing.

6.80. On the whole, the information that was shared with social care in Area A and B was not as a result of allegations of abuse or neglect but due to concerns that Sasha was at risk of harm because of her own actions. Responses from Area A, therefore, was that there was significant multi agency involvement and that the issues and concerns related to clinical management and need. It was therefore considered that these could be adequately managed by the CPA process with the lead professional being the care coordinator.

6.81. Adult safeguarding is a statutory process under the Care Act 2014 and requires that specific issues of neglect or abuse related to a person with care and support needs who cannot protect themselves is dealt with under Section 42 of the Act.

6.82. Whilst there were no allegations of abuse and neglect made, there was an issue of self-neglect that is covered by the Care Act. Professionals involved, stated that this was not a case of self-neglect as that is more akin to omissions to care and failing to eat, seek medical

[20] Multi-agency safeguarding hubs are structures designed to facilitate information-sharing and decision-making on a multi-agency basis often, though not always, through co-locating staff from the local authority, health agencies and the police. https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/collaborative-working-and-partnership/multi-agency-safeguarding-hubs.asp

[21] ADASS Safeguarding Adults Policy Network Guidance June 2016 Out-of-Area Safeguarding Adults Arrangements https://www.adass.org.uk/media/5414/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf

care, attend to one's personal hygiene etc.

6.83. The Care Act Guidance[22], however, is clear that self-neglect:

> "covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support"

6.84. Area B's Safeguarding Adult Board's self-neglect policies and procedures at the time states that self-neglect is:

- Either unable or unwilling to provide adequate care for themselves.
- Not engaging with a network of support.t
- Unable to or unwilling to obtain necessary care to meet their needs.
- Refusing essential support without which their health and safety needs cannot be met, and the individual lacks the insight to recognise this.

6.85. It also states that an example of self-neglect is '*Refusal of services that would mitigate risk of harm'.*

6.86. Area A's 4LSAB "Guidance on responding to self-neglect and persistent welfare concerns" also provides excellent guidance that includes consideration of those who self-neglect in the way that Sasha did.

6.87. It can be seen therefore that Sasha could have been considered to have been self-neglecting. Application of a safeguarding lens by applying the above considerations of Sasha's circumstances to self-neglect received some challenge within this review process. Self-Neglect does not always mean an automatic section 42 enquiry, the ability to consider this case may have led to other options as a way forward, only one of those being a section 42 enquiry. The author and some of the professionals involved in the review would suggest that as the difficulties were escalating, that a broader multi agency safeguarding meeting, would have drawn in professionals with safeguarding roles in various organisations who

[22] Care Act Guidance: Care and Support Statutory Guidance (2016) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Updated 2018 with no changes to Chapter 14 Safeguarding

were not directly involved. This may have also led to Area A and Area B adult social care being able to liaise and communicate effectively, with clarity over what each area was aware of. A possible outcome may have led to instigation of referral and management under Area A's Multi Agency Risk Management process.

6.88. A further outcome from a decision not to pursue a Section 42 enquiry, should still have elicited an assessment by Area A social care (who had those section 9 duties) under section 9 of the Care Act. Sasha had always declined social care input when offered a needs assessment (Section 9) so for this reason it was not undertaken. Whilst this is the right course in some circumstances, the Care Act also indicates further action under section 11 provision. In the case either where an adult lacks capacity or where the adult is experiencing or at risk of experiencing abuse or neglect, local authorities must still undertake an assessment as far as possible and document this. This could have led to a wider information gathering by Area A social care from all involved agencies and again may have led to a request for a multi-agency risk management meeting.

6.89. There were several reasons why a safeguarding response was not considered and that the referrals that were being made did not attract a safeguarding response.

- Professionals did not recognise any aspect of Sasha's circumstances as a case of self-neglect.
- Professionals did not consider the organisational safeguarding concerns when Sasha went missing subject to Section 2 and 3 of the MHA.
- Area A Self Neglect guidance that is not up to date is still available on the internet albeit superseded by a 4LSAB guidance.
- Staff did not attribute the way that parents presented as an issue that could have been considered as a safeguarding issue (resolution and discussion may well have led to realisation that this was not from an abuse motivation but it may have added to action planning to support a different perspective from the parents).
- Ambulance and police services were reporting adult at risk concerns that did not identify safeguarding issues but more aligned with welfare concerns- referral forms from those services did not differentiate between the two.
- MASH is the front door into social care for safeguarding referrals in Area B and therefore all referrals are triaged by the MASH. It is noted that some services send all referrals for Adult social Care to the MASH whether that be a wellbeing concern or a safeguarding concern and therefore the system was being swamped.
- Referrers in either Area A or B stated at the workshop that they do not get feedback from their referral, albeit this appears to be a general issue and was not related to any referrals regarding Ms D. As such, it is not for this report to consider this matter,

but it is drawn to the attention here of the Safeguarding Boards for them to consider if there is further work needed to address this within the audit recommendation for this review.

6.90. The second point above regarding Sasha frequently going missing when subject to Mental Health Act section 2 and 3 returned much debate within this review. Reports of absconsions in Area B or the responses to such reports did not receive a safeguarding consideration. The agency review report from Adult Social Care in Area B raised concerns about this. Area B will take this matter forward in their area.

6.91. The last two points above create possible inadequacies in the system and were discussed during the review. Police and ambulance services in both areas made multiple safeguarding notifications that were viewed on receipt as care and support issues. If the MASH is the front door to social care for safeguarding referrals, then there must be clarity and challenge back to services who do not easily identify whether the referral is for care and support or a safeguarding concern. The referrals into the MASH that do not have clarity take staff away from dealing with safeguarding concerns and put pressure on the system. It is of note that there has since been action from ambulance and police forces to alert staff of the need for clarity in referrals.

6.92. Due to the above issues of capacity in the system, referrers may not get feedback on their referrals. As this is a disputed issue it will require testing. It is also the case that alerters raising safeguarding concerns do not understand whether their referral had not met the threshold for section 42 enquiry. Not responding to referrals creates several issues:

- Referrers cannot challenge the response if they disagree with the decisions that it is not a safeguarding case.
- Referrers do not get to understand the thresholds and requirements of a robust safeguarding referral.
- Referrers get used to not having a response and do not follow up for a response.
- A belief that the referral will result in action may delay an alternative response and not offer other interventions in a timely manner.

6.93. There are therefore several areas of learning for the safeguarding system.

Learning Point 14: 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. (**Recommendation 7)**

Learning Point 15: Attitudes and behaviours of parents and carers should be challenged and considered as a safeguarding concern if there is an impact on the safety and well-being of a person with care and support needs. Resolution of disagreements between families and professionals may provide further insight and empathy for the position that carers find themselves in. (**Recommendation 5b, 6b)**

Learning Point 16: Where the level of risk is considerable, multi-agency risk panels provide a vehicle for sharing information and developing a multi-agency plan to help mitigate the risks identified. (**Recommendation 6c)**

Learning Point 17: Resolution to issues in the safeguarding system leads to better safeguarding responses to individuals in need of protection. (**Recommendation 6c)**

7. GOOD PRACTICE

7.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, Safeguarding Adult Reviews can also provide evidence of good practice. Attendees at the workshop were asked to identify these from their own and other agencies involvement.

7.2. 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 god 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.

7.3. It is important to note that, although there were anticipated cross border working issues, leading to being included in the terms of reference, there were no issues of that nature found in this review. The issues were of multi-agency working and communication regardless of county and local authority boundaries. The author considers that worthy of mention in this section.

8. CONCLUSION

8.1. 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. This appeared to trigger an escalation of stresses for her leading to more and more risky self-harm behaviours. Professionals involved, as well as her parents, considered that this was very likely to lead to her death.

8.2. Efforts to contain her stresses with various therapies and medications did not appear to alleviate her stated need to self-harm with overdoses and self-laceration as a way of coping with her thoughts and feelings. 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.

8.3. Sasha presented to emergency departments, mental health and other professionals sometimes on a daily basis and on occasions several times in one day. In trying to support her, those with case responsibility for her, often felt overwhelmed and frustrated that they were not able to put in support that might make a difference to how Sasha felt about her life. Sasha's parents also felt overwhelmed and stressed with this manifesting itself in complaints and feeling that professionals had little empathy for their situation.

8.4. This review has found that Sasha may have benefitted from a transition process such as is now being considered by the UK Government. Sasha did not get the diagnosis that might have made a difference to the way that she felt and was approached until just before she died, impacting on how coped with everyday situations and planned interventions.

8.5. It has been found that the Mental Health Act was applied in a way that was deemed to be in Sasha's best interests, but not in a way that is required by the provisions set out in the Act. Sasha often absconded whilst detained on a Section, self-harmed and was then not returned to hospital as a place of safety for treatment as is the intention of the Mental

Health Act. When there was a request to return her to hospital, there was confusion and frustration regarding whose responsibility it was to return her.

8.6. The review has also considered that application of the provisions of the Mental Capacity Act were not utilised in the way that they could have been and that her diagnosis of ASD may have changed the professionals' views of her ability to use and weigh information related to decisions to be treated or not as well as other decisions.

8.7. The application of the Mental Health Act and the Mental Capacity Act and the interface between the two caused difficulty for some professionals with a lack of clarity as to how to use the two together to effectively safeguard Sasha.

8.8. There were multiple action plans, care plans, and risk assessments in place. The inter-agency care plan was a good attempt to maintain consistency between agencies but had some difficulties as the review has identified.

8.9. The review also heard of some of the more recent processes for multi-agency working with high intensity users. These should lead to improvements as long as there can be full multi agency attendance and managerial oversight to support professionals, managing and holding risk at an appropriate senior level within organisations.

8.10. It has been found that an alternative view of the case may have come from a robust multi agency safeguarding response. The review has identified some issues within the safeguarding system that require review as well as improvements to the response to this type of case and whether recognition of self-neglect may have added a further lens that would have brought in a different type of expertise. There is also a view from some in this review that there were service provision issues that may have constituted neglect or organisational abuse when Sasha was allowed to leave and went missing under section. The debate regarding this was not resolved and is subject to recommendation.

8.11. The review has found that the parents of Sasha were often feared and not challenged or supported effectively due to their perceived level of affluence and community standing that gave them the wherewithal to challenge through legal routes and complaints. This was not helpful to Sasha, her parents or the professionals, as it diverted attention in an unhelpful direction. Solutions to better ways of working with the family were not sought.

8.12. It cannot be known if any of the above elements of learning would have prevented the sad outcome. It cannot be known if any of the above had been considered differently that Sasha would have engaged any more effectively or that her management of her feelings and thoughts would have been any less harmful. It is apparent though that there have been

lessons learnt from how agencies worked together to keep Sasha safe and therefore lead to recommendations for future practice.

9. OUT OF SCOPE LEARNING

9.1. During contacts that the author had with the family, there was a request from the family regarding post suicide support for families. Parents of Sasha felt that they would have benefitted from services that specifically related to issues faced post suicide of a family member. To date they have struggled to receive such support.

9.2. It is of note that NICE Guidance published in September 2019 identifies the need for this type of support in reducing further risk of suicide and to support families affected by suicide. The NHS 10-year plan also identifies this as a need for families and friends post suicide This review therefore adds recommendations related to that issue.

10. RECOMMENDATIONS

10.1. The findings identified above have been included in learning points throughout this report and lead to recommendations for sharing learning and improvement. There are recommendations for both the commissioning board and Area B Board where much of Sasha's care was delivered.

10.2. Several of the agencies involved have recognised significant learning through other investigation processes and from compiling reports for this review. Where agencies have made their own recommendations in their Agency Review Reports, the relevant Safeguarding Adults Boards should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

1. HSAB should receive assurance from the Transforming Transition Panel that in work being currently undertaken, that CAMHS to AMHS transition takes account of recommendations in HSIB report, the NHS 10-year plan and the learning referred to in this SAR. **Learning Points 1 & 2**

2. The Safeguarding Boards should receive an update report of current commissioning arrangements regarding ASD diagnoses and services. **Learning Point 3 & 4**

3. The Safeguarding Boards should send out a briefing note to all relevant agencies that guidance/protocols for care planning and multi-agency forum approaches identified this SAR i.e. those for frequent and/or high intensity users should include:

a. Prompt changes when diagnoses change. There is a need to ensure up to date care is offered and that planning takes account of changes. **(Learning Point 5)**

b. Clarity of ownership, review dates, plans are outcome focussed, are shared widely and are easy to follow in urgent and crisis situations. **(Learning Point 10)**

c. Access to supervision in recognising possibly unmanageable risk. (**Learning Point 13)**

d. Sharing of single agency plans where relevant. **(Learning Point 11)**

e. CPA, where in place, should feed into such processes and have multi agency input. **(Learning Point 12)**

4. The Safeguarding Boards should seek an update from relevant agencies, regarding responses to Coroner's report to prevent future deaths as assurance regarding application of Mental Health Act Section 17 leave. **(Learning Point 6)**

5. Safeguarding procedures should include:

a. Support/advice should be sought from organisational safeguarding leads, where appropriate, for multi-agency meetings where complex cases are taken and there is risk of serious harm when formal safeguarding enquiries (S42) are not required. **(Learning Point 12, 13, 14)**

b. Guidance to support staff to respond where there is not a shared understanding of the support plan/risk management plan.

6. Organisations should assure the SAB that staff have sufficient understanding of:

a. Assessing mental capacity in self harm and suicide, to include advice on advance decisions, impact of an ASD diagnosis, interface with Mental Health Act and seeking advice and support including legal advice. **(Learning Point 6, 13)**

b. Resolution for difficulties with family and carers. **(Learning Point 15)**

c. All learning points from this SAR. **(All Learning Points)**

7. HSAB, in its review of the 4LSAB Self Neglect Guidance, must consider the findings from this review. Area B Safeguarding Adults Board should also consider any update required

to their Self Neglect Policy/Guidance. **(Learning Point 14)**

8. The Safeguarding Boards should undertake periodic multi agency audit focussing on issues identified in this SAR in order to assess progress against these recommendations. **(All Learning Points)**

9. The Safeguarding Boards should write to commissioners to seek assurance that the current suicide prevention strategy takes account of the NHS 10-year plan and new NICE Guidance. This must include reference to supporting families and friends post suicide. **(Out of Scope Learning)**

Appendix One Terms of Reference (REDACTED)

Safeguarding Adults Review relating to Sasha
Terms of Reference and Scope

Safeguarding Adults Review relating to Sasha
Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):
A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

Condition 1 is met if—
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.
The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".
All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and HSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

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 was supported CAMHS. On the evening of her death, Sasha was found in a serious condition at a lake within a nature reserve close to where she lived. She died shortly afterwards in hospital from a suspected overdose of beta blockers.

An inquest into Sasha's death is scheduled to take place in April 2019 under the Winchester Coroner. It is listed for 3 weeks and the Coroner has agreed an Article 2 hearing i.e. they consider that there is some evidence that one or more public bodies involved with her may

have breached her right to life under the Human Rights Act. As such this will be a jury inquest.

3. Decision to hold a Safeguarding Adults Review

Sasha's case was referred to the Hampshire Safeguarding Adults Board for consideration for a SAR on 3rd October 2018 and at a meeting held on 20th November 2018 it was decided that the circumstances of the case meet the statutory criteria for conducting a SAR. A recommendation was made to the Independent Chair who endorsed this decision.

Sasha was largely known to services in on area but her ordinary residence was in another county close to the border. It is therefore Hampshire Board that is undertaking this SAR with the other Board and services supporting.

4. Scope

The review will cover the period from December 2016 being the period where risk was escalating and was the lead up period to the incident. It is believed that most learning can be gained and in-depth analysis of contemporary multi-agency working can be understood. However, gathering relevant background information will form part of the process to inform more recent episodes of care. There will also be a focus on transition from child to adult services.

- **Method**

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

HSAB has chosen to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a Reflective Workshop to review all of the material and identify key themes and learning. Learning and Reflection will continue with panel meetings and consultation with the practitioner group.

- **Key Lines of Enquiry to be addressed**

6.1. Transition

Please identify the transition pathways that Sasha experienced within your agency. Please highlight any best practice and difficulties. Critically discuss this against current guidance and transitions pathways in your agency.

6.2. Responding to Crisis

How did your agency engage in responding to crisis points that Sasha experienced? Analyse effectiveness of responses and suggest learning from this.

6.3. Family Involvement

How did your agency engage with Sasha's parents? How were they included in plans and assessments? What did you understand of the relationship between Sasha and her parents? Were there any issues of consent and confidentiality?

6.4. Mental Health Act, Mental Capacity Act and Human Rights

Critically analyse how the balance between use of these Acts were demonstrated within your agency. How did this support risk management? Was there any evidence of professional challenge? How effective these Acts in keeping Sasha safe?

6.5. Safeguarding and Risk Management

How were risk management and safeguarding processes applied? Provide evidence and critically discuss this against expected risk management processes.

6.6. Multi Agency Working

What did your agency understand of the other agencies involved? What evidence is there regarding multi agency coordination and sharing of risks, assessments and plans? Critically discuss this in terms of what would be expected for multi-agency working in a case of this complexity.

6.7. Cross Border working

Please identify any issues raised by the border proximity in this case. How well was information shared across border systems e.g. Health, Adult Social Care, Police, Ambulance, etc.

6.8. Good Practice

Please identify examples of good practice from your agency and others.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this SAR is **Karen Rees.**

8. Organisations to be involved with the review:

- Area A County Council Adults Health and Care and MASH
- Area A County Council Children's Services Department

- Area A CAMHS
- Area A Health Foundation Trust
- The Private Mental Health Unit
- Area B NHS Foundation Trust
- Area B Hospital NHS Trust
- Area B Partnership NHS Foundation Trust
- CCG for the GP Practice
- Ambulance Service 1
- Ambulance Service 2
- Area B County Council Adults Health and Care and MASH
- Area A Constabulary
- Area B Constabulary

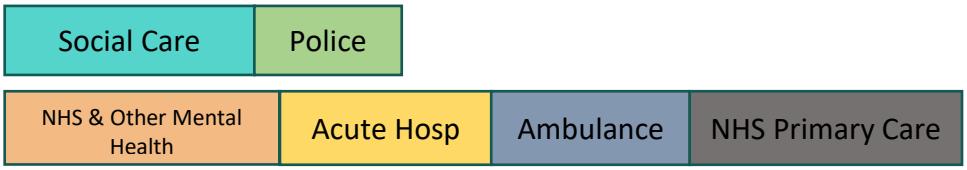
Additionally

- Out of Hours GP Service (became apparent later in process)

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The parents of Sasha have indicated a desire to be involved. The author and the Board Manager will meet with them prior to the practitioners meeting.

Appendix Two: Service provision to Sasha



Agency	Commissioned to provide
Area A Adults Health and Care and MASH	Services to Area A Residents
Area B Adult Social Care team MASH & Area B HSW Team	Safeguarding and Hospital Social Work Services in Area B
Area B Police	Police Service with jurisdiction for the County of Area B & when person goes missing in Area B
Area A Police	Police Service with jurisdiction for the County of Area A-& when person goes missing in Area A
Area C Police	Police Service with jurisdiction for the County of Area C-& when person goes missing in Area C.
Area B Partnership NHS Foundation Trust	Adult Mental Health teams: Covers area of residence plus mental health liaison for hospitals in Area B but different teams.
Area B Partnership NHS Foundation Trust **HISTRORIC**	Provides CAMHS in Area A
Area C Partnership NHS Foundation Trust	Sec 136 and Street Triage for Area C including Psych liaison in A and E in Area C Hospital
Mental Health Adolescent Unit **HISTORIC**	Area A NHS Foundation Trust agreed provider of inpatient services at Mental Health Adolescent Unit In Area A
The Private Mental Health Unit in Area C **HISTORIC**	Commissioned by specialist NHS commissioning Based in Area C
Area B Acute Hospital 1	Local hospital to area of residence but in Area B
Area B Acute Hospital 2	Local hospital to area of residence but in Area B

Area C Acute Hospital	Area C Hospital
Ambulance Service 1	Service offered based on residence. Ambulance Service1 has the contract for dealing with 111 calls in the area of residence
Ambulance Service 2	999 Service to residents in area of residence
GP Out of Hours Service	Out of Hours GP service for area of residence
Area A Medical Centre	Chosen practice by family