Trafford Safeguarding Adults Board

Safeguarding Adult Review

Executive Summary

for

'Chloe'

Introduction

The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. Trafford's Safeguarding Adults Board (TSAB) commissioned an independent author to carry out this review. The author of this review has experience in both children's and adult services, spanning more than 40 years. She has authored Serious Case Reviews, Safeguarding Adult Reviews and Local Child Safeguarding Practice Reviews and Domestic Homicide Reviews and is completely independent of TSAB and its partner agencies.

The purpose of SARs is '[to] promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'.[1]

This review considered the circumstances of 'Chloe'. Chloe was a young white British woman who died from suicide whilst in temporary hotel accommodation, in 2024.

Chloe

As a child, Chloe experienced mental health problems and suffered a number of traumatic life experiences in adolescence and young adulthood and had started drinking at an early age.

Her mental health deteriorated following the birth of her own child in 2019. Later she experienced a terrifying ordeal where she was kidnapped and raped and never recovered from the trauma.

The period for the review covers two years leading up to Chloe's death. Two significant events prior to this period were also considered as it was felt these had a major impact on Chloe's relationships and decision making throughout the rest of her life.

Chloe's life and the circumstances of her death highlight several key themes which are explored in the learning points below.

[1] Department of Health, (2016) Care and Support Statutory Guidance Issued under the Care Act 2014

The review specifically wanted to consider the following:

1. The extent to which professionals showed appropriate professional curiosity and the degree to which agency responses were informed by Chloe's history and responded to on a trauma informed basis.
2. How well did agencies share information and adopt a coordinated response as part of cross border working to ensure continuity of care for Chloe in respect of her mental health?
3. The quality of support given to Chloe during the criminal investigation, trial and subsequent plans for a retrial.
4. The process followed re allegations Chloe made when an inpatient and whether safeguarding policies and procedures were followed.
5. The management of Chloe's mental health care needs when an inpatient and the extent to which Chloe's discharge from hospital was supported by an appropriate care plan reflecting the complexity of her needs.
6. The coordination of the care experienced by Chloe during the transfer of support between community based mental health support teams and how this impacted on the care provided.
7. Understanding the impact of delays in support being offered by Adult Social Care (ASC) due to Chloe having multiple records under different names and whether this effected the quality of response.

Summary of Learning Points

Professional Curiosity and Trauma Informed Approach

Frequent presentation in crisis resulted in the response to Chloe's needs focussing on reducing risk and managing her presenting behaviour and symptoms. There was no evidence or a recognition of a need for a trauma recovery plan. The degree of professional curiosity varied, and the difficulty in joining up medical records is acknowledged as a national issue, but there is no record of professionals seeking to access Chloe's prior records to help inform treatment or risk management plans.

It maybe that Chloe's frequent moves contributed to disruptions in clinical oversight and mitigated against the development of therapeutic approaches but only Achieve, the alcohol recovery service for Trafford, record taking action to begin to address her therapeutic needs.

The records provided to the review suggest that services need to adopt a more holistic approach and reduce silo working. They do not appear to be sufficiently alert to the impact of trauma and not sufficiently informed by the considerable body of research about the impact of adverse childhood experiences and trauma, or the beneficial outcomes achieved by developing a trauma-based approach.

Cross Boarder Working

The one real opportunity to bring all Chloe's health and social history together and combine this with a person-centred approach that had Chloe at the heart of the future plans, was during her inpatient stay in the psychiatric unit. However, Chloe's previous history was not requested.

There are procedures in place across Greater Manchester, including Trafford, for the convening of Multi-agency Risk Management Meetings (MARM) to plan and coordinate services for adults experiencing multiple, complex risks who are involved with several agencies.

This was a missed opportunity to collate previous and current information as part of a comprehensive multi-agency risk assessment and develop a coordinated, multi-agency plan designed to support Chloe following hospital discharge. This could have brought together the accumulation of risks associated with her support needs in preparation for the new criminal proceedings where she was to be a key witness; consider her accommodation and homelessness issues and her readiness for discharge. The MARM and the subsequent plan would have provided the basis for the hospital to have an open and honest conversation with Chloe about their concerns and the potential risks of being discharged from hospital too soon and helped to assess her understanding and ability to weigh up the risks.

Support for victims during criminal investigations and trials

The support for Chloe during the initial investigation of kidnap and attempted rape reflected good practice and enabled her to participate effectively in the trial.

However, in relation to the appeal and possible retrial, up to date information about Chloe's well-being was not sought before contact was made. The police investigation team were therefore not aware of her recent mental health crisis, ongoing vulnerability or risk of self-harm. The geographical distance between Chloe and the investigating police team meant communication was via phone and their lack of contact with the local police force meant the Officer in Charge was unaware of other investigations that were ongoing with GMP.

Within GMP the National Guidance for vulnerable victims is in use across the force. However, TSAB partners identified learning at a national level regarding the need for more consistent use of the Police National Database (PND), enabling its routine use within witness enquiries to identify whether individuals are involved in investigations in other force areas. If this had been completed for Chloe, this would have alerted both forces to the involvement of the other.

Allegation Management

The management of risk and the conduct of investigations whilst a hospital inpatient was not in line with expected practice. Chloe raised concerns about staff with the hospital and police. The police did attend but found nothing to pursue. Chloe then raised her concerns with the Care Quality Commission with some support from an advocate, but it does not appear that hospital staff appropriately involved internal safeguarding leads to explore the safeguarding concerns. The review was informed that hospital safeguarding policies and procedures have been significantly reviewed and updated over recent months but safeguarding policies and procedures in place at the time were either not followed or were delayed.

In relation to allegations made against staff, the hospital did conduct and internal investigation. However, there is no record of any response to the allegation from the local authority Person in a Position of Trust (PIPOT) service. The current PIPOT arrangements have now been changed to ensure that effective systems for recording, monitoring and responding to PIPOT notifications are now in place.

Safeguarding Response

Whilst she was an inpatient in hospital, several safeguarding concerns relating to Chloe were raised but not immediately actioned by the Safeguarding Hub.

Chloe was perceived by the safeguarding hub to be in a safe place in hospital, despite some of the concerns relating to her time on the ward, and her case was not prioritised. A decision was made to delay the safeguarding response pending discharge. However, the ward did not notify the safeguarding hub before Chloe was discharged to temporary accommodation.

One of the safeguarding concerns raised whilst she was in hospital related to her relationships. The review found that it was possible to keep Chloe safe whilst her movements were constrained by being on a mental health Section, however this ceased to be the case once the Section was lifted and Chloe was free to spend time without supervision with B, about whom a safeguarding concern had been raised.

Hospital Discharges

At the time of the decision to return Chloe to the status of an informal patient, The Community Mental Health Team (CMHT) wanted to ensure she had some stability and proper engagement with community services before discharge. This had not been achieved when she left and the risks and behaviours that had led to her admission largely remained factors on discharge. In addition to this, information about the criminal conviction being quashed and the pending retrial for Chloe to give evidence at, had also been shared with the hospital but not factored into any risk assessment or discharge planning.

The discharge record from the hospital was an incomplete document but details the plan for her to be supported by the CMHT and the appropriate Home-Based Treatment Team (HBTT) in respect of her mental health needs, and by Achieve in respect of alcohol recovery. At the point of discharge, adult social care had four open Section 42 safeguarding referrals awaiting a decision as to how to respond. They had delayed their response, believing Chloe to be in hospital and therefore in a safe place. They were not aware of the plan for her discharge, so she left hospital with the four referrals still outstanding.

In essence the discharge care plan for Chloe was unrealistic and did not take account the multiplying effects of a range of complex risk factors and past trauma. It seems likely that only a more prolonged period of inpatient treatment, combined with abstinence from alcohol and the beginnings of trauma-informed counselling stood any chance of success.

Coordination of Care

On discharge there was confusion about where Chloe would live as she was homeless. The two Home Based Treatment Teams in Salford and Trafford worked well together and tried to coordinate their contact with Chloe to reduce multiple contacts until it was clear where she would be living. The assessment of Chloe's needs in the community was disrupted by her being intoxicated. There is no record that this led to any discussion about delaying discharge or whether further consideration needed to be given to detaining her in hospital if she was determined to leave.

A comprehensive multiagency risk management assessment and care planning meeting whilst Chloe was still an inpatient would have flagged these potential areas of concern, delaying discharge to a time where Chloe could access appropriate accommodation and continuity of care could be assured.

Appointments were in place for Chloe to be seen in the community within a reasonable timeframe but did not take account of the predictable likelihood of further serious self-harm or suicidal attempts.

Recommendations

Trafford's Safeguarding Adults Board (TSAB) should:

1	Consider providing multi-agency training in respect of professional curiosity and the importance of obtaining a full understanding of a person's history and prior involvement with agencies to inform risk assessments and developing therapeutic interventions.
2	Review the impact of the GM-wide initiative to develop trauma -based services and the extent to which Trafford's trauma training has been embedded in practice and supervision processes.
3	Adult Social Care should review the practice of delaying section 42 safeguarding enquiries in respect of inpatients. Cases should be allocated so a named worker could make links with the hospital and manage assessment of risk as circumstances changed.
4	Require the Mental Health Trust to clarify and strengthen its safeguarding leadership, ensuring they provide proactive oversight of safeguarding enquiries, coordinate multi-agency responses, and support staff in managing complex concerns.
5	Review and update its Multi-agency Safeguarding Adults' policies and procedures, and PIPOT policy to explicitly advise multi-agency strategy discussions or meetings when concerns involve multiple organisations, repeated allegations or potential staff-to-patient harm.

6	Seek assurance from the Mental Health Trust that appropriate processes for dispute resolution where key decisions regarding patient care are not agreed by appropriate partners.
7	Seek assurance that the Mental Health Trust have robust processes in place to plan, coordinate and oversee the discharge of adults with complex mental health, trauma and substance use needs. This should include ensuring that discharge decisions are informed by multi-agency risk assessment, that accommodation arrangements are stabilised wherever possible, and that care plans are realistic, coordinated and reflective of individual's history of issues such as dis-engagement and self-harm.
8	ASC to consider the routine recording of NHS numbers to improve the accuracy of recording and reduce the risk of multiple records.