SAR "Chloe"

Trafford Safeguarding Adults Board

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Safeguarding Adult Review

7 MINUTE BRIEFING

Under the Care Act 2014, TSAB commissioned an independent Safeguarding Adults Review (SAR) following the death of Chloe, a young woman who died by suicide in temporary accommodation in 2024.

The review, led by an experienced and independent safeguarding reviewer, aimed to identify learning and improvements to help prevent similar tragedies & strengthen multi-agency safeguarding practice.

Chloe:

As a child, she experienced mental health problems and suffered several traumatic life experiences in adolescence & 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. However, 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.

For more information, please visit:
Trafford Safeguarding Adults Board

Key Learning Themes:

- **Professional Curiosity and Trauma-Informed Practice:** Services focused on managing immediate risks and behaviours rather than addressing underlying trauma, with limited information-sharing, continuity of care, and use of trauma-informed approaches.
- **Cross-Border Working:** Opportunities to coordinate information, assess cumulative risks, and develop a person-centred multi-agency plan through existing MARM processes were missed.
- **Support for Victims in Criminal Proceedings**: Effective support was provided during the initial investigation, but later communication and information-sharing between police forces were insufficient, leaving vulnerabilities and risks unidentified.
- **Allegation Management**: Safeguarding concerns raised about hospital staff were not managed in line with expected standards, highlighting shortcomings in safeguarding responses and PIPOT processes.
- **Safeguarding Response**: Safeguarding concerns were not acted upon promptly, with assumptions about Chloe's safety in hospital contributing to delays and increased vulnerability following discharge.
- **Hospital Discharge Planning**: Chloe was discharged with significant unresolved risks, incomplete safeguarding actions, and a plan that did not adequately consider her trauma history, vulnerability, or complex needs.
- **Coordination of Care**: Uncertainty around accommodation, fragmented care planning, and insufficient multi-agency risk assessment weakened post-discharge support and failed to adequately account for the likelihood of self-harm or suicidal behaviour.

Recommendations:

1	Provide 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	ASC to 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	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.
8	ASC to consider the routine recording of NHS numbers to improve the accuracy of recording and reduce the risk of multiple records.