Safeguarding Adult Review:

Adult M — Learning brief

This briefing sheet has been prepared by a local safeguarding board to share the learning from the Adult M SAR to support professional practice and development. As such it contains key messages and lessons learnt to enable you and your team to reflect on how practice/systems can be strengthened to promote better outcomes for adults at risk. Full details of the report and all the recommendations can be found here.

Introduction and Background

Prior to her death Adult M took a very large number of prescribed drugs, probably with the intent of taking her own life. Despite being admitted to hospital and stating she did not want to die, she sadly passed away the next day due to multiple organ failure. The review noted that M had taken overdoses on four other occasions and attempted to end her own life on five others. The review noted that M was nine years old when her father had died by suicide and similarly experienced the loss of two other close relatives due to suicide. As a child M had substantial involvement with Children's Social Care Services and was known to have problems relating to her peers and her family. At age 11, M reported she had been sexually assaulted and over time went on to make further allegations of other sexual assaults. At age 13, M had begun to self-harm and first reported hearing voices. The following year M was detained by police under s136 of the Mental Health Act (1983) and by the time of her death was detained on six further occasions. From age 16, M also began to report physical health complaints (including seizures and a heart problem) that required medical/ hospital treatment. In the coming years M experienced at least nine further changes of placement/address that took the total number of changes of address in her life to 35. She also had COVID-19 and was reported to have symptoms of long Covid.

Report findings

M's presenting problems as an adult could really only be recognised by a thorough understanding of her childhood. Whilst her experiences of loss appeared to be a catalyst for her increasing vulnerability, the early childhood adversity she experienced within her life resulted in her being a child whose well-being was not assured. The accumulation of traumatic and disturbing events were increasingly harmful and led to M having diminished coping skills. M's history is littered with periods of calm that were then followed by crisis. As a teenager M would frequently run away, particularly when the relationship with her mother broke down. During such periods, M would regularly self-harm and exhibited self-destructive behaviours. Her increasing vulnerability saw her become susceptible to exploitation and it is likely she was trafficked. As a result of M going missing and harmful behaviours she was frequently in contact with emergency services. While safeguarding services had responded to the perceived inter-familial risks in M's life, the accumulative impact of her past separation, loss and lack of a secure base were not fully appreciated. In addition the review noted the lack of appropriate services available locally and the resulting impact of this on M.

Once M had turned 18, the agencies involved with her no longer had the legal and policy framework to construct a whole picture of what was happening to her. While M was nearly always judged to have the capacity to make decisions for herself (even though some of the decisions she took were unwise), such judgements did not always appear to appreciate the impact that a history of complex trauma can have on a person's executive functioning. This can result in such assessments lacking an understanding of a person's ability to turn a decision into an action and that trauma can impede working memory, mental flexibility and self-control. As a result people exposed to trauma may have the mental capacity to predict what will happen following a decision, but are less likely to act to prevent it from happening.

Recommendations

1. The Safeguarding Board is recommended to improve its policy and practice in relation to managing the risk of harm and safeguarding of young people who are transitioning into adulthood. This improvement work should strive to create a more integrated system of inter-agency effort to support young adults at risk of harm.

What can I do?

- Practitioners working with children should be thinking ahead for when the young person becomes an adult at 18 years. The law and policy framework for safeguarding /supporting adults is very different from that available for promoting the welfare of children.
- Try to anticipate what it will be like for an 18-year-old transitioning from children's services and help them to prepare for that eventuality.
- Practitioners working with adults should try to understand the person's entire lived experience since birth, especially traumatic events and how these affect the person's identity and capacity to make decisions.

2. The Children's Social Care service is invited to develop foster placements which can provide a comprehensive and tenacious service to children and young people who have experienced complex trauma.

What can I do?

Some foster parents can be prepared to look after children who present a range of challenges because of early life traumas. However, they will also need on going multi-agency support to help them to see the child behind the behaviour and to react accordingly. There are a wide range of resources to familiarise yourself with trauma and its implications How research can help foster carers - UK Trauma Council and Mentalization-Based Treatment (MBT) for Fostering & Adoption (annafreud.org)

4. The Safeguarding Board is invited to establish a task and finish group to develop alternative practice approaches to adults at risk of harm where there are concerns about the adult's ability to make decisions when they have experienced complex trauma.

What can I do?

Ensure you have familiarity with the relevant case law on mental capacity and a range of resources, for example: Executive dysfunction and the MCA | National Mental Capacity webinar (scie.org.uk) and Mental Capacity Resource Centre | 39 Essex Chambers

3. The procedures for the Approaching Adult Panel should be strengthened so that the needs of young people with complex trauma histories can be prioritised and given greater consideration.

What can I do?

Practitioners preparing reports (see recommendation 1) for the Approaching Adult Panel should include relevant details of past traumas and the impact these have had/are having/may have on the young person in question.

Further learning:

You can read more Safeguarding Adult Reviews and their learning briefs by visiting the following websites:

Slough Safeguarding Partnership

Bracknell Forest Safeguarding Board

Royal Brough of Windsor & Maidenhead Safeguarding Partnership