Southampton Safeguarding Adult Board
Safeguarding Adult Review

Safeguarding Adult Review

OLIVIA

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1. Introduction

1.1 This Safeguarding Adult Review (SAR) considers the tragic circumstances of Olivia, a young woman who sadly died, in June 2021, after jumping from her 10th floor flat. Southampton Safeguarding Adult Board recommended that this case met the criteria for a Statutory Safeguarding Adult Review and identified that there was learning relating to how agencies worked together.

1.2 There is much to learn from Olivia 's life and this review has tried to look at future learning from an understanding of Olivia's experience. It has been clear during this review that there were many people in different agencies who cared for Olivia and were concerned for her well-being. There is evidence of agencies working together to find alternative accommodation for Olivia and reduce the risk of suicide. Some of the learning in this review is focussed on strengthening process to ensure a clearer understanding of thresholds for statutory adult safeguarding process. Key learning is focussed on:

- The need to have a multi-agency trauma informed response to support parents with complex needs when a child is removed from their parents' care.
- A greater awareness of the impact of a diagnosis of Emotionally Unstable Personality Disorder (EUPD) on people's lives
- Building a foundation for a trauma informed workforce should be an aspiration for all of us

2. Context of Safeguarding Adults Reviews

2.1 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. Southampton Safeguarding Adults Board (SSAB) commissioned an independent author, for the review. The author is independent of SSAB and its partner agencies.

3. Methodology

3.1 'What builds a relationship, what solves problems, what moves things forwards is asking the right questions' (Schein, 2013: 4)

3.2 This SAR was carried out using an appreciative inquiry approach. Information and learning were drawn from a combination of narrative reports and chronologies from each agency with a learning event of practitioners who had worked closely with Olivia. The primary purpose is to

learn lessons and to use the learning to drive and sustain change. We must also be aware of understanding hindsight bias. This tends to blame professionals closest in time to the incident. Appreciative Inquiry does not apportion blame; rather it seeks to understand what has happened within a framework that is participative, collaborative, embraces professional curiosity and challenge, and focuses on what works well and what is valued.

3.3 "*What hindsight does is it blinds us to the uncertainty with which we live. That is, we always exaggerate how much certainty there is. Because after the fact, everything is explained. Everything is obvious. And the presence of hindsight in a way mitigates against the careful design of decision making under conditions of uncertainty."— Daniel Kahneman*

4. Terms of Reference (Appendix 1) and methodology

Key Lines of Enquiry (KLOE) are as follows:

- Evidence of collaboration between partner agencies including evidence of shared decision making around risks identified and that robust risk assessments were in place for agencies involved in the care and support of Olivia.
- Agency referrals were timely and appropriate.
- Evidence of agencies involved in the care and support of Olivia seeking expert safeguarding advice/support in the light of any risks identified.
- Use and impact of the Multi Agency Risk Management Framework, Care Programme Approach and High Intensity User Group, including engagement by services.
- The impact of Olivia's child being placed with family members, and this being reflected in work with Olivia.
- Evidence of a family approach being taken given the suggestion contact time between Olivia and her child was not satisfactory and that Olivia had been living for a time with her child and the family members caring for the child.
- Agencies holistic understanding of Olivia given the considerable history of service involvement and how this was demonstrated in the provision of support and services.
- Effectiveness of service engagement at critical moments, including the closure to Children's Social Care following the birth of Olivia's child.
- Impact of the allegations of sexual harm on multi agency practice
- If Olivia had a formal diagnosis of Emotionally Unstable Personality Disorder (EUPD) was the care and support provided in line with the EUPD pathway?

- Multi agency communication and sharing of information regarding Olivia's housing situation and associated risk factors.

5. Family Involvement

5.1 Olivia's mother was contacted as part of the review and the author is grateful for her valuable insight into how Olivia responded to the distress in her life and her thoughts on how services could be improved.

6. Summary and Reflection on Olivia's life

6.1 Olivia's mother described her as very quiet and private. She had been 'picked on' at school. She usually had her hair style in a French plait and was always seen wearing a 'hoody' and tracksuit. She had grown up surrounded by children and enjoyed being a live-in nanny.

6.2 As a child Olivia experienced domestic abuse and spoke of protecting her mother from her biological father. Olivia experienced difficult relationships in her early teenage years and had self-harmed with cutting behaviours as a way of dealing with distressing emotions.

6.3 Olivia shared that she had been the victim of a sexual assault at the age of 16 years but did not wish to disclose any information. She felt that she was seen as the 'difficult one' in her family. Her mother describes how Olivia and her cousin moved to stay with maternal grandma who died suddenly when Olivia was 18 years old. It was observed that Olivia did not cry openly. Olivia had a history of mental health problems with several diagnoses, anxiety, and depression. She was first referred to mental health services at the age of 19 years and spoke about thoughts to end her life.

6.4 In 2018 Olivia was pregnant and disclosed that she had been raped. Olivia had experienced homelessness and living in temporary accommodation such as the YMCA during pregnancy, and later after her daughter was removed from her care. Very soon after her daughter's birth, concerns emerged from professionals about parenting and attachment. As a result, Olivia and her baby were admitted to a Mother and Baby Unit. She was diagnosed with Emotionally Unstable Personality Disorder (EUPD) in November 2018, a few months after her daughter's birth. It was whilst staying here that there was a concern that Olivia had tried to drown her baby. This meant that her daughter was placed in the care of grandparents. The first few months were a difficult time for Olivia, and she was admitted to a psychiatric unit. Legal arrangements progressed quickly, and Olivia's parents gained a Special Guardianship Order for permanency.

6.5 This was followed by a time of instability in housing for Olivia until she was rehoused in late 2019 on the 10th floor of a tower block. Olivia 's life was characterised by trauma. Pregnant through rape and having a child removed soon after birth, plus she was constantly tormented by the thought that she had tried to drown her baby. Olivia spoke often to her support workers and psychologist about the fact that she was pregnant after she was raped, and practitioners spoke of how she struggled to deal with the range of emotions towards her daughter. She had some contact with her daughter, supervised by her mother. Although her support network seemed limited, she had contact with her mother and aunt, and occasionally met with her cousin and her children who lived in the same block of flats. She also had some contact with her sister. Olivia's mother describes how Olivia found it hard to be on her own. This was especially difficult during COVID as Olivia was not part of her parents' 'bubble'. This was because Olivia had wished to remain in contact with others in her network.

6.6 Olivia had been concerned about living on the 10th floor of a tower block and had requested a move to a lower floor and had been bidding for properties. There had been previous reports of threatening to jump out of her flat window. Over a three-year period from 2018-2021 there were numerous instances of self-harm such as cutting, overdose and ligature – then once in the tower block, wanting to jump off her 10th floor window ledge. She had been seen on her window ledge by neighbours, who had called the emergency services.

6.7 She heard voices and in the few months before she died these became more intense and she saw cartoon animals following her everywhere. She found all this increasingly distressing and was scared, asking to be sectioned. Her mother describes a significant point in April 2021 when Olivia (who had hair to the bottom of her back) not only cut her hair but shaved it. She had believed that her hair was falling out, although this was not her mother's perception. This was perhaps another indicator of a change in her mental health.

6.8 Different services and agencies worked with Olivia such as the Southampton General hospital (SGH) High Intensity User Group, Mental Health teams, GP and Housing departments. The Multiagency Risk Management (MARM) framework was used to agree an action plan to support Olivia on a couple of occasions. Olivia had been receiving Mental Health Services from the Community Mental Health Team (CMHT), SharedCare, a Care Coordinator and the Psychiatric Liaison Service. Olivia had two admissions to the acute mental health hospital and was detained

under Section 2 of the Mental Health Act 1983 for the second admission. The admissions were three months apart.

6.9 Although different people had pieces of information relating to Olivia's life, some common experiences were known and had been shared by Olivia. They are listed in the table below to illustrate the depth of trauma experienced by Olivia in her life.

- Disclosure of childhood sexual abuse
- Family dynamics – felt that she was seen as the 'difficult one'
- Rape leading to pregnancy and birth of her little girl
- Removal of a child and living with the additional trauma of whether she had tried to drown her daughter.
- The impact of not being able to see her daughter during COVID
- Temporary housing /moves into specialist unit and hostels
- Self-harm and suicide attempts
- Hearing voices and seeing cartoon animals

7. Findings and Learning

Impact of removal of a child -'*one more adversity to overcome'*(*Comment by a Practitioner***)**

7.1 There is evidence that Olivia had experienced mental health issues prior to pregnancy (including two overdoses in 2017, and difficult experiences in childhood. There was an exacerbation of serious distress and anxiety during pregnancy and then after her daughter was born. As stated earlier, this period also saw the diagnosis of Emotionally Unstable Personality Disorder (EUPD). Olivia subsequently disclosed during her pregnancy that her baby was as a result of a rape and expressed intense feelings of ambivalence towards her daughter. She disclosed childhood sexual abuse but did not wish to give further details.

7.2 Olivia expressed concern early in her pregnancy to midwives that she would not be able to cope, and a safeguarding referral was subsequently made to MASH. For reasons that are unclear, children's services closed the case prior to the baby's birth.

7.3 As previously stated, Olivia's baby was removed from her care following an alleged attempt to drown the baby whilst in a Mother and Baby Unit. This had many consequences including changes in housing status and impacted further on her mental health. The impact of removal of a child

cannot be underestimated and this has been aptly described in research [1] by Broadhurst and Mason who describe the '*collateral damage* 'of child removal evident for women who experienced an escalation and exacerbation of problems following the removal of a child.

> **'**It is imperative that we provide a safety net for women in the *immediate aftermath* of child removal because crisis can lead to further difficulties with profound longer-term consequences.[1]

7.4 A review of Olivia's attendances at ED by the High Intensity User Service (HIUG) indicates a significant increase in presentations following her daughter's removal, with overdoses, self-harm, and later when rehoused in a tower block, wanting to jump from the window of her 10th floor flat.

7.5 For Olivia, removal of her child meant the need for a plan from children's services to adult services to ensure that mental health services were aware of contact plans, and the potential impact on her mental health. Child removal compounds the multiple complex risks and impact of trauma already faced by young women such as Olivia. A key consideration of initial care planning by Children's Services for Olivia was ensuring that she was able to maintain her relationship with her daughter. By this time, following her child's removal into the care of grandparents, Olivia was in a psychiatric unit. This of course impacted on planning and delayed contact arrangements. Prior to discharge, there was a care review which was attended by children's' service practitioners to ensure a full discussion of Olivia's circumstances. There was, then, an attempt by children's services to share plans and information with adult mental health colleagues and care coordinators, and this is a strength. Yet, there is no formal guidance or process (locally or nationally) which would 'compel' a multiagency response to build in support for parents following removal of their child.

7.5 We often speak of 'transition' points for children from children's services to adult services but there is no coordinated response for parents such as Olivia. The National Pause[2] project highlighted this gap in their response to the Care Review [3], and recommended that there should always be a time to learn lessons from a child being removed and *must include* '*post removal trauma informed support'* for parents. Southampton is one of many areas that now has a Pause.[4]

[1] Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal Karen Broadhurst and Claire Mason

[2] Pause works with women who have experienced, or are at risk of, repeat removals of children from their care.

[3] independent-review.uk/2022/05

[4] Pause creating a safe space for change

project. The Southampton Pause team have suggested a local response to mirror the above national recommendation. This resonates with the findings of this SAR.

7.7 Pause in Southampton was not fully operational until September 2020. The Southampton Pause programme works with 24 women every 18 months but does have a waiting list. Pause prefers to work with a woman after a final court hearing. Working with Pause is about focussing on themselves and beginning to rebuild their lives without their children. Being part of the Pause programme will not result in their children being returned, and it is not an assessment or parenting programme.

7.8 It has not been possible to verify if Pause was ever considered as a potential programme for Olivia. An SGO was agreed in June 2019 and the case was closed by children's services. Therefore, there was an opportunity to at least nominate Olivia if she agreed. We know that 2020 was difficult for Olivia with increasing signs of distress as she was unable to see her daughter as regularly during COVID. The Pause programme may or may not have been appropriate for Olivia. However, there is learning to take forward to ensure that adult services consider the full range of opportunities to support women.

7.9 In June 2020, Olivia stayed at her parents, and there is no record of this other than a concern raised by emergency department (ED) staff about the potential adverse impact on both Olivia and her daughter (who was now in the permanent care of Olivia's parents). At this point Olivia, the CMHT and Psychologists recognised the impact that seeing her daughter or not being able to see her daughter had on Olivia's well-being. This escalated when a full SGO was agreed, and Olivia no longer had parental responsibility.

7.10The compounding impact of removal was heightened as previously stated during COVID and on occasions Olivia could only see her daughter through a window. This was because Olivia's father was shielding. She lived with the additional trauma of whether she had tried to drown her daughter. These were moments of intense trauma in Olivia's life and would correlate with frequent calls to her care worker and attendance at the emergency department. (ED)

- **MARM vs Statutory Adult Safeguarding**

7.11 Multi-Agency Risk Management Framework (MARM) *designed to provide guidance on managing cases relating to adults where there is a high level of risk, but the circumstances may*

sit outside the statutory adult safeguarding framework but for which a multi-agency approach would be beneficial.[5]

7.12 Two MARM meetings were held in the months before Olivia's death. A third had been planned to take place to review progress. Each MARM was coordinated by the Community Mental Health Team. There is no discussion of the potential interface with adult safeguarding at either of the MARMs.

7.13 Southampton has a Section 75 agreement with areas of health and social care commissioning covered by the Better Care Fund (BCF) Section 75. Budgets are shared including some responsibilities across services. This applies to the way in which statutory adult safeguarding concerns are actioned. As there is a joint responsibility with the local authority, completion of section 42 enquiries are re redirected back to the community mental health teams in SHFT covering Southampton.

7.14 The rest of the mental health teams in SHFT[6] ,covering areas beyond Southampton, will therefore have different arrangements in place, as they are not part of A Section 75 agreement. The findings of this SAR point to potential confusion within teams in terms of statutory adult safeguarding procedures. In addition, there has been no evaluation or audit of improvements associated with Section 75.

7.15 There were 9 safeguarding concerns between 2018 and 2021 with no clear recorded outcome or actions. The final safeguarding concern was, as described above, redirected by the Adult Social Care Connect Service (ASC front door) without triage to the community mental health teams responsible at that time for Olivia's care. The outcome of the S42 is not recorded and the MARM process continued to be the preferred approach. The MARM is not a substitute for statutory adult safeguarding.

7.16 The level of risk associated with Olivia was considered extremely high and there was rightly a high level of concern amongst professionals. The escalating attendances at ED and frequent calls to mental health teams suggested that the level of risk of serious harm or death was becoming

[5] 4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020

[6] SHFT covers a large area including Portsmouth and Southeast Hampshire, Southwest Hampshire, Mid and North Hampshire and Southampton

unmanageable and no longer mitigated. This, as per the guidance in the MARM framework and section 75 arrangements, should have prompted a notification in accordance with the duty under section 42 of the Care Act 2014 to undertake a safeguarding enquiry. The inclusion of ED staff in the MARM process might have developed a greater appreciation of risk and contingency planning.

7.17 Olivia was assessed under the Mental Health Act by the Adult Social Care AMHP[7] service on 4 occasions -once in 2019, twice in 2020, and once in early 2021.

7.18 Since Olivia's death SHFT have worked with the Southampton City Council Adult Safeguarding Lead to develop and deliver training on safeguarding processes. This has included a standard operating procedure (SOP) to underpin and guide staff through the steps necessary to raise safeguarding concerns and enquiries. Part of the training has included chairing of MARM meeting.

- **Housing**

7.19 Southampton is a unitary authority, and they are responsible for all local services within the city and provide the full range of local government services including housing.

7.20 The pivotal role of housing is highlighted through Olivia's experience and more so after her daughter was removed from her care. The three-year period up to her death was characterised by instability and uncertainty. Living on a high floor in the tower block very quickly compounded the risk of suicide.

'Quite poignant to think that I have only been to one MARM, didn't always get minutes. (People)need chairing skills.
Housing Officer

7.21 It is notable that the housing departments were not involved or consulted at key points of discharge such as moves from the mother and baby unit and a subsequent hostel placement. Housing officers were part of discussions once Olivia requested a move from the tower block, stating in a letter, that she had been 'sectioned' twice for trying to jump out of her 10th floor flat. A move was agreed but this required Olivia to 'bid' on properties as part of the standard allocations process. The process was delayed initially because of rent arrears. It was clarified during this review that because of Olivia's level of risk, rent arrears should not have impacted on decision making.

[7] AMHP -Approved Mental Health Professional

7.22 Olivia selected a few properties but for a few reasons these were not considered appropriate. Whilst waiting to be allocated a new property, plans were agreed to secure windows in the flat to act as a deterrent, although this does not seem to have been straightforward.

7.23 The Allocations Policy (the same as during Olivia's bids for rehousing) enables service managers to use discretion to move someone and have a direct let rather than having to bid. This discretion was not applied in Olivia's case. A review of the policy is now underway to ensure that it is clear what is available for someone with support and housing needs who is at high risk of suicide or harm. Further amendments are being added to include the possibility of a direct let to those who are at risk and unable to bid for accommodation. The service is reviewing practice and process to ensure monitoring of cases where people are assessed as having an urgent need for alternative accommodation.

- **Capacity**

7.24 Understanding and use of the Mental Capacity Act 2005 in assessing Olivia's' decision making capacity was inconsistent. There is some evidence that this might on occasions have been influenced by the diagnosis of EUPD. Assessing decision-making capacity in a person with Borderline Personality Disorder (BPD or EUPD following an act of self-harm is particularly challenging.

7.25 It has been argued[8] that at the extremes of emotional dysregulation, people with a diagnosis of EUPD or BPD may become unable to view things objectively. Therefore, as the MARM Framework points out *assessment of the person's mental capacity should include their executive function as well as their ability to understand e.g., can they manage in practice any risks and safety implications of the choice or decision being made[9].*

7.26 A serious incident investigation undertaken by Southern Health NHS Foundation Trust (SHFT) following Olivia's death, found that Olivia's capacity to make decisions regarding her treatment' *remained static throughout the review period and there was no evidence to demonstrate that there were any fluctuations in her capacity*.' This means that Olivia was assessed as having mental capacity throughout this period. The only exception referred to was when Olivia was admitted under Section 2 of the Mental Health Act.

[8] Fuchs, T. (2007). Fragmented Selves: temporality and identity in borderline personality disorder. Psychopathology.40:379-3874LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020.pdf

7.27 An assessment of ED attendance and outcomes by the reviewer suggests that there was not a clear or consistent understanding of mental capacity, or an understanding of what it means to act in a persons' Best Interest[10]'. Conversely, a decision that the person lacks capacity does not mean that the professional/clinician should impose their view of the right care or treatment. *'Even patients who lack capacity are entitled to have their views and perspectives given due weight.[11]'*

- **Emotionally Unstable Personality Disorder (EUPD)/Borderline Personality Disorder (BPD)**

7.28 SHFT has an existing care pathway[12] to support people with a diagnosis of BPD/EUPD. This is built on a set of trauma informed principles. The pathway was based on key documents[13] [14] and led to an initial delivery of training packages to enable staff to understand and work more compassionately with this group of people. This includes an understanding of the guiding principle of the Mental Health Act Code of Practice (1983) which states that the most appropriate clinician should be responsible for the needs of the patient. It is not clear if this approach was discussed as part of planning.

7.29 The primary treatment for people with EUPD is psychological and therefore a clinical psychologist with expertise in working with people with EUPD might be the most appropriate clinician to lead their care and treatment. Olivia received support from a clinical psychologist for over a year and had requested a fresh referral just before her death. A multi-professional Approved Clinician (AC) role would add quality of care provision to the management of patients with more complex psychological needs and who are less in need of medical management.

7.30 There are service variations across SHFT in terms of implementation of Transform. Southampton does not appear to be as developed as other teams. For example, other teams have an Occupational Therapist attached as part of reablement and Olivia would have received this offer. However, a review of the pathway in Southampton is taking place. This has revealed gaps in understanding and awareness. Findings of this review suggest that implementation of Transform

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[10] The Mental Capacity Act has a best interest checklist which outlines what health professionals need to consider before taking can action or decision if the person lacks capacity.

[11] youngPeopleWithBPD_GoodPracticeGuide_2019

[12] Treatment and Recovery from Borderline Personality Disorder Care Pathway, Narrative and Procedures 2016 Transform

[13] Personality Disorder: no longer a diagnosis of exclusion" (NIMHE, 2003a)

[14] Breaking the cycle of rejection: the personality disorder capabilities framework" (NIMHE, 2003b

needs revisiting, accompanied by training to minimise misunderstandings about EUPD. A one-minute guide is available via Portsmouth SAB which could usefully be part of training.

7.31 [15]It may be useful to remind people of the NICE guidance which states that people with EUPD should only be admitted briefly in a crisis but does not completely rule out admission to a psychiatric inpatient unit, EUPD NICE guidance (2015)[16]9 noted that the care that people with diagnoses of EUPD are given is often fragmented. The current narrative around standard 88 (NICE 2020)10 advises that '*Some mental health professionals may find working with people with borderline or antisocial personality disorder challenging. People with personality disorder can experience difficulties in communication, building trusting relationships and respecting boundaries. This can be stressful for staff and may sometimes result in negative attitudes*. NICE 2020[17]

7.32 The implementation of the EUPD clinical pathway has been met with some misunderstanding in a way that mirrors the experiences of the people with personality disorders. It is in part an organisational reaction to trauma. This has been described by Karen Treisman [18]

7.33 *Trauma can lead to people having to function in various survival modes … Therefore, we want services to not reinforce or mirror this survival mode or disintegration and be able to reflect instead of react and to be more connected and integrated.*

7.34 This is evident in the language used by professionals -such as self-harmer, frequent attender, high risk, or the way in which Olivia was described – '*Patient has EUPD and always wants to go to hospital even when it's not needed'.* This is potentially a systemic cultural issue and forms part of the wider discussions about EUPD and psychosocial models.

7.35 Similar challenges for SHFT of supporting people with a diagnosis of EUPD are raised in Learning Point 11 of a recent SAR [19] (see below)

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[15] portsmouthsab2022/08/One-Minute-Guide-to-EUPD.pdf
[16] NICE Guidance 2015
[17] NICE 2020 Organising and Planning Services for people with a personality disorder
[18] A Treasure Box for Creating Trauma-Informed Organizations: A Ready-to-Use Resource for Trauma, Adversity, and Culturally Informed, Infused and Responsive Systems - Therapeutic Treasures Collection 2021 Karen Treisman
[19] SAR Sam March 2022 Hampshire SAB

'**Learning Point 11**: Attention should be paid to the effect that the mental health diagnostic process is having on the person and their care and support. The purpose of diagnosis is to determine the most useful treatment approach. The person still needs support whilst this process is on-going.' Sar Sam 2022 [20]

7.36 It would be helpful to review the relevant recommendation in light of this review ' *The CCG (now ICB) is recommended to support a reflective meeting with staff from SHFT, GP surgeries, NPS and other interested partners to consider the findings of this SAR with particular reference to: • The impact of the diagnostic process on a patient, particularly when the diagnosis is considering personality disorder • The support the patient will need during this process. • consider how aware and confident frontline practitioners are in using a person-centred approach with people who are diagnosed with personality disorders and how organisations in the community can be supported whilst working with this group. (Learning Point 11 above)*

7.37 Other reviews following the death of people with a diagnosis of EUPD have highlighted the urgency of both greater awareness.[21] and the consequences of a diagnosis on care. Both Olivia and YL had children that they were not able to look after, both experienced the lack of planning for 'after care'.

8. Conclusions -revisiting the Key Lines of Enquiry

- **Evidence of collaboration between partner agencies including evidence of shared decision making around risks identified and that robust risk assessments were in place for agencies involved in the care and support of Olivia.**

8.1 Individual workers collaborated to discuss risks as evidenced in the two MARM meetings. However, this did not mean that there was a sense of shared decision making and ownership as a multiagency group. Individual workers in different agencies worked together to support Olivia's move from the tower block and demonstrated a high level of professional anxiety. This was not reflected in a collaborative plan.

8.2 There is evidence that Children's' services collaborated with other services, including mental health, to support Olivia. Earlier inclusion of housing colleagues would be useful in the future.

[20] SAR Sam March 2022 Hampshire SAB
[21] Portsmouth SAB YLApril2021

- **Agency referrals were timely and appropriate.**

8.3 In terms of referrals there were several examples of good practice. The Vulnerable Adult Support Team (VAST) based at UHS referred appropriately to the HIUG in light of Olivia's frequent attendances. Referrals to adult safeguarding took place but not consistently and were not timely. Olivia's care coordinator and psychologist demonstrated great care and compassion.

- **Evidence of agencies involved in the care and support of Olivia seeking expert safeguarding advice/support in the light of any risks identified**.

8.4 There was not sufficient evidence that agencies sought adult safeguarding advice and support. This was inconsistent and did not appear to be part of a coordinated approach either because of supervision, or case management. The MARM framework guides agencies to consider the need for statutory referrals and there is no evidence that this was discussed at each of the meetings.

- **Multi-Agency Partnership working. The use and impact of the Multi Agency Risk Management Framework, Care Programme Approach and High Intensity User Group, including engagement by services.**

8.5 Olivia was supported by a Community Mental Health Team under the Care Programme Approach (CPA[22]). This meant that a Care Coordinator was allocated to work intensively with Olivia as part of a care package and a case management approach. The approach would have benefitted from active involvement from other members of the multidisciplinary team and other agencies such as housing and the voluntary sector in the development of the care plan.

8.6 The CPA reflected some of the tensions raised in the implementation of Transform and a need to have a greater awareness of EUPD and the psychosocial factors that may lead to someone wanting to harm themselves. The CPA was flexible and did seek to understand Olivia's needs and the care coordinator liaised with housing. Yet, there were many groups and agencies working with Olivia and a closer look at who was doing what was needed. One coordinated care approach via MDT would prove helpful.

8.7 As described earlier the MARM framework was applied and formed part of the approach to agree a clear plan of action for Olivia. However, it did not always include the right people around the table, such as housing colleagues, members of the High Intensity User Group, or ED staff.

[22] The Community mental health framework replaced the Care Programme Approach (CPA) for community mental health services. August 2022

Although it was initiated by mental health the coordination and lead role were not clear to other agencies and staff. Minutes were not always available or circulated. An outcome of the MARM could have been to clarify roles and responsibilities and the boundaries and expectations of each agency.

8.8 Olivia was also supported via the High Intensity User Group (HIUG). A small proportion of patients referred to as 'frequent attenders' account for a large proportion of hospital activity such as ED attendances and admissions. The High-Risk User Group (frequent attenders is a small team seeking to understand the needs of the most high-risk people with mental health needs.) A tailored care plan was developed for Olivia by the team, but capacity means that the team cannot fully contribute to multiagency meetings. This is compounded by short term funding leading to a lack of resilience

- **The impact of Olivia's child being placed with family members, and this being reflected in work with Olivia.**

8.9 Olivia spoke about some tension in family relationships and at times did not want her allocated worker to contact her mother. This was recognised and understood by all those working with Olivia. However, Olivia frequently called her mother.

8.10 There was evidence to demonstrate that care planning took place by Children's' Services, and consideration given to maintaining Olivia's relationship with her daughter. Initially, Olivia had parental responsibility, but this changed with guardianship (SGO) awarded to Olivia's parents. The fact that her daughter would not return to live with her would have been devastating. The impact of being raped and then the removal of her daughter had a profound effect on Olivia's reactions and view of her life. It is crucial to develop guidance for a multiagency response for parents where children are placed for permanence outside of their care.

- **Evidence of a family approach being taken given the suggestion contact time between Olivia and her child was not satisfactory and that Olivia had been living for a time with her child and the family members caring for the child.**

8.11 There is evidence that this was explored sufficiently upto the point that permanency was agreed. Regular quality contact was a priority by both the family and local authority. This sadly changed due to the need for Olivia's father to shield during COVID. Contact was sometimes not straightforward and dependent on Olivia's struggles and distress.

8.12 During 2020, Olivia spent a short period in her parents' home. Contact was made by children's services and early help to offer support and advice for the family. The family felt at the time that they had sufficient family support. However, this was clearly a difficult time for the family and Olivia's mother described how hard it had been to contact the adult mental health team. This was at a time when one worker was on duty in the evening. This has now changed as a result of Olivia's experiences.

- **Agencies holistic understanding of Olivia given the considerable history of service involvement and how this was demonstrated in the provision of support and services.**

8.13 There is evidence that agencies tried to understand Olivia's lived experience as far as is possible. Earlier use of MARM or MDT would have helped, in following removal of her child. As stated earlier, coordination across adult and children's services would have helped to fully understand Olivia's perspective.

- **Effectiveness of service engagement at critical moments, including the closure to Children's Social Care following the birth of Olivia's child.**

8.14 The reasons for closure to children's social care are not clear other than it was felt that Olivia had support from her family. The situation deteriorated quickly after Olivia's child was born. There was good service engagement with Olivia at critical points by mental health teams and often daily contact with allocated workers.

- **Impact of the allegations of sexual harm on multi agency practice**

8.15 In discussions with agencies there is evidence that agencies were aware of the allegations of sexual harm and the impact of trauma on Olivia's life. Olivia had contact with a psychologist for over a year and found this relationship to be beneficial. It is possible that although there was an acknowledgement of the impact of allegations of sexual abuse that the diagnosis of EUPD and urgent presentations in crisis did not enable staff to reflect.

- **If Olivia had a formal diagnosis of Emotionally Unstable Personality Disorder (EUPD) was the care and support provided in line with the EUPD pathway?**

8.16 Olivia had a formal diagnosis of EUPD, and Interpretation of the Transform pathway was variable. There was evidence that planning was in place to manage transitions such as when a support worker was planning annual leave. However, one of the critical points was when an admission

was recommended by a clinician or indeed when Olivia herself requested help. The rationale for decisions in these cases was not always clear.

8.17 The NICE guidance for people with a diagnosis of EUPD is clear that admission to an acute psychiatric unit for a person with EUPD should only be considered after a referral to Crisis Resolution Home Treatment teams or other locally available alternatives has occurred. Brief admission[23] should be considered when the management of crises involves significant risk to self or others and cannot be managed within other services. It was the view of several people interviewed that the Transform pathway needs to be reviewed to ensure that this is understood.

- **Multi agency communication and sharing of information regarding Olivia's housing situation and associated risk factors**

8.18 The sharing of information improved following the second MARM but prior to this was reliant on individual workers rather than a collaborative approach. Housing had not been involved at crucial discharge points such as when Olivia was discharged from the Mother and Baby Unit or hostel accommodation. They had not been kept aware of crucial background information such as previous concerns that Olivia had wanted to end her life. This might have supported an urgent move from the tower block, or at least even prevented a move to the 10th floor of the tower block.

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[23] in contrast to the NICE guidance on management of patients with EUPD, there is some evidence in recent literature to suggest that longer term integrated inpatient treatment programmes sustainably improve core symptoms, reduce emergency department visits, and prevent readmission.

9. Next Steps and Recommendations

Recommendation 1 MARM and Interface with Statutory Safeguarding

The SSAB should review the findings of the 4LSAB MARM review considering the following:

- S42 have primacy and must be used where the criteria are met
- Actions should be taken to ensure there is maximum attendance by the right professionals
- Guidance should clarify that the chair is responsible for sharing information during and following the MARM.

Recommendation 2 Understanding of EUPD

- SHFT will review and further develop the complex personality disorder pathway

Recommendation 3 Understanding of capacity for people with a diagnosis of EUPD

- SSAB should consider additional training on understanding capacity with reference to people with EUPD
- SSAB should ensure that the learning from this SAR links to recommendations from SAR YL and SAR SAM.

Recommendation 4 Housing Allocations Policy

- Southampton City Council should ensure that the reviewed policy is disseminated and part of supervision and training to ensure that someone who is at risk of harm and has support and housing needs, does not remain in choice-based lettings

Recommendation 5 A coordinated model for people who use health services frequently

- UHS/the ICB/SHFT should consider working together to identify funding streams for an improved core HIUG service to bring professionals together and develop shared care plans, including greater links with psychology, ED, clinical leads, and coordination.

Recommendation 6 Creating a bridge between Children's and Adult services for Parents whose children are removed from their care. For Southampton SAB, Southampton SCP , and statutory Partners including Public Health. This recommended is aligned with SCC Corporate Strategy, Pause National Reports, and current conversations taking place beteen SCC and the Phoenix Service. It considers recent research from Pause that women are 36 more times likely to die following removal of children. (This includes death from suicide.

- There should be a coordinated multiagency system response for parents post proceedings. Such that when parents exit proceedings, a process should be triggered to include a review, summary of risks and pertinent sharing of information to adult services. This should include housing status. This should form part of routine practice in children's services.

- A key action should be Practice guidance developed in collaboration with Phoenix (PAUSE) Southampton for and with parents post proceedings. This should include details of the referral process for Phoenix, a summary review as above, and monthly multi agency support panels similar to MARAC for parents following proceedings to ensure that the most appropriate support is available, considering the high risk of distress and suicide. (This is aligned to recommendations in Set-Up-to-Fail-July-2022.pdf A Pause Report)
- Children's services should ensure that where there is continued access between mother and child risk assessments take place which link to the overall safety plan.

Recommendation 7 Section 75 (S75) Southampton City Council and ICB

- There should now be a review of the way in which S75 arrangements are working within mental health teams in Southampton to ensure that statutory safeguarding enquiries are raised when required, in particular following MARM and MDT meetings. This should include an audit of cases for 6 months to review the way S75 has benefitted outcomes for adults at risk of abuse and neglect.

Recommendation 8 SSAB, Southampton City Council and ICB Trauma Informed Practice

- The WAVE Trust is already working with Southampton City Council and training was commissioned for midwifery in the CCG/ICB to embed trauma informed practice. The SSAB and SSCP should coordinate a system response and approach to the work with the WAVE Trust, reviewing best practice such as in Scotland and Blackpool.
- Hold a summit to draw national best practice and learning

Appendix 1 Olivia Safeguarding Adult Review Terms of Reference

Safeguarding Adult Review

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

Reason for Safeguarding Adult Review

Olivia was found outside her home in a block of flats, she was conscious and breathing, although later died. It appears she had jumped from the block of flats (10th floor). Olivia had a young daughter who has lived with Olivia's parents for some time. Olivia had a history of mental health problems with a number of diagnoses. There had been a number of previous reports of threatening to jump out of her flat window. This has included being found on various occasions on the window ledge of her flat and neighbours calling emergency services for help. The day before Olivia was found she had been discharged from hospital.

Scope of the review

The LSAB Case Review Group recommended that this case met the criteria for a Statutory Safeguarding Adult Review. The time period review will be to June 2021.

This review will also request relevant background and contextual information regarding key factors. The review may also request information regarding significant events that was ***known or knowable by the agency at the start of the review period***.

Key Lines of Enquiry (KLOE)

- Evidence of collaboration between partner agencies including evidence of shared decision making around risks identified and that robust risk assessments were in place for agencies involved in the care and support of Olivia.

- Agency referrals were timely and appropriate.

- Evidence of agencies involved in the care and support of Olivia seeking expert safeguarding advice/support in the light of any risks identified.

- Use and impact of the Multi Agency Risk Management Framework, Care Programme Approach and High Intensity User Group, including engagement by services.

- The impact of Olivia's child being placed with family members, and this being reflected in work with Olivia.

- Evidence of a family approach being taken given the suggestion contact time between Olivia and her child was not satisfactory and that Olivia had been living for a time with her child and the family members caring for the child.

- Agencies holistic understanding of Olivia given the considerable history of service involvement and how this was demonstrated in the provision of support and services.

- Effectiveness of service engagement at critical moments, including the closure to Children's Social Care following the birth of Olivia's child.

- Impact of the allegations of sexual harm on multi agency practice

- If Olivia had a formal diagnosis of Emotionally Unstable Personality Disorder (EUPD) was the care and support provided in line with the EUPD pathway?

- Multi agency communication and sharing of information regarding Olivia's housing situation and associated risk factors

Family Engagement

The relevant family members will be invited to contribute to the review. In line with the duties set out for SARs within the Care Act 2014 the review will seek assurance to ensure that the Local Authority has considered, and where appropriate arranged for an independent advocate to represent and support the Adults involved with the Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them. The Lead Reviewer will request details and further information where necessary to support analysis and scope of the review. This may involve minutes of meetings, written assessments made and other relevant information.

8. AGENCIES INVOLVED

- **Hampshire Constabulary**
- **Southampton City Council, Children and Learning Services**
- **Southampton City Council, Adult Social Care**
- **Primary Care**

- **University Hospitals Southampton Foundation Trust**
- **Southern Central Ambulance Service**
- **Solent NHS Trust**
- **Southampton City Council, Housing Services**
- **Southern Health Foundation Trust**

Methodology:

The review will involve practitioners and their managers/case review group representative. The recommendations arising from the review will be summarised in a report and presented to the Southampton LSAB. (Reviewer and panel members to agree methodology). The methodology for this review will consist of:

- A review of relevant policies, procedures and processes that are in place and relevant to the issues highlighted
- Review of relevant case specific information as considered necessary
- Meetings with a panel of representatives from the agencies involved to seek advice, guidance and approval of the review process, terms of reference and progress
- Meetings with key professionals, workers, family members, managers, and service leads – individually and in groups where relevant
- Further panel meetings to discuss findings and finalise report and recommendations

The panel will be made of representatives from:

- **HIOWS City Clinical Commissioning Group CCG/Integrated Care System**
- **University Hospital Southampton**
- **Solent NHS**
- **Southampton City Council Legal Services**
- **Southern Health NHS Foundation Trust**
- **Southampton City Council Adult Social Care**
- **Southampton City Council Housing Service**
- **Hampshire Constabulary**

Children and Learning Services may be co-opted as required.

Statement of ethos

The Review will be conducted in the spirit of openness and fairness that avoids hindsight bias and any bias toward any one agency or individual involved. The review will also seek to the involve family and significant others in the review and manage this with compassion and sensitivity. The review will also adhere to the Equality Act 2010.

Appendix 2 Attendance at Emergency Department 2018 to June 2021

	Number of ED attendances
2017	5 (overdoses and self-harm) No consideration of a MARM or safeguarding
2018	9 (1 x Safeguarding adult concern and MASH child protection referral) Overdose and feeling low (baby in hospital at this point) Referral to mother and baby unit for assessment . Concern noted that Antenatal Psychiatry declined a referral for Olivia due to her background of EUPD. 4 attendances of self-harm following baby's removal into the care of Olivia's parents – no safeguarding adult concerns flagged
2019	13 1 x safeguarding adult concern form. 1 x detention under Section 5(2) of the MH Act 1983. Overdose, and self-harm by razor
2020	36 May to December – (no presentations Jan to May.) -Lockdown, worsening of mood due to reduction in contact with her daughter between May to December. On one occasion, assessed as' lacking capacity 'and discharged home. On other occasions 'has capacity'. July begins to express thoughts of jumping from the 10th floor ". Noted to have a two-year-old daughter of whom she retains 50% custody.
2021	22 Jan to June