Southampton Safeguarding Adults Board

Safeguarding Adult Review

Name - Lily Date – August 2024

Report by SSAB with contributions from Patrick Hopkinson

SSAB

A STATEMENT FROM LILY'S BIRTH PARENTS

'Lily was the youngest of our two daughters. She was vibrant, strong willed, intelligent and a pleasure to have as a daughter. She had a great sense of humour. She was selfless and always so helpful and caring for those around her. We were very proud of her. She dearly loved her father, mother, and sister. As a family, we all loved Lily dearly and are devastated by her loss. She also had very good relationships with her foster parents and their family.

Lily's hobbies included drawing and reading horror stories. She also liked to watch horror movies on Netflix. Her favourite music to listen to was rap. She loved designer clothes, especially trainers and wanted to start a business customising them. She was interested in forensic science and after taking several jobs at pharmacies, care homes and the NHS she decided to use her earnings to enrol herself in college to attain the necessary A-levels as a step towards going to university.'

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1.0 Introduction

1.1 Lily was 18 years old when she died in hospital following an overdose of the beta-blocker medication Propranolol. Her death was tragic and the Southampton Safeguarding Adults Board would like to express their deep condolences to Lily's family and friends.

1.2 There are lessons to be learnt for the multi-agency system from the circumstances of Lily's life and death and it is important that the learning identified during this review will prevent others from suffering in a similar way.

1.3 Southampton Safeguarding Adults Board agreed that the circumstances of Lily's life and death met the criteria for a statutory Safeguarding Adult Review to consider the learning around how agencies worked together.

1.4 The review raises serious questions for further action and consideration:

- Ensuring the transition from services for children to services for adults involves multi-agency communication, information sharing and planning across all agencies,
- Clear communication and planning when services involve cross border working, prioritising the needs of the person at the heart of decision making,
- Sharing information with community services when a person is admitted to hospital to support joined up care and clarity of medication prescriptions,
- Agencies to ensure that the impact of protected characteristics are considered when making decisions, such as the impact of mental health and the complexities of being in the care / leaving the care of a local authority.

2.0 Context of Safeguarding Adult 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 because of abuse or neglect and there is cause for concern about how agencies worked together. Southampton Safeguarding Adults Board (SSAB) commissioned an independent author to support with the review. The author is independent of the partner agencies.

2.2 The members of the Safeguarding Adults Review group were:

- Hampshire & Isle of Wight Integrated Care Board (ICB)
- Hampshire and IOW Constabulary
- Hampshire CAMHS – Sussex Partnership Foundation Trust
- Hampshire County Council Adults' Service
- Hampshire County Council Children's Service
- Southampton CAMHS - Solent NHS Trust
- Southampton City Council Adult Social Care
- Southern Health Foundation Trust
- University Hospital Southampton Foundation Trust (UHS)

3.0 **Methodology**

3.1 This SAR was carried out from information and learning from a combination of narrative reports, Individual Management Reviews and chronologies provided by agencies of their involvement with Lily, along with discussions with Lily's family. The review does not apportion blame, but instead seeks to understand what has happened and what lessons can be learned to do things differently.

3.2 A practitioner learning event was held to explore the practice perspective and to make recommendations for action and assurance.

4.0 **Key Lines of Enquiry (KLOE)**

4.1 The focus of this SAR is on learning around the barriers and enablers to developing a whole system response for young adults transitioning from services provided to them as children, with the added complexity of housing disputes between local authorities and the need to prioritise the impact of decision making on young people with mental health challenges and care experiences. This involves;

4.2 KLOE 1 - Transition from Children's to Adult's Services

- Explore the transition process between children's services to adult's services.
- Identify any gaps in policy, procedure and practice when supporting care leavers who are not placed in their placing authority area.
- Explore the shared understanding of legislation / statutory duties in relation to Lily.

4.3 KLOE 2 - Partnership Working Across Borders

- Consider the effectiveness of multi-agency working across borders, with a particular focus on responsibility for accommodation.
- Was there effective challenge and escalation to resolve critical issues, such as onward accommodation?

4.4 KLOE 3 - Lily's Voice and Making Safeguarding Personal

- To establish whether Lily's voice was represented – was she involved in decisions relating to her care and treatment?
- If Lily was involved in decision-making, and there were concerns for her safety and wellbeing, were the principles of the Mental Capacity Act (MCA) applied?
- To consider the extent of family/foster carer engagement. To what extent was the voice of the foster carer considered in planning for Lily.

5.0 **Family Involvement**

5.1 The Southampton Safeguarding Adults Board would like to express their gratitude to Lily's birth parents and her foster parents for meeting with the Partnership Team and the author. Their views have been incorporated into the report and their description of Lily as a person, her likes and aspirations are invaluable in understanding more about who Lily was. This helps to emphasise how important it is to ensure that recommendations for change are fully embraced in memory of such a 'vibrant', 'strong-willed' and 'intelligent' person (statement from birth parents).

5.2 Lily's birth parents and foster family knew her well and continued to care very much for her, supporting Lily to express her views and to know she was loved. Her foster family worked closely with practitioners to share what they felt would help Lily and to advocate on her behalf for an understanding of what life was like for her to involve the right services. They referred to the really positive support they received from the supervising fostering social worker and the Personal Advisor who worked closely with Lily.

6.0 Reflections On Lily's Life

6.1 Lily sadly died whilst in hospital where she had been for a number of weeks following a third suicide attempt in two weeks. She had been deemed medically fit for discharge, however there was a dispute about where she would be discharged to. Lily had been staying with her foster carers under a 'staying put' arrangement when she turned 18. Lily was placed in the care of the foster carers by Hampshire County Council Children's Services and was supported as a care leaver by her Personal Advisor.

6.2 At this time, Lily was trying to study for her A levels, whilst Hampshire and Southampton local authorities debated who should take responsibility for housing Lily. Lily's foster carers continued to visit her every other day whilst she was in the hospital, but had expressed concern around her return to their home due to her fluctuating mental health and suicide / self-harm attempts.

6.3 Lily's birth parents and foster family have described the aspirations Lily had for her future. She worked part time in a pharmacy, and whilst in hospital was trying to carry on with her studies and exploring work experience to support her future career opportunities, such as becoming a forensics officer. This shows remarkable strength and courage. The impact on Lily's mental health of the uncertainty of where she was going to live, whilst also trying to study in hospital, cannot be understated. Sadly, this traumatic time was one of many that Lily experienced in her life, through both her experiences leading up to her removal from her birth parents at the age of 14, and the subsequent impact on children and young people of living separately from their birth family.

6.4 Lily's birth parents visited her in the hospital each weekend. On their last visit, Lily gave them letters to read, which raised their concerns for her wellbeing. It has transpired through the review process that Lily had ordered 3 boxes of Propranolol from an online pharmacy, which were delivered to the hospital. These had been kept in a lock box, however Lily asked a staff member on the ward for what she described as a stress ball that had been delivered to her. Contrary to hospital protocol, Lily was given her package and left the hospital, where she went to a park and took the medication. She telephoned her birth father, who called an ambulance, however attempts to resuscitate Lily failed.

6.5 Lily had received support for her mental health over the years and records show that her self-harm increased around the time of her 18th birthday. Prior to this, Lily received individual psychology sessions from Hampshire CAMHS and was prescribed Sertraline. CAMHS records in 2019 state that Lily experienced mood swings, feelings of insecurity, marked anxiety and at times heard 'voices'. There is some reference to features of EUPD, however Lily was too young for a diagnosis. Lily was also described as being warm, thoughtful and considerate.

6.6 There had been a break of a year in the contact between Lily and her birth family in 2019, however contact resumed following this, which is a considerable period without seeing her family.

6.7 Lily was prescribed Propranolol in July 2020 by her GP after reports of shaking and anxiety and continued to take Sertraline alongside. She told her Personal Advisor that she was struggling with the lockdown arrangements in place during the Covid pandemic as she was again unable to see her sibling. Lily had self-harmed and used a razor, which was viewed as an escalation. This was all around the time of Lily's transition to adulthood and she was transferred to the Care Leavers Team, whilst discussions were planned for Solent CAMHS to transfer Lily's mental health support to adult mental health services.

6.8 By October 2020, Lily's foster carer contacted the emergency services due to a further escalation in her cutting her legs and arms and Lily was admitted overnight. Lily was advised to attend an Emotional Coping Strategies group, although she felt doubtful about being able to join this group. Lily attended a self-harm assessment the day after discharge from hospital by Solent West CAMHS. Lily had also lost her part time job at this time but was trying to access an online course to help her get back into work.

6.9 During the assessment, Lily expressed that she felt lonely, but also felt that she pushed people away and that she felt unstable and would continue to self-harm. Lily and her foster carer were concerned that Lily did not have a diagnosis. The Children in Care Specialist Nurse from SHFT (Southern Health Foundation Trust) made contact in the same week to arrange a review and was advised of Lily's hospital admission. They agreed to contact Lily directly. Lily was closed to the service following no contact from her, by which time Lily had reached 18 years of age.

6.10 There was a plan for a referral to be made to adult services by Solent CAMHS to address risk management / minimisation, review Lily's safety plan and create a coping and resilience plan, monitor her mental state and support the transition, however there is no record of this referral having been made. At this time, there was also an agreement to reduce and stop the Sertraline prescription and replace this with Fluoxetine.

6.11 The support from the Solent West CAMHS crisis team ended when Lily turned 18, however following a review in November 2020, whilst acknowledging that Lily was experiencing low mood and self-harm, it was considered that she would not meet the threshold for the community adult mental health team. Lily was instead signposted to Steps2Wellbeing, which is a service Lily would need to reach out to herself. Lily was discharged from Solent West CAMHS in December 2020. Lily expressed that she did not feel that she required Steps2Wellbeing, and despite concerns raised by Solent CAMHS and her foster carer about this, the view remained that Lily could access services through her GP in the future as she had turned 18. It is of significance that Lily had been receiving support for her mental health until the age of 18, but that this ceased and she was left to make contact with services for support herself. The impact on Lily of moving from intensive support to being told that she would no longer receive this unless she accessed it through her GP could have been considerable. In addition, Lily was discharged from Solent West Community Paediatric Medical Services for dietary support and had a change in her Personal Advisor in January 2021.

6.12 Later that month, Lily contacted Hampshire Children's Services asking to be reopened to CAMHS as she reported feeling worse and was advised to contact her GP, which she did, but the GP records state that Lily requested more Fluoxetine. It is important to reflect upon how difficult it may have been for Lily to now have to request services herself and to explain to different professionals how she was feeling, when just a few weeks previously, supports and planning were discussed in meetings with Lily and the professionals involved.

6.13 Lily's foster carer met with Hampshire Children's Services in April 2021, as they were concerned with Lily's self-harm and suicidal thoughts. The foster carer voiced her worries about something significant happening and also around the impact on the other children in the home. Lily herself contacted the GP in May 2021 to request support due to her mental health needs and that she had taken an overdose the previous month. The GP advised Lily to make contact with Steps2Wellbeing. Steps2Wellbeing liaised with the East Community Mental Health Team in May 2021 and a routine appointment was offered in June 2021.

6.14 By June, Lily had spoken of her plans to move into her own accommodation in the future, and a meeting was held with Lily, her Personal Advisor and a homeless prevention officer. Lily said that she would consider a supported adult services project or her own place with floating support.

6.15 Lily was admitted to hospital on the 4th June 2021 for four days following an overdose of Fluoxetine, and again on the 16th June following cutting herself with a razor blade. In between these dates, Lily had an assessment with the East Community Mental Health Team and was told that she would be allocated a care coordinator for a medication review and psychological input. There was a delay in allocation and Lily received support through the duty system. Lily's distress continued to escalate and she was admitted to hospital for a third time on the 17th June 2021 as her oesophagus had been perforated.

6.16 Following this, the foster carers were concerned that they would be unable to keep Lily safe at home and referrals were made to the hospital Discharge Team for accommodation when she was medically fit for discharge. The UHS staff raised a safeguarding concern in respect of Lily. Records show that Lily was deemed to be too vulnerable for hostel accommodation or B&B, but was also not considered to have care and support needs under the Care Act 2014. Lily remained in hospital whilst further discussions were taking place around her accommodation.

6.17 There were regular Multi-Disciplinary Team meetings held whilst Lily was in hospital, and communication between the liaison psychiatry team, Lily and the ward staff.

6.18 Lily continued to remain on the ward at the hospital and received a package containing Propranolol on the 29th July 2021, which was locked in her medication locker. At Lily's request, however, this was handed to her by a staff member on the ward. Lily's birth parents visited her on the 31st July 2021 where Lily told them that the only way out was to end her own life. She expressed finding the ward difficult due to the noise and the other patients' range of problems and was worried that she could not get on with her academic studies. Lily handed her parents a bag containing letters, a card and chocolates, which they read in the car park and upon realising that Lily intended to take her own life, they returned to the ward to find that Lily had left.

6.19 The Emergency Services were notified and Lily was taken back to the hospital via ambulance, however resuscitation attempts were unsuccessful and Lily tragically died on the 31st July 2021.

7.0 **Findings and Learning**

7.1 <u>Lily's transition from services for children to services for adults</u>

7.2 When interventions and support are provided for young people prior to their 18th birthday, this indicates that they have needs for services. In Lily's case, following her 18th birthday, she was advised that she did not have care and support needs and additionally that if she required support for her mental health, she would need to access this through her GP and was signposted to

Steps2Wellbeing. Lily and her foster carer were told that a referral would be made to adult mental health services, this did not happen. Lily did contact the GP, however the expectation on her to explain how she was feeling over the telephone when turning 18 would likely have been extremely difficult for her.

7.3 Lily had support from her Personal Advisor from the Care Leaving Team and this was deemed to be positive, however this did not impact on the planning around support provision for her when she turned 18. There is minimal use of transition planning meetings involving the key professionals who worked with Lily. Of note, there were no reports from CAMHS submitted to the Looked After Children Review meetings and not all professionals attended.

7.4 ***Reflection : Agencies are invited to reflect upon the impact on young people of this shift and to consider how effective multi-agency planning could prevent an escalation to more acute need as they enter young adulthood.***

7.5 ***It is essential that agencies consider a trauma informed approach when planning around transitions for care experienced young people to ensure that their needs are prioritised. It is known that signposting to services is not always enough and that in Lily's case, actions were required to help her to access services and to understand what she may have found difficult.***

7.6 <u>Partnership working across borders</u>

7.7 Lily became a care leaver to Hampshire County Council when she turned 18. Whilst in hospital, the matter of Ordinary Residence became a point of dispute over whose responsibility it was to find accommodation or a placement for Lily. Hampshire County Council were of the view that as Lily was in a Staying Put arrangement with her previous foster carers who resided in Southampton, that Southampton City Council held responsibility, however Southampton City Council were of the opinion that Lily remained the responsibility of Hampshire County Council due to her Care Leaver status and that they were indeed Lily's corporate parent.

7.8 Lily remained in hospital despite being medically fit for discharge whilst trying to undertake studies, which impacted on her mental health and wellbeing, and she tragically took her own life before the dispute was resolved.

7.9 ***Reflection: Agencies to consider the impact on individuals when there are corporate disputes over responsibility for future planning. It was important for Lily to have stability and clear plans for her future, and the securing of appropriate accommodation should have been the priority. Any disputes over responsibility and funding should be taking place outside of the needs of the individual concerned.***

7.10 <u>Lily's voice and Making Safeguarding Personal</u>

7.11 There is evidence of Lily's opinions being sought around her future plans for accommodation and when she described how she was feeling to health professionals and her Personal Advisor. Once Lily turned 18, however, she made contact requesting support with her mental health and the expectation was for her to contact her GP and Steps2Wellbeing. This is a significant change from the provision of services prior to her 18th birthday. Consideration has been given to a Mental Capacity Assessment as demonstrated in the records, and the principles of the MCA were followed in terms of starting from the presumption of capacity, however with the complexities of Lily's history

and her escalating self-harm and suicidal thoughts, the planning was key in supporting her to access services rather than being left to do this on her own when services she received as a child were removed. The uncertainty around where she would live and how she would be supported was known to be very difficult for Lily, and the decision not to refer to CMHT appears to have been made without Lily or her foster carer knowing. Indeed, they had previously been of the understanding that there would be service provision in place following her 18th birthday.

7.12 ***Reflection: Agencies to consider how it feels for young people to understand that they would be receiving support services when they turn 18, to then be told that this would not be the case and they would need to access supports themselves. This is difficult for most people, but for those with complicated mental health presentations and the impact of the trauma they have experienced throughout childhood, accessing services alone and re-telling of their stories and feelings is exacerbated.***

7.13 <u>The Impact of Covid-19</u>

7.14 Lily is recorded to have found the restrictions in response to Covid-19 difficult at times. For example, in September 2020, Lily told her PA that she was struggling with the lockdown arrangements and with not being able to see her sister, but the impact on her foster carers is not recorded.

7.15 Most agencies involved in this review did not consider that the restrictions in response to Covid-19 had a negative impact on their actions. However, they also recognised that the move from face to face to virtual (for example, video conference) or telephone contact made it more difficult to fully assess Lily's circumstances and made efforts to see her face to face as a priority.

8.0 Good Practice

8.1 There were examples of clearly recorded clinical notes and evidence of strong therapeutic relationships between Lily, the psychologist and her i2i worker and good engagement and communication with the foster carer. There was also evident concern for Lily and attempts to work with her.

8.2 Lily's foster carers described their family social worker as excellent and someone who went above and beyond their duties to support them.

8.3 Lily was allocated a PA (Personal Advisor). The Children & Social Work Act 2017, introduced a duty, set out in "Extending Personal Adviser support to all care leavers to age 25 Statutory guidance for local authorities February 2018" and commencing from 1st April 2018, for local authorities, to provide Personal Adviser (PA) support to all care leavers up to age 25 years old, if they want this support. Lily had two PAs during the time covered by the review and they appear to have had one of the most consistent professional relationships with Lily and maintained contact beyond the statutory guidelines. Lily's PA advocated on her behalf by contacting the East CMHT completing home visits, maintaining contact with hospital staff and with CAMHS, arranging move on plans and finding apprenticeships for Lily. Similarly, Lily's foster carer also gave a high level of support to Lily and advocated on her behalf. Lily's foster carer also highlighted her concerns about Lily's mental health to the relevant professionals.

9.0 Summary

9.1 There is a great deal to learn from Lily's experiences for the wider systems around young people transitioning from services for children to services for adults. This is particularly pertinent for young

people who have adverse childhood experiences, have been looked after by the local authority and struggle with their mental health.

9.2 The importance of effective communication, making decisions around future planning with the young person and their families and providing clarity around their future is essential. For young people to be expected to navigate access to services independently once they turn 18 after having received supports and interventions prior to this is somewhat unrealistic.

9.3 For Lily, the lack of stability around support for her mental health and her living arrangements made it very difficult for her to concentrate on what she wanted for her future, despite her incredible efforts at continuing with her studies and looking to gain work experience to support her chosen career pathway.

9.4 Lily's foster carers did not believe that they had been listened to and that their concerns about Lily were not taken seriously. They knew Lily well, had supported her when she self-harmed, considered her as part of their family and loved her. Despite having made the difficult and traumatic decision that they could no longer have Lily to stay in their home following her suicide attempts and self-harm in June 2021, they continued to visit her in hospital. Lily's suicide is still impacting on her foster family and on her birth parents.

9.5 Even though Lily had turned 18 years old, she still received a considerable level of emotional and practical support from her foster family. It would seem appropriate that their knowledge of Lily and their concerns about, and skills in supporting her could be incorporated into the management of Lily's transition to adulthood. This would have provided greater consistency during this important time of change.

9.6 Whilst in hospital, Lily was able to obtain enough Propranolol to end her life with. University Hospital Southampton has identified, and taken, a number of actions to reduce the likelihood of a reoccurrence. A Trust-wide communication has been issued regarding medications management, specifying that unqualified staff should not hold ward keys and that medication should be stored safely in line with the University Hospital Southampton Medications Management Policy. Medicines management refresher training has been provided for staff on the ward where Lily was cared for and additional training for the staff directly involved with Lily. Staff have been advised that if they believe that patient post contains harmful objects, it should be opened with the patient's knowledge and in their presence. Staff have also been reminded of the Missing Adults Policy and actions to be taken when a patient deemed to be at risk goes missing.

9.7 It is important that the lessons are learned and embedded across the Partnership to prevent similar experiences for young people transitioning into adulthood in memory of Lily.

10.0 Next Steps and Recommendations

10.1 <u>Recommendation 1</u>

10.2 Services for Children and Adults across the Partnership provide plans for transitions for young people moving from childhood to young adulthood to ensure a continuity of service provision that ensures their needs are met and they are supported. This should include an emphasis on multi-agency planning, the voices of young people and those who know them well. These plans should include the young person at all times and provide clarity for them.

10.3 Recommendation 2

10.4 If there are disputes across borders around responsibility for accommodation, these should be resolved secondary to prioritising the well-being of the young person. How can the SSAB be assured that the 4LSAB Escalation Protocol[1] is effective in practice?

10.5 Recommendation 3

10.6 The University Hospital to provide assurance to the Southampton Safeguarding Adults Board (SSAB) that the arrangements now in place around managing deliveries to patients, particularly medication, are working and are embedded in practice. This will ensure that there is a plan in place and information is shared around access to additional medication.

10.7 Recommendation 4

10.8 Partner agencies should commit to attending planning and review meetings for children in the care of the local authority when they have involvement in their care to ensure effective communication and planning for support. How can the SSAB be assured that agencies are following the 4LSAB framework for managing risk and safeguarding people moving into adulthood?[2]

10.9 Recommendation 5

10.10 Partner agencies to provide evidence to the SSAB of how they make safeguarding personal and involve individuals and their family members (where appropriate to do so), in planning to ensure no decisions are made without them.

[1] 4LSAB Escalation Protocol

[2] 4LSAB multi-agency framework for managing risk and safeguarding people moving into adulthood