SAFEGUARDING ADULTS REVIEW

EDEN

Executive Summary Report

March 2024

Author: Adam Colwood

Contents

1. Eden

'Eden was a creative individual and had so much potential to become a great author, artist and animator. She was also a voice for survivors of sexual abuse and used her artistic and writing skills in order to express her experiences in a manner suitable for young children and teens to comprehend, as well as take note of the warning signs before anything serious could happen.

She was destined for amazing possibilities in life but unfortunately did not receive the needed support for her autism, PTSD and mental health problems. When she would have a crisis, the mental health team would be there to support her, but with regards to her other issues (autism and PTSD) she would be left to fend for herself.

These failures sadly resulted in Eden taking her own life and we can only hope that nothing on this scale happens to anyone again, regardless of upbringing, culture, ethnicity and/or social class'.

The author is grateful for the contribution of Eden's mother and her brother who have provided this snapshot and given Eden a voice.

2. Introduction

2.4 The Care Act 2014 requires Surrey Safeguarding Adults Board to undertake a Safeguarding Adults Review (SAR)[1], 'where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is a concern that agencies could have worked better to protect the adult from harm'. The purpose of the SAR, as set out in Section 44 of the Care Act 2014, is not to re-investigate earlier enquiries or to apportion blame, or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- To inform and improve local interagency practice.
- To improve practice by acting on learning (developing best practice) and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Eden from harm.

2.5 The methodology used in this report seeks to capture systemic learning that can improve practice and outcomes for individuals for the future and has involved a review of two earlier enquiries relating to (1) Eden's experience following admission to Cygnet Hospital, Woking (CHW) in May 2021 and (2) the circumstances surrounding her death in September 2021 which were conducted by a Lead Enquiry Officer (LEO) from the locality mental health team under Section 42 of the Care Act 2004, in which recommendations were agreed by the parties involved and a safeguarding plan was created. The author is grateful to the LEO for the assistance provided in sharing these reports.

[1] Briefing for Safeguarding Adult Board chairs and business managers- Analysis of Safeguarding Adult Reviews Briefing for Safeguarding Adult Board chairs and business managers - Analysis of Safeguarding Adults Reviews | Local Government Association

2.6 The Surrey Safeguarding Adults Board website[2] provides useful reference to Section 42 of the Care Act 2014, which requires that…' each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom'.

2.7 In addition, agencies involved in Eden's care were asked to contribute by providing information summarising their involvement after a referral for a SAR was made in December 2022 by the Head of Safeguarding for Surrey County Council and the author has had access to the statements provided to the Surrey Coroner and created in connection with the coronial process. The report, including its findings and recommendations compiled as a result of that analysis were shared with contributing agencies and its accuracy agreed at a practitioner event in September 2023. The recommendations made are those of the author.

2.8 In order to avoid duplication, the findings and recommendations of those earlier two Section 42 enquiries were not re-examined in depth. In some instances, however, it has been necessary to review those recommendations as they are inextricably linked with other issues which were not considered in earlier enquiries, and which form the focus of this review. For clarity, the recommendations arising from those reviews form part of the executive summary.

2.9 The terms of reference for the SAR, considering the previous enquiries were set as follows:

(a) Adequacy and timeliness of social care assessments.
(b) Application and appropriate use of the inter-agency escalation process.
(c) How did agencies work together and share information.
(d) Management of risk and safety plans.
(e) The involvement of family members.
(f) What consideration was there of Eden ('her voice') in delivering person centred care, considering her ethnicity, complex needs and previous experience of care.

2.10 The SAR author is currently employed by Surrey Police in an audit capacity, working in the Public Protection Support Unit and has had no previous involvement with Eden or her family.

2.11 The author would like to express sincere condolences to Eden's family for their loss and is grateful for the honesty, engagement and commitment shown by Eden's mother, her brother and Godmother, to ensure that Eden's voice has been heard.

2.12 At the time of the completion of the SAR, efforts by the Safeguarding Adults Board to engage with Eden's father had proved unsuccessful.

2.13 The author would like to acknowledge the contribution provided by Jenny Rayner, CEO of The Lucy Rayner Foundation[3], who provided such valuable insight into the challenges faced by young black adults who experience anxiety, PTSD, depression, and suicidal ideation.

3. Summary

3.1 Eden was a 22-year-old young adult who died in Ashford and St Peter's Hospital (ASPH) in September 2021. She had lived in supported housing since April 2021 and prior to that had been housed in other accommodation by Spelthorne Borough Council.

3.2 Eden had complex mental health issues and in the last year of her life she was supported variously by her GP, the Community Mental Health Recovery Service (CMHRS), the Home Treatment Team (HTT), The Mindful Service, the Psychiatric Liaison Team at ASPH and key and support workers linked to her housing provider.

[2] The Safeguarding Enquiry Process Surrey Safeguarding Adults Board The Safeguarding Enquiry Process - Surrey Safeguarding Adults Board (surreysab.org.uk)

[3] The Lucy Rayner Foundation The Lucy Rayner Foundation – Mental Health Awareness & Support in Surrey

3.3 A post-mortem was conducted which recorded sodium nitrate toxicity as the cause of death.

3.4 At the time of her death Eden was also in contact with a mental health social worker from the locality mental health team following a complaint she made regarding her admission to CHW, in May 2021 which was subject to a Sn 42 enquiry. Subsequent to her death a second Sn 42 enquiry commenced, and both of these enquiries are considered in more detail here:

Concern (1): Eden submitted a letter of complaint regarding the way in which she was subjected to a change of clothes search, which she described as a 'strip search' shortly after her admission to Picasso Ward at CHW. The brief circumstances were that she was supplied with a toothbrush which subsequently could not be accounted for. After a search of her room, Eden was searched and taken for an X-ray to establish whether the toothbrush had been ingested or secreted about her person. Whilst the search was a proportionate response, Eden felt 'triggered' by her treatment by staff during this process, which exacerbated her PTSD (referring to her sexual abuse as a child) and indicated she would not want to return to CHW in the future.

CHW identified the following learning points (a) To create a search leaflet for patients (b) Provide staff with further training on how to respond to complaints (c) Staff to ensure they clearly document all interventions used in managing an incident and (d) Staff to consider lesser (sic) invasive searches in future as this can be quite distressing to anyone.

The safeguarding plan was finalised on the 17th March 2022 with a note to the effect that all the actions had been completed.

Concern (2): A SCARF (a referral form used by Surrey police to share information with statutory agencies) was submitted via the P-SPA (Police Single Point of Access; the Surrey Police unit which primarily assesses and shares relevant information with partner agencies) to Adult Social Care (ASC) which reported that Eden died on the 15th September 2021, having taken an overdose of sodium nitrate, sleeping tablets and an anti-emetic to prevent vomiting. On the previous day, Eden had attempted to die by suicide by hanging and was assessed and discharged by the Psychiatric Liaison Team (PLT) at ASPH in the early hours of the following morning. The SCARF indicated that 'Eden had told a member of staff at her supported housing that she had sodium nitrate in her room and no immediate action was taken'. As a result, a concern was raised that organisational abuse could have occurred.

The LEO concluded that investigation with the following recommendations and the responses are included from the relevant agency: -

(a) **Recommendation:** If someone is living in supported accommodation consideration should be given to sharing relevant information about hospital and emergency service contacts with them. The information gathered by the ambulance service and Psychiatric Liaison Team (PLT) affected Eden's level of risk and therefore was relevant.
Response: As a result, the PLT Operational Policy was amended to reflect the need to share information with accommodation providers in respect of discharge planning and to consider whether there was a requirement for a professional's meeting.

(b) **Recommendation:** Consideration to be given by Psychiatric Liaison to policy and best practice in relation to documentation around Mental Capacity Act 2005 for Psychiatric Liaison Staff.

Response: The same PLT Operational Policy was updated to include a section on the Mental Capacity Act.

(c) **Recommendation:** Consideration to be given by ASC to factors aside from time elapsed in reviewing referrals for a Section (9) assessment.
Response: The Deputy Director, ASC, referred to workshops that had been undertaken with duty staff and the issue had been taken up by the newly established Quality Improvement Group.

(d) **Recommendation:** Transform Housing to give consideration to risk assessment training. In assessing risk, clear information should be gathered regarding a person's intentions and plan. This includes their access to means of harm.
Response: Transform housing provided an update to the effect that all staff attended a suicide prevention training webinar on the 6th September 2022. This was recorded and remains available to staff as a refresher.

(e) **Recommendation:** Consideration to be given by all agencies regarding holding professionals meetings in situations where there are concerns about how someone is managing. This is in relation to their mental health issues around social care needs and any associated risks.
Response: Responses were received from Transform Housing the PLT and CMHRS, all of whom indicated a willingness to engage in professionals meetings to meet the concerns raised. This issue was considered by the Deputy Director, ASC, who expressed a view that a SAR would be able to address the issue of interagency working.

The safeguarding plan was finalised in July 2023 with a closing note indicating the findings would be shared with the Surrey Coroner and SAR author.

3.5 A referral for a SAR was subsequently made in December 2022 by a social worker employed by Surrey County Council.

3.6 The terms of reference were set in accordance with concerns recorded by members of the Safeguarding Adults Review Group which was convened in February 2023 and the review seeks to concentrate on professional practice, multi-agency working and its impact on Eden. Whilst the services involved with Eden were working within the constraints imposed by the response to Covid-19 at the time, the author has not specifically considered what impact those restrictions had, or the way in which policies were implemented by those agencies during the pandemic.

3.7 Whilst Eden was admitted to different mental health facilities during the last year of her life, the question of her fluctuating capacity has not been a specific consideration in this review and the author is mindful of the proposed changes to the Mental Capacity Act 2005 and the Codes of Practice, which will not now be debated during the course of this Parliament[4].

3.8 Fourteen recommendations have been made as a result of identified learning points and reflect common themes identified in earlier reviews both in Surrey and across England and Wales.

4. Background

4.1 Eden was born on the 8th April 1999 and died on the 15th September 2021, aged 22. She was of Black/Caribbean descent and at the time of her death was living in Ashford

[4] Changes to the Mental Capacity Act code of practice – Law Society response [Changes to the Mental Capacity Act code of practice – Law Society response | The Law Society]

and had just commenced studying a BTEC Level 3 course in animation at West Thames College.

4.2 Eden had complex needs, which included a diagnosis of depressive disorder, autistic spectrum disorder (ASD), post-traumatic stress disorder, an eating disorder (bulimia nervosa) and an Emotionally Unstable Personality Disorder and Dissocial Personality Disorder. The ASD diagnosis was completed before transition to secondary education and as a result Eden attended a special needs school as a weekly boarder.

4.3 In 2013 Eden made an allegation against a male known to her family, who had sexually abused her when she was aged eight. This male was subsequently charged with a range of sexual offences against Eden occurring over a period of time. He pleaded guilty at Court to three counts of sexual touching and was sentenced to a period of two years imprisonment which was suspended to allow the defendant to attend a course recommended by Probation Services. During this period Eden was admitted to hospital having taken an overdose of tablets.

4.4 Eden had a history of involvement with services commencing when she was aged nine-ten years including the NSPCC, Children's Services as a looked after child with an extended period in foster care and later as a resident in a children's home. Due to increased levels of need she was moved from her mainstream special school to a specialist centre for educational provision and received treatment from the Child and Adolescent Mental Health Services (CAMHS) As an adult, Eden was known to Surrey's Northwest Home Treatment Team (HTT) and at the time of her death was supported by Runnymede and Spelthorne Community Mental Health Recovery Service (RSCMHRS). Prior to her college enrolment she had been supported by the Mindful service, which supports young adults who are working towards reintegration into education. There was a documented history of self-harm, with further suicidal ideation and a pattern of attempts to end her own life, involving subsequent admissions to mental health facilities in Surrey and other London boroughs.

4.5 Eden had on occasion been violent or was threatening to others. In February 2020, whilst resident in a care home in Hillingdon, it was alleged Eden had punched a care worker and threatened to pour boiling water over other staff, who retreated and locked themselves in a separate room until the police arrived. In July 2020, the police were contacted by a nurse at Kingston Hospital as Eden was overheard talking to her mother on the phone, threatening to kill her and her brother by setting fire to their house. On both occasions the police took no further action due to a lack of support from those involved.

4.6 There was in place a support plan which had been agreed between Eden, her key worker and care coordinator, whilst she resided in a studio flat provided by Transform Housing, who are a registered provider of social housing with charitable status. This provision accounted for one hour of one-to-one support each week with her keyworker.

4.7 In addition, one staff member (a support worker) from Transform Housing was present on the premises between 8.30am and 5pm and was available to support residents if required. Whilst there was provision of an out of hours emergency contact at the supported accommodation, this was to respond primarily to concerns over property maintenance rather than specific safeguarding or welfare issues relating to residents.

4.8 Shortly before her collapse and loss of consciousness Eden had reported taking sodium nitrate and her access to this compound was documented on other, earlier occasions. In February 2021, police found a bottle of what was later identified as sodium nitrate within her possessions after she had been reported missing and three months earlier, in November 2020, she presented at hospital, disclosing she had taken strong painkillers and sodium nitrite. These instances are considered in more depth later in the report.

4.9 The post-mortem recorded sodium nitrite toxicity as the cause of death which suggests Eden ingested it with the intention of taking her own life.

4.10 Sodium nitrite is a yellowish white crystalline solid and can be used as a food preservative. Highly soluble in water, it produces a clear or yellowish solution. Sodium Nitrate is a white crystalline solid with a wider range of use in fertilizers and pyrotechnics but more commonly, like the nitrite, as a food preservative and antimicrobial agent and when mixed with water produces a clear or white solution. Both compounds are toxic when ingested, with the same toxicological effect.

4.11 Sodium nitrate, when ingested, reacts with bacteria in saliva and the gut to form a nitrite and oxidation of haemoglobin occurs. This gives rise to methemoglobinemia, in which the haemoglobin loses its ability to release oxygen effectively to body tissues. Symptoms vary dependent on the amount ingested; in cases of mild exposure patients report feeling tired and are pale, whereas more severe cases involve a shortness of breath, cyanosis (a grey colouring of the face, lips, and extremities) and confusion, loss of consciousness and eventually, death.

4.12 The purchase of sodium nitrate is not widely regulated and can be sourced on the internet. As a suicide method, ingesting sodium nitrate appears to be gaining in popularity, with suicide related websites and online blogs advocating its use.

5. Analysis of Information

5.1 **Adult Social Care Assessments:** Under Section 9 of the Care Act 2014[5], local authorities have a duty to carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. Similarly, under the Autism Act 2009, adults with autism and the professionals supporting them have an entitlement to request a Care Act assessment[6]. On two occasions, concerns were raised regarding Eden which resulted in assessments being considered by Surrey County Council Adult Social Care (ASC) during the relevant timeframe, and another assessment which was conducted earlier, in March 2020. These assessments specifically considered Eden's social care and support needs. Whilst the social worker involved in the assessments was a senior mental health social worker, it is understood the assessment was not focussed on Eden's mental health or any support she needed with her mental health. For the sake of completeness all three assessments are now considered in more detail: -

(a) On the 13th March 2020 the first assessment was conducted in respect of Eden's care and support needs. At the time she was living with her mother, having been evicted from her residential placement. Due to the support provided by her mother it was established Eden was not eligible for further support. It was highlighted that her mother was supporting her with her finances, shopping and cooking and was assisting, as required, with personal care. The social worker noted that Eden was keen to make a return to college and her general impression was that Eden did not have any unmet needs and was at the point of adjusting to adulthood and referred Eden's mother for carers' support. The social worker explained to Eden that if her circumstances changed, such as moving to independent living, she would be eligible for re-assessment.

The social worker had taken the time to engage with Eden, had spoken with her mother and has assessed the environment in which they were living to complete a thorough assessment, which met Eden's physical and social needs and also considered the wider impact on her mother as a carer, which was good practice.

[5] Assessment of needs under the Care Act 2014/scie.org.uk Assessment of needs under the Care Act 2014 | SCIE

[6] Assessments and Care Plans for adults in England, National Autistic Society October 2020 Assessments and care plans for adults in England (autism.org.uk)

(b) The second assessment was conducted by the same social worker, following a referral on the 6th May 2021 from Transform Housing, in which concerns were raised by Eden's keyworker who felt she needed more support. An appointment was made for the 18th May 2021 and whilst Eden had forgotten about the appointment, it did take place on that date. The social worker reported that the flat was clean, tidy and presentable. Whilst Eden is reported to have told the social worker she needed more help; she could not be clear about what help it was that she needed. At the time Eden indicated that whilst she could cook, she was eating 'snacky food'; the social worker saw that Eden was presentable and felt she was coping well and there was no evidence to suggest she had additional social care support needs. The social worker offered to refer Eden to the Welcome Project, who support people with issues relating to social inclusion, but Eden said she wanted time to consider this. At the time of the assessment the social worker was aware that Eden was supported by RSCMHRS and that a referral had been made regarding her eating disorder and that she was awaiting an input from the Mindfulness Service.

The social worker either did not speak with or record the fact she engaged with others involved in Eden's care. The assessment had been conducted as a result of concerns raised by Transform Housing, yet it appears unclear as to whether they were contacted or their concerns sufficiently explored to assist in the decision making process. Equally, whilst Eden stated she needed support she was unable to articulate what she meant and it is unclear whether this was clarified with others who may have been able to provide greater context, either with her keyworker or her mother, who was known to the social worker from the earlier assessment. Whilst Eden and her flat were described as clean and presentable it is unclear what steps were taken to establish whether this was as a result of Eden's efforts alone, or due to the work of others. The National Autistic Society offers advice on their website page[7] which makes it clear that 'a family member, friend or advocate' can be present during the assessment process and it is unclear whether this was a consideration or whether Eden was asked her views on whether she wanted another person to be present.

Chapters six and seven of the Care and support statutory guidance[8] considers the assessment process and at 6.58 refers to 'the condition of the individual at the time of their assessment (which) may not be entirely indicative of their needs more generally, local authorities must consider whether the individual's current level of need is likely to fluctuate…' and considers whether those needs may fluctuate over the course of a day or longer period of time. This 'comprehensive approach to assessment' is recommended in order to 'delay or prevent further needs in the future'. Chapter seven goes on to provide guidance on two conditions relating to the provision of an advocate by the local authority in cases where an individual may have 'substantial difficulty' in engaging with the 'care and support process' (7.4). It would appear there was an assumption made that Eden did not qualify for this support on the basis of her presentation; potentially an opportunity was missed in not exploring whether her complex condition limited her ability to engage and whether the provision of adequate independent support would have facilitated her involvement in the assessments that were undertaken.

(c) On the 20th May 2021 Eden attempted to die by suicide and was admitted to CHW, where she remained. Whilst she was receiving treatment, her care coordinator provided information on the 9th June 2021 to the Hospital Discharge Team outlining the concerns expressed by Transform Housing regarding their limited capacity to provide suitably trained staff who had the time to support Eden with the care she

[7] Ibid 'The assessor' Assessments and care plans for adults in England (autism.org.uk)

[8] Care and support statutory guidance (currently under review) Care and support statutory guidance - GOV.UK (www.gov.uk)

needed. Notes of a meeting recorded on the preceding day indicate there was a consensus regarding Eden's limited ability to care for herself, such that she struggled to wash her clothes, undertake food shopping and generally look after herself and it was agreed she needed practical help at home. The care coordinator records that the third assessment took place on the 21st June 2021 with the outcome being that Eden had no additional needs. The care coordinator reported that she discussed the possibility of a reassessment with the relevant social care team, but the decision remained unchanged. It would appear the actual referral to social care reflected a precis of concerns raised by Transform Housing, with a minimum amount of detail, rather than a detailed description of a shared consensus between professionals highlighting specific examples of unmet need.

The decision to refer Eden for an assessment was a reasonable one based on the fact she had been admitted to an acute facility, indicating a change in circumstances and additionally, concerns expressed by her housing provider regarding her unmet levels of need, was sufficient to justify an assessment on its own merit. The information provided was either not considered or was given insufficient weight as the decision not to conduct an assessment was made based on the information contained within the earlier assessment which took place two days before her admission, on the 18th May 2021. This is confirmed by information provided by the Hospital Discharge Team, which indicates that at the time of Eden's treatment as an inpatient, the team, was still in its infancy, having been created in March 2021 and the processes and procedures in place at the time have subsequently changed. The team manager was in her induction period at that time and has no recollection of the details relating to Eden, nor was a record created relating to the decision made on the 9th June 2021 when the referral was received. The manager recalls that the earlier assessment from the 18th May 2021 was noted and as the circumstances had not appeared to have changed, there was no requirement for any future involvement from the team. The manager recalls this feedback was conducted verbally. At the time, the team did not routinely provide feedback to service providers but again, this has since changed.

In the statement provided, the manager outlined the current process, in which an early assessment is conducted with the individual involved, and any decision would be discussed in a meeting with the ward staff and a multi-agency discussion would take place before involving housing providers. In this process, the manager restated it is the team's responsibility to assess the social care and support needs of the individual, rather than the mental health needs or the support required to address those mental health needs, which would be met by their care coordinator.

(d) On two other occasions it is unclear whether a social care assessment was requested and not completed, or not requested. The first instance was at (4.1) when, following the conclusion of the Section 42 enquiry, a social care assessment request could have been made by the mental health social worker who completed the enquiry. This would have supported the conclusion made earlier, when she was living at home, that a further assessment should be made when she moved to independent living arrangements; the second instance was at (4.29) when a request was made by her consulting psychiatrist at Farnham Road Hospital that an assessment should be made. It is unclear what happened to this referral, whether it was made, or how it was responded to.

5.2 Inter-Agency Escalation Process: Whilst Eden's care coordinator contacted Adult Social Care regarding the assessment of her care needs, the decision that Eden did not meet the eligibility criteria under the Care Act 2014 for assistance from Surrey County Council remained unchanged and this was not subsequently escalated by her care

coordinator or Transform Housing. There was a clear difference of opinion in respect of Eden's level of need and whose responsibility it was to meet that need. Information provided by the Hospital Discharge Team stated and reiterated that their responsibility is to assess and address the social care and support needs of the individual, rather than their mental health needs, which remained the responsibility of RSCMHRS.

In Eden's case, these issues were inextricably linked and she presented with a complex interplay between physical and mental wellbeing with medical conditions arising as a result, which practitioners were called upon to manage. It is difficult to understand how a full assessment of her needs could have taken place considering the nature of the interaction between professionals with an assessment taking place using a limited understanding of her condition and a narrow application of parameters reflecting the policies of that particular agency with a focus on remit, rather than being person centred and considering Eden's level of need.

The escalation policy relating to safeguarding concerns (referring to Sn 42 of the Care Act 2014), which is available on the Surrey Safeguarding Adults Board website[9], outlines circumstances in which a resolution can be sought when there is a difference of opinion or '…when agencies are working in a collaborative, person centred way to safely manage risks but have reached a point where elements of risk are unmanageable and beyond…(their)… level of accountability…' The policy outlines that disagreements can arise in any number of areas but the most likely being those involving the assessment of risk levels. However, when considering how to challenge a disputed decision following an assessment of an adult's needs for care and support, the appropriate channels are described on the Surrey Council Website, which involve advice on direct contact with the team involved, provision of an online complaints proforma or an email address for direct contact with the ASC Customer Relations Team. Eden's care coordinator had informally started this process and by referring this matter to a line manager, who could have liaised with their equivalent in the partner agency there would have been an opportunity for reflection and mature debate which would have encouraged those involved to adopt a holistic view which is key in a person-centred approach.

Whilst Eden was in CHW, Transform Housing requested that Eden was given a period of home leave prior to discharge to assess whether she was able to conform to boundaries set by them as they could only provide a low level of support for her and Eden, in their opinion, required intensive support. It is unclear what response this received and between the 14th - 22nd June staff from Transform Housing exchanged emails with CMHRS, CHW and the housing officer who had supported Eden's application to Transform Housing. The nature of this email chain highlights the concerns staff had about their ability to support Eden and there appeared to be some support for this view, particularly from the housing officer, who subsequently indicated Eden had sufficient additional needs to require alternative accommodation.

On Eden's discharge on the 22nd June 2021, her keyworker emailed her care coordinator, describing Eden's demeanour as 'frantic' on her return to the accommodation and asked whether they could meet together with a Transform Housing Manager to discuss how staff could provide the best support they could. The care coordinator responded two days later on the afternoon of the 24th June 2021, indicating she had spoken with Eden in the intervening period whilst she was with her mother, and Eden had been angry and had terminated their conversation. She explained the HTT

[9] Inter-Agency Escalation Policy and Procedure SSAB V6 April 2023 SSAB-Inter-Agency-Escalation-Policy-V6-April-2023-FINAL-1.pdf (surreysab.org.uk)

had called on Eden, but they had not elicited a response and suggested that Transform Housing could follow up with the HTT to arrange another visit. The care coordinator explained that she was in the process of 'trying to appeal against (the) social care decision that she has no eligible social care needs, but they have done many assessments on her and feels (sic) she doesn't meet eligibility'. The care coordinator went on to explain that Transform, as a housing provider were not responsible for managing Eden's mental health and if Eden tried to end her life this responsibility fell to Eden and the CMHRS. The care coordinator concluded that this risk either had to be managed in the community or in 24-hour care, although this latter option had previously been unsuccessful. The care coordinator advised that Transform should focus on their agreed support plan, assisting Eden with budgeting, goal setting and help with self-care and laundry.

It is evident that Transform Housing provided a level of support to Eden that was in excess of their initial agreement, with her keyworker supporting her with daily life skills including obtaining medication, attending appointments, help with her finances and encouraging her to engage with her care coordinator and facilitating contact with other professionals when Eden failed to do so. This intensive support was effective in ensuring Eden was able to maintain her engagement through the EHCP assessment process which is referred to later in (5.3). Her care plan involved two sessions each week on a one-to-one basis with her keyworker and additional measures were put in place to ensure Eden had an out of hours contact number to call. Transform Housing maintained a meeting log, documenting their contact with Eden which, whilst not recorded contemporaneously, gives an indication of the extent to which all staff and not just Eden's keyworker, attempted to respond to Eden's needs; clearly, she was unwell, complaining of a lack of sleep, dizziness and feeling weak which was probably linked to her eating disorder and some insight into her mood is provided by her text exchanges in which she oscillated between texting and leaving messages requesting help then ignoring or challenging any response. Whilst the staff worked hard to conform to the activity set out in the plan, it was clear that this was largely a reactive process and dependent on Eden's mood or intention on any specific day with little progress made in respect of a therapeutic intervention.

5.3 I**nter-Agency Working and Information Sharing:** The Care Programme Approach (CPA)[10] is a key component of the mental health delivery system in England and is a package of care used by secondary mental health services to support individuals with mental health problems. It promotes the establishment of a care plan for the individual concerned, that is subject to regular review and includes the consideration and assessment of risk. It promotes joint working and communication between health professionals who are supporting the individual. It provides the basis for multi-agency case conferencing and triggering of safeguarding action as well as co-ordinated planning of care and future moves of accommodation. The CPA may lead to an individual being supported by mental health services and their care allocated to a care coordinator. The care coordinator would be expected to coordinate and monitor the persons care which would be written into a care plan, have regular contact with the individual, work with other health professionals to assess the individuals needs and regularly review the care plan to check progress. Due to difficulties Eden experienced with her caseworker and the subsequent breakdown of that relationship, a care coordinator from RSCMHRS assumed responsibility for this function in January 2021.

[10] Care for people with mental health problems (Care Programme Approach) 18 March 2021 Care for people with mental health problems (Care Programme Approach) - Social care and support guide - NHS (www.nhs.uk)

Different health care professionals were involved with Eden at different times, representing a range of teams including those based in the community and in acute and residential settings, with additional support provided by housing officers from the local borough and later, by Transform Housing. Each of those teams had their own management and meeting structures at which Eden was discussed and information was shared, in most cases, appropriately. In June 2021 there are examples of agencies working well together to consider how to manage her care during her treatment as an inpatient at CHW. These included virtual meetings and present were those involved in her hospital treatment, her care coordinator, and her housing provider as well as Eden and on occasion her mother, so that Eden's perspective could be considered.

In January 2021 the relationship between Eden and the RSCMHRS caseworker became strained (see 4.14) and it was evident Eden did not trust her and was initially hostile towards her care coordinator, who made attempts to re-engage with Eden and as a consequence those around her struggled to implement a joined up multi agency approach. At this point Eden had engaged with a practitioner from The Mindful Service, who acted as a conduit, feeding information back to her care coordinator, who sought advice from her manager regarding the difficulties they faced. As a result, her care coordinator wrote a letter to Eden, outlining that the team were keen to engage with her and explained what support was available to her. The HTT experienced similar challenges in communicating with Eden after her periods of in-patient treatment and they document a pattern of limited and eventual disengagement before passing responsibility for her care back to RSCMHRS. This was a pattern that was evident from earlier incidents, with assessments being conducted by the Psychiatric Liaison Team following acute admissions in October and November 2020, with referrals being made by them to the HTT, who were unable to undertake any meaningful work with Eden.

The Surrey and Borders Partnership Trust (SABP) issued a policy on the 21st February 2021[11] aimed at clinicians and practitioners which set out the action to be taken in respect of people who use services and do not engage with treatment and care which set out three key principles relating to '… ensuring that people's views are heard; an assumption that a person has capacity unless it is established they lack capacity and the co-development of services between professionals and the people using services, including their families, in the context of an equal and reciprocal relationship…' The policy comments on the need to '…engage and communicate proactively with other key stakeholders and partners, such as…family/carers, regarding individuals who are at potential high risk of disengagement….' and '…where appropriate, involve independent advocates in the process…'[12] This was an opportunity for the agencies involved to reach out to Eden's family as her housing support worker had done (at 4.26) to formalise that relationship and consider whether an independent advocate could act as an intermediary, facilitate communication with Eden and attend professionals meetings, which may have enabled those involved to pool their knowledge of Eden and to generate a new and coordinated approach to engagement to meet her complex needs and protect her from harm.

There are particular examples where individuals from different agencies were able to engage with Eden productively and when that occurred, they were able to achieve positive outcomes in line with their remits:

[11] Engagement and Disengagement with Services Policy SaBP SABP/Risk/0033 Engagement and Disengagement with Services Policy : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)
[12] Ibid (pge7)

- The Mindful Service supported Eden with her aim of re-entering education and between January- September 2021 the practitioner engaged with Eden repeatedly, by text message, voice mail and eventually in-person follow up visits. This support was successful, with the practitioner facilitating a review of Eden's EHCP and eventual return to education.
- The work undertaken between February and April 2021 by the housing support worker to provide Eden with practical help in facilitating attendance at GP appointments, obtaining medication and encouraging engagement with her care coordinator was commendable. She initiated information sharing with Eden's mother (4.26) and acted as a conduit between Eden and others involved in her care by sharing information on her wellbeing and providing some insight into her mental state in an attempt to meet her needs and support her application to be accepted into supported accommodation, which was subsequently successful.

In both these instances there was a clear objective and a target Eden identified with; she was invested and clearly focussed on securing a place in college to pursue her educational goals and moving into supported accommodation with her own front door and a private space would support that aim.

Each crisis or escalation Eden experienced was an opportunity by those involved in her care to potentially consider the involvement of other professionals. Whilst information was shared with a limited number of agencies involved in her care and in some instances, excluded others (see 4.73 and 4.74 relating to the Section 42 enquiries) the collection and assimilation of information appeared to be seen as a notification process, rather than an opportunity for consultation and the significance of multiple strands of information, when considered alongside each other was lost. Following the incident in Fulham in March 2021 (see 4.27) detailed information was shared by West London NHS Foundation Trust regarding the disclosures made by Eden relating to her social network, which provided insight into her online behaviour and focus on suicide related websites and forums and her plans to meet with members of that community to take her own life. Eden indicated she regretted leaving a suicide note as it had led to her discovery.

Whilst Transform Housing were subsequently involved in multi-disciplinary team meetings in relation to Eden's treatment prior to her discharge from Farnham Road Hospital it is unclear whether the information known at the time was shared in its totality and what impact that would have had on Transform's assessment of risk regarding their capacity and capability to provide a level of care commensurate with Eden's level of need. Had the full extent of Eden's behaviour been disclosed to them at that meeting on the 30th March, Transform Housing would have had an opportunity to consider the suitability of their offer of accommodation, considering Eden's level of need and taking in to account her history of sodium nitrate use and could potentially have adopted additional measures, or recommended consideration of alternative accommodation prior to her moving in on the 6th April 2021.

5.4 Management of Risk and Safety Plans: The Royal College of Psychiatry CR229, 2020[13] refers to studies by Smith, Zuromski and Todd (2018) with regard to eating disorders as a factor in suicide, where suicide is thought to account for over 20% of deaths involving eating disorders, which themselves have the highest mortality rate amongst health disorders. It reports that individuals with anorexia nervosa have a likelihood of death by suicide 18 times higher than gender and age matched individuals;

[13] Self-harm and suicide in adults. Final report of the Patient Safety Group CR229 Royal College of Psychiatrists July 2020 college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)

individuals with bulimia nervosa are seven times more likely to die by suicide and non-suicidal self-injury is a risk factor for the onset of purging behaviour, a relationship that is 'mediated by emotional dysregulation' (Riley et al, 2016). The same publication goes on to explore risk factors and 'red flag' warning signs, a red flag being a risk factor with special significance in that it indicates a person is at heightened risk of suicide at that particular moment in time and whilst 'suicidal thoughts and risk can vary across a relatively short period of time', Eden presented with a significant number of those red flags, namely: -

- Demographic and social – belonging to an ethnic minority group.
- Personal background – use of suicide promoting websites and access to lethal means.
- Clinical factors in history – previous suicide or self-harm, relapse or discharge from in-patient mental health care, disengagement from mental health services and impulsivity.
- Mental state examination and suicidal thoughts – hopelessness and helplessness, suicidal ideas becoming worse or suicidal thoughts with a well-formed plan.

In the risk assessment conducted on the 12th May 2021 by Transform Housing, following a disclosure made by Eden about a recent episode of self-harming, her triggers (relating to being lonely, having no friends and her ongoing eating problems causing her to be nauseous and fatigued) and factors contributing to potential risk are considered, with the likelihood of 'risk to self' by suicide attempt is considered medium and the 'total risk' is assessed as medium. The plan concludes with a list of six actions and a review set for two days later. Risk management measures include potential changes to her financial arrangements as this was causing arguments with her mother; Eden requested a higher level of support and she was provided with contact numbers for Crisis Line and provided with on call details of staff at Transform Housing. Under the section relating to 'other agencies', it was documented that an application would be submitted to secure a transfer to a local General Practitioner. In this assessment it is documented that Eden agreed not to harm herself on that day but refused to hand over to staff the rope she possessed.

The second risk assessment indicates the 'risk to self' by suicide attempt remains at medium with an additional 'risk to self' of 'unreliable with medication' assessed as high. The 'total risk' grading remains unaltered at medium. In the body of the notes made in the second assessment under 'triggers' it indicates that Eden 'had spent £40 on poison and was waiting for this to come through the post' but she later 'agreed not to take the poison' and whilst she would not give (her caseworker) the rope she would not use it. The action plan remained unchanged from the plan agreed two days earlier. It is unclear whether any further specific plans were completed at a later date.

The latest data regarding deaths by suicide in England and Wales published by the Office of National Statistics[14] in 2021 accords with Eden's intentions to self-harm and reports that the most common method of suicide continues to be hanging, strangulation and suffocation (all grouped together), accounting for 58.4% of all suicides in 2021. The second most common method continued to be poisoning and accounted for 20.5% of all suicides. Eden's age and autism were also factors in terms of considering risk of harm. The ONS report goes on to report that females aged 24[15] and under have seen the largest increase in the suicide rate since the time series began in 1981. Whilst there is little research currently available to explore this further, as a statistic, it is significant and warrants consideration when undertaking risk assessments and engaging with young

[14] Suicides in England and Wales; 2021 Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (page 9)
[15] Suicides in England and Wales; 2021 Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (pge 7)

adults within this age group. An additional factor was Eden's autism. Recent analysis of 372 inquest records[16] and interviews conducted with next of kin indicate that of those who died by suicide in England between January 2014 and December 2017, 41.4% had elevated autistic traits and is consistent with a growing body of research showing that autistic people and those with elevated autistic traits are at increased risk of contemplating, attempting and dying by suicide[17]. The report goes on to reiterate that it is imperative for clinical services to address barriers to treatment and support that are experienced by autistic people, and to develop programmes with and for autistic people to reduce their risk of suicide.[18]

The SABP promotes a Strategy on suicide prevention[19] and in their policy on Clinical Risk Assessment and Management[20] it asserts that the period following discharge from hospital is a time of particularly high risk of suicide and emphasis is placed on the need for a well-co-ordinated follow up. It refers to risk peaking in the first week of release with the highest risk occurring on the day after discharge, which therefore requires early keyworker contact; this is balanced by the belief that good practice may entail taking risk…'to balance protection versus promoting independence and enabling individual independence…'[21] Whilst Eden was visibly agitated upon her discharge from CHW in June 2021, and Transform Housing were sufficiently concerned to make contact with her care coordinator to highlight those concerns, the care coordinator responded by reiterating earlier advice, which should have been escalated to service managers in accordance with the policy .

Following her acute admissions to Ashford St Peters Hospital following incidents of self-harm, a risk assessment was conducted by the Psychiatric Liaison Team and information was shared in accordance with their policy which was in place at the time. As such, these risk assessments reflected on a snapshot in time and were based on how Eden presented on those occasions. On the 14th September 2021, what she told the clinician involved and what other information was immediately available provided conflicting information regarding her intent; she had told the ambulance staff she had sodium nitrate and intended to use it and then indicated a short time later to the PLT clinician that whilst she had it in her possession, it was not her intention to take the sodium nitrate. Prior to her discharge the clinician involved recorded a risk assessment indicating the risk of harm she presented to herself was unpredictable due to her impulsivity.

5.5 The Involvement of Family Members: In January 2021 Eden's care coordinator contacted her mother (see 4.14) in an effort to elicit Eden's engagement, however she was unable to help as Eden had at that time disengaged from her mother. Her mother reported that between this point and her eventual death, she lost between four to five stone in weight, which was attributed to her eating disorder. Later, at (4.36) Eden's

[16] Autism and autistic traits in those who died by suicide in England by S Cassidy et al published in the British Journal of Psychiatry, February 2022
Autism and autistic traits in those who died by suicide in England | The British Journal of Psychiatry | Cambridge Core
[17] Cassidy, S. Suicidality and self-harm in autism spectrum conditions. In Oxford Handbook of Autism and Co-Occurring Psychiatric Conditions (eds White, S, Maddox, B, Mazefsky, C) 349-68. Oxford University Press, 2020. Google Scholar
[18] Cassidy, S, Goodwin, J, Robertson, A, Rodgers, R. INSAR Policy Brief: Autism Community Priorities for Suicide Prevention. International Society for Autism Research, 2021
[19] Our Suicide Prevention Strategy sabp.nhs.net Our Suicide Prevention Strategy : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)
[20] Clinical Risk Assessment and Management Policy and Procedure SABP/Risk/030 approved February 2016 Clinical Risk Assessment and Management Policy and Procedure : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk) (page 9)
[21] Ibid (page 11)

mother was involved in attending the meetings regarding her treatment as an inpatient at CHW and she was contacted by the clinician involved in Eden's assessment (4.54) following her attempt to die by suicide.

Eden's mother describes the relationship she had with her daughter as a positive one. She spoke with her daily by phone and they saw each other twice a week. She describes a regular routine which included managing Eden's money as she was inclined to spend it impulsively and she made online food orders on her behalf. Whilst Eden could manage her own personal hygiene, her mother reported she regularly helped her clean her flat and encouraged her to wash her clothes using the facilities at Transform Housing, as this was something Eden often neglected. Eden's mother indicated she could tell whether she was in a low mood or considering self-harm by her mannerisms and the way in which she spoke. She said that on such occasions she could talk to Eden and help her de-escalate.

5.6 Eden's Voice: Eden's mother reported that her daughter expressed frustration about her experience of key workers and the Community Mental Health Team, whom she felt 'talked at' her and did not listen to her or know her as a person. Eden felt those responsible for her care did not know her in the way her mother did as they spent so little time with her and they could only respond to what she told them which meant Eden felt she was being watched all of the time; she was not given the opportunity to be understood. In the risk assessment conducted on the 12th May 2021 by Transform Housing, triggers and factors contributing to potential risk are considered, one of which refers to '…. (care coordinator) saying she can't be bothered going to appointments and Eden is being lazy not attending appointments….' Whilst there is no evidence to indicate her care coordinator actually said this, it may have been Eden's perception, which in itself created challenges to health professionals involved as those directly responsible for managing any therapeutic interventions were perceived by Eden in a negative light and any opportunity to build a 'therapeutic alliance'[22] was limited.

Eden had few obvious friends or role models and her interests involved gaming and online forums, writing stories, and creating dolls who were characters in those stories with limited interaction with others, which was consistent with her diagnosis of autism. Eden had moved three times within the preceding year and whilst she was initially positive about her move to supported accommodation in April 2021 in that it provided her with her own front door and a private space alongside a proximity to college and her mother and Godmother, this had contributed to her social isolation in the 'real' world, where the majority of her daily contact was purely with healthcare professionals. On occasions Eden indicated she wanted to move on from the accommodation provided by Transform Housing to a different provider, but she would then change her mind and her reluctance was understandable given the upheaval and the stress a fourth move would cause.

As referred to earlier, she researched extensively online, exploring self-harm related websites and in the month leading up to her death her online activity (4.71) indicated a preoccupation with self-harm and suicide. These themes were interwoven with a desire to understand and confront the nature of the abuse she suffered and there was a complex interplay between her desire to seek therapy, her experience of the post-

[22] Self-harm and suicide in adults. Final report of the Patient Safety Group CR229 Royal College of Psychiatrists July 2020 college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)
(Page 47)

traumatic stress as a result of her abuse and her capability to confront this trauma, which was affected by her autism and mental health conditions. Whilst Eden had indicated a willingness to seek treatment for her PTSD, which she discussed with her care coordinator just days before her death, there was no clear agreement about the initial steps in this process, with Eden preferring direct contact with her consultant psychiatrist to discuss this. It is clear she was preoccupied with her experience of abuse at the time she commenced college and was in a distressed state when she spoke to her mother about her abuse on the day before her death. This highlights the importance of professionals having the time to establish a trusting relationship and skill in sensitively exploring extreme emotional distress which in Eden's case was often a precursor to an episode of self-harm. Whilst Eden had established a positive relationship with staff at Transform Housing and they had some insight into the issues affecting her, her Godmother commented that 'they knew enough to know that their care was insufficient'; they flexed resources and made considerable efforts to support Eden but struggled to provide the time and create the environment she felt she needed to able to engage with them.

Eden disclosed to both her mother and Godmother she believed her treatment was influenced by her ethnicity. She explained that she wanted to live in an area where there were more black people and on one occasion stated she 'wanted to be white' as she felt she 'would be treated differently'. The Surrey and Borders Partnership Trust (SABP) set out their policy on Equality and Human Rights[23], relating to individuals working for, or with, the trust and people who use their services, and their families or carers to ensure they 'are treated with dignity and respect and are not subject to discrimination, harassment or victimisation on the grounds of any of the protected characteristics as required by the Equality Act 2010'. The report refers to the ethnic breakdown of people who use the services of SABP 'where 10.4% of the population are from a black, or minority ethnic background with Woking having the highest BME population at 13.2% and Waverley the lowest at 7.3%'[24]. Whilst the policy is available on the publicly accessible SABP website and reflects a focus on promoting equality of opportunity it appears to have an internal focus which is largely aimed at staff. The website provides reference to Equality, Diversity and Inclusion and links[25] to LGBTQIA+ support provided by external agencies; additional reference to Ramadan and Mental Health and a key events timeline celebrating black NHS workers but it is unclear what support is immediately accessible to members of the black communities present in Surrey and what consideration is given to any diverse cultural and social needs they may have with any account taken of their ethnicity in a predominantly white community.

6. Findings and Recommendations

6.1 Adult Social Care Assessments: The decision on the 9th June 2021 that Eden had no additional social care needs took in to account only what was contained in the earlier assessment conducted on the 18th May 2021.That earlier assessment considered information provided by Eden and did not reflect on, or consider, the perspective of those close to her or involved in her care, nor was an independent advocate considered and effectively, her rights under the Care Act were not met. Whilst Eden may have presented well and given a credible account, she struggled to clearly articulate her needs and a contextual approach, involving others who were close to her would have provided a fuller picture of the challenges she faced. This assessment may have resulted in a limited

[23] Equality and Human Rights Policy SABP/Workforce/0016 2023_6.0_Equality_and_Human_Rights_Policy (4).pdf (page 1)
[24] Ibid (page 24)
[25] Equality, Diversion and Inclusion NHS care Equality, Diversity and Inclusion : Surrey and Borders Partnership NHS Foundation Trust (hereforyousurreyneh.nhs.uk)

understanding of a complex situation and those involved in the subsequent decision not to conduct a further assessment did not consider in sufficient depth the information known to Transform Housing and as such, missed an opportunity to assess whether Eden's current care provision was commensurate with her levels of need. Whilst it is important that decision makers consider earlier assessments to provide a bigger picture, the decisions emanating from earlier referrals should not be used on their own as a basis for informing current activity.

Furthermore, a better understanding of the Care Act by practitioners involved in the care of adults is discussed by the House of Lords Social Care Committee[26] which asserts that a cultural shift is required to ensure that practitioners move more towards consideration of 'the assessment process… (as) a collaborative experience, rather than merely establishing eligibility for services based on a narrow criteria'. The report goes on to highlight the opportunities presented by co-production 'as a sustained and two-way relationship between the individual and the care professional' which supports the assertion by the House of Lords[27] that this requires genuine conversations between both parties where the individual involved is an active agent of change, 'rather than a passive recipient of care'.

Recommendation 1:
SCC Adult Social Care will ensure that social care assessments support the recommendations at section 6 and 7 of the Care and support statutory guidance and show evidence of co-production.

At the time of Eden's treatment as an inpatient in May 2021, the Hospital Discharge Team was assimilating new practices, and their manager was completing an induction period.

Recommendation 2:
SCC Adult Social Care should ensure that the current policies and practices implemented by the Hospital Discharge Team regarding assessments of social care needs are now embedded and consistently applied.

It has been difficult to assess whether there is an efficient and effective process involving the submission and assessment of social care referrals. The author has been unable to confirm what submissions were made in respect of Eden and whether there is a correlation between those referrals and the action taken as a result. Whilst recommendation (2) will go some way to resolving the concern regarding assessments of need, there is still potentially, work to be done in measuring outcomes and the timeliness of those referrals.

6.2 Inter- Agency Escalation Process: In accordance with the advice provided on the SCC website an appeal should have been made directly to the manager of the Hospital Discharge Team to escalate the concerns that Eden had unmet social care needs; either Eden's care coordinator or Transform Housing could have challenged the subsequent assessment decision and adopted the steps outlined to secure the best possible outcome for Eden in light of the decision made by the Hospital Discharge Team. At the same time, the response provided by Eden's care coordinator to emails from Transform Housing regarding their attempts to highlight concerns about their ability to continue to care for Eden on her discharge from CHW was limited to reiterating what had previously been agreed and, in the circumstances described did not consider other options. Whilst it may be difficult for one agency to challenge another when they are working together,

[26] A 'gloriously ordinary Life': spotlight on adult social care; House of Lords Adult Social Care Committee, Report of Session 2022-23 page 68 committees.parliament.uk/publications/31917/documents/193737/default/
[27] Ibid page 73

particularly when those involved perform different functions and are at different levels of seniority, challenge and challenging conversations are an important feature in managing the risk posed by people who, whilst they may have capacity, make decisions that are not in their best interest.

Eden presented with fluctuating levels of need which was something that required a high level of skill, knowledge, and training to overcome, which required a level of coordination that was not readily available but could potentially have been delivered following a mature assessment of her needs, involving a contribution by all the parties involved in her care. Transform Housing should have challenged the response by Eden's care coordinator as there were ample examples of Eden's escalating needs, as documented in their contact logs, which would have been highlighted during the escalation process; by involving managers at more senior positions within each organisation there would have been the opportunity to reflect on and support the concerns raised by those closest to Eden and provide sufficient supporting information to warrant consideration of a different approach to her needs.

Recommendation 3:
Transform Housing should ensure that there is guidance available to staff, documenting how they can escalate concerns regarding service users and staff are trained in its use and supported and empowered to challenge other agencies.

6.3 **Inter-Agency Working and Information Sharing:** There were critical moments which presented opportunities to consider whether Eden was receiving effective support. Eden maintained a pattern of limited or non-engagement with some practitioners which appeared to be linked to her complex needs and her interpretation of what those professionals were attempting to achieve. In effect, professionals around her responded by maintaining the same approach without considering whether other support was available or whether a different approach would be more effective. As a consequence, an attritional relationship evolved which culminated in further non engagement and ultimately, episodes of self-harm. By arranging a case conference or professionals meeting, those involved in her care would have been able to share what they knew, review the totality of the information available and consider the perspective of others involved to explore what viable alternatives existed and break what became a reactive cycle of care delivery and effectively, a stalemate. Within this process, those closest to Eden, and probably those least experienced in terms of managing complex situations involving vulnerable and young adults with fluctuating levels of capacity would have the opportunity to be heard, their views considered, and effective support provided.

Recommendation 4:
SABP should confirm that care coordinators consider the opinion of other agencies and utilise the Care Programme Approach effectively to facilitate multi-agency meetings in support of service users. This policy must be based on the fundamental principles of making safeguarding personal[28] by securing engagement; utilising relationship-based practice; applying a knowledge and understanding of history; promoting participation and voice and personalising intervention.

Surrey Heartlands Integrated Care Board (ICB) is now implementing new guidance to provide an All-Age Dynamic Support Register[29] (DSR) which will assist in the earlier identification of children and young adults requiring support to avoid admission to mental health hospitals and reduce escalating periods of crisis. By referring to the DSR Multi-Agency or Multi-Disciplinary

[28] Making Safeguarding Personal LGA March 2013 making safeguarding personal.pdf (adass.org.uk)
[29] Dynamic support register and Care (Education) and Treatment Review Policy and guidance January 2023 (page 25) PR1486-Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf (england.nhs.uk)

teams, those with the most complex needs will receive additional advice and guidance from the ICB Health Care Planning Team, to appropriately support people with learning disabilities and, or autism. Individuals are required to consent (or best interest decisions will be made where someone lacks capacity) to a referral to the DSR.

In line with the NHS Long Term Plan[30], the Key working service launched in October 2023 and funded by Surrey Heartlands and Frimley ICB will be coterminous with Surrey County Council and hosted within the council. The Surrey Key working Service works with children and young people with learning disabilities and, or autism, aged 5-25 years old who have complex needs that increase their risk of being admitted to a hospital or placement breakdown. This will ensure children, young people and their families' voices are heard and represented and they have the right support from services at the right time. The aim is to avoid admission to hospital or when already in a specialist hospital, support faster and safer discharge, as well as helping to improve their experiences and outcomes.

Recommendation 5:
The Safeguarding Adults Board must seek an assurance from Surrey Heartlands and Frimley Integrated Care Boards that the provision of key workers is fully effective by March 2024 in order to provide support to children and young adults with learning disabilities and, or autism in Surrey.

It is unclear why the SABP policy relating to engagement and disengagement from services, which was issued in February 2021, was not considered, or applied during the period of Eden's involvement with mental health services after that time. This policy promotes the involvement of family members and the use of an advocate, which would have been beneficial, in providing Eden with representation in meetings and by seeking 'the assistance of other professionals when discussing treatment options'.[31] It is understood this policy has just recently been reviewed and changes implemented which include ensuring that concerns involving individuals at risk of non-engagement are escalated and monitored on a weekly basis through multi-disciplinary team meetings.

Recommendation 6:
SABP must consider how their policy on engagement and disengagement is applied effectively; specifically, what has been its impact, what outcomes achieved and what has been learnt in relation to the use of advocates and engagement with families.

6.4 Management of Risk and Safety Plans: Transform Housing created specific safety plans to mitigate the risk Eden presented to herself and these reflect best practice recommendations made by the Royal College of Psychiatrists. Their challenge was twofold in that there was often a mismatch between what Eden said and what she did and Eden's perception of the relationship she had with her mother, who was not seen as a protective factor. Whilst Eden viewed her mother as a 'trigger' regarding the management of her finances and Transform Housing sought to limit her mother's influence, the involvement of family and friends is recognised by the Royal College of Psychiatrists as a central pillar in the effective management of risk and 'clinicians can gain useful and important information from third parties, such as families, friends or first responders'…[32] In this case more could have been done to understand the relationship Eden had with her mother and Godmother, and whilst both of them described a fluctuating pattern of engagement that presented challenges, their combined insight into Eden and her life skills could have been used to better effect in managing risk.

[30] Children and Young People Keyworkers NHS England » Children and young people keyworkers
[31] Engagement and Disengagement with Services Policy SaBP SABP/Risk/0033 (page 8)
[32] Self-harm and suicide in adults. Final report of the Patient Safety Group CR229 Royal College of Psychiatrists July 2020 (page 50) college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)

The Consensus Statement[33] reflects the government's commitment to consider the experience of families bereaved by suicide and has identified issues of confidentiality as a recurrent theme. First developed and published in 2014, it has been republished in 2021 and reflects that 'obtaining information from and listening to the concerns of families are key factors in determining risk'.

Recommendation 7:
Where suicide is a risk factor, Transform Housing must ensure their safety plans fully document what efforts have been undertaken to obtain consent from the person involved to engage with family members and those closest to them to establish whether they can contribute to the plan and record whether any additional measures can be agreed to help reduce or mitigate risk.

Taking all these factors into consideration, at the time the safety plans were agreed, Eden was in possession of commonly available items which could be purchased without restriction, with which she could cause herself harm and Transform Housing, as her landlord, had no power to compel her to surrender. The Royal College, in the report referred to earlier, makes explicit reference to the removal or mitigation of the means to harm themselves. Whilst elements of this safety plan are included in Eden's assessment of risk, considering what was known about previous suicide attempts and her potential access to harmful substances purchased online, this was something that warranted further exploration to support an accurate assessment of risk.

Whilst Transform Housing were able to create plans based on what they knew, additional information was readily available to other agencies at that time which would have contributed to a better understanding of risk; Eden had previously taken sodium nitrate, had subsequently been found in possession of it on a separate occasion and had disclosed accessing online sites which advocated suicide and self-harm. If this had been known to Transform Housing staff at the time, they would have a fuller understanding of the risks and more confidence to have those challenging conversations. Whilst being sensitive to Eden's emotional distress, staff would have been able to look beyond her presenting symptoms and take time to come to an informed decision based on what they knew about her history of involvement with substances she had ordered online, whether any intervention was a possibility and reach an agreement with Eden regarding how Transform staff would respond once she was in possession of the substance. Whilst Transform Housing would have found it difficult to maintain a positive relationship with Eden it was particularly important to probe for this information and elicit her support when it was known that there was often a mismatch between what she said and did, 'particularly when suicidal thoughts and risk can vary significantly within a short period of time'[34].

Recommendation 8:
SABP must ensure they share information with housing providers which relates to a specific risk of self-harm in support of the compilation of robust safety plans.

Recommendation 9:
Transform Housing will ensure that their staff are trained in the compilation of safety plans for their service users which clearly document what the risks are considered to be, what action has been taken to confirm what those risks are and what specific action has been taken to mitigate those risks.

[33] Information sharing and suicide prevention: Consensus Statement Information sharing and suicide prevention: consensus statement - GOV.UK (www.gov.uk)
[34] Ibid page 51

At the start of September 2021, Eden commenced her studies at West Thames College which for her, was a significant and new chapter in her life. It had been her sole focus over the preceding year and with the support of professionals around her she had achieved her aim. However, no risk assessment was considered in order to reflect on the challenges this would pose and effectively by the time Eden commenced her studies she had disengaged from those around her. Whilst she was insistent that everything was going well, considering her complex needs, autism and PTSD, and the significant changes which impacted on her lifestyle it is difficult to accept this was actually her reality. Whilst Transform Housing supported her on the first day, providing her with a lift to college, and checking in with her regularly to ensure she had support, a risk assessment would have served to focus on her changing circumstances and subsequent needs and consider the risks inherent in the situation. By the 13th September 2021, her keyworker was considering re-assessing her needs as the risks had appeared to have diminished but neither the keyworker, the college or other professionals around her appeared to be cognisant of the mounting pressure of her coursework and fluctuating weight, which she disclosed to her mother and the PLT clinician on the following day.

Recommendation 10:
Transform Housing will review their policy relating to risk assessments and safety plans to ensure that the potential impact of future lifestyle changes or other transitions are considered to ensure assessments are used as a proactive tool to minimise risk, rather than as a reactive response once risk has escalated.

Each agency involved with Eden had their own risk assessment, reflecting the perspective of that agency which was based on what was known by them at that point in time. However, the absence of a shared risk assessment involving a rigorous and jointly owned process meant it was unclear what significance could be attached to information owned by other agencies. With limited engagement with other professionals the risk assessment process that informed her discharge from hospital on the 15th September took place in a silo, rather than being holistic and coordinated. The nature of Eden's metal health diagnosis and her complex needs compounded the need for an accurate shared assessment as the risk she posed to herself was assessed as unpredictable. As such, a pooling of knowledge between agencies would have helped in the completion of a mature assessment which took time to consider the complex relationship between her mental and physical ill health in order to mitigate that risk. This complexity illustrates the need for person centred care with the involvement of a bespoke team and a lead professional who is best placed to react dynamically to coordinate that care.

Recommendation 11:
The Safeguarding Adults Board must seek an assurance from the Surrey Suicide Prevention Board that they will consider the need to review the risk assessment process in Surrey so that there is a shared understanding of risk between the agencies involved in the care of that person.

6.5 Involvement of the Family: Eden's mother and Godmother maintained an ongoing interest in her welfare and in March 2021, acting on advice provided by her housing support worker, Eden subsequently agreed that the RSCMHRS could exchange information with her mother, (3.26), which was good practise. Whilst Eden's care coordinator had approached her mother earlier, towards the end of January 2021, and she could not offer any immediate assistance it appears there was very little further consideration as to how she could provide additional support to those working with Eden and consideration could have been given to using her knowledge of Eden and the relationship she had to better effect, in line with the policy relating to engagement and disengagement which is discussed earlier at (5.3). Whilst this policy was not effective

until mid-February 2021, elements within that policy would have provided a framework for greater engagement with those close to Eden and generate opportunities to reach a consensus on her care. The third key principle of the policy[35] highlights the need to reflect 'an equal and reciprocal relationship… between professionals and the people who use their services, including their families'. If this policy had been adhered to, subsequent efforts to engage with Eden may not have changed the eventual outcome but it would have created a framework for engagement and reflected the central tenet that 'co-production' encourages investment by all the parties involved and is a more effective way of ensuring that people's views are heard. It is understood that this is now reflected in clinical records and subject to discussion in the multi-disciplinary team meetings that are held, and staff have a new risk assessment process which informs an agreed course of action.

Recommendation 12:
SABP must ensure that clinicians and practitioners are complying with the Engagement and Disengagement with Services Policy to include families voices within care plans.

6.6 Eden's Voice: nothing is recorded which would suggest Eden's experience as a person of colour was considered or whether her culture played a significant part in her life. Her experience of the world was different to those around her because of her ethnicity; her self-esteem and self-worth were measured against social norms of a predominantly white culture which she viewed through the prism of her autism, complex mental health issues and PTSD. Whilst 'she wanted to be loved' (her Godmother's phraseology), she was isolated and alone and due to the nature of the relationships with those professionals around her, either due to their limited involvement, duration of the task they were committed to, or weight of their workload, no one really had the opportunity to understand her and see the world from her perspective.

NHS Scotland refer to their Equality and Diversity Messages[36] reflecting that good equality and diversity practice involves understanding the role that cultural and religious beliefs play in health care and peoples' experience of the health service and ensuring that everyone is provided with a level of care commensurate to their individual needs. As such practitioners 'must be able to identify and respond to the specific needs of diverse patients, service users and carers which arise from their personal, social or cultural background'; this goes beyond treating everybody equally and reflects the imperative to treat everybody according to their needs.

Recommendation 13:
SABP must undertake a review of their policies and care plans to ensure action is documented to consider the personal, social and cultural background of the individual involved and take in to account their cultural and religious beliefs.

Social isolation was a significant factor in Eden's life and is evident from the information she provided following her admission to Farnham Road Hospital in March 2021, where she disclosed that the entirety of her social engagement was online and limited, largely, to websites advocating self-harm. Her application, submitted to Transform Housing in April 2021 indicated she wanted to live separately from others and struggled socially and later, in the risk assessments and safety plans completed by Transform Housing in May 2021, Eden complained of having no friends. It is unclear what action was taken to consider whether peer support programmes or befriending schemes were available throughout the period of her

[35] Engagement and Disengagement with Services Policy SaBP SABP/Risk/0033 Engagement and Disengagement with Services Policy : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk) (page 1)
[36] Effective Practitioner Equality and Diversity Key Message NHS Scotland Effective Practitioner (scot.nhs.uk)

involvement with the RSCMHRS, but these are seen as effective responses when considering how to remove barriers to treatment and support for autistic people.

In April 2021, Surrey County Council published their All-Age Autism Strategy 2021-2026 which aims to improve the lives of autistic people living in Surrey and refers to consideration of a peer support scheme[37], but it is unclear what progress has been made since that time.

Recommendation 14:
The Surrey Safeguarding Adults Board to share this report with the strategic lead for the Surrey Autism Partnership Board and request an update as to what progress has been made regarding the All-Age Autism Strategy (21-26), workstream 3; particularly what specific consideration has been given to the provision of peer support and a peer support network to support young autistic adults.

7. Conclusion

The review has sought to examine key episodes in Eden's life and consider the response of agencies involved in her care, concentrating on professional practice and multi-agency working and the impact this had on Eden. Common themes have been identified which are reflected in the recommendations and which seek to maximise the opportunity for reflection and learning, both for individual agencies and across the wider partnership and the lack of detail does not in any way diminish the impact of what happened to Eden, her family or the professionals involved with her.

What is clear, is that Eden had persistent and fluctuating levels of need which, due to their challenging and complex nature, generated episodic responses which were reactive and focussed on her presentation, rather than any treatment being managed as part of a coordinated plan. It is clear that Eden's experience of sexual abuse and the subsequent trauma affected the quality of her life and ultimately, she was unable to manage the impact of this abuse without therapeutic intervention. There was little evidence of practitioners thinking flexibly, considering how family members, community resources or voluntary agencies could contribute to interventions and build on relationships and networks of support. This highlights the importance of practitioners having the time to establish trusting relationships and sensitively explore emotional distress with housing, mental health and social care practitioners working together to address Eden's accommodation, health and care and support needs.

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