South Gloucestershire Safeguarding Adults Board

'Adult K'

What Happened?

Adult K* was a young woman in her early twenties who was found deceased on the railway tracks at Victoria Train Station in October

The Bi-Borough of Kensington and Westminster SAEB considered if there was any learning for them, however Adult K was not known to their services prior to this incident and so the information was then shared with South Gloucestershire SAB where Adult K lived. It was decided to undertake a SAR in January 2023 as Adult K was well known to services in South Gloucestershire.

A short period of July to October 2022 was considered by the SAR author as there were so many contacts with organisations taking place prior to Adult K's death.

*Adult K is a pseudonym chosen to protect anonymity

> Click here to read the full report about Adult K

The review was led by an facilitator - Julie Foster



Professionals from all the key agencies who worked with Adult K in Westminster and South Glos took part in the review

Key Learning Point

This SAR highlights serious gaps in resources for people with mental health difficulties, especially whilst in crisis, which results in significant risks to their safety.

Professionals worked in underresourced systems and communication systems did not facilitate information sharing in a

Recommendations

- SGSAB seek assurance that acute trusts (NBT & UHBW) review the High Impact User Group teams to ensure they are working with all organisations involved, that there is a Regular User Protocol in place underpinned by a trauma informed approach
- SGSAB seeks assurance that they are kept informed of commissioning arrangements to review availability of services to meet the needs of people with mental health needs in crisis in a timely way
- SGSAB seeks assurance that escalation process for extra contractual referrals operates out of hours to reduce patient waiting times in inappropriate settings
- SGSAB ensures the findings from this SAR are used to highlight the fatal consequences of the lack of availability of HBPOS (Health Based Place of Safety) and mental health beds across England
- SGSAB partners to investigate why safeguarding adults legal framework is not consistently considered in mental health situations when the Care Act Criteria are met
- SGSAB to seek assurance that improvements are made to ensure key risk information is saved in an easily accessible location and includes contact information for key professionals
- SGSAB to ensure training is available across all organisations about EUPD and the presentation of people with this diagnosis, to include conscious and unconscious bias
- SGSAB to seek assurance that when people with complex mental health problems move area the most appropriate option for maintaining services is put in place.

Recognise the impact of secondary or vicarious trauma, and signs of burn out for staff. Click here for more

Mental Health Difficulties can be a result of trauma. Ask 'What happened to you?' rather than 'what is wrong with you?

Click here to find the new SGSAB multi agency Mental Health and Suicide Prevention Guidance

Theme for Learning – Dual and Triple Diagnosis

- Adult K had multiple contacts with organisations, often several times in a week. Her vulnerabilities were increased as she misused substances alongside mental health diagnoses and professionals were often falsely reassured that others were dealing with issues.
- A new vision for multi agency service is required to provide effective support for people with complex mental health and substance misuse difficulties



Click here for Trauma Awareness & Recovery



EUPD Diagnosis (Emotionally Unstable Personality Disorder)

- Complex Diagnosis characterised by a disorder of mood and how a person interacts with others
- Carries a perceived stigma and can remove hope for both the individual and professionals
- Click this box to understand more about EUPD

Adult K considered that her diagnosis of EUPD led to people not taking her seriously. Unconscious bias may affect decision making about how care proceeds. It may underlie the assumptions made that other people were dealing with the situation, and they did not need to act. Always make a safeguarding referral when the criteria is met, and don't assume other organisations/people are doing so.

Good Practice Identified

- NBT and UHBW developed a high impact user personal support plan in collaboration with AWP, the Police tactical plan and SWASfT High Intensity user plan. This made consistent and helpful responses to crisis more possible
- Safe Link made multiple attempts to engage
- The Bridge & SWASfT made Safequarding Adults Referrals
- Good multi agency liaison between professionals