Essex Safeguarding Adults Review

Megan

2021/22

Author: Nicola Brownjohn

Essex Safeguarding Adults Board

Contents

1. Author's Introduction

1.1 A death caused by the actions of the individual themselves is particularly difficult for those grieving for their loved ones. It creates a situation of seeking answers to the questions of why their loved one took their life and how the death could have been prevented. For Megan's family this has become a prolonged process due to having to wait until 2022 for the Coroner's Inquest. This was completed in March 2022. There was a narrative conclusion that it was not clear whether Megan intended to end her life when she used a scarf as a ligature around her neck, and that the neglect of the mental health services contributed to her death.

1.2 I offer my condolences to Megan's family, and I hope that they can start to move forward in their grieving for the loss of such a loved individual.

1.3 Essex Safeguarding Adults Board (ESAB) made the decision to commence the Safeguarding Adults Review (SAR). It is important to note that the purpose of a SAR is about learning to ensure that agencies work together to commit to preventing future deaths in similar circumstances.

1.4 I was commissioned some 18 months after Megan's death to undertake the review. This is the first time I have worked in Essex and with the organisations involved. I am a registered nurse with over 30 years' experience. Although I am not a mental health nurse, I have worked in safeguarding for 20 years as well as leading on quality and patient safety work which has involved extensive work with mental health settings. I have authored several SARs and patient safety reports which have focused on suicide.

1.5 It is important to recognise that the learning from deaths such as Megan's is not solely for mental health services. If it was, then her situation would not meet the criteria for a SAR. The issues surrounding Megan's death involve a range of agencies. Each agency has reviewed their own practice in relation to their contact with Megan.

1.6 For this SAR, I will only summarise what happened to Megan. It is her story, and she was a private person who did not always let others know how she felt. I will not dramatize her life but, rather, use her legacy to question how agencies worked together and why they made the decisions they did. I will then consider how Megan's experience illustrates the wider system across Essex. This will enable the ESAB and agencies to be able to think about the changes that are needed and commit to take this forward for sustainable improvements in how they work together to safeguard individuals such as Megan.

1.7 I am grateful to Megan's family for providing me with a good sense of who Megan was and what she meant to them. I am very aware of how intense their grief is as they have waited for two years to gain answers. I hope that this review provides them with reassurance that those agencies involved have undertaken considerable reflection following Megan's death and have already made considerable changes to their services and continue to identify learning. I hope that Megan's family can feel that Megan's legacy will be better recognition of how to safeguard those with mental illness who have suffered trauma and exploitation at key times in their lives.

1.8 The gap in this SAR has been the absence of a practitioner event. I would have appreciated being able to talk with those who directly supported Megan. Nevertheless, I

realise that two years have passed, and those practitioners will not all be in the same roles. In mitigation of this, I am reassured that all the agencies involved have taken forward the early learning from Megan's death. Therefore, I consider this SAR needing to facilitate the ESAB's follow up of the early learning and ensure that improvements are embedded within the system.

1.9 The methodology used has involved each agency providing an individual management review or serious incident report, with additional conversations with some services and leaders to clarify any issues. There has been a review panel in place, comprised of managers from the agencies involved. This panel has been helpful in considering the questions posed by the case and providing advice on specific Essex policies and procedures. This has also enabled real ownership of the learning by the agencies that need to work together to take forward the changes.

2. Terms of Reference

2.1 S44 of the Care Act 2014 requires that the Essex Safeguarding Adults Board must arrange for there to be a review of cases involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2.2 Reviews **must** also be arranged if an adult in its area has not died, but it is known or suspected that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. ESAB can also arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

2.3 ESAB SAR group reviewed the initial information provided by the agencies involved with Megan and concluded that the criteria for a SAR was met.

2.4 The following terms of reference were agreed:

The period to be covered by the review will be. **January 2016 until 16 January 2019**

2.4.1 To develop an understanding of Megan's vulnerabilities, her health and care needs, capacity to care for herself and her level of independence and consider:

- How did agencies perceive and assess Megan's risks of self-harm and were responses in accordance with agencies policies/procedures?
- What support Megan was offered in relation to substance misuse and whether her mental health and mental capacity were considered?
- How practitioners perceived and assessed risks of sexual exploitation and abuse to Megan and how these were responded to?
- How effective was inter-agency collaboration, communication and information sharing in providing support for Megan following her disclosures of sexual abuse/exploitation?
- How effective was inter-agency collaboration, communication and information sharing in providing support for Megan during transitions in care? (this has been reviewed within the EPUT SI)
- To what extent was Megan's voice heard and her wishes and feelings considered by practitioners when planning her care and assessing risk?
- What support was offered to Megan following bereavement and to what extent did practitioners perceive and assess this life event as a risk to Megan's mental health and potential further self-harm?
- Any difficulties agencies encountered when supporting Megan that impacted on the case?
- To what extent was Megan's mother involved in care plans and risk assessments for Megan and how was the support for her considered, including the Care Programme Approach?

2.5 To explore how agencies can respond effectively when an adult, who is deemed to have mental capacity appears to be making decisions that are deemed unwise for their physical and/or mental health.

2.6 To explore how agencies can involve and support families who are caring for an adult deemed to have mental capacity who appears to be making decisions that are deemed unwise for their physical and/or mental health.

2.7 To explore what this case tells us about sexual abuse service provision across Essex for adults with care and support needs.

2.8 To consider what preventative actions could have been taken by agencies that may have made a difference to the outcome.

2.9 To identify good practise that was in place.

2.10 To identify lessons to be learned to improve future professional practice.

2.11 The agencies involved:

- Essex Partnership University NHS Trust (EPUT)
- GP
- Colchester Hospital
- Basildon Hospital
- Adult Social Care
- Essex Police
- East of England Ambulance NHS Trust

3. Summary of the Case

3.1 Megan was a 28-year-old, white British woman, who had a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and attention deficit hyperactivity disorder (ADHD).

3.2 Megan had been known to Essex Partnership University Trust (EPUT) since 2015 both as an inpatient service user, to several different psychiatric wards, and within community mental health settings. According to the EPUT patient safety report, Megan had, over the three years prior to her death, been admitted to the inpatient psychiatric units eleven (11) times. The reason for the admissions were due to various methods of self-harm, suicide attempts and polysubstance abuse primarily cocaine dependency.

3.3 The EPUT patient safety report considered the evidence from the psychology sessions Megan received. Within these Megan was described as having had a "*long history of emotional dysregulation leading to multiple self-harming episodes and polysubstance misuse primarily cannabis and cocaine. In addition to the above there were also other factors that impacted upon her which included:*

- *Sexual Abuse aged 11 years*
- *Sexual exploitation during her adult life*
- *Death of her father in October 2018*
- *Financial difficulties"*

3.4 The information regarding historical sexual abuse had not been disclosed previously by Megan. The detail of the alleged perpetrator is not known. What is known is that Megan's father, during Megan's childhood, would accommodate men in the home who had drug and alcohol problems. When Megan's father died, she was seen to struggle and reported to a Clinical Psychologist, shortly before her death, that she had unresolved issues to address with her father regarding the sexual abuse she had been subject to in her childhood.

3.5 Megan was well known to the GP Practice Team. Although she would not answer calls from the GP, she used the surgery frequently when she needed support.

3.6 In the year prior to her death, Megan came to the attention of the police, ambulance service and hospital on multiple occasions. The table sets out a summary of events during the timescale of the review. It is not a comprehensive account of Megan's situation. It also does not set out in full chronological order. What the summary does is to demonstrate the cumulative impact of events on Megan's mental health and wellbeing.

3.7 Summary of Megan's experience between January 2016 and January 2019.

3.7.1 By early 2016, Megan's self-harming was escalating. She sought help from mental health service due to crisis. She requested an admission as she had plans for suicide. It was during this time that she took an overdose of her father's medication. She reported being afraid to be discharged.

3.7.2 Subsequently, Megan was diagnosed with Emotionally Unstable Personality Disorder (EUPD). She struggled to maintain her work.

3.7.3 In the later months of 2016, Megan disclosed a rape to the police. The investigation was not completed due to insufficient evidence. Megan continued to self-harm leading to an admission to an inpatient mental health unit under S2 of the Mental Health Act 1983 (2007). Whilst on the unit she took overdoses.

3.7.4 Over the next year, Megan undertook a routine of daily self-harm, binge drinking and cocaine use. Her marriage ended and she moved in with her mother, who asked services for help for her daughter. Megan was under the care of the Crisis Home First Team and commenced weekly GP visits for prescriptions for her treatment.

3.7.5 By 2018, Megan was struggling to maintain her medication. She was expressing suicidal intent and made attempts to end her life. During admissions to mental health inpatient units, either under section or as an informal patient, she continued to self-harm. Whilst on the unit, she continued her cocaine habit which was costing her £200 per day. Then there was a safeguarding investigation on the ward regarding another patient who was targeting others to get them to take out loans. Megan was one of those targeted and she gave the other patient her bank details and took out a loan.

3.7.6 Megan's father raised concerns with ASC about financial abuse as he had not been informed about the safeguarding issue by the ward. He also reported the abuse to the police, but no further action was taken as Megan was on the ward. At this time, Megan's divorce was underway.

3.7.7 Between April and August 2018. Megan continued to lose money to another patient and there were reports of drugs being supplied by another patient. Meanwhile, she was having relationship problems with her father and stepmother.

3.7.8 In August 2018, Megan was discharged to her mother's home, into community care. She continued to use cocaine and was harming herself. She was also reported to be using dating websites and met a male for sex.

3.7.9 Whilst in the community, the Home Treatment Team (HTT) visited Megan. She admitted using cocaine on the day she was discharged. She had ongoing suicidal thoughts. A personal budget care package was arranged for Megan. Carers reported visiting in pairs. At this time, Megan reported seeing men for money and she was found to have been a victim of an internet fraud.

3.7.10 In October 2018, Megan's father died. She was reported to struggle with her grief. Between November and December, Megan took an overdose, she reported that she was in a relationship with a man who also took an overdose.

3.7.11 She was admitted informally to a mental health unit and then detained under s3 due to stress of father's death, recent rape allegation, 'sex work' to fund cocaine, not concordant with her medication, concern about exploitation. She was discharged but took further overdose following her father's funeral.

3.7.12 Subsequently, Megan was readmitted, informally, to the mental health unit. At this point, she had a court order for non-payment of a loan and made the disclosure about child sexual abuse. She also reported she had been raped and was advised to attend the sexual health clinic. She was discharged from the mental health unit two days after admission.

3.7.13 Following discharge, Megan attended the sexual health clinic and spoke to the police about the rape. There were reports of her being trafficked. A refuge was contacted but there were no beds. The police had insufficient evidence to progress the investigation but encouraged Megan to ring 999 if at risk. Megan continued to self-harm.

3.7.14 In January 2019, Megan harmed herself, misused alcohol, and cocaine. She had a hospital admission where she attempted suicide. She was discharged but continued to harm herself and had to be readmitted. On 11 January 2019, she reported that a male and female had exploited her through violence and sexual exploitation. She reported having been made to leave the ward and attend a house where she was raped three times.

3.7.15 The police found factual inaccuracies in her account. Meanwhile, Megan continued to self-harm. She was admitted to hospital and transferred to another unit on 15 January 2019. When transferred she was on level 3 observations (continuous 1 to 1 eye level), but the receiving ward staff did not realise this and did not provide this level of observation.

3.7.16 On 16 January 2019, whilst still an inpatient, Megan died after she tied a ligature around her neck.

4. Information from the Family

4.1 Megan's family provided a clear picture of who she was and the challenges she faced during her life.

4.2 Megan was the youngest in the family. Her siblings described her as

"bubbly, either happy or sad, no inbetween"

"lively, the most caring person ever, she would bend over backwards to help friends"

4.3 This helping of 'friends' led to Megan finding herself in great difficulty prior to her death, whilst in hospital. Her family reported that she lent money to other patients by taking out short term loans herself.

4.4 When Megan was 10 years old her parents separated and, along with her siblings, Megan went to live with her father and visited their mother a couple of times a week.

4.5 As a child Megan's family reported that, when she was 11 or 12 years old, she was believed to have witnessed a 'violent act of crime' involving a man. She asked a teacher for help but was reportedly blamed for getting involved with the man.

4.6 Megan was diagnosed with attention deficit hyperactivity disorder (ADHD) at the age of sixteen. This resulted in her moving schools to obtain the support she needed to keep on track to achieve her GCSEs.

4.7 Megan wanted to be a nurse. She commenced her training but was unable to manage the academic work, despite gaining good marks within her placements. Her family reported that Megan had been diagnosed with dyslexia at university but had

not been provided with any support. She left her course and worked as a Health Care Assistant in a GP Practice and for an agency, looking after elderly people in their own homes.

4.8 Megan loved her nieces and nephews. She was desperate to have children of her own. She had a good vision of her life. She married but the relationship did not last, and, at the time of her death, she was going through a divorce. Her siblings reported that this had a huge impact on the deterioration of her mental health.

4.9 Megan was loved by her family but kept herself separate from them. From the conversation with her mother and siblings, it was clear that she would tell one person part of her story but not the whole. When her marriage broke down, she started to take drugs and got involved with the wrong crowd. This led to her getting into trouble at work.

4.10 On Christmas Eve 2016, Megan took an overdose. This was the first time her family viewed her mental health as being severely compromised. Her siblings found out much later that, over a period of many months, Megan was dealing with having been raped. Initially Megan did not tell anyone, until she went to the police. The case did not progress.

4.11 Megan's family believe she tried a further overdose before receiving the diagnosis of Emotionally Unstable Personality Disorder, in 2016.

4.12 Megan had been close to her father, but she did not get on with his new partner. This led to Megan moving in with her mother, after her marriage breakdown. Her mother explained that Megan would self-harm and overdose frequently whilst living with her, taking an overdose, then calling an ambulance and getting her mother out of the home before the ambulance attended.

4.13 Once the mental health services were increasingly involved with Megan, her family described a situation where Megan would often not be home when the Home

Treatment Team (HTT) visited. She was not keen on getting help and was open about her cocaine use. Her family explained that she seemed to have no intention of stopping which meant it was difficult for professionals to help her but there were unfair expectations on her when she was unwell.

"she didn't have the mindset to be able to stop"

4.14 Megan's family described how Megan had no consistent case worker and feel that she was never taken seriously. When she was admitted to hospital Megan would 'smuggle' in cigarettes and tobacco, as well as there being drug use on the ward. Megan's family described how she was a victim of financial abuse whilst under section. She was able to use her mobile to apply for loans to support other patients. This led to Megan being chased by debt companies until her family addressed the situation with them. [1]

4.15 In the Essex County Council (ECC) chronology there was a record of Megan's father's referral to them which highlighted that Megan, whilst on a psychiatric ward had been asking her family to be guarantors for her to take out a loan and subsequently, she disclosed to her grandmother that "*she was in big debt, that a patient …. had taken her bank card off her and emptied her account. She then confessed to taking loans out with Wonga, Sunny, Pounds to Pocket, Uncle Buck, Satsuma, and Piggy Bank, she had asked us to guarantee a loan with Amigo loans."*

4.16 In October 2018, Megan and her mother had a holiday abroad. Her mother described how Megan was different, engaged and talking, as she had been removed from those who were abusing her. Then Megan's father died. This was seen as the turning point for Megan and led to her not seeking any help at all.

4.17 In the days prior to her death, Megan had told her family that she was working sexually to pay for drugs and, whilst a patient, she was reportedly contacted by a man who threatened her and she went out of the hospital to a car park, where she

[1] EPUT confirmed that Megan was allowed to have cigarettes, and her phone, on the ward.

reported that she was raped due to owing money. Megan's family explained that this had been reported to the police but there was no evidence to take it forward.

4.18 Megan's family described the impact of her behaviour on the rest of the family. Her mother's own health deteriorated whilst trying to support Megan. There were reports of threats to the family due to Megan's involvement with drug dealers. This led to the siblings making the decision that their own children could no longer visit their grandmother and aunt, due to safety concerns. This was a difficult decision for the family to make but they needed to safeguard their children.

4.19 There were no improvements, Megan was admitted to a psychiatric ward and then she took her own life.

5. Analysis of Practice

5.1 Context

This section will use the terms of reference to look at specific issues. Where the terms of reference are not used within the heading, this means that there is a thread throughout relating to that term of reference.

5.1.1 As an overview, the issues faced by Megan:

- Childhood trauma
- Deliberate self-harm
- Misuse of drugs
- Mental illness
- Exploitation
- Mental Capacity

5.1.2 The individual management reviews and patient safety report explored key areas for the agency which will be used to inform the analysis from an inter-agency perspective.

5.2 How did agencies perceive and assess Megan's risks of self-harm and were responses in accordance with agencies policies/procedures?

5.2.1 The period reviewed showed a spiral of self-harm and suicide attempts by Megan. At time of crisis, she sought the help of emergency services leading to mental health assessments and admissions to provide the immediate protection.

5.2.2 Megan would call for an ambulance when she took overdoses at home. The ambulance trust noted that there was less contact with her during 2017, but 17 contacts between October 2018 and January 2019. The IMR noted that she should have met the criteria for being a frequent caller, more than fifteen calls, but did not. Again, in the Emergency Department (ED) or Minor Injuries Unit (MIU) she should have been assessed as due to being a frequent attender. However, this was not done, which is thought to be due to assumptions regarding the mental health team were already involved with her. It is of note that neither ED nor the ambulance service were included in the Multi-Disciplinary Team (MDT) discussions. Had they been, there could have been more consideration of the cumulative impact of the repeated attendances. The role of ED/MIU was seen as just to patch up her wounds and then pass to the mental health services.

5.2.3 EPUT did admit or detain Megan appropriately, but the Trust has concluded that its policies and procedures were not followed, including the safeguarding, observation, clinical risk, Mental Capacity Act policy and procedures, and the Sexual Health and Behaviour in Mental Health Inpatient Units Guidelines

5.2.4 The care coordinator supported Megan to work through her issues. However, the Trust did not consider strategic, long term, planning for Megan to be able to function within the community. The focus was on her behaviour, rather than the impact of the trauma, mental illness, and substance misuse on Megan's ability to care for herself. This meant that Megan was trapped in a cycle of self-harm, assessment, emergency treatment and discharge, without a clear plan

for how she could escape the cycle. There were long term plans for extensive psychology.

5.2.5 There was recognition, by EPUT, of the safeguarding issues related to her disclosures of rape and sexual abuse. However, the referral was not sent, and information was kept within the service. This was a missed opportunity to ensure that Megan was listened to and for a multi-agency approach to investigate the issues.

5.2.6 Additionally, there was insufficient review of her mother's own mental health needs and capability in supporting Megan. It would be expected that the needs of any carers would be assessed when an individual is discharged to the community for long term care.

5.2.7 A critical time during which practice was not good enough was during Megan's final weeks. She was frequently verbalising suicidal intent and informing services about the sexual exploitation. She went through a cycle of deliberate self-harm. This would lead to admission to hospital, where she was on high levels of observation due to the continued self-harm, but then would be deemed safe to discharge the next day, despite Megan raising concerns about being exploited by a man. This would be followed by further incidents of self-harm and re-admission.

5.2.8 Good practice would have been for Megan not to be discharged without a safeguarding referral and multi-agency plan to address how to keep Megan safe from the exploitation. Good practice would have been for there to be clear recording of how Megan's mental capacity was assessed in the context of her mental illness, drug use, and fear for her safety.

5.2.9 Instead, too much weight was given to an assumption that she had the capacity to make decisions about how she operated within a world of drugs and sex work. This meant that she was discharged too quickly, without a holistic

assessment of her needs. There was no indication that there had been any assessment of the impact on her mental capacity when she was actively taking cocaine that was costing her £200 a week. Had there been consideration of her best interests at these times, then her siblings could have been included in the planning for how to support her through the difficult times.

5.3 What support Megan was offered in relation to substance misuse and whether her mental health and mental capacity were considered?

5.3.1 Megan was known to use drugs whilst in the community and as an inpatient of acute psychiatric wards. In November 2018, she was due to be assessed by the Dual Diagnosis team, but she did not answer their call and she was discharged. It is recognised that those with mental health and substance misuse issues can be complex for services to support due to their 'chaotic lives.' However, this gives the impression of services being powerless to help those individuals who are among the most at risk of abuse.

5.3.2 This raises questions about how the Mental Health Act and Mental Capacity Act could have been used more effectively by practitioners to prevent harm and support Megan when she was in her greatest need, as set out in the safeguarding principles.[2]

5.3.2.1 **Empowerment**: Megan was not empowered to take a lead in her own life. Agencies used the MCA and Human Rights Act to inform their view that Megan was able to make unwise decisions. However, this was due to the tendency for agencies to label Megan by her diagnoses rather than take a personalised approach to how she was a young woman who could not keep herself safe when her mental health was deteriorating to such an extent. This led to recording that Megan had the capacity to make unwise decisions without evidence of how professionals considered the impact of her decision making when under the influence of drugs.

[2] Six safeguarding Principles. Care Act 2014.

5.3.2.2 **Prevention:** Agencies did not work to prevent Megan from being abused and exploited. For example, this could have been considered through observation procedures within the psychiatric wards to prevent individuals from being able to share their bank details with others.

5.3.2.3 **Proportionality:** This relates to agencies needing to provide the least intrusive response to the risk presented. However, in Megan's case, it was known that she was being sexually exploited to pay for her drugs. Therefore, agencies should have been more proactive in their response to support Megan in reporting those abusing her and persevering to engage her in addressing her substance misuse.

5.3.2.4 **Protection:** Megan was a woman who could not keep herself safe due to her severe mental illness. She was known to have been subject to sexual abuse in her childhood and more recently as an adult; she was known to have been victim of financial abuse whilst in the care of services. Therefore, she should have been viewed as being someone in the greatest need of protection.

5.3.2.5 **Partnership:** During the period reviewed, there was a lack of examples of agencies working together to find a solution to stop those exploiting Megan in the community.

5.3.2.6 **Accountability:** The agencies involved with Megan did not demonstrate how they were accountable or responsible for safeguarding her. The onus was on EPUT to address her safeguarding needs. The ambulance service reported that they are only able to refer on to others, due to the transience of their involvement with individuals. The hospital and police looked to EPUT for action. ECC did not discharge their accountability for s42 enquiries effectively as they delegated EPUT to undertake the enquiries without sufficient oversight. This meant that there was no alignment of the agencies that could work together to keep Megan safe.

5.4 How practitioners perceived and assessed risks of sexual exploitation and abuse to Megan and how these were responded to?

5.4.1 Megan had a been a victim of sexual abuse as a child. As such, she had to live with that trauma. In 2016, she reported multiple rapes to the police. The investigation took several months, and the outcome was no further action due to lack of evidence. The suspects denied the allegations. The trauma of these previous episodes does not appear to have been fully incorporated within the risk assessments for the sexual exploitation reported by Megan in 2018.

5.4.2 Megan was viewed as having the capacity to make decisions about her life. This included being able to make poor decisions, such as leaving the ward to go to locations for sex with men in order to pay for her drug habit. There was no consideration of the impact on Megan's capacity to make decisions when she was using drugs or that she was being exploited by others to continue her drug habit. Given that she required inpatient care and treatment should have alerted professionals that Megan was unable to meet her own care and support needs, thus making her vulnerable to abuse from others.

5.4.3 Megan was deemed as being knowledgeable about her condition and her options. There was an onus on the coordination of EPUT for her care. This meant that other services, such as ED, assumed that reports of domestic abuse, sexual abuse and trafficking would be addressed as safeguarding concerns by EPUT. There was no exploration of concerns by agencies. Megan described herself as being involved in 'prostitution' which seems to have led to an absence of professional questioning of what that meant for Megan who was known to have serious mental illness and substance misuse problems. The fact that Megan used the term 'prostitution' should have alerted practitioners to question the level of coercion she was facing to use sex in order to get access to the drugs she could no longer afford. This suggests that the practitioners did not have sufficient knowledge of sexual exploitation and coercive control to enable them to understand the impact on Megan's welfare and to take appropriate action to safeguard her.

5.4.4 EPUT staff had advised Megan to attend the sexual health clinic, when she disclosed rape. She did attend. She disclosed that she was a victim of trafficking, had suicidal intent and felt unsafe. Yet, there was no safeguarding referral made by the clinic.

5.4.5 The rape was reported to the police. An investigation commenced and Megan was supported by the police to ring 999 if the man contacted her. However, Megan died during the investigation, and it was subsequently closed due to insufficient evidence. Had the agencies worked together to give Megan a greater sense of safety, there might have been a chance for more evidence to be gathered, and for Megan to have hope in her life.

5.5 How effective was inter-agency collaboration, communication and information sharing in providing support for Megan following her disclosures of sexual abuse/exploitation?

5.5.1 The key services involved with Megan following her disclosures, were police, EPUT and the sexual health clinic. The police IMR demonstrated how there were several missed opportunities to work with other agencies to find out more about Megan's disclosures to ensure she was protected. The responses were no further action due to either lack of evidence, assumption that she was safeguarded due to being in hospital or reported non engagement by Megan. The Police Sexual Offences Team tried to work with Megan in relation to four, related offences, but received a mixed response from her. This seems to have been due to single agency work rather than engaging support from the mental health service to gain a better understanding of how Megan would be affected by having to tell people about the abuse, having suffered trauma in her childhood. Additionally, the Sexual Offences Team was not always aware of the wider information regarding incidents of concern for Megan's welfare and her going missing. The Police have identified this as an area of learning to ensure that all concerns about an individual are connected to inform the appropriate team undertaking ongoing work with the person.

5.5.2 Therefore, Megan was not safeguarded from sexual or financial exploitation. From reading the information about Megan and hearing from her family, there is a sense that she was left to feel that she was to blame for the abuse she suffered, which was reminiscent of how she reported being treated at school when she made a disclosure about an abusive episode.

5.5.3 The Police representative on the Review Panel confirmed that there have been changes to the structures for the teams working with those at risk of modern slavery and safeguarding. Additionally, there is recognition that there should have been more checks completed when Megan came to the notice of the police, due to previous disclosures.

5.5.4 Meanwhile, EPUT's patient safety review following Megan's death, identified a number of learning points for the Trust in relation to how to work with other agencies to safeguard those who are exploited. The Trust led the safeguarding enquiries without effectively reviewing with other agencies. There was a presumption that, because Megan had capacity, that she was able to make poor decisions such as using sex work to pay for drugs. The Trust acknowledges that there was insufficient consideration of the impact on her capacity when she was using drugs and that Megan should have been seen as being under coercive control of others who exploited her. There should also have been more importance placed on supporting Megan when it was known that she had been subjected to considerable financial abuse.

5.5.5 As a result of this case, EPUT have made changes to how staff receive training about sexual exploitation, modern slavery, and sexual safety. There is also sexual health information provided for those using EPUT services.

5.5.6 In March 2018, Megan's father had alerted ASC to the risks posed by another patient who had used Megan's bank card. This had led to Megan taking out numerous pay day loans which caused considerable debt which she could not

address without help. ASC passed the information to EPUT to undertake a s42 safeguarding enquiry. The outcome was that Megan informed staff that she had given the card to the other patient to buy her drugs. There was a further referral in April 2018 which recorded that Megan had *"admitted to being supplied drugs (Cocaine) by another service user."*

5.5.7 The language used in the records for the safeguarding enquiry minimised Megan's vulnerability to exploitation and portrayed her as a willing accomplice. The consequence of this was that Megan was left to tackle the debt alone by professionals. Due to her non-payment of the loans, she was chased by debt collectors and threatened with legal action due to her non-response. Once her siblings were aware of the situation, they dealt with the companies but there had been no support from the services under whose care she was when the abuse occurred.

5.5.8 Megan had care and support needs which, at that time, meant that she was unable to protect herself. This included being unable to protect herself from other individuals who had more access to the outside world, whilst she was detained under the Mental Health Act.

5.5.9 The conclusion of the safeguarding enquiry suggests that because she willingly gave her card to the other patient, and asked for the drugs to be delivered, then she was not a 'victim' of abuse. However, the Care Act guidance states that:

"statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting"[3]

[3] DHSC (updated 2021) Care and Support Statutory Guidance. S14.6.

5.5.10 EPUT have delegated responsibility via a S75 agreement from the Local Authority to lead on S42 safeguarding enquiries involving patients under the care of the Trust. The expectation is that there is monitoring of the enquiries by the Trust Safeguarding Team and that enquiries are closed appropriately and passed to ASC for oversight. EPUT acknowledge that the system was not enacted efficiently at the time of Megan being exploited. Both EPUT and ASC confirm that the system has been improved since Megan's death which means greater scrutiny by the EPUT safeguarding team and new arrangements for Local Authority oversight of S75 arrangements. Nevertheless, it is acknowledged that there needs to be continued strengthening of the system which can only be achieved through the Local Authority and EPUT working together and for the S75 Partnership Board to provide assurance that the system is effective in keeping individuals safe.

5.6 How effective was inter-agency collaboration, communication and information sharing in providing support for Megan during transitions in care?

5.6.1 In November 2018, Megan had reported to the Police, and her Care Coordinator, that she had been raped. The EPUT report noted that no information was shared from Essex Police to the mental health services, although the Care Coordinator supported her during her police interview.

5.6.2 The EPUT report suggests that Megan herself informed ward staff about the exploitation and rape when she was admitted, but there was no formal liaison from the Police. The impact of this was, according to the EPUT report author's conversation with the Consultant Psychiatrist, that it was not fully considered in the discussion to reduce the level of observations for Megan.

5.6.3 The EPUT report goes on to discuss how staff on the psychiatric wards encouraged Megan to contact the police about the incidents of rape and she was supported when attending police appointments. In November 2018, the increased risk of sexual exploitation was a factor in the decision to place Megan on s3 of the Mental Health Act.

5.6.4 Therefore, the police and EPUT were aware of the involvement of the other with Megan during the period of escalating sexual exploitation. However, neither seemed to consider the need to work together to develop a safety plan for Megan.

5.6.5 It is not possible to be able to fully comprehend how Megan felt about the way the services were dealing with her disclosures at this time. However, there had been times when Megan informed EPUT staff that she was afraid to report a rape.

5.6.6 The EPUT report included information about Megan's final two weeks. In January 2019, during her last admission, she disclosed, to a psychologist, her anxiety and apprehension about her sexual exploitation, rape, and trauma during sexual encounters as well as fear of further abuse. She was urged by the psychologist to disclose this to the police and the ward staff members were informed. She also received a call from the refuge advising her how to remain incommunicado from the men who molest her. However, 2 days later, after returning from leave, she disclosed to the ward staff, she again had been sexually assaulted.

5.6.7 The Police were informed and later came to interview Megan, taking her clothes for investigation and arranging with her further rape investigations. Following this, Megan was seen to self-harm over a number of days. Then, after police came to the ward to ask her more questions, she was reported to have engaged in further episodes of self-harm to the point that she needed physical treatment for her wounds.

5.6.8 When Megan was subsequently transferred to another ward, information was not shared about the stress of the recent abuse that Megan had suffered. This meant that a clinical judgement was made to place her on a low level of observation without having the full information about Megan's situation.

5.6.9 This suggests that there was not sufficient consideration of the impact on her current mental wellbeing, of the rape and exploitation on Megan, her fear of further abuse and memories of her childhood trauma.

5.6.10 The EPUT report identified that there was no clear joining up of agencies and organisations in relation to coordinating the safeguarding issues that were raised during Megan's final months. Also, that there should have been recognition that the ongoing issues could have allowed her childhood trauma to resurface and cause traumatic feelings of behaviour for Megan.

5.7 To what extent was Megan's voice heard and her wishes and feelings considered by practitioners when planning her care and assessing risk?

5.7.1 Given the extent of Megan's continual presentations of self-harming behaviour, suicide attempts and drug misuse, alongside the history of sexual abuse and more recent sexual and financial exploitation, it is questioned as to how much Megan was really heard by professionals.

5.7.2 The patient safety review concluded that: *A safeguarding alert was raised on 02 April 2018 due to concerns that a male patient was putting pressure on (Megan) to access more pay day loans, I believe this should been widened to include vulnerability to sexual and financial exploitation. She had reported accessing an online dating site, TINDER, where she had come across the photo of someone who abused her as a child; she had also reported using online dating agencies to meet men, possibly for the purpose of funding her cocaine misuse through sex working. This had been recurring themes in subsequent admissions.*

5.7.3 Megan was well known to services. NICE guidance[4] sets out how those with EUPD should only be admitted to an acute psychiatric unit for crises or when

[4] 1 Guidance | Borderline personality disorder: recognition and management | Guidance | NICE

detained under the Mental Health Act. NICE also promotes the need to actively involve the patient in decisions and reasons for admission and the need to move to voluntary admissions as soon as possible. In Megan's case, it was clear that she was usually admitted for crises and would revert to being informally admitted when possible. However, there were times when her mental health was so poor, she could not participate in any decision making. There is a sense that she was passive and often just accepted professional decisions, which would lead to her being discharged and she was able to avoid services until the next crisis.

5.7.4 Megan does not appear to have had an advocate whilst an inpatient. There were reports of her father raising concerns with staff. Additionally, her mother was her carer but had her own health needs which meant that she could not always be fully available to her daughter. Megan had siblings who would provide her with support when they were aware of any problems. She was deemed to have the capacity to make the decisions for her care and treatment and would refuse to allow her mother into consultations. Therefore, she had the right to choose what support and advocacy she wanted.

5.7.5 Yet this was a young woman who was known to have been exploited, financially and sexually, whilst under the care of services. When returning to the community, she would be discharged into the care of her mother. There was no assessment of her mother's needs as a carer.

5.7.6 Before his death, Megan's father had moved, and Megan went to stay with him for a few weeks. She needed a month's supply of her medication. The GP reported undertaking a risk assessment and having a discussion with Megan about the risks. The GP reported that Megan was looking forward to her trip and the GP was of the opinion that she had to have the opportunity to be trusted not to take an overdose. This approach would seem proportionate. Indeed, Megan obliged and did not cause herself harm during the trip. However, her family reported that she seemed unwell, very lethargic, sleeping

a good deal, and taking a large amount of medication. The family reported that Megan would use PRN[5] medication to the maximum both when in the community and as an inpatient.

5.7.7 This presents a picture of an individual who did not have a well-balanced treatment, although it is not clear to what extent she was also using substances at this time. In November 2018, when she was at home, Megan did not answer calls from the dual diagnosis team and so was discharged, only to then be admitted shortly afterwards.

5.7.8 Practitioners tried to work with Megan to give her autonomy, when possible, over her life. However, this is difficult for those outside of the mental health service to fathom when there were no improvements to Megan's health, and she was known to be exploited. Megan had changes of Care Coordinator which diminished the continuity of care she received due to needing to develop new relationships and trust practitioners.

5.8 What support was offered to Megan following bereavement and to what extent did practitioners perceive and assess this life event as a risk to Megan's mental health and potential further self-harm?

5.8.1 Megan was reported not to seek any help following her father's death. Her siblings view this event as the final turning point for her. She had been close to her father but had problems in her relationship with him and her stepmother in those latter months.

5.8.2 Megan's father had a significant role in Megan's life. He tackled the school when they reportedly blamed Megan for the alleged violence she witnessed as a child; he placed her in a private school when she was struggling to attend state school having been diagnosed with ADHD; he raised concerns about the financial abuse Megan had been victim of whilst in the care of mental health

[5] PRN = Pro Re Nata, which is medication that is used as required.

services. Yet Megan also reported that she had unresolved issues with her father, that she found difficult to come to terms with after his death.

5.8.3 It is difficult for any adult to lose a parent suddenly. For Megan who was struggling with her mental health and substance misuse, the loss of her father who was a strong figure in her life, this was too difficult for her to get through alone. She did not inform the mental health service immediately but did contact the GP practice. Yet there is no record of any consideration of what bereavement support she might need. When she was detained under s3 in November 2018, this was promptly rescinded and she was discharged into the community, returning as an informal patient. However, it was reported that bereavement support was included in the psychotherapy she received.

5.9 Any difficulties agencies encountered when supporting Megan that impacted on the case?

5.9.1 The difficulties of single agencies, in the main, have been due to constrained inter-agency working. For example, there was limited liaison between the mental health team, GP and ED which led to assumptions that the mental health service would lead. The GP reported high levels of mental health issues in the population, yet there did not seem to be joined up working with the mental health services. The GP reflected on this, in discussion with the reviewer, and wondered if this could be something to raise with the Primary Care Network as an opportunity to improve the liaison between the services.

5.9.2 Within the mental health service there were staffing issues during this period which meant that Megan did not have consistently coordinated care.

5.9.3 The Police IMR found that, during 2016, when Megan had reported multiple rapes to the Police, there were delays in interviewing the suspects due to staffing pressures at the time. The outcome of the investigation was that there was insufficient evidence. For Megan to have gone through months of this investigation without any charges being made, must have been difficult for her

to process and might have had an impact on her level of trust of the police when she made the allegations in November 2018, and January 2019.

5.10 To what extent was Megan's mother involved in care plans and risk assessments for Megan and how was the support for her considered, including the Care Programme Approach?

5.10.1 Within the information and conversations held for the review, there was an absence of any understanding of involvement of Megan's mother, beyond practitioners checking in with her at times of crisis and the mother taking Megan to hospital. As a carer, she appears invisible and there is no indication that any offer of a carer's assessment was provided. This is of concern as Megan had not lived with her mother throughout her life but moved in when her marriage broke down and her mental health deteriorated. There was no acknowledgement of her mother's own health issues. This was a missed opportunity for the professionals to form a supportive network around Megan and her mother.

6. Conclusion

6.1 The reason that Megan's death was considered to meet the criteria for a SAR was due to concerns that there were indicators of neglect by agencies involved with Megan, in terms of the recognition and response that she should have been safeguarded from financial and sexual exploitation. Her death, on that day, in that situation, could have been prevented.

6.2 Megan had severe mental illness at the time of her death. Over the preceding years she had attempted suicide on numerous occasions. There were multiple agencies involved in supporting her through those times when she harmed herself. Yet, on the final occasion they were unsuccessful in saving her. This incident was the culmination of an intense period of fear for Megan of the sexual abuse she had suffered and thought that it would continue. She had been left weakened by the financial abuse she had been victim of, whilst in the care of services. Yet, Megan was not viewed as needing to be safeguarded as she had

capacity to make decisions. It was not recognised that she did not have the ability to safeguard herself due to the acute care and support needs. When she was transferred to a different ward, the day before her death, the information that was crucial to any clinical decisions about her care, was not shared effectively. When she was transferred, procedures were no followed to check for any ligature risks.

6.3 What does Megan's situation say about the wider system in Essex? The IMRs and patient safety report have highlighted that her case shows significant challenges for the wider system. Some areas of concern have already been considered by agencies and changes are in progress. However, there is more inter-agency learning to take forward.

7. Themes for Learning for the wider system

7.1 Safeguarding is everyone's responsibility

7.1.1 This case raises concerns about how agencies are applying the six safeguarding principles to their practice and also the level of knowledge of those working in mental health settings in relation to the meaning of abuse and their responsibilities to safeguard those in their care.

7.1.2 It is positive that EPUT has made substantial changes to its safeguarding system, processes, and training. There has been a change to how staff record safeguarding incidents to ensure that these are aligned with the risk management system. There is work with the Community Safety Partnership too through which EPUT is able to gain information about community risks to enable better safeguarding of service users.

7.1.3 In Essex there is a S75 agreement between ECC and EPUT in relation to s42 safeguarding enquiries. However, both ECC and EPUT have acknowledged that this system has not been coordinated and managed well. There is now more scrutiny by the EPUT Safeguarding Team prior to closure of enquiries and improvements in the oversight by ECC of the S75 delegation to EPUT.

7.2 Inter-agency response to sexual exploitation

7.2.1 This case demonstrates how language is important to understanding whether an adult is being sexually exploited. In the EPUT patient safety report there were several examples of Megan describing herself as being in prostitution. Yet, back in 2009, Harding and Hamilton (2009) described how sex workers did not use the term 'prostitution'. Nevertheless, Megan's self-description was not challenged by any professional throughout the services involved with her during this time.

7.2.2 When Megan reported to the police and Sexual Health Clinic, there was a view that she was involving herself in sex work. There were examples of police investigations being closed when there was insufficient evidence of exploitation. There was no examination of how this would make Megan feel about herself.

7.2.3 Other SARs have identified the blocks to successful safeguarding of those most vulnerable to exploitation. These include police inexperience in collecting and appraising evidence or failure to seek specialist advice; the difficulties in achieving a prosecution if the victim was uncooperative or taking drugs; lack of understanding of the impact of coercive and controlling behaviour on a person's willingness to disclose abuse or neglect.[6] These findings resonate strongly in Megan's case.

7.2.4 It was reported at the Review Panel that there is now inter-agency work in place to address the risks of perpetrators of exploitation. This should provide support for victims who find it difficult to disclose abuse.

[6] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

7.3 Safety of acute psychiatric wards for those vulnerable to exploitation

7.3.1 Individuals detained under the Mental Health Act are extremely vulnerable due to their inability to keep themselves safe. Admission to psychiatric units is undertaken to provide the appropriate assessment and treatment, as well as keeping the individual safe.

7.3.2 It is recognised that there will be a risk of drugs being brought into the wards and there needs to be sensitivity in how staff approach searching patients. However, as this case demonstrates, it can be the relationships between individuals on the ward that can lead to a risk of exploitation. This should be part of personalised risk assessment and care planning to ensure that all staff are aware of what the risks to the individual might look like, and what mitigating actions are needed. For a someone who misuses substances, the risk assessment should include the realisation that the individual might try to gain access to drugs, therefore, thinking about the safety of the individual's finance might be pertinent.

7.3.3 The Review Panel also considered the need for a Sexual Safety Strategy and the benefit of single sex wards to prevent peer on peer exploitation. In Megan's case, she had been exploited by other patients, both male and female. She was unable to keep herself safe sexually, due to being able to leave the ward.

7.4. Safety of acute psychiatric wards in the context of location and community environment

7.4.1 During the review it was explained that the location of the unit Megan had spent time at, was in an area where there was known gang activity. Since Megan's death there has been improvement in the liaison between EPUT and

the police to look at how patients can be protected when they are placed there.

7.4.2 Families will expect that their loved ones who require acute psychiatric support will be protected from external exploitation. There will be considerable knowledge from police and Community Safety groups about the risk locations.

7.4.3 Practice has changed within Essex since Megan's death. Agencies are reported to work with the police within six neighbourhoods. Additionally, the police are actively working with EPUT settings to ensure that there is greater understanding of the risks to those leaving the premises to visit local areas.

7.5 Carer assessments

7.5.1 In this case, there is no evidence that Megan's mother was offered a carer's assessment, or that her needs were assessed by any agency. There was a care package in place for Megan, but there was still reliance on her mother to help her to keep safe or to manage her crises.

7.5.2 Lack of recognition of a carer's own needs and vulnerabilities has been highlighted in many SARs.[7] There can be insufficient assessment of who the carer is, and how much of a protective factor they can be for the individual; an absence of understanding the impact of the relationship between the carer and the individual.

7.5.3 The result of the needs of carers not being considered, is that families and individuals can struggle to cope which can lead to isolation or more acute needs for services.

[7] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

7.5.4 The Care Act 2014, set out the responsibilities of Local Authorities to offer carers an assessment of their own needs and ability to be able to provide the care.[8] For an individual with severe mental illness and substance misuse, this requires a carer who can manage the daily emotional conflict.

7.5.5 SARs have widely documented how agencies, not solely Local Authorities, have missed the opportunity to work with carers to ensure that they are not left isolated and unable to cope with the continual caring for their loved ones.[9]

7.5.6 EPUT reported that there is now a carers' framework established as well as training for staff, and quality reporting. Carers are followed up 6 weeks after their assessment and subsequently annually.

7.6 Implementation of the Mental Capacity Act for individuals with complex needs

7.6.1 This case demonstrates the need for multi-disciplinary teams to be more focused on weighing up the mental capacity of individuals before discharging from inpatient mental health units, when they are voicing suicidal intent.

7.6.2 The National Analysis of SARs (2020) found that attention to mental capacity was "*one of the most frequently noted deficiencies in direct practice in the SARs".* This included failures to assess, or where mental capacity was not considered in cases where individuals were making chaotic choices or where they were involved in coercive or exploitative relationships.[10]

7.6.3 The impact of decisions to discharge an individual expressing suicidal intent and having disclosed abuse, has specifically been addressed in other SARs. For example, in Jo SAR (Stockport, 2021) states that:

[8] https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

[9] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

[10] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

"If a person is at imminent risk of suicide there can be doubt about their mental capacity at that point in time and professional judgements must be based on knowledge of the person, and what is in their best interests." [11]

7.6.4 In Megan's case, she was quickly deemed to not have suicidal intent, despite continuing to demonstrate serious self-harm. A view from the panel was that an individual diagnosed with EUPD can use self-harm as a coping mechanism. However, in Megan's case, she was deliberately causing herself significant harm and taking extreme risk when doing so. This would indicate that she either had the capacity to make the decision to cause herself harm, in which case it could be questioned how her treatment was formulated; or that she did not have the capacity to make the decision to harm herself due to the trauma she had experienced at times, throughout her life, and which had become heightened in the previous months.

7.7 Voice of the individual (trauma informed approach)

7.7.1 This case illustrates how a young woman was viewed through the lenses of her mental illness diagnosis and substance misuse. As such, those with dual diagnoses can be viewed as having 'chaotic lifestyles' and, therefore, unlikely to be able to change.[12]

7.7.2 This means that professionals can miss the impact of historical and current traumatic experiences. There can be 'blaming' of the individual to place themselves in the position of being exploited. Thus, the voice of the individual is not heard by those who they rely on to protect them. The individual becomes lost in the midst of their diagnosis.

7.7.3 Yet, it can be extremely difficult for services, and families, to support individuals such as Megan. There can be the temptation to take a risk averse approach, just to keep them alive, but this means that there is no

[11] Stockport SAB *2021. Stockport-SAR-executive-summary-Jo-June-2021*

[12] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

improvement, no exploration of what needs to change for the individual to be in a mindset to modify their behaviour.

7.7.4 A trauma-informed approach has the following key principles:[13] [14]

- Safety
- Trustworthiness
- Collaboration
- Empowerment
- Choice

7.7.5 When using this to evaluate Megan's experience of acute psychiatric wards:

7.7.5.1 **Safety:** She was not psychologically or physically safe whilst an inpatient due to financial exploitation by other patients; she was vulnerable to sexual exploitation due to the access that outsiders had to her whilst a patient; the observations were not consistent to ensure her safety from herself; lack of checks for potential ligatures.

7.7.5.2 **Trustworthiness**: When Megan reported financial and sexual abuse, there were limited safeguarding procedures put in place to protect her. She was seen to have made the decisions herself to get involved in taking out pay day loans and undertaking sex work whilst on leave. This would indicate that there was a lack of trust in the relationship between Megan and the staff on the wards.

7.7.5.3 **Collaboration**: Megan was viewed as complex and could be a challenge to care for. This meant that the relationship with her became somewhat of a power struggle between Megan being detained, to being an informal patient, whereby she could do her own thing. Without consistent

[13] https://www.integration.samhsa.gov/clinical-practice/trauma

[14] Wilkinson, J. (2018) *Developing-and-leading-trauma-informed-practice* Research in Practice

practitioners who can develop relationships with individuals to be able to manage the times of significant challenge, it is difficult for those, such as Megan, to gain any sense of healing from their trauma.

7.7.5.4 **Empowerment**: There needs to be a strengths-based approach to individuals to help them see a way forward and to support them to develop the necessary skills to do this. In Megan's case, she could not see her life improving, practitioners tried to reassure her that she could improve, but without understanding the impact of the events she had experienced, this was not going to be an effective approach.

7.7.5.5 **Choice**: In hospital, Megan's situation was not seen as unique. She seems to have been viewed through the lens of her diagnosis and drug use, rather than a young woman with a family who would support her to move forward. Throughout the services involved with Megan, there was an absence of communication with the family, beyond her parents. This would have been due to her rights to choose who was involved in her care and her capacity to make decisions. However, this is an example of how individuals are considered through a legal framework rather than a moral and sociological context. Many SARs find the excuse of mental capacity and human rights to explain why more was not done to safeguard an individual. However, the legal aspects might only have been considered on a superficial level, e.g., in Megan's case, there was no indication that there had been any assessment of the impact on her mental capacity when she was actively taking cocaine that was costing her £200 a week. Had there been consideration of her best interests at these times, then the potential options of including her family in the planning for how to support her through the difficult times, or an application to the Court of Protection.

8. Recommendations

NB: please also refer to the document explaining the identified themes for the 6 x SARs published in November 2022.

8.1 Assurance regarding S42 enquiries

It is positive that there has been a change to the level of scrutiny of the S75 delegation in relation to S42 enquiries. However, the SAB needs to be assured that this is a sustainable, and suitable, arrangement. It is recommended that the ECC report on the effectiveness of S75 agreements for S42.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)

8.2 Safeguarding those who find it difficult to disclose abuse

The review panel were informed about improvements to multi-agency work to ensure that there are effective safeguarding arrangements in place for those perceived to be involved in sex work. There needs to be scrutiny of how Police, EPUT, Hospital and Sexual Health Clinics are identifying risk factors and responding to disclosures of sexual exploitation. Insufficient evidence of sexual exploitation must not be a reason for all agencies to close the concern. A multi-agency discussion, with specialist advice, should be held to ensure that decisions are recorded, and a plan is in place to support an individual who is finding it difficult to disclose abuse.

(Links to Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk)

8.3 Personalised Care within psychiatric units

On acute psychiatric units there needs to be a personalised risk assessment and care planning to ensure that all staff are aware of what the risks to the individual might look like, and what mitigating actions are needed. For a someone who misuses substances, the risk assessment should include the realisation that the individual might try to gain access to drugs, therefore, thinking about the safety of the individual's finance might be pertinent.

(Links to Theme 1: Challenges when working with those who experience Complex Needs & Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk)

8.4 Community Safety

Since Megan's death there has been an improvement in how Police work with EPUT to identify community risks in locations where there are mental health units. The SAB should liaise with the Community Safety Partnership to ensure that there is intelligence about risks to those leaving mental health units to visit local areas.

(Links to Theme 5: Improving interagency communications between Health and Social Care)

8.5 Carer Assessment

All services need to be aware of who is taking on caring responsibilities for an individual with care and support needs. All services must take responsibility to check with the carer to ensure they are offered a carer assessment by the Local Authority.

(Links to Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk)

8.6 Application of the Mental Capacity Act in psychiatric units

As demonstrated in national SARs, it is of concern that mental health trusts are not consistently applying the MCA to question an individual's capacity to make decisions when they are expressing suicidal intent. EPUT must demonstrate how they make decisions and plan for discharge of those known to have suicidal tendencies.

(Links to Theme 1: Challenges when working with those who experience Complex Needs)

8.7 Trauma Informed Approach

The SAB should consider how a complex trauma informed pathway can be developed for use across agencies, following the key principles:[15] [16]

- Safety
- Trustworthiness
- Collaboration

[15] https://www.integration.samhsa.gov/clinical-practice/trauma

[16] Wilkinson, J. (2018) *Developing-and-leading-trauma-informed-practice* Research in Practice

- Empowerment
- Choice

This will raise awareness of the need to listen to individuals and recognise the impact of trauma on their ability to keep themselves safe. Any work already undertaken in regard to a trauma informed approach should be factored into any discussions. *(Links to Theme 1: Challenges when working with those who experience Complex Needs)*