WOLVERHAMPTON SAFEGUARDING TOGETHER
7 MINUTE BRIEFING: TIA

What is a Safeguarding Adult Review (SAR)?

A SAR is a multi-agency review process which looks at whether the relevant agencies and individuals could have done things differently which may have prevented harm or death of an adult with care and support needs. s44 Care Act 2014 states that a SAR must be arranged when an adult in its area dies as a result of abuse or neglect whether known or suspected (or could have died), and there is concern that partner agencies could have worked more effectively to protect the adult.

What next?

Transition Pathway is being reviewed by social care. Guidance on professional curiosity being developed by social care. Review of safeguarding documentation by health and use of safeguarding processes by mental health. Bitesize training in identified areas. Wider MDT discussion and escalation re non-attendance and disengagement.

Background:

Tia was 19 when she died of a mixed drug overdose. Tia experienced multiple adverse childhood experiences and trauma. She was affected by poor mental health and whilst she had a history of suicidal ideation and self-harm, there was no indication of a deliberate act to overdose. Tia and her family were known to multiple agencies.

1 2 3 4 5 6 7

7 Minute briefing

Key learning:

Transition – Missed opportunities in supporting Tia in transitioning from children's services to adult services in mental health and social care.
Disengagement – Common theme of disengagement with little evidence of exploring why and/or follow up.
Professional curiosity and safeguarding – Areas of risk not fully explored and concerns not raised.

Background cont:

Tia was supported by an Education and Health Care Plan (EHCP) and, for a while, a Child in Need plan. She was also supported by CAMHS and later accessed adult mental health services. There were concerns about intrafamilial abuse, drug abuse and sexual exploitation during her childhood and adult life.

Root Cause Analysis (RCA):

An RCA did not identify one root cause but found during the investigation process, 'multiple contributory factors, and care and service delivery problems. These included a lack of professional curiosity, lack of consideration of the adult safeguarding process, and the need to escalate non-attendance/disengagement with the wider Multi-Disciplinary Team. Tia's voice was not always heard.

Key Lines of Enquiry:

What interventions took place and what was the outcome of these • Where there was no engagement, what action was taken? How did you try to engage Tia? • Were any transitions considered for when Tia turned 18, if so, what were they and what was the outcome? Was Tia's voice heard? How is this evidenced? • Did agencies work together? Information share? Was this effective? • Any other relevant information, what could have been done better? Missed opportunities?