Teeswide Safeguarding Adults Board

JJ

A Safeguarding Adult Rapid Review (S-A-R-R)

Presented to TSAB on 12 June 2024

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Preface:

The Independent Reviewer[1] would like to express his heartfelt condolences to JJ's family and friends and anyone who was touched by JJ's passing. The reviewer would like to thank JJ's family, agencies and professionals involved in JJ's care and support for their input into this review and for sharing the information in the form of verbal accounts, chronologies, single agency reports, and for attending meetings, including the practitioners' workshop.

The following agencies have contributed towards this SAR:

Area 1- Agencies involved during the scoping period within the Tees area:

- Mental Health Trust
- Police
- Ambulance Service
- Acute Trust A
- Acute Trust B
- Local Authority A
- Housing A
- Housing B

Area 2- Agency involved during the scoping period outside of the Tees area:

- Local Authority B

1. Introduction:

1.1 JJ was a 23-year-old, white British transgender male, born in the Local Authority B area. JJ had moved to the Local Authority A area in 2020. JJ had announced in 2021 that from that date he wished to be referred to by his chosen male name. JJ was raised by his mother, although his father was absent throughout his life, JJ made numerous attempts to build a relationship with his father. JJ had six siblings; he was the second eldest. JJ loved arts and drawing.

1.2 JJ was well known to numerous services, including Children and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (inpatients and community), including Personality and Relational Services, Adult Social Care across two different local authorities, Housing, Crisis Team, Police, Street Triage[2] Team and Accident and Emergency. JJ was diagnosed with the following conditions: Childhood Autism[3], Complex Post Traumatic Stress Disorder[4] (PTSD) and Emotionally Unstable Personality Disorder (EUPD) (also known as Borderline Personality Disorder[5]). JJ had physical health conditions: hereditary deficiency of blood clotting factors (Fibrinogen, factor I deficiency[6]) and coeliac disease[7].

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[1] Greg Purta is the independent reviewer appointed by the TSAB to undertake this SAR. The reviewer has over 12 years of experience as a Social Worker, including managerial experience within Health and Social Care Integrated Adult Mental Health Services. The reviewer had no prior contact with JJ, his family and is independent of the agencies involved in this review.

[2] The street triage team provides a service to assist police officers with their decision making if they have concerns regarding someone's mental health or when considering Section 136 of the Mental Health Act: https://www.tewv.nhs.uk/services/street-triage-county-durham-darlington/

[3] https://cks.nice.org.uk/topics/autism-in-children/

[4] https://cks.nice.org.uk/topics/post-traumatic-stress-disorder/

[5] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/symptoms/

[6] Factor I | NBDF (hemophilia.org)

[7] Coeliac disease - NHS (www.nhs.uk)

JJ was known to use illicit substances and was at risk of death due to misadventure, as a result of self-harm, in the form of ligature, other risks were linked to overdosing on insulin and cutting. JJ reported adverse childhood experiences (ACEs)[8] and this was taken into account throughout professional assessments. JJ passed away in December 2022, the cause of death is yet to be confirmed by the Coroner.

1.3 At the time of writing this review the following are pending: Coroner's inquest, Serious Incident (SI[9]) and a LeDeR[10].

2. Legal context of a SAR:

2.1 The Care Act (CA) 2014, section 44, requires that Safeguarding Adult Boards (SABs):

(1) (…) Must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) **Condition 1 is met if—** (this condition is applicable to this SAR)

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

In addition, under section (5) of the CA the purpose of a SAR is to:

(a) identify the lessons to be learnt from the adult's case, and
(b) apply those lessons to future cases[11].

3. Views of family:

3.1 Family views play an important part of the SAR process as they allow the reviewer to gain a much better understanding of the person, as well as the support provided to them. It provides an opportunity for the reviewer to identify what worked well from the family's point of view and where changes to practice should be considered and learning applied.

3.2 The independent reviewer, together with a family key worker, met JJ's mother and his sister to discuss the process of a SAR, gather their views and answer any questions. JJ's family are supportive of this review, and they wish for the report to be published so any applicable learning can be shared widely. The views of the family are reflected throughout this report.

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[8] ACEs- Please refer to point 9.1 of this report for further information about adverse childhood experiences.

[9] serious-incidnt-framwrk.pdf (england.nhs.uk)

[10] https://leder.nhs.uk/about

[11] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

3.3 Based on the account provided by JJ's family, JJ had an Autism assessment in 2016. A request for an assessment was first made when JJ was 8, however JJ's mother was advised that JJ was displaying 'behavioural issues'. JJ's mother feels that he was let down by the wider system in that his needs were not fully recognised or understood by services. JJ had an Education, Health and Care (EHC)[12] plan, which according to family was not taken into account in the years prior to JJ's passing.

3.4 Family felt that housing provided to JJ was inappropriate and overall communication could have been better between agencies and family. JJ's mother felt she knew very little or nothing at all when it came to the arrangements being made by individual agencies. According to family, there was limited information provided to them about JJ's conditions and treatment. It is important to acknowledge that family were aware and had acknowledged the agencies' limitations when it comes to information sharing, in the circumstances when JJ did not want specific information to be shared. Family members had expressed a number of views and raised a series of questions and were advised that these can be addressed through another pending review.

Statement from JJ's Family:

"There are many questions that I have that I don't yet have the answers to. I visit Jay frequently at the cemetery to refresh the flowers and clean the headstone as it's the only thing I can do to care for my child who is now gone. A small comfort in what is now a very large hole in my heart.

I'll never get to see Jay's beautiful artwork again which was a real passion and outlet or his witty sense of humour and love he had for all his siblings. It pains me to think that I was kept away from important medical information during the 2 years leading up to his death. Why was I locked out? There are many things that happened of which I am only learning now. How can a mentally ill, autistic individual be deemed to have capacity to make such decisions about what I was allowed to know? Is this right? Would this have changed anything if I knew?

How many cries for help are too many? 1hr and 30 minutes before you left this world you disclosed your pain and sought help. Were you taken seriously?

In the weeks following Jay's death I have seen and read so many beautiful tributes. Underneath that hard, stubborn exterior was a caring person who made people laugh with his humour and whit. His early career goals of being a paramedic and only wanting to help others. We always lived in hope that Jay would heal and start living his life with happiness and a new outlook on the world.

The loss to the family has been devastating. We feel so let down by the events that led up to Jay taking his own life.

Jay is one of 6 children and the 2nd grandchild that was born into the family. We are a large but a close family.

One of the younger family members still asks where "Tia" is. Tia being the name Jay was given at birth, it's a struggle everyday to hear her little voice asking for someone who is no longer here. Family members are mourning the loss of Jay and frequently post photos and memoirs on social media accounts as a tribute to Jay and a way of grieving and remembering Jay.

[12] Children with special educational needs and disabilities (SEND): Extra help - GOV.UK (www.gov.uk)

Another family member was the only boy in the family for a long time and struggled to deal with Jay's loss. He took a significant time away from work and lost himself for a little while whilst trying to make sense of what happened. It was a concern that he too would follow down a dark path but with the support of his family he is now doing better and getting his life back on track.

Other young family members would frequently facetime Jay even when he lived around the corner. Jay's favourite younger sibling had her own phone and would text and message Jay a lot. She struggled to understand why messages were left unanswered at times or the phone calls were never picked up, especially when Jay was in the secure units. They are aware that Jay is no longer here but are too young to know the circumstances that surround his death. They are confused and have a lot of questions we cannot give them answers to".

4. Scope of the review, methodology and key lines of enquiries (KLOEs):

4.1 The review covers a period of six months prior to JJ's death. The review aims to understand how JJ was supported by individual agencies and the wider system and to what degree support was effective and what could be done differently.

4.2 A rapid review methodology was selected by the TSAB. Chronologies were used to determine the KLOEs and a reflective workshop was undertaken using an appreciative enquiry approach. The LeDeR reviewer was invited to take part in the practitioner's workshop. Single agency reports were requested and provided to the Independent Reviewer to support the review process and KLOEs.

4.3 The following KLOEs were identified:

4.4 Application of relevant legislation, policies, and procedures, as well as care pathways and good practice guidance by individual agencies/ care providers (legal literacy).
4.5 Interventions offered and provided to JJ.
4.6 Trauma informed practice and protected characteristics.
4.7 Engagement with JJ, risk assessment, safety planning, including care planning and interventions provided to JJ.
4.8 Support for staff (vicarious care).
4.9 Multi-Disciplinary Team (MDT) working across the system.

5. Analysis of support provided to JJ during the scoping period linked to KLOEs, strengths of the system, lessons learnt and recommendations:

5.1 This section of the report, will provide analysis using information gathered from the initial chronologies, SAR notification, single agency reports, practitioner's workshop and contact with family. The aim of this section is to better understand how JJ was supported by agencies involved in his care and treatment from a strength-based perspective, but also to learn lessons and identify, if practice could be improved. The purpose of the analysis is not to attribute blame to any individual or organisation.

5.2 Application of relevant legislation, policies, and procedures, as well as care pathways and good practice guidance by individual agencies/ care providers (legal literacy).

5.3 The Mental Health Act 1983, as amended in 2007[13].

5.4 During the review period JJ was supported by numerous agencies, some of them had more input than other service providers. There is some evidence that JJ was supported by individual agencies through the application of numerous legislative frameworks, policies, procedures, protocols, and locally agreed risk management systems were used. Due to the volume of the information provided, a summary is provided of those relevant to the review; some of the dates of events falls outside of the review period.

5.5 JJ was detained for the first time in February 2020 under section 2 of the Mental Health Act 1983 (MHA), as amended in 2007. It was reported by the responsible Mental Health Trust (MHT) that there were a further 26 admissions into mental health hospitals since this date.

5.6 JJ was detained under section 3 of the MHA in March 2020, meaning he became eligible to free of charge services (some) under section 117 aftercare of the MHA.

5.7 JJ was readmitted to hospital in February 2022, which was JJ's longest admission lasting over four months (discharged in July 2022). This admission followed a breakdown in JJ's tenancy at supported accommodation. JJ was served notice, which meant he was homeless.

5.8 During the review period JJ had a total of eight mental health inpatient admissions. JJ's legal status often changed during an inpatient stay where the following sections of the MHA were applicable: section 5(2), 5(4), 136, 2, informal.

5.9 JJ's final admission, (during which the fatal incident took place), was in December 2022, which was just 13 days after JJ's discharge. This admission was informal following an insulin overdose and once at the A&E Department JJ used a ligature. Both events took place and resulted in the MHA assessment and admission.

5.10 Based on the above historical information, it is clear that the MHA was key piece of legislation applied to support JJ and to manage the risk of self-harm. The nature of the risk was often very dynamic and rapidly changing. JJ was known to use a ligature and inflict injuries by cutting. In addition, while in the community, JJ was accessing insulin. Firstly, medication was taken from JJ's friend, who moved medication to his sister's house to reduce the risk to JJ, however JJ was also purchasing this medication off the street in order to overdose. This resulted in a high number of A&E attendances; during the six-month period JJ had 58 attendances, 8 of which resulted in admissions, which were short in duration ranging from 3.5 hours to 24.5 hours (seven admissions were as a result of self-harm and one required an intravenous administration of Fibrinogen[14] replacement).

5.11 Staff members involved in JJ's care and support were responsive to the risk and mental health act assessments and admissions were swift and often took into account JJ's wishes, as far as possible and as safe to do so.

5.12 Risk module was updated by the responsible Mental Health Trust on an electronic recording system accordingly with the risk presented at the time and in line with policies.

5.13 As part of each psychiatric hospital admission a formulation was completed for JJ, outlining the nature of admission, any identified risk(s), the purpose of the admission and

[13] The Mental Health Act 1983 (as amended) is legislation applicable in England and Wales which provides certain powers and duties to assess and treat a person if they have a mental health condition(s), once certain conditions are met to detain, or provide with support on a voluntary basis, which is determined on an individual basis. https://www.legislation.gov.uk/ukpga/1983/20/contents and https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/mental-health-act/

[14] Fibrinogen: Our Discoveries - Centre for Trauma Sciences (qmul.ac.uk)

treatment plan. In addition, any wishes, views and desired outcomes expressed by JJ were captured.

5.14 JJ was entitled to aftercare under S117[15] of the MHA, which was the responsibility of Local Authority (LA) B. Based on the chronologies provided, it was noted that the responsible LA was of the view that JJ's housing sat outside of S117 and he did not have identified social care needs 'within the s117'. It was noted by the LA B that there were three aftercare plans, the last one being briefly updated in August 2021. It was acknowledged by the LA B that these aftercare plans were lacking in detail and were prepared quickly in preparation for hospital discharges without evidence of full multi-disciplinary team involvement.

5.15 In November 2022 a Principal Adult Safeguarding Practitioner from LA A raised a challenge at the point of a meeting held with LA B responsible for S117, Police, Mental Health Trust, and Acute Hospital in regards to JJ's ability to manage a standard tenancy as it would be unsafe and that there is a risk of death by misadventure. In addition, Safeguarding Practitioner acknowledged, that the duty for housing still sits with LA B and a specialist placement is required to manage JJ's mental health needs. LA B disagreed with this. In February 2022 at the Team Around the Individual Meeting (TATI)[16] LA B once again confirmed that 'JJ has no care needs, and his housing needs sit outside of S117 aftercare'. Reference was made to having sought legal advice in relation to whether S117 should encompass housing, however JJ passed away before this action was followed up.

At the meeting held in December 2022 between the Police, Acute Trust A, LA A and B and a Mental Health Trust (MHT), it was noted, that the MHT identified a need for a specialist autism focused placement as JJ's 'actions are not due to a mental disorder, but are due to his autism'[17].

5.16 Section 117 of the MHA and section 9 of the Care Act 2014 should not be confused in terms of eligibility, needs assessment and care and support planning as services provided under each legislation should be determined separately on its own remits. It is useful to refer to the Mental Health Act 1983: Code of Practice, Chapter 33 and 34[18] and Care and Support Statutory Guidance issued under the Care Act 2014[19] for further guidance. In addition, consideration should be given to services/ care provision(s), which could prevent deterioration in mental health and further hospital readmission(s) as part of the S117. This particular section of the MHA would not be applicable to all agencies involved in this review, but to some, i.e. Local Authority where JJ was an ordinary resident at the time of section 3 detention and the Integrated Care Board[20] (ICB). S117, when used as intended can be of great benefit to the recipient and could result in more positive outcomes and reduction of risk.

5.17 In response to the crisis, management of risk and subsequent use of the powers under the MHA there is evidence of agencies working together (inpatient team members, community mental health team, housing, crisis team, psychology, local authorities) and sharing information. JJ was invited to the meetings on the Ward(s) and was encouraged to

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15 Mental Health Act 1983 (legislation.gov.uk) and Care Act 2014 (legislation.gov.uk)

16 Team Around the Individual (TATI) panel | Middlesbrough Council

17 The Mental Health Act 1983: Code of Practice provides key guidance for staff working with and supporting people with Autism; in particular Chapter 20- points 20.18-20.30- Mental Health Act 1983 (publishing.service.gov.uk)

18 Mental Health Act 1983 (publishing.service.gov.uk)

19 40573_2902364_DH Care Guidance accessible pdf (publishing.service.gov.uk)

20 ICB-statutory bodies that are responsible for planning and funding most NHS services in the area, they were know formerly as: CCG- Clinical Commissioning Group and were abolished as of 01/07/2022; https://www.kingsfund.org.uk/publications/health-and-care-act-key-questions

share his views. It was acknowledged that at times JJ would listen to the conversation without contributing and at times he would choose to express his thoughts with a smaller number of professionals.

Learning from good practice:

- The MHA was utilised promptly to manage risk to JJ.
- JJ was involved in decision making about his care and treatment and information was shared with him as much as he wanted to.
- Staff members did their best to repatriate JJ to the local psychiatric hospital as soon as it was possible.
- The MHT staff were attending meetings at the point of JJ's admission to a psychiatric hospital where JJ was not familiar with staff there.
- Reassurance was provided by the Mental Health Trust that as part of the admission process formulation was arranged in a timely manner for each episode of care.
- There is good evidence of MDT working as part of admission/discharge process.

Learning points:

- Ensure timely discharge planning meetings and that all relevant partners are informed in advance to ensure attendance/ information sharing.
- Involved agencies should consider the holistic needs of an individual and applicable legislation, including section 117 aftercare, in order to support needs, including accommodation. If it is felt that any of the needs fall outside of s117 in case of the eligible person, then s9 of the CA should be considered. Consideration should be given to Schedule 4 of the CA (Direct payments: aftercare under the Mental Health Act 1983).
- Legal advice should be sought at the earliest opportunity to avoid any delays in providing care and support to the person concerned, in the case of a disagreement between partners.
- When agencies are unable to agree on who should meet needs/provide services, local escalation processes should be used by individual agencies (professional challenge) as soon as possible.
- Consider alternative methods of engagement, based on the service user's wishes and expected outcomes.

Recommendations:

- TSAB is encouraged to remind its partners of the **Professional Challenge and Professional Curiosity learning briefing:** https://www.tsab.org.uk/key-information/learning-briefings/ as well as the **Professional Challenge Procedure**: https://www.tsab.org.uk/key-information/policies-strategies/ which can be used when agencies are in disagreement, or are unable to reach a consensus.
- TSAB is encouraged to seek assurance from its partners that there is an adequate provision of training provided to staff who undertake statutory duties, whether it be Local Authority, or the NHS provider (Mental Health Trust) in relation to s117 aftercare.
- Partner agencies to provide assurance to the TSAB in relation to the quality of s9 assessment(s) under the Care Act and linked care and support plan(s) as well as s117 aftercare plans.
- TSAB to request a statement from the Local Authorities/Housing in its area in relation to accessibility of accommodation for service users with ASD and whether local demands are adequately met. The statement should include steps taken, or to be

taken if it is identified that the provision of specialist accommodation for service users with ASD is not adequate, or does not exist and what are the short and long-term contingencies to mitigate risk to the individual if being supported inappropriately.

6. The Mental Capacity Act 2005[21]:

6.1 Every day decisions are being made by people around us in relation to all types of matters, whether that be in relation to finance, health, or well-being. JJ was no different and he made decisions too, some of them where in relation to day-to-day activities classed as 'low level', but on other occasions they were more significant and could have potential consequences for his well-being as described under Section 1(2) of the Care Act 2014, including but not limited to: personal dignity, physical and mental health and emotional well-being, or suitability of living accommodation[22].

6.2 Throughout the scoping period agencies were referring to JJ's 'capacity' however at times the term was used as a general statement to describe the situation rather than a specific decision, which needed to be made at the specific time. In cases of significant decisions, such as change of accommodation on a long-term basis, or refusal/acceptance of a medical treatment, including medication, practitioners should carefully consider undertaking a formal mental capacity assessment with sound rationale by applying the two stage (diagnostic and functional) assessment[23]. Also, practitioners should consider the concept of 'executive' functioning (the ability to carry out a decision).

6.3 Across the system, responses varied regarding completion of the capacity assessments for JJ. Individual agencies have confirmed that at times good practice guidance was not followed and the assessments were not recorded or partially recorded. In addition, some partner agencies were of the view that matters arising from the capacity of an individual does not apply to them, and therefore they have no obligation to assess capacity.

6.4 Based on the practitioner workshop and the feedback gathered it was acknowledged by colleagues that there was small number of formal capacity assessments undertaken. Colleagues felt that JJ's capacity was always considered and there was no need for formal capacity assessments as JJ did have capacity to understand the decisions he was required to make, however it was also confirmed that JJ was treated by an Acute Trust under the best interests as he was deemed not to have capacity to refuse treatment required at the time.

6.5 There is strong evidence to suggest that JJ was making decisions which were very harmful, and many would argue that they were unwise.

The Mental Capacity Act 2005: Code of Practice[24] provides guidance to '*anyone who is working with and/ or caring for adults who may lack capacity to make particular decisions*' (Code of Practice.p.1[online]). The Code outlines the groups of people who will have to have a regard to the Code when supporting an individual, such as doctors, nurses, social workers, ambulance crew, housing workers, or police officers.

Learning from good practice:

- Individual agencies had regard to the fact that formal capacity assessments were required at the time of crisis, and they were followed (by some agencies) in order to support JJ and to minimise the risk to him.

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[21] The Mental Capacity Act (MCA) 2005 is a law in England and Wales which provides protection for people aged 16 and over who are deemed as lacking the mental capacity to make a specific decision at the specific time and allows people to plan if they were to lose mental capacity in the future. Mental Capacity Act 2005 at a glance | SCIE

[22] https://www.legislation.gov.uk/ukpga/2014/23/section/1/enacted

[23] Mental Capacity Act 2005 at a glance | SCIE

[24] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

- At the system level there was acknowledgement of JJ's ability to make decisions for himself, which sits in line with the first Principle of the MCA: A person must be assumed to have capacity unless it is established that they lack capacity (presumption of capacity).

Learning points:

- Any formal capacity assessment(s) should be fully recorded on agencies' recording systems in line with their policies/procedures.
- Staff should be specific when reference is made to 'capacity' as to what is it that they are referring to rather than using broad statements such as 'he/she can make all decisions'.
- Staff should make use of and reference to the Code of Practice(s) and legislation when performing their duties.

Recommendations:

- TSAB is encouraged to seek assurance from partner agencies in relation to accessibility of training concerning MCA and associated Code of Practice.
- TSAB to send a reminder to its partners in relation to training provided on its platform concerning MCA and seek confirmation how it was shared across the agencies.
- TSAB to seek assurance about the quality of capacity assessments concerning service users with ASD and to share any learning back with partner agencies involved in the SAR.

7. The Care Act 2014[25]:

7.1 JJ was subject to safeguarding concerns, which were underpinned by section 42 of the CA[26].

The Local Authority A received three safeguarding concerns in relation to JJ. The final one was progressed to a s42 enquiry and JJ's case remained open to safeguarding until JJ's passing. On reflection the Local Authority felt that a s42 enquiry should have been carried out earlier as multiple Police and Emergency Duty Team[27](EDT) referrals were received with requests for MHA assessments and raised concerns in relation to JJ's presentation and associated risk.

7.2 In addition, the CA places a duty on local authorities to assess an adult's needs under section 9[28].

7.3 There were different views in regard to JJ's level of needs, what they were and how they should be managed and by whom. One of the issues raised within this review is in relation to s117, which places duties on the local authorities and Integrated Care Boards to meet identified needs for eligible service users; JJ was eligible for s117 aftercare services

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25 https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

26 **Enquiry by local authority**
(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and
(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
(2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

27 The EDT is part of Social Care and provides immediate support and advice out of office hours, including weekends and public holidays.

28 https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted: Assessment of an adult's needs for care and support
(1)Where it appears to a local authority that an adult may have needs for care and support, the authority must assess—
(a)whether the adult does have needs for care and support, and
(b)if the adult does, what those needs are.

following his detention under section 3 of the MHA. Another issue raised was in relation to the 'care needs assessment' and which local authority should complete this piece of work.

7.4 The Care and Support Statutory Guidance[29] is an important one and practitioners should be familiar with its content as it provides clarity as to what steps must (duties) or could (powers) be taken in certain situations. The CA gives certain powers to the local authorities in cases in which an adult with capacity refuses an assessment of their needs, under section 11[30] and the Guidance states:

The Care Act provides local authorities with the powers to meet urgent needs where they have not completed an assessment. Authorities may meet urgent need for care and support regardless of the person's ordinary residence. See the Care Act 2014, Section 19.

7.5 In addition to the above, it is worth noting that access to an Independent Advocate should be considered by a local authority in cases where a service user is supported under safeguarding arrangements as per Section 68(3, a-d) of the CA. The Autism Act 2009[31] places a duty to act on a local authority and NHS bodies.

7.6 The views of the family are that JJ's needs were not adequately met and his accommodation was neglected; based on the family accounts there were signs of self-neglect.

Learning from good practice:

- Agencies raised concerns in relation to JJ's safety/needs and this was important.
- Reflecting on what could be done differently in regards to the past safeguarding concerns is a positive approach taken by the Local Authority A.

Learning points:

- Practitioners should apply professional curiosity and question/critically analyse information available to them, in JJ's case this was in relation to the safeguarding concerns received.

- Local authorities should refer to all applicable sections of the relevant legislation (MHA, MCA) and accompanying Code of Practice, in this case the Care Act 2014 and the Care and Support Statutory Guidance in order to consider available options.
- In case of any doubt, legal or senior management advice should be sought at the earliest opportunity to prevent a delay in service response.
- Consider if a 1:1 meeting between local authorities would be of greater benefit to discuss disagreements and agree solutions, as opposed to having discussions at the MDT level where often other professionals were not familiar with the duties and powers of the local authorities and could get confused as to what is happening and why.

Recommendations:

- TSAB is encouraged to seek assurance from its partners (local authorities) what processes are in place to address cross-boundary issues linked to s117, assessing needs for care and support under s9/11 of the CA.

[29] Care and support statutory guidance - GOV.UK (www.gov.uk)

[30] https://www.legislation.gov.uk/ukpga/2014/23/section/11/enacted (Paragraph 6.26)

[31] The Act provides a structure for the improvement of the lives of autistic people and their families and has been supported by the issuing of Strategies and Statutory Guidance from the Department of Health (now DHSC) from 2010 onwards. Autism Act 2009 (legislation.gov.uk); Must-know guide – Autism | Local Government Association

- TSAB to ask local authorities to provide assurance what support is available to staff when challenge is raised in relation to assessing needs under s9/ providing services when cross-boundary issues arise and/or are linked to s117 aftercare entitlement.
- TSAB to seek assurance regarding out of area arrangements when s42 enquiry is required[32].

8. Interventions offered and provided to JJ:

8.1 As highlighted throughout this review, JJ was provided with numerous interventions, which were offered by partner agencies across the system. Interventions would vary, depending on the role of the agency involved, however there was an overall sense of duty across agencies to help JJ especially when JJ was in crisis. There is strong evidence that agencies were very determined to provide JJ with a response and support based on his needs and presentation at the time.

8.2 One of the main interventions provided to JJ during the scoping period was based on the psychiatric admission(s) and associated support within the hospital. As part of JJ's hospital admissions a formulation would be completed and JJ was therefore actively involved in identifying his therapeutic goals and these goals were focused on the stabilisation of his mental state, in line with a trauma informed care and autism informed approach. This included reviews of medication to help manage distress and trauma related symptoms. There was a strong emphasis on safety planning and building skills. In addition, JJ was provided with Occupational Therapy assessments and an impact of autism assessment to inform and adopt care to JJ's needs.

8.3 JJ was prescribed medication to manage his mental state, and associated distress he was experiencing. JJ was prescribed Quetiapine and Haloperidol in order to manage anxiety and emotional instability symptoms (later the Quetiapine was reduced and stopped and replaced with Haloperidol, which had a positive effect on JJ). It was noted that JJ was aware that a clinical team did not expect the medication to resolve the core problems JJ was facing and were more of a psychological nature.

8.4 JJ's compliance with medication was dependant on the environment he was in. While supported on the Ward, during his admissions, it was easier to monitor JJ's medication compliance (at times JJ would refuse medication), however the Community Mental Health Team had great difficulty engaging with JJ and it was acknowledged that JJ would have gaps of days and weeks without any medication which possibly impacted on his mental state and associated risk. JJ's community mental health team made attempts to build a therapeutic relationship in line with the principles of structured clinical management. The mental health teams identified that the Impact Assessment was completed within an inpatient setting and there was a need to review this with JJ from a community perspective, however JJ found it difficult to engage with this process. The intended purpose was to help signpost a community treatment and safety plan. This process was not fully completed before JJ's passing.

It is important to acknowledge that regardless of the setting JJ was in, staff communicated as a MDT in relation to issues identified regarding this matter.

[32] The CA is clear in that regardless of the ordinary residency status it is a responsibility of the LA to undertake necessary enquiries if that person is in the LAs area if an evident leading to that enquiry took place within boundaries of that LA; however at the local level would there be any circumstances considered when out of area LA, would ask a LA where the person in ordinary resident, to conduct that enquiry?.

8.5 The Mental Health Trust had completed an impact of autism assessment to ensure reasonable adjustments were made in order to support JJ's care, interventions delivery, and strengthen JJ's engagement, which as per above was completed during an inpatient stay.

8.6 At the practitioner workshop colleagues discussed options considered to support JJ and reduce the risk. It was acknowledged that JJ was offered a referral to STR (Supporting Time and Recovery) Worker or supporting independence worker to assist with tasks, such as shopping and personal care, however JJ would not engage with this help.

8.9 Housing was provided to JJ in July 2022, however it broke down. It was expressed by some practitioners that the information was shared on a 'need to know, or must know basis' meaning there were gaps in the information shared about JJ, including his mental health history and the risk, however the Housing Provider was informed of some of JJ's diagnoses and it appears that based on the interactions with the Support Worker, there were no concerns with regards to the support being given.

8.10 The reviewer was made aware of the Psychology input prior to and throughout the scoping period. JJ was involved in identification of his therapeutic goals, which were focused on the stabilisation of JJ's mental health, in line with a trauma informed care and autism informed approach. Staff were attempting to work with JJ on the past trauma, linked to his childhood experiences and it was noted that JJ had difficulty opening up, which was identified as one of the barriers to building a therapeutic relationship. As a result of this, JJ's psychological needs were not fully explored and understood despite a significant effort being made by the clinical team. At the point of contact JJ's family shared similar views, that it was a great challenge for JJ to speak to strangers, or people he did not know well and would not engage in any meaningful activity, such as therapy since JJ was an adolescent.

8.11 JJ had six hospital admissions following acute episodes of hypoglycaemia after taking an overdose of insulin, which belonged to his friend. These episodes were treated effectively despite intermittent non compliance with advice and treatment. It is worth noting that JJ had shown improved compliance when staff who he knew cared for him. In addition, staff at the A&E Department felt that JJ was lonely and he made attempts to develop friendships with staff on the Wards.

8.12 The Ambulance Service would support JJ's needs around his physical health presentation at the time. Any management plan would be based on clinical findings and available options. Conveyance to hospital in most cases would result in JJ being assessed by Psychiatric Liaison to determine any ongoing risk and potential for support.

8.13 Police interventions were at the point of crisis, rather than being more structured in nature, which is understandable given the nature of the service. Within the review period there are over 70 police records linked to JJ. Many of the reports to Police took place when JJ was either in hospital premises or grounds and were reported by medical staff or concerned members of the public. The Police have made use of the powers under section 136 of the Mental Health Act when necessary to prevent harm to JJ. Furthermore, the Police are in the process of introducing the 'Right Care, Right Person' approach to ensure that the right professionals are involved with the person who is in a mental health crisis[33].

8.14 Based on the responses provided by agencies involved, a number of interventions provided to JJ were linked to the crisis JJ found himself in. Staff members worked within remits of their agencies and did what they had to do to manage the risk of self-harm, such as ligature, or insulin overdose. Long-term interventions were not as effective as hoped, such

[33] Introduction of Right Care, Right Person model | Metropolitan Police

as stabilisation of JJ's mental health and acute nature of the risk, which JJ was putting himself in on a regular basis.

Learning from good practice:

- Agencies were not dismissive of JJ's needs/risks to JJ and have shown empathy and a caring attitude when supporting JJ.
- Agencies on an individual level did their best to meet their duties by providing JJ with support he needed at the time.
- There were examples available to the Reviewer that at a system level, JJ was supported when in crisis by, for example, applying a section 136, or 5(2) to prevent immediate harm to JJ.
- Implementation of the Right Care, Right Person Approach by the Police in order to support individuals experiencing a mental health crisis is a positive step.

Learning points:

- Sharing relevant information in a timely manner and in line with legislation and policies, concerning the key aspects of risk and health needs, can assist other agencies to meet their duties.

Recommendations:

- TSAB to seek assurance that for service users, who may find engagement challenging, agencies are considering/ evidencing in their practice approaches, such as assertive outreach to support engagement/help provided to a service user.

9. Trauma informed care and protected characteristics:

9.1 Adverse childhood experiences (ACEs), such as sexual abuse, physical abuse, psychological or emotional abuse, can lead to the development of a range of harmful behaviours, including drug abuse, or violence and are linked to disease such as mental illness, or diabetes and can result in premature death[34].

9.2 In the context of this SAR this is an important factor to consider as JJ disclosed on a number of occasions alleged abuse within his family home as a child. JJ was known to use harmful quantities of class A drugs in order to manage his mental health and distress. In August 2022 there was an email sent by JJ's mother to the Police expressing her concerns of JJ not speaking to family for over eight weeks other than when JJ requested money as his mother was receiving Personal Independence Payment (PIP) into her account, which she was reluctant to send back to JJ due to her concerns that JJ will spend the money on drugs.

9.3 In September 2022 JJ was brought to A&E following a ligature in the woods and was found by a member of the public. A Psychiatry Liaison assessment was conducted, s136 of the MHA was used. It was recorded that JJ was at high risk of death by misadventure due to maladaptive coping and impulsivity and that risks were further increased by use of drugs.

9.4 It was reported by the Mental Health Trust practitioner that JJ's mental health difficulties began during his childhood and were associated with his experiences of childhood abuse. There are other accounts within shared agency reports (Acute Trust), which makes reference to a childhood trauma and difficulties in JJ's relationship with his mother. In February 2022, which falls outside of the scoping period a conversation was documented

[34] Adverse experiences in childhood | Local Government Association and The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis (thelancet.com)

between JJ and the Police Mental Health Liaison Officer, where JJ referred to 'the abuse suffered at the hands of his mother'.

9.5 The Reviewer would like to acknowledge, that at the point of contact with JJ's family, JJ's mother did share that JJ at times was aggressive towards her and attacked her when they lived together, which was difficult to cope with.

9.6 The Mental Health Trust has acknowledged that JJ's care was delivered in line with the Trust's Trauma Informed Care approach. JJ was assisted to gain an understanding of the impact of his past experiences on his mental health and was supported to learn coping strategies, however JJ's ability to use these strategies varied.

9.7 It is evident that JJ's past experiences around ACEs were discussed at the meetings and between agencies, however it is not clear to the Reviewer, how much agencies/ staff understood the impact of these experiences on JJ, resulting in risk-taking behaviour.

9.8 Under the Equality Act 2010[35] there are nine protected characteristics giving individual legal protection in certain circumstances. In relation to JJ those applicable are: disability (JJ had ASD) and sexual orientation (based on the reports provided, first JJ was identifying himself as being gay and then as a transgender male). As part of his transition JJ changed his name and appearance, in addition JJ was prescribed hormonal therapy, meaning he was able to grow facial hair.

9.9 The Mental Health Trust in response to JJ's gender identity informed staff that JJ wished to be referred by his male pronouns and electronic records were updated to reflect this change, this was in line with the Trust's Admission, Transfer and Discharge and Trust's Privacy and Dignity Policy. The Trust's equality, diversity and human rights team have developed training for staff with the aim to improve the experience of transgender patients.

9.10 At the point of some psychiatric admissions, JJ was subject to safeguarding concerns in relation to discriminatory abuse towards JJ's gender, sexual orientation and inappropriate contact. Some concerns were managed through clinical risk management and contact with JJ's social care officer, whilst others were referred to the Local Authority. Management plans were put in place to safeguard JJ.

9.11 When providing care and treatment to a person with autism, the Code of Practice requires hospitals to make reasonable adjustments in line with the Equality Act, as per sections 20.31-20.34. In the case of JJ, it is believed the adjustments were made by the Mental Health Trust when JJ was receiving treatment.

9.12 It was noted within chronologies, and individual agency reports that some agencies were referring to JJ as 'she'. At the practitioner workshop members, as part of reflection, were in agreement that this is learning in itself and one's identity must be accepted and embraced.

9.13 Family expressed their view that JJ initially came out as being gay and then as a transgender male. It was a surprising discovery to family as they found out this announcement via social media. Initially family had difficulty adjusting to JJ's gender identity as it was explained to the Reviewer that family, including JJ's siblings would refer to him as 'she' and by referring to JJ by his name assigned at birth. After a period of time JJ's transition was accepted by the family. Another point raised by the family was in relation to the Ward environment; family wanted to know whether JJ was provided with care and

[35] Equality Act 2010 (legislation.gov.uk)

treatment within the Ward environment which was safe for JJ given his gender identity. This should be further explored within the SI.

Learning from good practice:

- Individual agencies, i.e. the Police had recently delivered Trauma Informed training to a range of staff across the force and this will be embedded into future practice.
- The Mental Health Trust has a policy in place, which recognises individual's diversity and a designated team to ensure good practice is followed by its workforce.

Where practice could be improved:

- Agencies to ensure individual's identity: preferred name, pronouns are reflected on the internal recording systems and in day-to-day practice.

Recommendations:

- TSAB to share a reminder to its members about the Trauma Informed Practice training provided by the TSAB and to seek assurance that this information was shared across agencies to raise the awareness of the subject matter. In addition, TSAB to share presentation which was part of a learning briefing in relation to Molly's SAR: Safeguarding Adults Reviews (SARs) Reports | Teeswide Safeguarding Adults Board (tsab.org.uk)
- TSAB to seek assurance from its partners in relation to gender identity and how this is reflected on agency systems and in practice.

10. Engagement with JJ, risk assessment, safety planning, including care planning and interventions provided to JJ:

10.1 Engaging a service user in intervention can be challenging as the individual may not engage for a number of reasons, from lack of trust in agencies or professionals to a lack of funds to attend meetings and to cover associated travel costs, or due to trauma which can impact on the individual's perception of self and others and ability to communicate their experiences. Each individual will be different as well as their reason(s) why engagement might not be as productive as expected.

10.2 Throughout this report we have learnt that JJ had a very complex presentation and the risks associated with it were very high, including the risk of death due to misadventure. Staff involved in JJ's care and support were having difficulty engaging with JJ in some vital work, such as psychological therapy and reference has been made to JJ not being ready, or not accepting support. This was particularly evident in the community, where JJ's Community Mental Health Team expressed concerns over JJ's disengagement and the risks already described in this SAR report. The Community Mental Health Team noted in August 2022 that due to limited engagement with services, a safe discharge plan needed to be considered, however in October 2022 another entry has confirmed improvement in JJ's engagement with the Community Team and Police Liaison, however this was short-lasting.

10.3 The Acute Trust where JJ would attend on a regular basis had access to JJ's care plans provided, as part of risk assessment and safety planning, by the Mental Health Trust (those were updated on the healthcare records in September and October 2022), where risk to self was highlighted. The Trust 'flagged' JJ on the internal system as a risk of suicide. Staff members supporting JJ were well aware of JJ's risk of self-ligature, which was higher at the point of discharge from hospital. Distraction techniques were routinely used with varying effect. The Trust has an anti-ligature risk assessment in place, which is part of health and safety management processes. On reflection provided by the Trust, the most effective way of approaching JJ was to explain what staff wanted to do one step at the time, with the least

number of people required to complete identified intervention, and staff would step away from JJ if he was getting agitated.

10.4 The Mental Health Trust ensured that JJ's safety summary and incident/ event log were updated on a regular basis and JJ's observation and engagement levels were frequently reviewed. In addition, the community team made efforts to maintain contact with JJ when he was admitted into an out of area hospital, to ensure continuity of care. Whilst on the Ward, intervention plans would be updated on a regular basis. The Trust recognised that MDT working was an important part of the risk management and the information sharing process. There were weekly professionals meetings, frequent attender meetings, blue light meetings and daily Ward reviews when JJ was an inpatient. In addition, staff would involve JJ in discharge planning meetings, however those were not always attended by JJ. JJ was on the Dynamic Support Register[36] (any service user with learning disability or autism, at risk of detention, is included on this register).

10.5 The Police assessed JJ as a High Intensity User of emergency services and measures were put in place to mitigate this and support JJ by bringing JJ's case into the High Intensity User[37] Group (HIUG). In addition, given the concerns raised around JJ and him using a ligature on a very frequent basis and the risk of death associated with it, JJ was subject to a Problem Orientated Policing (POP)[38] approach, which is a multi-agency approach, using Objectives, Scanning Analysis Response, Assessment (OSARA) model, which provided an additional layer of engagement with JJ, however this was limited. In addition, JJ was subject to an Acceptable Behaviour Contract (ABC)[39].

10.6 As mentioned above, in relation to the High Intensity User group, I would like to draw attention to another SAR (Sam)[40] which was published in March 2022 by Hampshire Safeguarding Adults Board. There are themes within this SAR, which are relevant to JJ's case in particular: responding to crisis, adverse childhood experiences (ACE) and s117 aftercare.

10.7 JJ's case, due to significant risk, which was not managed by agencies, was referred to the Team Around the Individual (TATI)[41]. The TATI was established across the Tees area as a result of Carol's SAR[42] to strengthen partnership working and manage high risk cases more effectively by bringing agencies from across the system, their knowledge and skills. In October 2022 a TATI referral was made by the Mental Health Trust to the Local Authority A however it was declined with recommendations to be heard by the Local Authority B, which had similar processes in place. In November 2022 the LA A recorded the rationale for rejecting the referral as: 'JJ has been placed in [name of psychiatric ward] as an inpatient on numerous occasions and has been placed back in the Local Authority A. Local Authority B holds s117 responsibility for JJ and it is felt that they are more appropriate to discuss JJ at their equivalent panel to TATI, referrer has been notified'. Once again in November 2022 another TATI referral was submitted for consideration, the referral was screened and was accepted; the LA B was invited to attend this forum. JJ's case was listed on the agenda and a meeting took place as agreed in December 2022. The meeting was held virtually with the following agencies in attendance: Mental Health Trust, Police, Housing, Neighbourhood,

[36] Dynamic Support Register and Care (Education) and Treatment Review policy and guidance | Local Government Association

[37] https://www.england.nhs.uk/high-intensity-use-programme/

[38] Problem-oriented policing | College of Policing

[39] Cover (publishing.service.gov.uk)

[40] Learning from Regional and National SAR cases | Teeswide Safeguarding Adults Board (tsab.org.uk)

[41] As of 6/11/2023 the TATI will be replaced by: HRAP- High Risk Adults Panel: High Risk Adults Panel (HRAP) | Teeswide Safeguarding Adults Board (tsab.org.uk)

[42] https://www.tsab.org.uk/wp-content/uploads/2018/10/Carol-Final-Report-for-Publication-TSAB.pdf

Recovery Solutions, Acute Hospital. It was confirmed that JJ was discharged from a psychiatric hospital in December 2022 and he will not return to his old property having been served an abandonment notice. JJ was staying with his friend, who was supporting JJ throughout this review period. Concerns were expressed that JJ was accessing his friend's insulin, which he used to overdose on. The Acute hospital confirmed that JJ continued to be admitted due to use of ligature and abuse of insulin (last admission was noted in November 2022). As a result of JJ's housing situation, a duty to refer notification was sent by the Ward (Mental Health Trust), which was noted at the professionals meeting (JJ was subject to s2 of the MHA at the time) held in November 2022.

10.8 A professionals meeting took place in December 2022 between the Ward Manager, psychology student and autism project representatives (JJ was detained at this point). Discussion took place around the possibility of an autism placement in line with recommendations from the independent care review. The plan was: 'To gain more insight into what an autism diagnosis would mean for the patient, for the community team to work with an ASD approach and the wider specialist team to have a better understanding of the impact of autism. To consider Community Treatment Order[43]'.

10.9 The above information is important from the risk management point of view and management of JJ's conditions. JJ's Responsible Clinician was treating JJ for complex post-traumatic stress disorder, and it was acknowledged by them that JJ's diagnosis of autism was relevant, but insufficient to explain the entire presentation. At the practitioners workshop the above mentioned independent review was discussed and it was acknowledged that it was an ongoing process to understand the chronic pattern of JJ's risk and possible causes, however the process was not fully completed before JJ's tragic passing.

10.10 Agencies have adopted and utilised a number of strategies in order to share the information, including risk with partners, and manage the risk within limitations of not fully understanding the nature of the risk and how it could be managed effectively. Systems of escalating the risk was used in the form of the TATI, which is widely used across the Tees area.

Learning from good practice:

- There is strong evidence of agencies having access to a number of risk escalation forums, such as the Team Around the Individual (TATI), Problem Orientated Policing approach (POP), or High Intensity User Group (HIUG).
- MDT meetings were held regularly amongst partner agencies in order to share updates in relation to work undertaken by agencies, share risk and agree actions.
- JJ was given the opportunity to take part in the meetings in order to capture his views and expectations, regardless of whether he would engage or not and where possible updates were provided to JJ.
- An independent care review was requested, however was still ongoing at the time of JJ's passing.

Where practice could be improved:

- Reference was made to the consideration of a Community Treatment Order; it would have been of benefit to consider a CTO earlier in JJ's treatment journey, knowing JJ's risk patterns, and non-compliance with treatment offered and provided to JJ. In

[43] Mental Health Act 1983 (legislation.gov.uk)

addition, consideration should be given to a Guardianship Order[44], given JJ's diagnosis of ASD and associated needs and mentioned possible option of more specialist placement where JJ's holistic needs could be met.

- Having access to numerous forums and using approaches to manage the risk is positive in its own right, however on reflection, if there was little positive change in the risk pattern presented by JJ it would have been of benefit to go back to 'basics' and reflect on the effectiveness and usefulness of adopted techniques. Professionals at times should ask themselves: 'Is less sometimes more?' rather than engaging service user in numerous meetings, schemes and practices which can be confusing for them and professionals alike with little or no positive outcomes.
- Knowing how significant the risk was to JJ agencies should consider, if making a request for an independent review earlier would impact the potential outcome.

Recommendations:

- TSAB to consider a review of the Multi- Disciplinary Team Guidance alongside considering what forums are available to practitioners for case discussion.

11. Support for staff (vicarious trauma[45]):

11.1 JJ was known to number of staff across different services. Some of them knew JJ better than others. When support is provided to a service user on a long-term basis it is possible to form professional relationships with that individual, which is a natural part of human interaction and in fact can support building a more therapeutic and trusted relationship and can enhance overall communication.

11.2 Given JJ's past experiences as a child and recent events that JJ was part of, staff were exposed to the events that many people would find difficult to cope with. Prolonged exposure to traumatic events, such as listening to a victim of abuse, or reading their files continuously can impact upon staff member's mental, or physical health.

11.3 Based on the practitioner event, it was shared that staff were given the opportunity to discuss how they felt within their teams whether that be as a debrief, or in a more formal forum. It was also acknowledged by staff, that when supporting a service user like JJ with risk of death and significant harm, some staff could be exposed to flashbacks and trigger an emotional response.

11.4 Each agency provided a response to support this section of the report and based on the agencies' replies it is clear that each organisation has in place a number of ways to support its staff: one to one with line managers, referral to specialist teams, including a Mental Health Advocacy, 'Hot debrief' process within the Acute Trust, occupational therapy, psychology, stress risk assessments and support plans.

11.5 Based on the staff experience whilst supporting JJ the assumption was that this area may be challenging for staff/ agencies, however based on the collective feedback this is not the case.

Learning from a good practice:

- Across the system partner agencies were able to demonstrate availability of support to their staff at different levels.

[44] Mental Health Act 1983 (legislation.gov.uk)

[45] Vicarious trauma in nursing (independentnurse.co.uk)

Recommendations:

- TSAB to consider sharing periodical reminders/updates with its partners in relation to vicarious trauma and available support- this can be based on the agencies responses as per their individual areas of work.

12. MDT working across the system:

12.1 Throughout this SAR report there is very strong evidence of an MDT approach when supporting JJ. Agencies across the system made significant efforts to discuss updates, share intelligence in relation to JJ, including self-harm behaviours and associated risks.

12.2 It was identified that single agencies were not involved as much as they wanted or expected to be involved and this was addressed in the learning section(s) of this SAR.

12.3 Based on the practitioner's workshop and the feedback provided, there were strengths and barriers identified of a MDT working across the system:

Strengths:

- Involving JJ in meetings and providing JJ with debriefs when JJ did not want to attend
- Responsiveness of agencies
- Staff were available for MDT meetings at short notice
- Good understanding of roles
- Cross-agency working
- Having access to different forums: High Intensity User Group, or TATI
- Understanding of agencies' limitations.

Barriers:

- Some meetings had approximately 30 representatives and on reflection it was acknowledged by agencies that maybe smaller meetings could be more productive
- Cross-boundary working between local authorities meant delays in responses in relation to safeguarding concerns, which were raised and the TATI referral was initially rejected.
- Care and treatment review process for Autism was interrupted when JJ moved to the Tees area
- Applied legislation, policies and procedures were at times confusing and it was difficult for staff to follow them.

Learning from good practice:

- Agencies and individual staff members were very open and honest about their experiences of supporting JJ.
- Agencies took an active role in supporting this SAR by sharing their knowledge of JJ.
- Staff were honest about their limitations; however it was evident how much individual agencies/staff members cared about JJ and wanted to achieve positive outcomes for JJ.
- Staff members were willing to identify and shared their individual learning from JJ's case and what changes can/will be implemented as a result of JJ's case.

13. Service improvements following JJ's SAR or related to:

13.1 Individual agencies have identified following actions:

13.2 The Police workforce will ensure that if substance use is apparent alongside other concerns, this information will be referenced in any referral for support and where possible the subject's consent to share/refer will be obtained.

13.3 The Local Authority A will undertake a review of cross boundary working in safeguarding cases.

13.4 Acute Trust A will:

- Update its MCA policy and will relaunch with updated MCA forms
- An audit of MCA/DoLs will be undertaken to evidence the impact
- MCA form will be embedded into the Trust's electronic system
- Training to staff across the Emergency Department will be provided on capacity assessments and related documentation
- The Trust will review its mental health strategy and the MHA training for staff and will review its safer bed spaces on the Wards

13.5 Acute Trust B will:

- Seek clarification of medication regime through MDTs
- Alcohol Care Team (ACT) referrals should be offered to known substance users regardless of non-related presentation to hospital.