WOLVERHAMPTON SAFEGUARDING TOGETHER PARTNERSHIP

Safeguarding Adult Review (SAR)

Helen
(Assigned Pseudonym)

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1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. A senior Social Work Manager made a Safeguarding Adult Review (SAR) referral in January 2025 following the death of Helen. Helen was a white British female. Although post death, Helen's mother identified that Helen was gay, this was not disclosed by Helen, having told professionals about boyfriends. Helen's sexuality therefore remains unclear to this SAR; as a result, professional practice relating to this protected characteristic has not been addressed. Helen died at a local general hospital at 18 years of age. Her cause of death was initially confirmed by the coroner as a staggered paracetamol overdose, anxiety and depression. Later the formal cause of death was recorded as 1a) Fulminant liver failure, 1b) Hepatic necrosis, 1c) Paracetamol toxicity.[1]

1.2. Helen and her father had left the family home due to concerns relating to domestic abuse between Helen's father and mother, which resulted in them being homeless and staying with family and friends in Area B (border area). Helen's father returned to the family home, however, Helen did not – at the time of her death she was residing in temporary accommodation. Concerns were raised around Helen's general vulnerability due to her poor mental health and ability to live independently.

1.3. Helen was diagnosed with Emotionally Unstable Personality Disorder (EUPD)[2], anxiety, depression and suffered with chronic pain and other physical healthcare conditions identified later within this report.

1.4. Unless stated otherwise, all of Helen's care and treatment was delivered in her local area. On a limited number of occasions, Helen visited and received services in a border area, noted in the SAR as Area B.

2. PROCESS, SCOPE, AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, including, referral, decision making, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a 14-month period prior to the death of Helen, being the time that Helen was transitioning to Adult Mental Health Services. Wolverhampton Safeguarding Together (WST) commissioned an independent reviewer to lead this SAR[3].

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[1] **Fulminant Liver Failure.** This means the liver suddenly stops working properly in someone who didn't have liver problems before. It happens very quickly—within weeks—and can make people very sick, causing confusion and bleeding. It's an emergency and often needs hospital care or even a liver transplant.
Hepatic Necrosis. This is when liver cells die because of severe damage. It can happen from infections, lack of blood flow, or harmful substances like drugs or alcohol. When too many liver cells die, the liver can't do its job, which is dangerous for your health.
Paracetamol Toxicity This happens when someone takes too much paracetamol (also called acetaminophen), either by accident or on purpose. The liver can't process the extra medicine, and a harmful chemical builds up, damaging the liver. If not treated quickly, it can lead to liver failure and even death. Doctors can give an antidote if treatment starts early.

[2] **Emotionally Unstable Personality Disorder (EUPD)**, also known as Borderline Personality Disorder (BPD), is a mental health condition characterised by pervasive instability in interpersonal relationships, self-image, and mood, along with impulsive behaviour. It often involves intense emotional responses, fear of abandonment, and episodes of self-harm or suicidal behaviour. Patient.info. (2022) *Emotionally unstable personality disorder (EUPD)*. Available at: https://patient.info/doctor/mental-health/emotionally-unstable-personality-disorder (Accessed: 10 September 2025).

[3] **Karen Rees** is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of WST and its partner agencies.

3. FAMILY INVOLVEMENT IN THE REVIEW

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide views and insights that practitioners may not have. A more complete picture of the person is often available from families who can provide a unique perspective. In this case, the lead reviewer was informed that the family had not engaged with internal review processes instigated in an NHS Trust. The Lead Reviewer sent a letter to the family to explain the nature and purpose of a SAR and to invite them to be an integral part of the review. To date no response has been received.

4. BACKGROUND SUMMARY PRIOR TO SCOPING PERIOD

4.1. Helen grew up at home with her parents and her half-brother from her mother's previous relationship. Her half-brother was nine years old when Helen was born, her sister completed the family when Helen was 12.

4.2. Information gathered for this review indicated that Helen's parents both suffer from mental health conditions and that in particular her father was agoraphobic and had not left the house since Helen was eight years old.

4.3. Without the privilege of being able to speak with family the SAR has not been able to understand who Helen was as child, her personality or her specific likes and dislikes as a younger child. Information from her senior school indicates that Helen first had difficulties when in primary school following an argument with friends where she pushed another child who subsequently broke her arm. Following the incident, a dispute arose between the parents, during which Helen's mother was subjected to an assault. This is reported to have had a significant negative impact on Helen.

Adolescence

4.4. From around age 12, Helen began showing signs of emotional distress, including low mood and social difficulties. By age 14, her mental health had deteriorated significantly, with repeated self-harm, suicidal thoughts, and multiple crisis episodes. She had several hospital admissions for overdoses and ingestion of harmful substances (paracetamol, bleach, nail varnish remover). During this period, she was under Child and Adolescent Mental Health Services (CAMHS) care, had risk assessments at school, and was prescribed medication for depression and anxiety. She was also diagnosed with autoimmune hypothyroidism just before her 15th birthday and referred to an Eating Disorder Team.

Education & Support

4.5. Helen struggled to attend mainstream school due to her mental health. She was placed on reduced timetables, received home tuition, and later attended an alternative provision. Despite these support efforts, and the communication between school and CAMHs, she continued to experience crises, including suicidal ideation and self-harm. She was supported by CAMHS, had medication adjustments, and was referred for specialist assessments (including for autism and eating disorders). Her family context was complex, with parental mental health issues and strained relationships.

Physical & Mental Health

4.6. Helen continued to experience chronic mental health difficulties, including treatment-resistant depression and emerging traits of Borderline Personality Disorder. She also reported chronic pain, fatigue, migraines, and dizziness, leading to referrals to ear nose and throat services, endocrinology, and cardiology. Just before her 17th birthday, Helen remained under CAMHS, with medication changes and ongoing psychological support. She was described as struggling with daily functioning, including getting out of bed and maintaining self-care.

5. BRIEF SUMMARY OF KEY EVENTS DURING THE SCOPING PERIOD OF THE REVIEW

5.1. No specific details are given within this section as they are discussed as relevant to learning within section six. They are detailed here merely to give a picture of the Helen's journey to the end of her life.

5.2. The Scoping Period (See Appendix 1) was set as the 14-month period before Helen's death. In order to maintain the anonymity of this SAR, dates are not used. The scoping period is described using month numbers with month one used to denote the first month of the scoping period etc. The age of Helen at the time of an incident will also be used.

5.3. During the scoping timeframe of the Safeguarding Adult Review, Helen's situation became increasingly complex, marked by a transition from child to adult mental health services, escalating mental health crises, and significant housing instability.

Transition to Adult Mental Health Services

5.4. At the end of month one, CAMHS formally planned Helen's transfer to adult mental health services. At this point, she was on multiple medications, including antidepressants and antipsychotics, and continued to experience severe emotional dysregulation, chronic suicidal ideation, and physical health concerns such as chronic pain and fatigue.

5.5. A consultant review confirmed the need for ongoing psychological therapy and specialist input. Helen was diagnosed with Borderline Personality Disorder traits and treatment-resistant depression. Plans were made for her to engage in Dialectical Behaviour Therapy (DBT)[4] and other structured interventions.

Escalating Mental Health Crises

5.6. In month three, Helen presented to the Emergency Department in her local area with worsening dizziness, migraines, and mental health concerns. She reported being largely housebound and reliant on a wheelchair for mobility.

[4] **Dialectical Behaviour Therapy (DBT)** is a form of talking therapy adapted from Cognitive Behavioural Therapy (CBT), designed specifically for individuals who experience emotions very intensely. It aims to help people understand and accept difficult feelings, learn skills to manage them, and make positive changes in their lives. The term "dialectical" refers to the idea that two seemingly opposite things—such as acceptance and change—can both be true at the same time. Mind, 2020. *Dialectical behaviour therapy (DBT)* [online]. London: Mind. Available at: https://www.mind.org.uk/media/6816/dbt-2020-pdf-version.pdf [Accessed 11 Sep. 2025].[1]

5.7. By month five, her mental health had deteriorated further. In the middle of the month, she was taken to hospital by ambulance after expressing suicidal intent linked to chronic pain and frustration with delays in accessing mental health services. She was admitted under the Crisis Resolution and Home Treatment Team (CRHT) and later discharged with community follow-up.

5.8. At the end of month five, Helen was admitted to a psychiatric ward following another crisis episode involving self-harm and suicidal ideation. A consultant psychiatrist assessed her and concluded that inpatient care offered limited benefit, recommending intensive community-based psychological therapy and that placement/relocation to be considered should her mother still be struggling to manage Helen at home. She was discharged in the early part of month six.

Ongoing Risk and Therapeutic Engagement

5.9. Helen began DBT pre-treatment sessions in month nine and engaged well initially. However, her risk profile remained high, with repeated episodes of suicidal thoughts and self-harm urges.

5.10. During this period, she also faced multiple physical health challenges, including migraines, dizziness, and fatigue, leading to referrals to cardiology and neurology.

Housing Breakdown and Homelessness

5.11. In month 12, Helen's relationship with her mother broke down completely, and she was asked to leave the family home along with her father following a domestic abuse incident. This triggered a period of homelessness, during which she stayed intermittently with friends, in hotels, and later in temporary supported accommodation.

5.12. Housing services and adult social care became involved, but securing stable accommodation was complicated by Helen's mental health needs and her insistence on keeping her support cat, which many providers could not accommodate.

High-Risk Period

5.13. From midway through month 13, Helen secured emergency accommodation with a housing provider due to her vulnerability. Despite this, her mental health continued to decline. She disclosed suicidal thoughts, self-harm, and an eating disorder. Multiple agencies, including mental health services, housing, and social care, coordinated to manage her escalating risk.

5.14. In Month 14, Helen experienced several severe crises. Helen was found unresponsive on occasions, requiring emergency ambulance responses and hospital attendance for overdoses of paracetamol and other substances.

5.15. Despite repeated interventions, Helen self-discharged from hospital against medical advice on two occasions at this point from two different hospitals in two different areas one of those being Area B. Helen died in the local general hospital a few days later following multiple organ failure caused by a staggered paracetamol overdose.

6. ANALYSIS OF PRACTICE REGARDING THE KEY ISSUES FACING HELEN

6.1. This section will use the Terms of Reference key lines of enquiry and other discussions that took place with practitioners to inform the analysis and identify key areas for learning.

Transition

6.2. The review begins at a critical point in Helen's life, as she approached her 18th birthday. This period involved substantial change while she continued to experience significant emotional dysregulation, suicidal ideation, and chronic physical health issues—some of which remained undiagnosed or under investigation.

6.3. Helen faced multiple, concurrent transitions, each with distinct challenges. At some stage around her 16th or 17th birthday she would no longer been seen by paediatric services for her physical health needs. From the age of 16 Helen would have been supported to make her own decisions under the terms of the Mental Capacity Act[5] (MCA), although the Children Act[6] (1989) could also be used to prevent harm to Helen if those caring for her were concerned for her safety. In acute hospital emergency departments, Helen would have been treated as an adult at 18.

6.4. Although Helen had never been known to children's social care, she was referred to Adult Social Care when she became homeless. From that point, she was treated as an adult within the systems she encountered. The impact of homelessness on a young person with complex physical and mental health needs is explored later in this report.

6.5. Helen identified the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) as her most challenging change. AMHS frameworks emphasise adult autonomy, human rights[7] and self-determination in treatment and recovery, which can feel markedly different from adolescent services.

6.6. CAMHS operates differently. Helen had known and trusted her CAMHS psychiatrist for many years, at the SAR practitioners' workshop, they described helpful insights from Helen's earlier adolescence.

6.7. Although her psychiatrist spent several sessions preparing Helen for transfer, Helen later reported that the actual experience felt different from what she had expected.

6.8. Research frequently highlights the risk of young people "falling through the net" when they meet CAMHS thresholds but not those of AMHS. This did not apply to Helen: she was accepted by AMHS without significant delay. The concern here is the limited joint working between services to ensure a smooth, seamless transition with minimal negative impact on the young person.

6.9. In this area, both CAMHS and AMHS are provided by the same organisation, which in principle should facilitate easier transition. A handover meeting between the allocated CAMHS and AMHS

[5] HM Government (2005) *Mental Capacity Act 2005*. Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents (Accessed: 4 September 2025).

[6] HM Government (1989) *Children Act 1989*. Available at: https://www.legislation.gov.uk/ukpga/1989/41/contents (Accessed: 4 September 2025

[7] **Human Rights Act 1998, c.42. Available at:** https://www.legislation.gov.uk/ukpga/1998/42/contents

practitioners is the standard process. However, practitioners at the workshop noted that aligning busy clinicians' diaries can be difficult. In Helen's case, the planned handover did not occur because the CAMHS consultant was away from work at the time. Workshop participants discussed what good practice should look like and what the evidence suggests constitutes an effective transition.

6.10. Records indicate that Helen received a prompt review in AMHS and was diagnosed with borderline personality disorder/emotionally unstable personality disorder. This diagnosis is consistent with the trauma she experienced throughout childhood (discussed in detail later in this report).

6.11. The conclusion in this section relates to the process of transition rather than the efficacy of treatment or the quality of services in either CAMHS or AMHS.

6.12. While the local mental health NHS Trust has a transition policy, it largely describes operational procedures and the service "switch," rather than centering the young person's experience. Research in 2010[8] and 2013[9] comments that transition experience of young people from CAMHS to AMHS to is rarely smooth and yet in 2025 Helen still did not receive a transition in line with best practice therefore action needs to be taken to improve this.

6.13. It is not the first time recently that the issue of transition has come up in local learning in the area. A recent SAR, "Beth", found that her transition lacked planning, support, and recognition of her developmental needs. As similar themes apply to this SAR, learning and recommendations will be added to the already ongoing workstream and priority set out in the Board's work for the year to 2026. It is fair to say that the Beth SAR was talking more about transitional safeguarding[10], however the principles are much the same; the difference with this SAR is that transition from CAMHs to AMHs learning and recommendations will be focussed on the organisation who provides those services.

6.14. The Mental Health Foundation NHS Trust undertook a Patient Safety Investigation Report (PSII) following the death of Helen. This has discussed the new transition service that demonstrates evolving local practice. This will be supported by a new transition policy and standard operation procedures for effective operationalisation.

6.15. For Helen, transitional safeguarding had a different emphasis because she had not been open to children's social care; her family had not previously come to the attention of those services. An offer of Early Help in Helen's early adolescence had been, at that time, declined by her mother.

6.16. In Month 12 of the review period, Helen required support from Adult Social Care after a domestic altercation led to her mother asking Helen and her father to leave the family home. While the nuances of domestic abuse are addressed later in this report, this section focuses on transitional

[8] Singh, S.P. et al. (2010) 'Process, outcome and experience of transition from child to adult mental healthcare: Multiperspective study', *The British Journal of Psychiatry*, 197(4), pp. 305–312. doi:10.1192/bjp.bp.109.075135

[9] Paul, M. et al. (2013) 'Transfers and transitions between child and adult mental health services', *The British Journal of Psychiatry*, 202(s54), pp. s36–s40. doi:10.1192/bjp.bp.112.119198

[10] Holmes, D. and Smale, E. (2018) *Transitional safeguarding: adolescence to adulthood – Strategic briefing.* Research in Practice. Available at: https://www.researchinpractice.org.uk (Accessed: 4 September 2025

safeguarding.

6.17. Practitioners at the workshop discussed Helen's apparent caring role for her father, who had mental and physical health difficulties and used a wheelchair. Helen appeared focused on securing accommodation where they could live together. She took the lead in housing applications and other administrative tasks linked to homelessness. To housing and Adult Social Care staff, she presented as a capable self-advocate, and her mental capacity was not in doubt.

6.18. What was less visible in these interactions was Helen's age and limited life experience. She was only just over 18, had never lived away from home, and—unlike some young people with complex needs—had not spent time away from the family environment. Although she received Personal Independence Payment, she had not previously managed independently, even if she had taken on some responsibilities at home.

6.19. The emotional impact of her father returning to the family home without her was not fully considered, nor were the reasons why she could not also return explored in depth.

6.20. If transitional safeguarding had been considered alongside Helen's mental and physical health needs, a fuller assessment of her care and support requirements could have been undertaken. This might have led to additional support and a multi-agency plan to enhance her safety and minimise risks during this exceptionally challenging period.

6.21. Whichever service a young person is transitioning through, NICE Guidance [11] suggests the following are key points that should be considered that were of relevance to Helen:

- **Developmentally Appropriate Support**
  - Tailor plans to maturity, cognitive and psychological needs, health conditions, social context, and communication requirements.
- **Strengths-Based and Person-Centred Approach**
  - Focus on what is positive and possible.
  - Treat young people as equal partners and support them to make informed decisions.
- **Holistic Outcomes and Regular Review**
  - Address education, employment, health, wellbeing, housing, and community inclusion.
  - Agree goals with the young person and review plans at least annually or when needs change.
- **Integrated Working Across Services**
  - Ensure children's and adults' services collaborate through shared protocols and joint planning.
  - Proactively identify and plan for those with transition support needs.
- **Safeguarding and Continuity**
  - Share safeguarding information appropriately.
  - Confirm GP registration and consider assigning a named GP.

[11] National Institute for Health and Care Excellence (2016) *Transition from children's to adults' services for young people using health or social care services (NG43)*. Available at: https://www.nice.org.uk/guidance/ng43 (Accessed: 4 September 2025)

Learning Points

- **Opportunities for Holistic Transition Support**
  Multiple transitions—healthcare, housing, and social care—highlight the chance to design integrated, person-centred pathways that reduce stress and promote stability.
- **Strengthening CAMHS-AMHS Continuity**
  The experience shows how enhanced collaboration and joint planning between CAMHS and AMHS can create smoother, more reassuring transitions for young people.
- **Building on Existing Policies**
  Current transition policies provide a strong foundation. By embedding the young person's voice and lived experience, services can move from process-driven to truly experience-focused care.
- **Championing Transitional Safeguarding**
  Recognising developmental needs during early adulthood offers an opportunity to proactively safeguard and empower young people, especially those facing housing or caring challenges.
- **Learning from Systemic Reviews**
  Previous SARs provide valuable insights. These lessons can drive continuous improvement, ensuring multi-agency collaboration and focused planning.

Supporting Mental, Physical health and identifying care and support needs

6.22. Helen experienced not only significant mental health challenges but also a range of emerging physical health needs, many of which remained under investigation. While it is unclear to what extent her physical health impacted her mental health (and vice versa), practitioners attending the workshop suggested the relationship was likely to be significant. This would indicate that Helen did, in fact, have care and support needs.

6.23. Helen had a complex array of physical health conditions referenced across multiple reports contributing to this SAR, including:

- Joint hypermobility
- Chronic pain and fatigue
- Autoimmune hypothyroidism
- Migraines
- Atrial septal defect
- Orthostatic hypotension
- TMJ disorder (Jaw joint disorder)
- Dizziness, low blood pressure, and fainting spells

6.24. GP records show consistent monitoring and referrals to relevant specialists (e.g., endocrinology, rheumatology, cardiology, neurology). Emergency Department attendances often involved physical symptoms that were exacerbated by mental health crises. Housing support workers and mental health teams noted her fatigue, low BMI, and use of a wheelchair due to physical exhaustion. Concerns about an eating disorder were raised and referred to the All Age Eating Disorder Service,

though support was ultimately deferred due to her mental health instability. These needs were largely addressed in isolation rather than through a coordinated, holistic approach. While impacts were discussed across agencies, each condition required specialist input, and there was no single, up-to-date document outlining progress or a unified plan for supporting Helen. It is likely that a coordinated care plan integrating her mental, physical, and social care needs would have helped Helen better understand her situation and reduced the burden of repeatedly explaining her circumstances to different professionals.

6.25. This fragmented approach may have contributed to Helen's frustration and compounded her trauma (see next section). Helen was clear that she had an eating disorder and wanted help. While the decision to defer treatment until her mental health was more stable may have been clinically justified, it lacked empathy and failed to acknowledge what mattered most to Helen. Records show that Helen agreed with the plan but as a young person on her own in front of two professionals it is not clear how easy it would have been for Helen to disagree in the clinic setting. Had this been kept under review rather than resulting in discharge, the goal of receiving eating disorder treatment might have served as a protective factor and motivation to stay safe—especially during a time of housing instability and increased vulnerability.

6.26. While it is important to respect Helen's developmental stage and promote independence, it is evident that she did not perceive the response to her needs as coordinated. This likely contributed to her sense of not being heard, particularly in relation to the issues she most wanted to address.

6.27. Recent research and national guidance underscore the critical importance of integrating physical and mental health care, particularly for individuals with complex and overlapping needs. A longitudinal study[12] found that patients with mental health challenges treated in integrated care settings experienced significant improvements in depression and anxiety symptoms, while their physical health outcomes remained stable. This supports the growing consensus that integrated care can improve overall health outcomes, reduce fragmentation, and enhance patient experience. However, given the current climate within the NHS—marked by severe workforce shortages, escalating financial pressures, industrial action, and a substantial backlog of elective care—achieving fully integrated care is unlikely to be a realistic goal at this time[13],[14].

6.28. There may be future potential, however, to move towards more integrated care if the proposals in the NHS 10 Year Plan15 with a move of outpatient care to the community and integration of physical, mental, and social care through community hubs. For now, though, the existing systems that are in place could be used more effectively to manage and deliver care with more coordinated

[12] Bhatta, D., Sizer, M.A., Acharya, B. *et al.* (2005) Assessment of mental and physical health outcomes over time in an integrated care setting. *BMC Prim. Care* **26**, 181 (2025). https://doi.org/10.1186/s12875-025-02876-0

[13] Dorney, R. (2025) 'The financial strain on the NHS: Current challenges and the road ahead', *Open Access Government*, 24 June. Available at: https://www.openaccessgovernment.org/the-financial-strain-on-the-nhs-current-challenges-and-the-road-ahead/194548/ (Accessed: 28 October 2025).

[14] The King's Fund (2024) 'Tight budgets, tough choices: The financial reality for the NHS', *The King's Fund*, 18 July. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tight-budgets-tough-choices (Accessed: 28 October 2025).

[15] Department of Health and Social Care (2025) ***Fit for the Future: 10-Year Health Plan for England***. London: GOV.UK. Available at: https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf (Accessed: 28 October 2025).

and collaborative care e.g. Care Programme Approach (CPA)[16] or similar updated frameworks and multi-disciplinary team meetings for those who are vulnerable and were there are concerns that fall below the level of Section 42 Care Act.

6.29. In Helen's case, her physical health conditions—including chronic pain, fatigue, autoimmune hypothyroidism, and dizziness—were documented across multiple services. However, these were not consistently integrated into her mental health treatment plan. Her engagement with mental health services, including DBT and Community Mental Health Team (CMHT), was robust, yet there was no unified care plan that addressed both domains in a coordinated way. This reflects a broader systemic issue where services are siloed, and individuals must navigate multiple disconnected pathways.

6.30. Best practice guidance advocates for a holistic, person-centred approach that treats individuals as whole people rather than separate diagnoses. This includes the use of multidisciplinary teams—comprising GPs, psychiatrists, psychologists, social workers, and other specialists—who collaborate through shared treatment plans and regular communication. Where possible, services should be co-located or virtually integrated, with shared records and systems that enable continuity of care.

6.31. Importantly, decisions about treatment thresholds—such as deferring eating disorder support due to mental health instability—should be made with empathy and revisited regularly. Maintaining engagement with the individual's goals, even when full treatment is not immediately possible, can foster hope and motivation.

6.32. In Helen's case, the lack of a coordinated response and the deferral of eating disorder treatment may have contributed to her sense of frustration and isolation. A more integrated approach, with a single care coordinator and a unified plan, could have helped her better understand and manage her health, reduced the burden of navigating multiple services, and potentially offered protective factors during periods of crisis.

6.33. Ultimately, integrated care is not only a clinical imperative but a compassionate response to the realities faced by individuals with complex needs. It requires systems to work together, listen deeply, and respond flexibly to what matters most to the person.

6.34. Despite clear indicators that Helen had care and support needs, a formal assessment under the Care Act was not undertaken during the period of agency involvement. Several contributing factors can be identified from the chronology and agency records.

6.35. Firstly, the involvement of Adult Social Care and Housing Services in Helen's case was notably brief. She first came to their attention in late Month 12 and tragically passed away in Month 14. This short timeframe significantly limited the opportunity for Adult Social Care to initiate and complete a

[16] The **Care Programme Approach (CPA)** in UK mental health is a framework for assessing, planning, reviewing, and coordinating care for people with severe or complex mental health needs. It was introduced by the Department of Health in 1991 to ensure that individuals receive comprehensive, person-centred support. NHS (2021) *Care for people with mental health problems (Care Programme Approach)*. Available at: https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/ (Accessed: 28 October 2025).

thorough assessment, especially given the complexity of her situation.

6.36. Secondly, Helen's presenting needs were primarily framed around homelessness and mental health crises. These were actively addressed by housing services, mental health teams, and emergency responders. While these responses were appropriate and timely, they may have inadvertently led to her broader care and support needs being overlooked or deprioritised.

6.37. Thirdly, the multi-agency involvement in Helen's case—spanning The multi-agency safeguarding hub (MASH)[17], housing, mental health, GP, ambulance services, and the housing provider—was fragmented. There was no clear pathway or lead professional responsible for coordinating care or ensuring that a Care Act assessment was considered. This lack of coordination may have contributed to gaps in understanding the full scope of Helen's needs.

6.38. Additionally, the initial safeguarding referral focused on Helen's father, whose visible physical health conditions and housing requirements were prioritised. Her Father's return to the family home may have reduced the perceived urgency of the situation, despite Helen's continued instability and vulnerability. This shift in focus may have unintentionally overshadowed Helen's own needs.

6.39. Finally, Helen's engagement with mental health services, including DBT and the CMHT, may have led to assumptions that her care needs were being adequately met within that domain. As a result, the potential for a social care assessment to address her wider support needs—including physical health, trauma, and independent living—was not fully explored.

6.40. This missed opportunity for a holistic assessment under the Care Act highlights the importance of integrated, person-centred planning, particularly for individuals with complex and co-occurring needs.

6.41. There was also a missed opportunity to prevent Helen from becoming homeless. On discharge from a mental health ward in month six, a consultant psychiatrist noted that alternative accommodation might need to be considered, as Helen's mother was struggling to manage her distress at home. This recommendation was passed to the community team; however, the documents for this SAR contain no record of what action was taken or why no alternative placement was arranged. It is unclear whether this was discussed with Helen, what type of provision was envisaged, and what level of support would have been included—particularly given that Helen had just turned 18 and had no prior experience of living independently. Ultimately Helen's relationship with her mother broke down and led to Helen searching for accommodation for herself and her Father and then by herself.

[17] A **MASH**—**Multi-Agency Safeguarding Hub**—is a collaborative arrangement that brings together professionals from various agencies to improve safeguarding for children and vulnerable adults. The purpose of a MASH is to enable **timely information sharing**, **joint decision-making**, and **coordinated responses** to concerns about an individual's welfare. ***What are Multi-Agency Safeguarding Hubs (MASH)?*** **Care Learning. Available at: https://carelearning.org.uk/blog/safeguarding/what-are-multi-agency-safeguarding-hubs-mash/ (Accessed: 30 September 2025).**

Learning Points

- **Early and Holistic Assessment**
  Even brief periods of involvement can be used to initiate Care Act conversations. A holistic approach that considers physical, mental, and social care needs from the outset helps ensure individuals with complex vulnerabilities are not overlooked.
- **Integrated Multi-Agency Coordination**
  Multi-agency involvement is a strength, but clearer pathways for coordination—such as assigning a lead professional or care coordinator—can improve continuity, reduce duplication, and ensure shared understanding across services.
- **Whole-Family and Individual-Focused Practice**
  When multiple family members are involved, it is important to assess each person's needs independently. This helps prevent one individual's visible needs from overshadowing another's less apparent but equally significant vulnerabilities.
- **Cross-Disciplinary Curiosity and Communication**
  Assumptions that one service is meeting all needs can lead to gaps. Encouraging professionals to explore beyond their own remit—especially between mental health and social care—can help identify unmet needs and prompt appropriate referrals.
- **Person-Centred and Trauma-Informed Engagement**
  Listening to what matters most to the individual, even when full treatment isn't immediately possible, fosters trust and motivation. Empathetic communication and revisiting deferred decisions (e.g., eating disorder support) can offer protective factors during periods of instability.
- **Supporting Young Adults Through Transitions**
  Young people navigating independence benefit from structured support during transitions—whether in housing, services, or care teams. A coordinated approach can help them feel secure, empowered, and better able to engage with services.

Trauma informed practice

6.42. Helen's life was marked by a series of significant and compounding traumas that began in early childhood and continued into her adolescence and young adulthood. The details are included in sections four and five and are added here for ease of reference:

- Witnessing parental assault at school, which proceeded to court
- Expulsion from school for carrying a knife, leading to educational disruption.
- Persistent bullying and social isolation throughout school years.
- Disclosure of sexual abuse by a family member and suspected abuse in supported accommodation.
- Not being believed by her mother regarding sexual abuse disclosure.
- Multiple suicide attempts and self-harm incidents, including ingestion of toxic substances.
- Experiencing homelessness and transitions between temporary accommodations.
- Rejection from the family home during a mental health crisis.
- Being declined support by services due to complexity of needs.

- Disrupted education and missed formal examinations.
- Uncoordinated transitions between CAMHS and adult mental health services.
- Unresolved safeguarding concerns including coercive control and domestic abuse.
- Isolation and lack of consistent support during periods of crisis

6.43. The above listed traumas, and in particular those from her early life will have had a significant impact on Helen as she was growing up. The feelings that trauma had built up within Helen would have then been compounded by her ongoing challenges in life that would add to her emotional dysregulation, anxiety and feelings of self-worth. It was apparent during the practitioner's workshop that not all those who came into contact with Helen, understood how far back this trauma was situated within Helen's life.

6.44. Research has consistently shown a strong link between trauma—especially in childhood—and the later development of Emotionally Unstable Personality Disorder (EUPD), also known as Borderline Personality Disorder (BPD).[18]

6.45. It can therefore be seen that Helen's diagnosis would fit with her life experiences. Practitioners in Mental Health services were sensitive to her needs and chose a therapy (DBT) that was in keeping with treatments for BPD. The DBT Therapist provided consistent, flexible trauma informed support including home visits, telephone coaching and collaborative safety planning. Whilst this was the case in Mental Health services, and demonstrated good trauma informed care, it is clear that there is more than just identifying the right treatment and there are researched approaches to managing and supporting those who have experienced trauma that require further embedding across all agencies.

6.46. Trauma-informed care is grounded in five core principles that guide therapeutic practice. First, safety is prioritised, both physically and emotionally, with therapeutic environments designed to minimise the risk of re-traumatisation. Second, trustworthiness and transparency are essential, achieved through clear boundaries and consistent communication that foster trust between client and clinician. Third, peer support is encouraged, recognising the value of shared experiences through group therapy or peer-led initiatives. Fourth, collaboration and empowerment ensure that clients are active participants in their treatment, with an emphasis on autonomy and informed choice. Finally, trauma-informed care involves a deep understanding of trauma as a root cause of emotional and behavioural difficulties. Behaviours are interpreted as adaptive responses to past trauma rather than manipulative or pathological, such as recognising that fear of abandonment may stem from early attachment disruptions.

6.47. Albeit that there are some good examples of trauma informed approaches detailed above, it appears that Helen was able to mask her needs on occasions presenting as capable and a support for her father at a time of crisis. It is important to note, however that in her last few weeks of life she

[18] Bozzatello P, Rocca P, Baldassarri L, Bosia M, Bellino S. The Role of Trauma in Early Onset Borderline Personality Disorder: A Biopsychosocial Perspective. *Front Psychiatry*.*Frontiers Media S.A.* 2021;12. doi:10.3389/fpsyt.2021.721361

was attending emergency departments at two different hospitals having taken significant overdoses that indicated that indeed she was not coping and that her trauma experienced life had left her feeling abandoned by her family and professionals not listening to her.

6.48. During the process of this review, it has become apparent that the most significant trauma was possibly not being heard by her parents or professionals when she disclosed sexual abuse by a family member. Helen disclosed the abuse to ambulance staff and to staff at her temporary accommodation. None of these disclosures resulted in a safeguarding referral or support to talk to the police. In terms of trauma informed practice this fell below what is discussed above as to best approaches.

6.49. The Safeguarding Partnership has identified the need to evaluate how effectively trauma-informed approaches are embedded across agencies. This has been established as a priority workstream within the current Strategic Plan, running through to 2026. While some agencies demonstrate strong outreach and awareness of trauma and its presentation, the evidence suggests that a fully integrated, trauma-informed pathway for understanding and supporting individuals affected by trauma is not yet consistently in place.

6.50. At a time of significant crisis for Helen, there was little understanding that Helen needed a trauma embedded pathway to keep herself safe. The was too much reliance on her own self determination and decision making which left her self-discharging from emergency departments with no direct support in place or direct conversations with her support workers in mental health and the accommodation provider.

6.51. The self-discharge from Area B Emergency Department (ED) is of particular concern as it was known that her levels of paracetamol were dangerously high. Helen was deemed to have capacity to make this decision and had been able to convince medical staff that it was a mistake and that she would be going home. The fact that she had been taken to Area B hospital at her insistence to the ambulance crew was in itself indicative of trying to go somewhere where she was not known. Helen left the department having been told that she would be very likely to die as a result.

6.52. Helen's ability to mask meant that she presented in a manner that conveyed resilience and control, which influenced decision-making within the ED. This presentation led to an interpretation that she had made an isolated mistake in taking a significant and staggered overdose and that returning to her parents' care was the most appropriate course of action. Helen assured ED clinicians that she did not wish to remain in the department and that she would be at home under parental supervision, with her parents prepared to seek help if necessary. In reality, Helen was living alone in accommodation where she was not monitored overnight and had no contact with her parents at that time. Believing that no further intervention was possible for an adult with mental capacity to make autonomous decisions, Helen left the ED without receiving the required treatment.

6.53. The hospital in Area B recognised this as a serious incident and as a result have investigated fully, made recommendations and changes to procedures. Viewing Helen through a trauma lens would have helped to understand the mental health crisis that she was in at that time.

Learning Points

- **Helen's life experiences provide a clear foundation for understanding her needs through a trauma-informed lens**, offering valuable insight into how early adversity can shape emotional and behavioural responses.
- **Mental health services demonstrated thoughtful clinical judgement** by selecting Dialectical Behaviour Therapy (DBT), a recognised and appropriate treatment for Borderline Personality Disorder (BPD).
- **Practitioners showed sensitivity to Helen's therapeutic needs**, particularly during her time in temporary accommodation, where her DBT therapist continued to engage with her in a flexible and person-centred way.
- **Helen's ability to present as capable and supportive of others** highlights the importance of recognising masked distress and the resilience individuals may show, even during periods of crisis.
- **There is an opportunity to strengthen safeguarding responses**, particularly around disclosures of sexual abuse, ensuring that all professionals are equipped to respond with empathy and appropriate action.
- **Embedding trauma-informed principles across all services**—including safety, trust, empowerment, and understanding trauma as a root cause—can enhance consistency and reduce the risk of re-traumatisation.
- **Helen's self-discharges from hospital underline the need for coordinated crisis planning**, where trauma-informed risk management can support safer decision-making and continuity of care.
- **Viewing Helen's behaviour as adaptive responses to trauma** rather than as non-compliance or manipulation can foster more compassionate and effective support.
- **The Safeguarding Partnership's commitment to embedding trauma-informed approaches** across agencies by 2026 is a positive step toward systemic change and improved outcomes.
- **Greater emphasis on collaborative care and shared responsibility** can reduce reliance on individual self-determination during times of vulnerability, ensuring that people like Helen are not left to navigate crisis alone.

Domestic Abuse from a whole family contextual perspective

6.54. Helen lived in a household marked by complex mental health needs, instability, and strained relationships. Her mother had a history of anxiety, depression, personality disorder, and previous suicide attempts. Her father was described as agoraphobic, paranoid, and suffering from multiple physical and mental health conditions, including schizophrenia and vascular disease. Helen also had a younger sister who was also part of the household.

6.55. The family dynamic was described as chaotic and emotionally volatile, with Helen frequently in crisis and her parents struggling to manage her needs. There were frequent breakdowns in relationships, including the issues already discussed within this report from month 12.

6.56. A whole family approach in Helen's case would have involved coordinated, multi-agency support that recognised the interconnected needs of all family members. Had this been accepted by the family, it would begin with a joint planning involving adult social care, children's services, mental health, and housing, to understand the dynamics and risks affecting Helen, her parents, and her younger sibling. A named lead professional would ensure continuity and reduce the burden on Helen to repeatedly explain her situation. A shared care and support plan would address Helen's physical and mental health, her father's complex needs, her mother's mental health and parenting capacity, and the safety of her sibling. Therapeutic support or mediation could have helped the family navigate conflict and improve communication. Housing solutions would be developed with the family's vulnerabilities in mind, avoiding fragmented responses. Safeguarding concerns, including coercive control and sexual abuse disclosures, would be triangulated and acted upon. Helen's role as a young carer and her sister's exposure to trauma would be acknowledged and supported. Overall, this approach would promote stability, safety, and a sense of being heard and supported across the entire family unit. If the family had not accepted such support, there would have been evidence of what had been offered with opportunities to come back and offer again at a later point.

6.57. As it was, Helen was not seen as a victim of domestic abuse at any point. It was acknowledged that her parents were possible both victims of each other's volatile natures and mental health challenges and her sister was also identified as a victim. Both her parents were offered DASH[19] risk assessments and support at various times in the timeline of the review. Her father was referred to the MASH as he was seen as vulnerable; Helen was at the time seen as the person managing the situation. All of this links with trauma informed practice and recognition of Helen as a victim of many traumas throughout her life.

6.58. There is clear evidence that Helen played a pivotal role in managing aspects of the household, particularly in supporting her father, who had significant physical and mental health needs. Helen actively engaged with housing officers and support services, advocating for her family and seeking stable accommodation. Her involvement in daily routines, such as taking her younger sister to school, further highlights her caregiving responsibilities. Professionals noted her ability to present as competent and helpful, often masking her own emotional needs, which may have led to an underestimation of her vulnerability and the informal young carer role she fulfilled.

6.59. Whilst this whole family approach may not have been accepted, it would have been recognised that the family issues were all impacting on each other and that family contextual context was recognised which may have benefitted the whole family and have encouraged a staged approach to rebuilding the family as a unit.

6.60. Helen's experience highlights the critical role that support networks—both formal and informal—play in safeguarding and wellbeing. While there were examples of professional commitment, such as

[19] The **DASH Risk Assessment** stands for **Domestic Abuse, Stalking, and Honour-Based Violence**. It is a structured checklist used by professionals—such as police officers, social workers, and domestic abuse specialists—to identify and assess the level of risk faced by individuals experiencing domestic abuse. *Dash risk assessment resources for professionals*. SafeLives. Available at: https://safelives.org.uk/resources-for-professionals/dash-resources (Accessed: 30 September 2025)

timely access to Adult Mental Health Services and DBT provision, the review found limited evidence of sustained engagement with family, peers, or community resources. Family conflict was acknowledged, but there was little indication of structured efforts to mediate relationships or involve family members as partners in planning and decision-making.

6.61. Similarly, there was no reference to peer or community-based support, which could have provided protective factors and reduced Helen's sense of isolation. This suggests an over-reliance on statutory services, with insufficient emphasis on building resilience through informal networks. The absence of these relational supports left Helen particularly vulnerable during periods of transition and crisis.

6.62. There is an opportunity to strengthen family engagement by developing approaches that actively involve families and carers, even where relationships are complex, to create shared understanding and support plans. In addition, building partnerships with voluntary and community organisations can help leverage community and peer resources, providing accessible and non-stigmatising support. Finally, embedding network mapping into practice—through tools and processes that identify and strengthen informal support networks—should become a core element of holistic assessment and care planning.

Learning Points

- **Whole-family approaches foster holistic understanding**: Recognising the interconnected needs of all family members enables more effective and compassionate support planning.
- **Multi-agency collaboration enhances outcomes**: Coordinated input from adult social care, children's services, mental health, and housing can reduce fragmentation and improve stability.
- **Named lead professionals reduce burden**: Assigning a lead professional ensures continuity and prevents individuals like Helen from having to repeatedly explain their situation.
- **Shared care plans promote safety and wellbeing**: Joint planning that includes physical and mental health, parenting capacity, and safeguarding needs can support all family members more effectively.
- **Therapeutic support strengthens family relationships**: Mediation and therapy can help families navigate conflict and improve communication.
- **Housing solutions should reflect family vulnerabilities**: Tailored housing responses can prevent further instability and support recovery.
- **Young carers need recognition and support**: Acknowledging informal caregiving roles, like Helen's, ensures their emotional and practical needs are not overlooked.
- **Trauma-informed practice is essential**: Recognising the impact of cumulative trauma on individuals like Helen helps shape more empathetic and responsive interventions.
- **Contextual safeguarding protects all family members**: Understanding the dynamics of coercive control and abuse within the family allows for more accurate risk assessments and protective actions.
- **Family rebuilding is possible with staged support**: Even in complex situations, recognising family context can lead to gradual healing and improved relationships.

Legal Literacy and Opportunities for Enhanced Support

6.63. Helen's story illustrates how legal literacy—an understanding of the laws, rights, and responsibilities that underpin safeguarding and care—can be a powerful tool in promoting safety, stability, and wellbeing for vulnerable young people. When professionals are confident in applying legal frameworks such as the Care Act 2014, Children Act 1989, and Mental Capacity Act 2005, they are better equipped to identify risks early and respond with clarity and compassion.

6.64. Greater awareness of Helen's rights under the Care Act could have led to a timely and holistic assessment of her care and support needs. Despite her brief engagement with Adult Social Care, Helen's complex physical and mental health challenges, housing instability, and caregiving responsibilities for her father all pointed to significant unmet needs. Legal literacy would have empowered practitioners to initiate conversations about support, even during short windows of contact, ensuring Helen's voice was heard and her circumstances fully understood.

6.65. Understanding safeguarding legislation also helps professionals navigate the delicate balance between autonomy and protection. Helen's ability to self-discharge from hospital during a mental health crisis was legally permissible, yet a trauma-informed lens might have prompted deeper reflection on her capacity to make safe decisions in that moment. Similarly, her disclosures of sexual abuse—shared with ambulance staff and accommodation providers—could have triggered safeguarding referrals had practitioners been more confident in their legal duties to act given that Helen had a younger sister who remained within the household.

6.66. Legal literacy also supports smoother transitions between services. Helen's move from child to adult mental health care was a pivotal moment, and knowledge of transitional safeguarding principles could have ensured developmentally appropriate support. Recognising that turning 18 does not automatically confer emotional readiness, professionals could have worked collaboratively to maintain continuity and reduce the stress of change.

6.67. In the context of housing, legal knowledge around homelessness rights and reasonable adjustments could have strengthened advocacy for Helen's needs, including her wish to keep her support cat. Understanding her entitlements might have opened doors to more suitable accommodation and reduced the emotional toll of instability.

6.68. Importantly, embedding legal literacy within trauma-informed practice allows professionals to interpret behaviours—such as masking distress or presenting as capable—not as signs of resilience alone, but as adaptive responses to trauma. This perspective fosters empathy and encourages proactive support, rather than relying solely on the individual's self-determination during times of vulnerability.

6.69. Finally, legal literacy enhances multi-agency coordination. When all services share a common understanding of their legal responsibilities, it becomes easier to assign a lead professional, develop unified care plans, and ensure consistent support. In Helen's case, this could have reduced fragmentation and helped her feel less alone in navigating complex systems.

6.70. Overall, legal literacy is not just knowledge—it is a foundation for compassionate, rights-based practice. By embedding it across services, professionals can better protect, empower, and support

young people like Helen, ensuring that their needs are met with dignity, clarity, and care.

Learning Points

- **Early recognition of Care Act rights** could have prompted a holistic assessment of Helen's care and support needs, even during brief service involvement.
- **Understanding safeguarding legislation** helps professionals balance autonomy with protection, especially during high-risk decisions like hospital self-discharge.
- **Clear statutory duties around abuse disclosures** ensure that professionals respond appropriately and consistently to safeguarding concerns.
- **Transitional safeguarding principles** support developmentally appropriate care during service transitions, reducing stress and fragmentation.
- **Legal knowledge of housing rights and reasonable adjustments** enables better advocacy for vulnerable young people, including accommodation needs linked to emotional wellbeing.
- **Embedding legal literacy within trauma-informed practice** fosters empathetic responses and helps interpret behaviours as adaptive rather than non-compliant.
- **Shared legal understanding across agencies** improves multi-agency coordination, enabling consistent support and reducing reliance on individuals to navigate complex systems alone.
- **Legal literacy empowers professionals** to act confidently, compassionately, and in alignment with best practice, promoting safety and dignity for young people like Helen.

7. SUMMARY AND CONCLUSION

In terms of thinking about the overarching summary and conclusion for this SAR, it is useful to consider Helen in terms of the systems around her to support and protect her. This SAR has considered the good practice and points for future practice at several systemic levels as depicted below. In this SAR, learning was found in several domains.

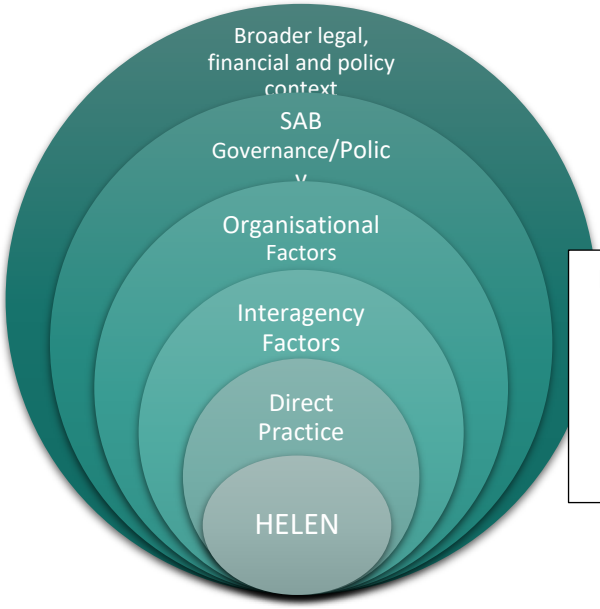

Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

7.1. Helen's life journey reflects both her resilience and the dedication of professionals who supported her through complex challenges, including mental health needs, emerging physical health conditions, housing instability, and family conflict. There were notable examples of good practice—such as timely access to Adult Mental Health Services and the provision of DBT—which demonstrate the system's capacity to respond effectively. However, the review also highlights opportunities to strengthen transition planning, embed trauma-informed approaches, and enhance holistic care coordination to ensure consistent, joined-up support.

7.2. Helen's voice was present in parts of her journey, but not always central to decision-making. She expressed aspirations for stability, safety, and meaningful relationships—goals that should guide future practice. Recognising and amplifying the voices of young people is essential to building trust and achieving better outcomes.

7.3. Three key domains for learning emerged:

- **Direct Practice:** Many professionals showed commitment and sensitivity, and there is scope to build on this by embedding trauma-informed approaches more consistently, responding robustly to abuse disclosures, and ensuring continuity during crises.
- **Interagency Collaboration:** Multi-agency involvement was evident and provides a strong foundation for improvement. Developing a more coordinated framework will help reduce duplication, close safeguarding gaps, and lessen reliance on young people's self-advocacy.
- **Organisational and Systemic Factors:** Existing transition policies and legal frameworks offer valuable guidance and applying them more consistently can enhance the young person's experience. Strengthening pathways and reducing service silos will help ensure that every voice is heard and supported.

Impact of the Broader Legal, Financial, and Policy Context on Helen's Experience

7.4. Helen's journey unfolded within a wider system shaped by legal duties, financial realities, and policy ambitions. While these frameworks aim to safeguard and empower individuals, their practical application influenced the support Helen received in several ways:

- **Transition Policies and Legal Frameworks**
  National policies provide clear guidance on supporting young people through transitions, yet these were not consistently applied in Helen's case. This created gaps in continuity and left her without the fully integrated care envisioned by policy. Strengthening legal literacy and ensuring consistent application of statutory duties would help translate these principles into practice.
- **Resource and Funding Pressures**
  Financial constraints across health and social care services likely limited the availability of specialist placements and intensive community support. This contributed to fragmented pathways and placed additional responsibility on Helen to navigate complex systems largely by herself—something particularly challenging given her mental health needs.
- **Systemic Fragmentation**
  Structural issues, such as separate funding streams and siloed services, made it harder to

deliver a single, coordinated plan of care. While professionals worked hard within their own remits, the absence of a unified framework meant Helen's voice was not always central to decision-making.

- **Policy-Practice Gap**
  Although national strategies promote trauma-informed, person-centred care, these principles were not consistently embedded in frontline practice. Bridging this gap requires aligning policy ambitions with operational realities and investing in workforce development.

7.5. By addressing these systemic challenges—through stronger governance, better integration, and sustained investment—the safeguarding system can ensure that young people like Helen experience care that is not only legally compliant but also compassionate, coordinated, and responsive to their needs.

7.6. Helen's story reinforces the importance of integrated, person-centred, and trauma-informed systems that recognise the unique vulnerabilities of young adults navigating multiple transitions. While there were many examples of professional dedication, this review identifies opportunities to translate policy into practice more effectively, strengthen interagency governance, and embed legal literacy across services.

7.7. Leadership at all levels must champion these changes and ensure that learning translates into practice. This includes prioritising equity, anti-discriminatory practice, and meaningful engagement with families and communities as partners in safeguarding. Strengthening informal networks is essential to reducing isolation and improving resilience, ensuring that young people have both professional and relational support during critical life stages. By building on existing strengths and addressing these gaps, the safeguarding system can deliver care that is coordinated, empathetic, and continuous ensuring that young people like Helen are supported with dignity and hope for the future.

8. RECOMMENDATIONS

8.1. Where agencies have made their own recommendations in their own investigations and as a result of this SAR, WST should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

8.2. The **recommendations for change and improvement** in the *Overview Report for Helen* stem from several key areas of concern and learning identified throughout the Safeguarding Adults Review (SAR). These areas reflect systemic, interagency, and direct practice issues that impacted Helen's care and safety. While these recommendations are rooted in Helen's case, it's important to note:

- Safeguarding frameworks and interagency protocols may have improved since the events described.
- The WST partnership have previously recognised two elements of learning from this SAR as their strategic priorities and therefore work is ongoing**.** This SAR will therefore acknowledge this within its recommendations.
- Single agencies have undertaken their own reviews and investigations post Helen's death and have implemented their own action plans.

- These recommendations recognise the specific issues that related to unfriended young people who transition to agencies' adult services.

1. Transitions Pathways

1.1. Transitional Safeguarding

In recognition of the significant ongoing work within the WST strategic priorities, that may be extended to 2027, the following must be ***considered*** as part of the expected outcomes across partners:

- Co production with young people aged 16-25 with lived experience.
- Clarity across agencies of the purpose and meaning to 'Transitional safeguarding'
- Develop 3-5 'Always events' in transition pathway (See appendix 3 for examples)
- Evidence of a co-produced multi agency transition pathway for safeguarding centred around the young person's experience (developmental needs, parallel working, holistic outcomes, consented information-sharing, and clear escalation if handovers slip).
- Advocacy for the unfriended if appropriate
- Named transition worker

1.2. Transition from CAMHS to AMHS

In recognition of the identification by the Mental Health NHS Trust that there will be a Transition Policy and associated Standard Operating Procedures, WST should seek assurance from the Trust that the final processes will include the following:

- Co production with young people aged 16-25 with lived experience.
- Include 'Always events' for transition
- Developmentally-appropriate practice at 18- Embed standards for maturity, cognitive/psychological needs and social context; mandate strengths-based planning,
- Named transition worker

1.3. All Transitions

As part of the ongoing strategic priority work, the Transitional Safeguarding Group should be informed about the work of the Multi Agency Transitions Panel and ensure its input is incorporated into current priorities. This collaboration is vital to prevent duplication, maintain continuity of support, and deliver a holistic approach to transitional safeguarding across all agencies.

2. Trauma-Informed Practice

- Trauma Informed Practice is another strategic priority for WST, with Barnardo's involved in its embedding. WST should ensure the work is fully assessed for efficacy. This can be done through audits and by observing effective practice in future investigations, SARs, LSCPRs, DHRs, etc.

- WST should scope and explore opportunities to collaborate with local and regional partnerships to assess the feasibility of introducing trauma alert cards. This work should include identifying

best practices, understanding potential benefits for individuals with lived experience, and ensuring alignment with existing safeguarding and support frameworks.

- **Purpose:** Helps individuals quickly inform professionals (e.g., doctors, therapists) that they have experienced trauma and may need adjustments in care.
- **Features:**
  - Wallet-sized or fold-out format.
  - Space for personal triggers, "what helps" and "what not to do."
  - QR codes linking to resources for professionals.
- Examples:
  - Healthwatch Essex Trauma Card – Used in NHS settings to discreetly alert staff and improve trauma-sensitive care.[1]
  - Survivors Unite Alert Card – Includes instructions for what helps and what to avoid during triggering situations.[2]

3. Integrated Care Planning

Given the current resource constraints faced by many partners, this recommendation focuses on integrated care planning rather than integrated care delivery.

- WST should seek assurance that all individuals entitled to multi-agency care coordination under the Care Programme Approach (CPA), or its equivalent have a single, integrated care plan. This plan should be co-produced with the person and reviewed regularly, ensuring full engagement from all relevant professionals—mental health, physical health, social care, housing, and any other services involved.

- WST should receive regular updates from health partners on the opportunities from the UK Government's 10 Year Plan on the movement to integrated community care hubs.

4. Legal Literacy and Rights Awareness-Embed Legal Literacy into Practice and Workforce Development

- All relevant partner agencies should assure WST that they have plans in place to strengthen professionals' understanding and confident application of key legal frameworks—including the Care Act 2014, Mental Capacity Act 2005, and Housing Act 1996—through mandatory training, supervision prompts, and case audits. This includes:

Consider:

- Commissioning a shared legal literacy curriculum covering statutory duties, safeguarding thresholds, and practical application in complex cases.
- Integrating legal literacy checks into reflective supervision and multi-agency audits.
- Develop quick-reference tools (e.g., one-minute guides) for Care Act conversations and safeguarding referrals.
- Partnering with regional safeguarding boards and workforce development networks to co-deliver training and share best practice resources.

- **Strengthen Understanding and Use of Advocacy Across All Agencies**
  WST should seek assurance that partner agencies consistently understand the role of both **statutory advocacy** (e.g., Care Act, Mental Health Act) and **informal advocacy**,

and make timely, appropriate referrals to advocacy services when a young person has **no family member, friend, or informal supporter** who is appropriate and willing to help.

- WST should recirculate the website links to Voiceability, the local provider and encourage the addition of these links on agency intranets etc.,

5. Continue to Embed "Think Family" Principles into Adult Safeguarding Practice

WST should review recommendations (Patrick SAR and any others) regarding *Think Family* and update guidance to ensure that adult safeguarding work consistently considers the learning from this SAR:

- Young adults as carers and the support they may need.
- Risks to all family members arising from domestic abuse incidents.
- Impact of family dynamics on vulnerability and decision-making.

Consider:

- Refreshing multi-agency resources to include these principles.
- Developing a practice checklist for safeguarding meetings and assessments.
- Provide workforce briefings and supervision prompts to reinforce whole-family thinking.

6. Crisis Response and Risk Management

Rationale:

Helen died as a direct result of leaving Emergency Departments against medical advice following critical overdoses. This recommendation is therefore critically important to prevent future deaths of this nature. The Acute NHS Trust in Area B undertook a critical incident review within their ED and identified actions and updates to processes regarding self-discharges following critical overdoses. The local area Hospital NHS Trust were unable engage with the SAR panel and therefore self-discharge from ED following critical self-harm overdose processes are not understood.

WST should therefore seek to understand what multi agency framework of support is required specifically for this cohort of people regionally. Collaboration with the wider Suicide Prevention Forum is advisable.

Consider a mission statement such as:

"As partners, we are committed to ensuring that individuals who leave A&E after a critical overdose are not left without support. Before they leave, we will take timely, coordinated action and look at all available services to provide comprehensive support, reduce the risk of preventable harm, and create a clear pathway to safety and recovery. This includes liaising closely with all services required depending on patient's holistic needs and presentation, including mental health crisis teams, social care services, housing services (including homelessness support services), substance misuse services as well as relevant physical healthcare services, whilst considering and applying all relevant legal frameworks, such as the Mental Capacity Act 2005, Mental Health Act 1983, etc., to their full legal strength."

Consider the following Guiding Principles

- **Shared Responsibility**
  Every partner commits to collective action to safeguard individuals at highest risk when leaving ED against medical advice after a critical overdose.
- **Immediate Response**
  Prioritise rapid engagement and intervention at the point of discharge to prevent avoidable deaths.
- **Continuity of Care**
  Ensure seamless transition from emergency care to community-based wrap-around support.
- **Holistic Approach**
  Address physical, psychological, and social needs through integrated multi-agency support.
- **Information Sharing**
  Maintain timely, accurate communication across agencies to coordinate care effectively.
- **Person-Centred Practice**
  Respect individual choice while ensuring safety, dignity, and access to life-saving support.
- **Accountability and Learning**
  Monitor outcomes, share best practices, and continuously improve collaborative responses.

7. **Disclosures Of Historic Child Sexual Abuse Where There Is Direct Risk To An Identified Child**
   WST should consider formatting and circulating the briefing attached in appendix 2 as a reminder of statutory duties and best practice following such disclosures.

8. **Develop a Multi-Modal Briefing Package for the Helen SAR**
   WST should develop a multi-modal learning package summarising the Helen SAR, designed to accommodate different learning styles and professional contexts. This should include visual, auditory, written, and interactive formats to ensure accessibility and engagement across the workforce.

Rationale:

The Helen SAR contains complex, sensitive, and multi-agency learning. To ensure that all practitioners—regardless of role, background, or preferred learning style—can engage meaningfully with the findings, the briefing should be delivered in varied formats.

Consideration should be given to the following options:

- Involve practitioners in co-design to ensure relevance.
- Use real quotes (anonymised) from the SAR to humanise the learning.
- Include reflection prompts and links to further resources (e.g. dementia training, safeguarding guidance).
- Ensure accessibility (e.g. subtitles, screen-reader compatibility).

Format	Description	Learning Style Targeted
Executive Summary (PDF)	A concise, plain-language summary of key findings and recommendations.	Verbal/Linguistic
Infographic or Poster	Visual summary of key themes, timelines, and learning points.	Visual/Spatial
Short Video Briefing	5–10 minute narrated video with visuals and voiceover.	Auditory & Visual
Interactive through supervision and team meetings	Scenario-based learning with reflection questions and quizzes.	Reflective
Facilitated Workshop Slides	PowerPoint deck for team-based learning and discussion.	Interpersonal & Verbal
Podcast or Audio Summary	Audio-only version of the briefing for on-the-go learning.	Auditory

Appendix One Terms of Reference (REDACTED)

Safeguarding Adults Review
HELEN

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

An SAB 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.

Condition 1 is met if—

(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).

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.

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).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "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".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

A senior Social Work Manager made a Safeguarding Adult Referral following the death of Helen who had died in Hospital at 18 years 11 months of age. Her cause of death has been confirmed by the coroner as a staggered paracetamol overdose, anxiety and depression.

Helen and her father had left the family home due to concerns relating to domestic abuse between Helen's father and mother, which resulted in them being homeless and staying with family and

friends in Area B. Helen's father returned to the family home, however, Helen did not – at the time of her death she was residing in temporary accommodation. Concerns had been raised around Helen's general vulnerability due to her poor mental health and ability to live independently.

Helen was diagnosed with EUPD, Anxiety, Depression and suffered with chronic pain.

3. Decision to hold a Safeguarding Adults Review

Following the extensive scoping information being gathered by agencies a Rapid Review meeting was held on 24th February 2025, with all key partners who had worked with Helen. The meeting agreed that the criteria for a Safeguarding Adult Review were met.

4. Scope

The review will cover the period of 14 month prior to Helen's death, being the time that transition to Adult Mental Health services from CAMHs was required and her physical and mental health needs were escalating. Historical information particularly related to Helen's lived experience as a child growing into adulthood will be also considered where there may be learning.

5. Method

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

WST chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a Learning and Reflection Workshop to review all of the material and identify key themes and learning. A Review workshop will take place to review the first draft of the overview report.

6. Overarching Purpose of the Review

The SAR will explore how agencies worked individually and collectively to safeguard and support Helen, with particular attention to:

- Her transition to adulthood and independence.
- The management of risks associated with homelessness, domestic abuse, and mental health.
- The application of trauma-informed and whole-family approaches.
- The effectiveness of social support networks and community resources

7. Key Lines of Enquiry to be addressed

The review will consider the following areas:

a. Care and Support Needs

- Assessment and response to Helen's care and support needs as an 18-year-old experiencing homelessness for the first time.
- Consideration of her mental health and any additional needs

b. Whole-Family and Trauma-Informed Approaches

- To what extent agencies adopted a "Think Family" approach, considering the needs and dynamics of the wider family.
- Use of trauma-informed practice in assessment, planning, and intervention.

c. Domestic Abuse

- The identification and management of domestic abuse within the family home.
- The impact of domestic abuse on Helen's wellbeing and decision-making.

d. Risk Management

- How risks were identified, assessed, and managed, particularly following Helen's homelessness.
- The effectiveness of multi-agency risk management processes.

e. Transition to Adulthood

- How well the transition from children to adult services was planned and executed.
- The extent to which learning from previous SARs, including the Beth SAR, and national best practice is embedded in practice.

f. Social Support and Networks

- Exploration of Helen's access to informal and formal support networks.
- The role of community, peer, and voluntary sector support in promoting resilience and safeguarding.

g. Legal Literacy and Rights Awareness

- To what extent professionals demonstrated legal literacy in relation to safeguarding, homelessness, mental health, and transition to adult services.
- Whether Helen was informed of her legal rights and entitlements, including access to advocacy, housing, and support services.
- How legal frameworks (e.g., Care Act 2014, Children Act 1989, Housing Act 1996, Mental Health Act 1983) were applied in practice and whether there were any gaps in understanding or implementation.

8. Identification of Good Practice

In addition to identifying areas for improvement, the review will also seek to highlight examples of effective practice and positive outcomes. This includes:

- **Evidence of Person-Centred Practice**: Instances where Helen's voice, wishes, and lived experience were central to decision-making and care planning.
- **Effective Multi-Agency Collaboration**: Examples where agencies worked well together to share information, coordinate support, and manage risk.
- **Timely and Proactive Interventions**: Actions taken early or creatively to prevent escalation of risk or to support Helen's wellbeing.
- **Use of Strengths-Based and Trauma-Informed Approaches**: Where professionals demonstrated empathy, understanding of trauma, and built on Helen's strengths and resilience.
- **Legal and Procedural Adherence**: Where professionals demonstrated strong legal literacy and applied statutory duties effectively to safeguard and support Helen.

9. Independent Reviewer and Chair

The named independent reviewer commissioned for this SAR is **Karen Rees.**

10. Organisations to be involved with the review:

- Adult Social Care
- The Partnership NHS Foundation Trust
- Children's Social Care
- Integrated Care Board/GP
- Accommodation Provider
- School
- Area A Hospital NHS Trust
- The Ambulance Service
- Police
- Area A Homes Service
- Area B Hospital NHS Trust

11. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The author has written to the family to invite engagement bearing in mind key sensitive dates.

Appendix 2

ONE-MINUTE GUIDE

Responding When an Adult Discloses Historic Child Sexual Abuse and Younger Siblings/Other Identified Children Are at Risk

Purpose: To ensure professionals act promptly and lawfully when an adult (18+) discloses historic child sexual abuse and there are other identified children at risk e.g. younger siblings in the household.

Key Principles

- Listen and Validate: "Thank you for telling me. I believe you." Stay calm, avoid judgment, and let the person set the pace.
- Explain Safeguarding Duty: "Because you've told me this and there are younger children at home, I must share this to keep everyone safe."
- Do NOT Investigate: Do not ask for graphic details—just enough to understand risk and trigger referral.

Immediate Actions

1. Record the disclosure factually (date, time, words used).
2. Inform your safeguarding lead immediately.
3. Make a referral to Children's Services (MASH) for siblings.
4. Consider Adult Safeguarding under the Care Act if the adult has care and support needs.
5. Offer support and signposting (sexual violence services, advocacy, mental health).

Legal Frameworks

- Children Act 1989: Duty to protect children from harm.
- Care Act 2014: Adult safeguarding duties.
- Working Together to Safeguard Children (Statutory Guidance).

What to Say vs What Not to Say

Say	Don't Say
✓ "I'm glad you told me."	✗ "Why didn't you tell anyone before?"
✓ "You are not to blame."	✗ "Are you sure this happened?"
✓ "I need to share this to keep you and others safe."	✗ "I promise not to tell anyone."

Appendix 3

ALWAYS EVENTS – What Young People Can Expect Every Time
(EXAMPLES)

Co-produced standards for safe, person-centred transitions (Ages 16–25)

1. Named Contact After Crisis

You will always leave ED or crisis care with the name and phone number of someone who will contact you within 24 hours.

2. Joint Handover Before Service Switch

You will always have at least one joint meeting between your current and new care team before your transition is completed.

3. My Voice in My Plan

You will always be asked what matters most to you and see this written in your care plan.

4. Safety Plan in My Hands

You will always leave any crisis or discharge point with a personalised safety plan that you understand and agree with.

5. No Decision Without Me

You will always be involved in decisions about changes to your care, explained in a way you can understand.