Safeguarding Adult Review

“Beth”

Nikki Holmes

In the UK, the legal age in which we become recognised as adults is 18. This is an age when we are typically deemed as being fully independent, self-sufficient, and responsible.

Yet some might argue that the concept of an adulthood is a mere social construct. We as humans, are not homogenous, but rather unique, individual beings. Our lives are a tapestry of our individual contexts and histories.

As such, our journey and transition to adulthood is equally individualised and unique. The path we tread as we walk away from our childhoods can be littered with many obstacles, challenges and complex life events. Therefore, reaching a milestone 18th birthday does not always mean we are able to survive and thrive independently in the world.

And yet, the support that is available to our young adults as children, is so very often pulled away as soon as the curtain falls on their 17th year of life.

This was certainly the case for Beth. She was 22 at the time of her death. Legally an adult. However, Beth's young life had been blighted by complex trauma and adversity which resulted in her being sectioned under Section 3 of the Mental Health Act at the age of 17. She remained under section as an inpatient for three years. This trauma, coupled with the lack of exposure to life experiences needed to prepare us for independence, undoubtedly had an impact on her ability to navigate the complexities of adulthood, which is explored in depth throughout this review.

Because of Beth's age at the time of her death, and the identified challenges that were present during her transition to adulthood, it was deemed appropriate that the scope of this review, (whilst a Safeguarding Adult Review) should also encompass a review of the support that specialist key services, such as the Child Adolescent Mental Health Service, (CAMHs) provided to Beth during her childhood. This was determined as important and necessary to understand the efficacy of transitional safeguarding arrangements and to provide additional context needed to fully understand her lived experience.

This review is dedicated to Beth, and to all those like her, who do not live to experience all the seasons of life.

When we sit, stare and look up at the sky,

We see a pair of wings go floating by,

It's not a bird, but an angel we see,

Through the clouds, she smiles at me.

And when we see the wavey long hair,

We know then it is our Beth that is floating there.

Our arms long to hold her close to us,

But knowing Beth she'll say don't worry Mom & Dad, please don't fuss.

She waves and continues on her way,

So, it's without her that we must face another day.

We can only remember her in our heart,

but with the love and her memories, we are never far apart.

We will never forget you as life passes on by

Your memory lives on within us, no one remembered, really ever dies

We will see you again in our dreams every night

Goodbye our darling princess, God bless and goodnight.

Wings of an angel- a poem read at Beth's funeral. This poem has been included in this review at the request of Beth's father.

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1.Introduction

1.1 Safeguarding Adults Reviews (SARs) were introduced in the Care Act (2014) to inform and facilitate learning following the death of an adult at risk of abuse or neglect, and where there are concerns that partner agencies could have worked more effectively to safeguard and protect the adult at the centre of the review.

1.2 The purpose of a SAR is not to allocate blame or responsibility to an individual or organisation, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves (Department of Health and Social Care, 2020)

1.3 This statutory SAR is focussed on the short life of Beth, who at the time of her death resulting from a drug overdose in May 2022, was just 22 years of age.

1.4 Beth's life was one that presented her with significant challenges. She had experienced complex trauma and adversity throughout her childhood and adolescence. She had been the victim of Child Sexual Abuse (CSA), the trauma of which understandably adversely impacted her mental health and wellbeing. This cumulated in her being sectioned firstly under Section 2, and then under Section 3 of the Mental Health Act (1983)[1] when she was 17 years old.

1.5 Beth remained under section as an inpatient for three years and was discharged from hospital in July 2020 on a Community Treatment Order at the age of 20.[2]

1.6 Beth was also further exploited in adulthood and disclosed that she had been subjected to further acts of sexual violence. She had made a disclosure of rape prior to her death and at the time of writing this review a decision was made to take no further steps to investigate this allegation, as her death meant it was not possible to obtain further evidence required to process this investigation further.

1.7 Beth would often self-medicate, resorting to the use of illicit and street bought substances as a means of managing the unpleasant symptoms of her trauma and mental health. Dual Diagnosis (co-occurring mental health conditions and substance dependency) increased Beth's levels of vulnerability and added an additional layer of complexity for practitioners to consider when formulating plans to keep Beth safe from further harm.

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[1] Section 3 of the Mental Health Act (1983) is a provision that allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital.

[2] A community treatment order enables patients to be discharged from hospital and receive care and treatment in the community, but enables the responsible clinician overseeing the Community Treatment Order to recall the patient to hospital if re-admission to hospital for treatment is considered appropriate and necessary.

2. Governance and Methodology

2.1 Beth was from and lived in Wolverhampton at the time of her death. Therefore, this particular SAR was commissioned by Wolverhampton Safeguarding Together Partnership.

2.2 Terms of Reference for the review were developed and agreed by the commissioners of this review and the Wolverhampton Scrutiny and Assurance Panel. The full Terms of Reference that steered and underpinned this review process can be found in **Annex A.**

2.3 The Scrutiny and Assurance Panel consists of representatives of partner agencies who had oversight and opportunity to scrutinise, challenge and quality assure the review process. The panel worked with and supported the review author whilst ensuring that the review was conducted in alignment with the agreed Terms of Reference.

2.4 The methodology and scope of the review was also agreed with review commissioners and members of The Scrutiny and Assurance Panel. The methodology of this review was carefully considered to ensure that the recommendations arising from it will improve outcomes for young adults who have a shared lived experience to Beth.

2.5 Evidence to support the review process was provided by all agencies who had involvement and/or contact with Beth during the review scoping period. Each agency provided a chronology of their individual involvement, and an appraisal of their response and interventions. Given a key focus of the review was exploring the efficacy of transitional arrangements, CAMHs and Children's Social Care were also invited to provide a chronology of events, which they did, to support the review process.

2.6 This review focuses on **key episodes** that have been identified as being particularly pertinent for the purposes of this review, and therefore this review does not encompass every chapter or facet of Beth's life. That said, events and information deemed as pertinent that fall outside of the scope of these key episodes, have been analysed and included within this review where relevant, to provide further understanding, insights and context.

2.7 Strategic review panels consisting of senior managers from key agencies were convened to support in-depth analysis of the case alongside the use of chronologies and individual agency reports as a starting point for this analysis.

2.8 A Practitioner Learning Event was also held to support understanding of key events. The engagement of front-line practitioners and the managers that supervise them at this event was invaluable at informing the analysis and conclusions outlined in this review. All the practitioners involved in the review process demonstrated great candour and reflection. As such, the author of this review extends her thanks to them all for providing their honest, critical reflections.

2.9 A list of agencies who provided chronologies and contributed to both the strategic panel and the practitioner learning event can be found in **Appendix B.**

2.10 Beth's situation has been analysed by applying an evidence-based learning lens. This means that the learning from both research, national guidance, policy, and key findings from previously published SARs has been considered and referenced where pertinent to do so. This

approach supports the identification of systemic barriers and challenges which impeded safe and effective practice.

2.11 This review is also strengths-based, and as such seeks to simultaneously identify areas of effective and/or innovative practice which should be further replicated across the system to strengthen existing safeguarding practice.

3. Review Author

An Independent author, Nikki Holmes, was commissioned to lead the review and author this final overview report. The author is an accredited Independent Reviewer, criminologist and independent safeguarding consultant, with extensive expertise of working operationally and strategically within Children's and Young Adult Services. She has extensive experience in the field of Children's Safeguarding which includes knowledge of transitional safeguarding and has authored a number of reviews and led and contributed to several national review processes.

4.Family Composition and Key Relationships

Bethany was a white British female. She was born and raised in Wolverhampton in the West Midlands.

At the time of her death, Beth was residing in supported accommodation where she was housed after being discharged from hospital in 2020. Before being admitted to hospital under the Mental Health Act in 2017, Beth lived with her parents and older brother.

It is apparent that Beth had a sometimes complex relationship with her family, particularly with male family members, namely her father and brother. Records reviewed suggested that Beth felt her upbringing was "*strict*", with Beth sharing her memories of her and her brother being "*encouraged to learn to swim and not being allowed to stop lessons until they reached gold award standard*".[3]

However, professionals that knew her, shared that she had a close relationship with her mother and maternal grandmother, and that her parents sought to continually support her in the best way that they knew how in her short life.

5. Family Involvement

5.1 The involvement of family, friends and the people that knew the person at the centre of the review, is vitally important. In the case of Beth, talking to family and friends that knew her is especially important in order to gain an insight into who Beth was as a person, behind the multiple mental health labels that were attached to her which can influence one's perception of a person.

Beth's family were made aware of the review process. Her mother made the decision not to contribute to the review, but her father met with the review author. He fully supports the review and wants to ensure that it is used to drive forward systemic change and learning.

[3] Initial scoping and information sharing, Mental Health Intake Team.

Beth was described as a promising young sports woman, a hard worker, and someone that made friends easily. It is evident that despite being so young at the time of her death, her passing leaves a great void for all that knew her.

Beth's father clearly loved his daughter dearly. He recognises that her complex presenting behaviours and the challenges faced as a family meant that their relationship was at time stained as he did not "*always understand her*". This will perhaps resonate with families of young people who shared a similar lived experience to Beth.

Subsequently, it is recognised by Beth's father that some of the review findings may not always present their relationships in a favourable light as the review has rightly focused on Beth's voice and perspectives were possible to do so. Yet despite this, he does not want the review to omit information that may result in learning being missed and was clear that Beth's real name should be used. His view was that "this is about Beth".

The review author unreservedly thanks Beth's father for his bravery and candour, and full support for this process at what is such as sad and difficult time.

6. Chronology and Key Learning Episodes

6.1 This review focuses on **three** key episodes which are periods of Beth's life which have been identified as being significant to understand practitioner involvement and systemic strengths and areas of challenge.

6.2 Therefore, as above-mentioned, this review does not encompass every element of Beth's life but is representative rather, of the most key actions and activity, which has been considered as most helpful to highlight as part of the wider review and learning process.

7. Key Learning Episode 1: Feb 2017 – July 2020

7.1 *This episode is focussed on the point of Beth's life where she was admitted to hospital under the Mental Health Act (1983) up to the point of discharge. This Key Learning Episode also seeks to examine and understand Beth's childhood context and agencies' response to her disclosures of sexual abuse made whilst she was an inpatient.*

7.2 Beth's childhood was one that had been blighted by trauma and adversity. In 2016, she reported to West Midlands police that she had been sexually abused by her Martial Arts Instructor. Her disclosure led to a police investigation that spanned two police force areas (West Midlands and Staffordshire) and cumulated in the identification of several other victims and a successful conviction.

7.3 It would appear that the trauma associated with the sexual abuse that Beth had been subjected to, correlated directly with a decline in her mental health and emotional wellbeing. She was first referred to CAMHs in 2016, due to "*concerns of psychosis*" and was supported by the Early Intervention Service (EIS) until 2017.

7.4 Despite input from the EIS team, Beth's mental health seemingly worsened. She was presenting with low mood, expressing suicidal ideation and would self-harm to the point that medical intervention and treatment was sometimes required. Beth was discharged from the

EIS service, and into the CAMHs counselling psychology service where she was prescribed anti-depressants.

7.5 Although provided with more intensive intervention from the CAMHs counselling service, Beth was reported to "*show a high level of risk-taking behaviours and queries of Psychosis*". In March 2017, Beth was taken to her local Accident and Emergency department (A and E) as she had left home, walked for 5 miles and was found in a distressed and paranoid state, stating that "*her reason for leaving home was due to thoughts [that] her parents and the Government were part of a conspiracy to poison her*".[4]

7.6 In May 2017, Beth was admitted to Woodbourne Priory hospital as she stated that she felt unsafe at home. Whilst hospitalised, she was given an additional diagnosis of Emotionally Unstable Personality Disorder[5] and prescribed mood stabilisers. Beth was discharged back to the CAMHs Early Intervention Service after one month as it was felt that Beth was no longer presenting with signs of psychosis and that her needs could be meet safely in the community.

7.7 In July 2017, Beth was taken to New Cross Hospital as she had overdosed on 30 Tramadol tablets which had been prescribed to her father. Whilst being clinically assessed, she absconded and was found by police wandering into traffic. She was detained under Section 136 of the Mental Health Act and taken back to hospital. Concerns regarding risk to self (feeling unsafe, thoughts of cutting, taking an overdose, wanting to be run over by vehicles, and suicidality) resulted in Beth being admitted to a Psychiatric Intensive Care Unit (PICU), namely Cygnet Hospital Bury on July 7th, 2017, initially under section 2 of the Mental Health Act (later transferred to section 3).

7.8 An Early Help assessment was completed, but due to her hospital admission, it was decided that there was no role or need for Early Help Support.

7.9 Beth was 17 years and 3 months at the time of admission and would remain under section for the next three years.

7.10 Just days after her admission, Beth made a further disclosure of rape and stated that in April 2017, she had been assaulted by three males after being taken in a car. A Multi-Agency Safeguarding Referral (MARF) was made which prompted Section 17 enquiries, however the decision was made that there was no role for Children's Services due to the fact that Beth was likely to remain as an inpatient for a number of months.

7.11 Although the police were made aware of her disclosure, no action was taken, as it was deemed at the time that Beth was too unwell to be spoken to by police officers. Therefore, the decision was made by police to file her complaint, until she became well enough to speak to police. However, this review found no evidence of Beth's disclosure being explored when her health stabilised or following her discharge from hospital in 2020. This was a missed opportunity

[4] information taken from referral to Cygnet Hospital Bury CAMHS PICU):

[5] Emotionally Unstable Personality Disorder (also referred to as Borderline Personality Disorder) is a diagnosable condition that is characterised by long-term patterns if intense and unstable interpersonal relationships, a distorted sense of self and strong emotional reactions. Those diagnosed with this may engage in self-injurious and other dangerous behaviours and may experience feelings of emptiness, abandonment, and detachment from reality.

which curtailed the opportunity to identify perpetrators who may pose a threat to other vulnerable young people. **(Recommendation 1)**

7.12 A further disclosure was made by Beth, stating that she had been sexually abused between the ages of 8 and 14. Whilst Beth did not name the perpetrator of this abuse, she did confirm to hospital staff that this person was "still *in her life*".

7.13 Although the multiple disclosures of sexual abuse in both familial and extra-familial contexts prompted a referral to the Wolverhampton Multi- Agency Safeguarding Hub (MASH)[6], the review found there to be significant fragmentation, drift and delay in ascertaining the action that agencies took in response to the multiple disclosures made. As such, it has not been possible to determine the efficacy of the safeguarding response to this disclosure.

7.14 Despite evidence of hospital staff supporting Beth to speak with police, she withdrew her complaint, citing that she was "*too scared*" for the complaint to be pursued further. It is clear that she has concerns about how her family would respond, and she was seemingly particularly concerned about the response of her father.

7.15 The relationship and dynamic between Beth and her father appeared to be particularly problematic. When in hospital she shared with practitioners there that when she made the disclosure of sexual abuse against her Martial Arts instructor, her father became "*angry at her for not having said something sooner*"[7] Therefore, it would appear that her familial relationships, particularly those with male family members were at least compounding her trauma as well as potentially being a source of her trauma and distress, yet there is no evidence of this link being made or being explored.

7.16 Whilst it is recognised that Beth did not provide the names of those that abused her at the point of her initial disclosures, there appeared to be little evidence of professionals working in co-ordination to further consider the information provided by Beth in order to ascertain if there were any further risks to Beth or other children and young people. This is a task that is undoubtedly more complex when the identity of an abuser is not known, however Beth did clearly state that the person who subjected her to abuse between the ages of 8 to 14 was still present in her life. At the time, Beth's circle was small due to her hospitalisation, and yet the likelihood of her abuse being perpetrated by a family member did not appear to be considered. There appeared to be no use of genograms or to help ascertain those that may pose a risk of harm to Beth and potentially others.

7.17 Beth was discharged from Cygnet Hospital Bury after 83 days in September 2017, to Ebbw Vale Hospital, Wales. The rationale behind the transfer to this setting was to ensure that Beth was closer to her home in the West Midlands and able to access longer term psychological intervention.

7.18 In May 2018, as Beth approached her 18th birthday, she was transferred to Cygnet Hospital in Derby, a specialist low secure service for women with a primary diagnosis of emotionally unstable personality disorder.

7.19 Whilst the handover provided by Ebbw Vale was detailed, providing a detailed contextual history of Beth, it was noted that practitioners felt that the transition planning occurred "very

[6] Multi Agency Safeguarding Hubs are structures designed to facilitate the multi-agency information sharing and decision making.
[7] Initial Scoping and Information Sharing Submission, Adult Social Care

close to her 18th birthday", which narrowed the window of opportunity for effective parallel working between adolescent and adult services. For example, the review found no evidence of Beth being provided with familiarisation visits to the setting she was due to be transferred to.[8] **(Recommendation 2)**

7.20 The transition from Ebbw Vale did however ensure that clinicians at Cygnet Hospital Derby had a detailed contextual history of Beth, including a comprehensive overview of the chronology of disclosures of sexual abuse that she made shortly after admission, including the disclosure of rape from April 2017.

7.21 It was also noted that at the point of handover, the Clinical Psychiatrist responsible for Beth's ongoing treatment and care at Cygnet Hospital Derby was informed that whilst an inpatient at Ebbw Vale, Beth had disclosed that it was indeed a male family member that had sexually abused her between the ages of 8-14. They were informed that this information had been shared with Police and Wolverhampton Children's Services, but due to being too unwell to interview, the case was placed on hold. However, improvements in Beth's mental health did not prompt any further enquiry or exploration. This meant that no practitioner could be assured that there was no risk to any other child or young person at this time.

7.22 A further entry in clinical records from December 2018, stated Beth disclosed to practitioners that "*when she was 14yrs old she had a sexual relationship with a 20-year-old and that he bought her gifts and alcohol in exchange for sex*". Beth stated that this male only stopped pursuing her when she told him that she was pregnant and that her pregnancy had ended in miscarriage.

7.23 Despite a chronology of disclosures providing evidence of Beth being a victim of Child Sexual Exploitation on separate occasions, the review found no evidence of further exploration or professional curiosity. This meant that there was no consideration of how her exploitation as a child may increase the propensity and risk of her being exploited in adulthood. **(Recommendation 3)**

7.24 A multiplicity of concerns in relation to the dynamic between Beth and her father were raised by clinicians during Beth's time as an inpatient in Cygnet Hospital Derby. It was recorded that communication with her father was "*challenging*" as he would dominate discussions relating to Beth's care. The concerns flagged were significant enough to result in plans being in place to ensure that clinical staff were accompanied when meeting with Beth's father, due to concerns for their safety.

7.25 These concerns were coupled with documented observations of how Beth appeared to "*present as frightened of her father and how he may react to situations*". She also shared with practitioners that her father "*can get really cross*" and it was further documented to tell staff that that she felt "*pressured by her parents to be given section 17 leave[9] so that they can take her out.*"

7.26 It was also well documented that Beth's mental health would decline following visits with her parents and there was also a noticeable increase in risk incidents following contact, such

[8] Transitions from adolescent secure to adult secure inpatient services: Practice Guidance for all secure services. NHS England and Improvement (2020).

[9] Section 17 of the Mental Health Act 1983 allows those detained under certain sections of the Act to be granted leave. S17 leave should only be granted by responsible clinicians when it is safe to do so, and when it is decided that absence of leave is beneficial for recovery.

as risk purging, head-banging, use of ligatures, attempting to abscond from the ward and re-opening self-harm wounds. Beth also presented with issues regarding dietary intake, and it was observed that when her eating improved, she would often restrict her food intake following visits from her parents.

7.27 In response to concerns made, home visits were temporarily suspended.

7.28 However, despite the clear documentation of concerns relating to Beth's family dynamic, these concerns were not raised as safeguarding concerns or viewed through the lens of domestic abuse.

8. Key Learning Episode 2; July 2020 – Jan 2021

This episode explores the commencement and management of Beth's Community Treatment Order (CTO)and her care in the community. This episode also provides a focus on the response to disclosures of further abuse.

8.1 Beth was discharged from hospital in July 2020. She has been subject of a Mental Health Act Assessment[10] which found that her mental health had stabilised enough for her to be discharged and cared for in the community under a Community Treatment Order.

8.2 Beth was assigned a Care Co-ordinator in July of 2020. Her care co-ordinator was a Community Psychiatric Nurse (CPN)[11] from the Complex Care Service (CCS) whose role was to provide continual support to Beth in the community. It was ascertained that upon discharge, Beth should receive weekly contact from the CPN, via a combination of face to face and telephone interventions, and that the frequency of contact should be reviewed in accordance with identified levels of risk and presenting vulnerability.

8.3 As part of discharge planning, a decision was made for Beth to be accommodated at Firsbrook House a supported accommodation provider, to enable Beth to develop her independence whilst simultaneously ensuring continued supervision and day to day support.

8.4 For the first few months post discharge, Beth appeared to be coping well in the community and the support that was in place was sufficient to meet her needs. However, In November 2020, a safeguarding concern was raised by an independent housing officer from Beth's supported housing provider. This concern was in relation to the fact that Beth had entered into a sexual relationship with another resident, who had "*cheated on her*". There were concerns highlighted in the safeguarding referral that was submitted to the adult Multi-Agency Safeguarding Hub that Beth was "*susceptible to sexual, domestic and emotional abuse*".

8.5 Records reviewed, highlighted a correlation between the end of Beth's relationship and a decline in her mental health and emotional wellbeing. After the aforementioned period of stability, there was an escalation of safeguarding concerns raised in relation to Beth. There were clear concerns raised that Beth was misusing illicit substances and sex working in the community and had connections with local drug dealers. Beth had also disclosed that she

[10] A Mental Health Act Assessment is an assessment carried out by approved mental health professionals to ascertain the treatment options that are most appropriate to respond to the presenting needs of the patient.
[11] A Community Psychiatric nurse is a specialist nurse that provides specialist support for patients with a range of diagnosable mental health conditions in the community.

did not feel safe in her relationship and that she had had "*Experienced fleeting thoughts of self-harm but no plans [to harm herself]*.

8.6 Despite the rapid escalation of serious and significant concerns, a decision was made by the Complex Care Team to allow Beth's CTO to expire in Jan 2021. It would appear that this decision was reached with little multi-agency input, meaning that the Complex Care Team and Care Co-ordinator were not aware of Beth's substance and alcohol use or how Beth's emotional wellbeing had been adversely impacted by her recent relationship breakdown.

8.7 Upon cessation of the CTO, Adult social care became the lead agency responsible for co-ordinating and overseeing Beth's care. The decision to review Beth and how well she was coping in the community was booked for three months after her CTO ended. However, no review was ever carried out. **(Recommendation 4)**

8.8 It was shared with the review by Beth's housing providers (Creative Support and Midlands Heart) that they were advised by the MASH to share the concerns identified directly with Beth's allocated social worker rather than submitting MASH referrals due to the volume of referrals being submitted. However, this advice was not adhered to, and referrals were still made via the MASH in-line with their internal safeguarding procedures. Housing practitioners had a demonstrable understanding of the role and function of the MASH and recognised the need for a multi-agency focus and response to the concerns identified given that the risks to Beth were enduring and ongoing.

8.9 There is no evidence of the multiplicity of referrals made via the MASH triggering a multi-agency professional meeting to discuss Beth's risk and to co-ordinate a plan to respond to her presenting needs.

8.10 Beth was registered with a new GP practice in February 2021, and during a routine new patient health check appointment Beth disclosed to the GP that her alcohol consumption was approximately 50 units per week; significantly higher than the safe recommended alcohol limits for women.[12] However, there did not appear to be any further contextual exploration of Beth's alcohol misuse and no exploration of referring Beth to local substance misuse services that could provide Beth with psycho-social support and help reduce her alcohol consumption safely. **(Recommendation 5)**

8.11 It was recorded that at this appointment that Beth refused to be weighed, a standard health check for all new patients. It was observed by support staff at her supported accommodation that Beth had rapidly lost weight, approximately 10 stone in total, during a 6–8-month period by restricting her food intake, purging, using laxatives and excessive exercise. Despite Beth's history of restricting dietary intake which was first observed when an inpatient, her extensive weight loss did not appear to be viewed in the context of self-harm or as an indication that Beth was not coping well. Furthermore, these observations did not prompt any further consideration or assessment of Mental Capacity at this point.

8.12 Beth attended her GP again in March 2021, where she disclosed that she had not had depot injection of anti-psychotic medication and was still using illicit substances. Beth was advised to contact the Home Treatment Team. Whilst it is acknowledged that the GP gave advice about substance misuse, there was a further missed opportunity to explore signposting Beth to specialist substance misuse services. Furthermore, given evidence of the increasing

[12] Current government guidelines states that women should nor drink more than 14 units of alcohol per week.

chaotic and complex nature of Beth's life, the review questions the appropriateness of placing the onus on Beth to contact the Home Treatment team, and that contact should have been made by agencies supporting Beth to ensure they were sighted on risks posed by lapses in prescribed medication and ongoing substance misuse issues. **(Recommendation 6)**

8.13 In March 2021, it is documented that Beth was spending increasing amounts of time away from her supported accommodation and residing at the homes belonging to her parents and grandmother. This decision appeared to be underpinned by her wanting to avoid contact with her ex-boyfriend who was still accommodated at Firsbrook House.

8.14 Further concerns relating to the dynamics between Beth and her family members were raised by Beth to her CPN in April 2021. She disclosed that "*being at her father's house was difficult at times due to getting flashbacks of abuse*". She also shared that being left alone with her another male family member was a trigger for her. She also shared that she had "hit her brother as she felt threatened by him."

8.15 Support Staff at Firsbrook House also documented that they had observed bruising on Beth's arms and suspected that these bruises may have been inflicted by a family member. This was reported to the MASH, and resulted in police officers attending Firsbrook to speak with Beth. It is recorded that Beth "*explained how often she visited her parents and brother and how sometimes her [a male family member] assaulted her [but that] she never told her parents through fear her father would kill himself*." Despite Beth's escalating vulnerability, and a clear disclosure of a criminal offence having had taken place, the decision was made to file this incident.

8.16 It is recognised that decision making in response to this incident was driven by officers aiming to listen and respond to the wishes and feelings of Beth. Whilst that is admirable, and making safeguarding personal is best practice, risks to Beth remained and as such this should have prompted further multi-agency discussion to explore how these risks could be responded to whilst simultaneously managing Beth's concerns and anxiety regarding agency involvement.

8.17 The previous allegation of sexual abuse made by Beth against a male family member does not appear to have influenced decision making. There was also a missed opportunity to undertake further risk assessment that would have potentially led to wider multi-agency conversation, safety planning and exploration of risks posed to Beth by family members. It would have been appropriate to undertake a Domestic Abuse Stalking and Harassment (DASH) risk assessment with Beth. Omitting to do so would suggest that the abuse that Beth was exposed to was not viewed through the lens of domestic abuse.

8.18 The review acknowledges that professionals were presented with a challenging dichotomy that undoubtedly played a role in steering their decision making and actions. On one hand Beth was repeatedly disclosing the abuse that she was subjected to, arguably a clear indication that she wanted professional help, but would then decline any further professional action and support. Beth disclosed that the reason why she refused agency intervention and support was because she was "*fearful of repercussions*", and worried about professional intervention causing further family facture. She also expressed concerns about the potential of her being placed under-section again.

8.19 However, although Beth was now an adult and as such had more choice over how information about herself is shared, it would have been appropriate to consider over-riding

consent and sharing information as a safeguarding concern, due to the historic disclosure of abuse and continuation of concerns that were having a demonstrable adverse impact on Beth.[13]

8.20 The review questions if there was anywhere at this time that Beth felt truly safe and comfortable. It is evident that Beth had an open relationship with support staff at Firsbrook who were a great source of continual support, but Beth was avoiding staying at Firsbrook to avoid other residents and consequently staying at her parents' home which was also not a place of sanctuary and safety. There is little evidence of any professional having duly considered the impact that safety, security and stability may have had on exacerbating Beth's mental health.

8.21 At this time, it is evident that Beth was not only at risk of intra-familial harm but also escalating harm in extra-familial contexts. Beth had disclosed that she had been seriously sexually assaulted by a male in a car in April 2021. The details of this assault provided additional evidence of Beth sex-working but prompted little exploration of the multiplicity of risks Beth was exposed to.

8.22 This was particularly apparent when Beth sought help from the sexual health service to obtain screening and emergency contraception following the disclosure of assault. Despite her complex history and vulnerability, no vulnerable adult risk assessment was undertaken or signposting to specialist support services appear to have been considered.

8.23 In April 2021, Beth was paid a back payment of Department of Work and Pensions (DWP) benefits totalling the sum of eight thousand pounds. Despite the fact that she was known to be misusing substances and had limited opportunity to acquire and develop financial management skills in adolescence due to her hospitalisation, there was no consideration of either how Beth may use this money in a way that might cause her further detriment, or how access to this money may exacerbate exploitation risks. **(Recommendation 7)**

8.24 In May 2021, concerns regarding Beth's involvement in sex work continued to escalate. Practitioners at her supported accommodation frequently observed her "*standing on street corners and getting into cars.*" There is evidence of the issue of sex work being explored with Beth by the Complex Care team who identified and documented that whilst Beth was in receipt of payment in exchange for sexual acts, the reason that Beth engages in sex work was not financially motivated, but to regain a sense of control over her life. *The complex care team also identified that "The need for control is very strong for [Beth] and she has identified that having [control] reduces her suicidal thoughts"*[14]

8.25 Despite the need for control being identified as pertinent to reduce risk factors, the review found no evidence or care plans being put in place that specifically aimed to support Beth to regain a sense of control and autonomy.

8.26 In response to concerns related to Beth's sex work, the Complex Care Team did explore with Beth, linking her with third sector organisations that could provide her with specialist advice and support. This was good practice. However, although Beth declined further support, there should have been repeated attempts to signpost Beth to these important specialist services.

[13] Safeguarding Adults: sharing information. SCIE, (2015).
[14] Complex Care Team. Initial Scoping and Information Sharing Document

8.27 A further psychological assessment of Beth was carried out in June 2021. It was concluded that "Risk to self and others deemed to be low". At this point, there appears to be a fragmented understanding and assessment of the level of risk that Beth was exposed to. Beth's housing provider at this time documented "serious concerns" due to sex work, ongoing drug misuse and exploitation risks, yet these concerns do not appear to be unanimously recognised by all agencies. This is perhaps indicative of an absence of co-ordinated multi-agency discussion and care planning.

8.28 Between June and December 2021, Beth became a "frequent attender" at ED. She was frequently attending or conveyed to ED via police or ambulance most frequently due to overdose of illicit street bought substances and intoxication. It is documented that between September and November Beth was ED at least once every two weeks.

8.29 The response that Beth received in ED was variable and inconsistent. Despite Beth's clear and apparent vulnerabilities, there was a lack of professional curiosity exercised by clinicians regarding Beth's presenting needs and behaviour. For example, there was frequent mention of self-harm documented in her notes but this did not consistently prompt further investigation of the triggers for self-harm and information sharing with the Complex Care Team responsible for Beth's care and treatment in the community.

8.30 During both the scope of the review period and at the time of writing this report, there was no "Frequent Attender" policy or pathway in place. A "frequent attender" is a patient that presents to ED 5 or more times per year.[15]

8.31 Whist the demography of frequent attenders is varied, those with chronic mental health conditions coupled with social and substance misuse issues typically frequently attend ED. These patients are often highly vulnerable. Research has also shown that frequent attenders have double the mortality of non-frequent attenders and that increase of mortality may result from suicide. [16]

8.32 Therefore, patients who frequently attend ED would benefit from a Frequent attender's pathway that ensures that frequent attenders benefit from bespoke ED care plans (that help identify unmet need and improve accessibility of appropriate support services in the community and manage ongoing care that reduce repeat ED attendances, which in turn put incredible strain on ED departments that are already under-resourced). **(Recommendation 8)**

8.33 The impact of Beth's escalating substance misuse, disordered eating and the interface with her mental capacity also was not consistently considered or documented appropriately.

8.34 However, in addition to inconsistent and fragmented responses to Beth in ED, there are also some areas of strengths-based practice. For example, when Beth was admitted as an inpatient, a care plan was completed daily for patients who may have anxiety related to or as a cause of their admission. This ensured that clinicians providing care and treatment for Beth were aware of her need and anxieties which prompted discussions with Beth about how to best support her whilst in hospital.

8.35 It is also worthy to note that at the time of undertaking this review, The Royal Wolverhampton Trust has undertaken a detailed scoping that has identified areas for learning

[15] Frequent Attenders in the Emergency Department. The Royal College of Emergency Medicine. (2017).
[16] Moore L, Deehan A, Seed P, Jones R. Characteristics of frequent attenders in an emergency department: analysis of 1 year attendance data. Emerg Med J. 2009

and development and the safeguarding adults' team have been proactive in reviewing Trust-wide processes and pathways in advance of publication of this final report.

8.36 Despite Beth's ongoing and escalation of illicit substances, a referral to the commissioned specialist adult substance misuse service *Recovery Near You*, was not made until mid-September 2021. This was due to Beth not consenting to a referral for support being made. It is documented that Beth eventually agreed to make contact with the service because practitioners at her supported accommodation "*kept going on about it*". This perhaps highlights the benefits of practitioners continually and sensitively exploring the benefits of wider sources of support.

8.37 Recovery Near You contacted Beth 2 weeks after the initial referral for support was made by Creative Support (supported accommodation). Although Beth was offered support, advice and group work interventions, Beth declined all support. The review concludes that there was drift and delay in contacting Beth following the initial referral and that may have been a contributory factor as to why Beth withdrew her consent to engage with the service.

8.38 For context, small third sector organisations such as Recovery Near You were also adversely impacted by the Covid-19 pandemic. High levels of practitioner sickness, a move to remote working and in this case, high practitioner turn over were all factors that when combined, contributed to delays in triaging referrals and undertaking assessments during the scoping period of the review.

8.39 Whilst Beth's housing provider clearly recognised the important role that specialist substance misuse services could play in supporting Beth to safely address her substance misuse, other agencies who had interactions with Beth did not appear to have considered making referrals to Recovery Near You. This perhaps suggests that the risks associated with substance misuse and the adverse impact that substance misuse may have on Beth's mental health and wider contextual risks are not well recognised across the system.

8.40 Beth disclosed to her CPN in September 2021, that she was no longer taking her prescribed medication as she felt it no longer managed her symptoms, and that Beth had what she described as a "*stash*" of medication. It is documented that at the time that whilst Beth "*denied current suicidal thoughts she [found] it reassuring to have [medication] there in case she ever felt she [did] need to act on [suicidal] thoughts.*"

8.41 It was recognised that despite the absence of immediate risk, there was a possibility that Beth could "*act impulsively*" and there was a potential of overdose in the future. However, this did not appear to trigger any professional discussion about if it was safe to continue to allow Beth to take and look after her own medication independently and did not prompt wider discussion about medications' management with her supported accommodation provider.

8.42 In November 2021, Beth did indeed overdose with her prescribed medication whilst in secure accommodation, albeit seemingly unintentionally, in an attempt to induce sleep. Whilst this incident promoted a safeguarding referral, the review found no evidence of a review or a multi-agency discussion taking place to review the risks of allowing Beth to manage and take her own medication unsupervised. Furthermore, there was no consideration of how her continued use of illicit substances (predominantly amphetamines) was impacting on her inability to sleep which triggered the overdose. This was a missed opportunity for robust risk management, and the failing to consider medications' management meant that the risk of future overdose remained. **(Recommendation 9)**

8.43 Beth was visited by her social worker at Firsbrook House in November 2021 and agreed at this meeting to be signposted to Power 2, a locally commissioned service that provides specialist support and interventions to children and young people who are at risk of exploitation. However, it would appear that a referral was not made to Power2 until March 2022, some 4 months after Beth voiced a willingness to accept support.

8.44 Whilst Beth met the threshold for Power2 intervention and was accepted as a referral in April 2022, due to there being a waiting list of 10-12 weeks before support could commence, the delay in signposting Beth to Power2 meant that she was not provided with much needed support and intervention before her death.

8.45 It would appear that the extent of her exploitation risks had not fully been realised and that this perhaps underpinned the delay in referring proactively to Power2.

8.46 One of the reasons that the full picture of risk posed by potential exploitation was not realised was inconsistent information sharing. One such example of this relates to a disclosure made by Beth in December 2021 to her CPN. Beth shared that she had used illicit substances and a male had attempted to force her into a taxi.

8.47 It is worthy to note that the police were called to this incident as it was reported to them via West Midlands Ambulance service, who had been contacted by the public. They and attended this incident, returned Beth home and upon clearly recognising her vulnerability and the fact that her mental capacity may have been temporarily diminished due to substance use, re-visited Beth at Firsbrook House at a time where she felt secure and safe to make a statement. This was good, person-centred practice and removed the responsibility and onus from Beth to visit the police station to make a formal report.

8.48 However, the police did not appear to have triangulated this incident with previous incidents that involved Beth coming to harm in similar contexts. Beth's disclosure to her CPN also did not appear to prompt a safeguarding referral, liaison with Beth's social worker or prompt the completion of an adult exploitation screening tool to understand the extent of risks Beth was exposed to. This meant that not all professionals with a responsibility to support Beth were aware of this incident and escalating risks.

8.49 Beth was candid and open about the worlds she was navigating. As such there were multiple "reachable" moments where practitioners could have repeatedly revisited engaging Beth with specialist services such as Changing Lives that could have provided Beth with advice support and intervention. However, opportunities to engage Beth in specialist services were too frequently missed and delayed.

8.50 Towards the end of 2021, Beth's disordered eating appeared to become particularly problematic, cumulating in a multiplicity of ambulance call outs and attendance at ED. Beth would frequently attend with dangerously low blood sugar levels and would disclose that she had gone up to five days without eating. On two occasions when Beth self-discharged and absconded from ED respectively, it was documented that Beth "had capacity" despite no formal capacity assessment having been undertaken.

9. Key Learning Episode 3: Jan 2022 – Date of Death (May 2022)

This episode is focussed on the factors that underpinned and contributed to the deterioration of Beth's mental health and wellbeing and her disclosure of rape. This episode seeks to understand how effectively partners worked in a co-ordinated way to identify and respond to risks identified.

9.1 Beth's wellbeing continued to deteriorate in early 2022, evident from increased ED attendances and police and ambulance call outs. However, despite frequent ED attendances due to overdose, intoxication and concerningly low blood sugar, the review found no evidence of any multi-agency meeting taking place to provide a forum for professionals to share their collective concerns and formulate a robust multi-agency response to Beth's complex presenting needs.

9.2 The continuation of siloed, fragmented working meant that no one agency had a complete understanding of Beth, and the escalating risk of harm that was so very apparent.

9.3 It would seem that Beth had insight into how her escalating substance misuse was having a detrimental impact on her physical and mental health. Despite previously declining support to address her substance misuse, Beth made direct contact with Recovery Near You at the end of February 2022 and left a voicemail asking for support. No contact was received, prompting Beth to contact the service again two weeks later in early March 2023. A triage assessment was conducted over the phone, but Beth refused to give consent for the service to contact her GP. Despite the practitioner explaining to Beth why consent to share information is sought, Beth declined to give consent for information sharing which led to her self-referral being closed.

9.4 This was a significant missed opportunity to seek further creative ways to engage Beth who had taken the brave step to seek support herself. Whilst obtaining consent from service users is important to enable the service to liaise with professionals about prescribing that may be required and emerging concerns that may not meet the threshold for a safeguarding referral, the absence of consent at initial assessment should not prevent access to help, support and intervention, particularly when that help is directly sought.

9.5 Recovery Near You have established processes in place to explore ways to engage highly vulnerable and complex service users such as Beth who do not give consent to share information from the outset. This process involves discussing cases such as Beth's at weekly managers meetings which are attended by service and designated safeguarding leads. However, Beth was never discussed at a manager's meeting for reasons that have not been able to be ascertained. This resulted in missed opportunities to explore ways to engage Beth in support at a critical juncture of her life.

9.6 On March 16th 2022, British Transport Police (BTP) had contact with Beth after they were contacted due to concerns for her safety as she was observed on tram tracks and sat on a railway bridge. It is documented that although Beth stated that she had no intention to harm herself, she was clearly distressed which prompted swift information sharing with Beth's GP. This was good practice, as was the prompt safeguarding referral made via the adult MASH, and the request made by attending officers for a suicidal marker to be added to the Police National Computer (PNC) which would ensure that officers attending future call outs were well sighted on Beth's vulnerability.

9.7 A Mental Health Act assessment was conducted on the 29th March 2022. The outcome of the MHA was that Beth had capacity and that there were no grounds to detain Beth, despite risk of harm being high. The outcome of the assessment was that it was suitable for her CPN to continue to provide psychological support and an appointment was scheduled for Beth to attend hospital for blood tests and a physical health check.

9.8 However, the hospital appointment that was scheduled for Beth was cancelled. Beth appeared to be understandably frustrated by this stating that she intends to "*lower her blood sugar that much that [I] will need to be hospitalised*. In response, her social worker liaised with her CPN and shared concerns about continued risk to her physical health due to her refusal to eat and suggested that Beth may benefit from a voluntary admission. However, there is no evidence of a voluntary hospital admission being collectively explored as a viable care option by all agencies.

9.9 Beth's CPN liaised directly with a consultant psychiatrist who is documented to have concluded that Beth's restricted eating was not a medical emergency and would not be deemed as such unless Beth was "*detained under the Mental Health Act for an eating disorder. It seems that the patient is refusing to eat (to die) rather than losing weight, and [so] it will not be classified as an eating disorder*."

9.10 This response from the consultant psychiatrist would suggest that their professional assessment of the situation was that Beth's disordered eating was a symptom of suicidality. Therefore, the review questions the appropriateness of continuing care for Beth in the community and why further consideration was not given to the need for psychiatric crisis or inpatient treatment.

9.11 Beth's disordered eating continued to be an enduring factor that manifested in her presenting at her local Emergency Department (ED) on multiple occasions throughout early 2022. In early April 2022, with concerningly low blood sugar, there is evidence of a referral to the eating disorders clinic being made, but rejected as her Body Mass Index (BMI) did not meet the threshold for intervention at that time.

9.12 However, single measures such as BMI should not be solely relied upon to determine whether to offer treatment and intervention for eating disorders and early intervention at the first signs of emaciation and rapid weight loss is paramount. [17] **(Recommendation 10)**

9.13 The review found evidence of good, robust multi-agency liaison and information sharing between The Royal Wolverhampton Trust who contacted the Mental Health Liaison team to ascertain further background information relating to Beth to support the referral process. The clinician overseeing Beth's care also made contact with the Complex Care Team to inform them of the details of her attendance at ED and presenting medical needs. A discussion took place between the Consultant and the Complex Care Team and it was decided that Beth's limited dietary intake was "*an attempt at admission rather than an eating disorder*"[18]. As such, Beth was discharged from hospital.

9.14 However, the review has found little evidence of Beth's voice being considered and influencing professional opinion and decision making. Furthermore, there appears to have

[17] Eating Disorders: Recognition and Treatment. National Institute for Health and Care Excellence (NICE) December 2020.
[18] Complex Care Team. Initial Scoping and Information Sharing Document.

been an insufficient exploration of why Beth may make "an attempt at admission" given that she had expressed her fearfulness of re-admission to a hospital environment previously.

9.15 Beth reported that she was raped by a male who was also a fellow resident at Firsbrook on April 14th 2022. She had been in a casual relationship with this male for approximately 6 months, however there was no mention or exploration of this relationship up until this point in any of the agency chronologies provided. This indicates that there had been insufficient exploration and professional curiosity in relation to the appropriateness of this relationship and the bearing it may have had on Beth's emotional wellbeing and safety.

9.16 Beth contacted the police to report this incident, and this led to the swift arrest of the accused and the commencement of a full Rape and Serious Sexual Offence (RASSO) investigation and early forensic samples being taken from Beth. However, it is not clear if a full forensic examination took place.

9.17 A Domestic Abuse Stalking and Harassment (DASH) Assessment was also completed. This assessment was initially graded as "medium risk" but was upgraded to high risk due to Beth disclosing that strangulation had been used during the offence. This is good practice given the evidence base which highlights how strangulation and choking increases risk of serious harm and homicide.[19]

9.18 Understandably, this incident sent Beth into further decline. It is apparent from records that she disengaged from services, even rejecting support from practitioners from supported housing with whom she previously had a good rapport and relationship.

9.19 Due to escalating concerns and the recent allegation of Rape, a Mental Health Act Assessment was scheduled for the 24th April 2023. However, as the assessment team arrived, Beth left home with a friend. Despite attempts to convince Beth to return home and the importance of the assessment, Beth declined. There is evidence of the assessment being carried out promptly without delay as soon as Beth returned home.

9.20 During the assessment, Beth denied any thoughts of ending her life or self-harm, however she was still restricting her eating to the point that she was attending ED with lower than acceptable blood sugar levels and restricting eating to the point of collapse. Again, it was deemed that assessing agreed criteria for admission to ED was not met, which suggests that restricted eating and excessive exercise were never viewed through the lens of self-harm.

9.21 BTP had further contact with Beth again at the end of April 2022 as Beth had been observed at a railway station, looking " *vacant*". Attending officers quickly ascertained that Beth was not intending to travel and had no other reason to be on the platform. Although Beth was initially hostile, officers spent time building a rapport with Beth who then informed them of the recent sexual assault she had been subjected to, her concerns around her living arrangements and the impact that these factors when combined were having on her mental health. Officers made the assessment that there were no grounds to detain Beth, but did take her to more familiar surroundings and made prompt safeguarding referrals to the MASH and contacted Beth's GP.

9.22 Although Beth consistently denied suicidal intent, this incident coupled with the previous incident reported to BTP where Beth was observed on tram tracks, continued dietary restriction, drug overdoses and stockpiling of medication arguably present a picture of

[19] Strangulation and suffocation: Policy Paper. UK Home Office. July 2022.

suicidality. However, the risk of suicide was overlooked, perhaps given that professionals accepted that Beth denied suicidal intent. However, this review concludes that professionals should have been more cognisant of the very real risk of suicide, given the combination of individual and relational factors in Beth's life that are known to exponentially increase the risk of suicide.

9.23 A Multi- Agency Risk Assessment Conference (MARAC) was held on May 10TH to discuss Beth's case and the recent allegation of rape. The review has concluded that MARAC was the first time since Beth's discharge from hospital that all relevant agencies came together to collectively discuss the concerns that they had in relation to Beth, and to formulate a collaborative, multi-agency risk management plan.

9.24 Beth contacted the police for an update on the investigation on May 16th and was informed that her accused had his bail conditions rescinded some days before on May 12th 2022. This information appeared to have deeply impacted Beth. She is documented as presenting as very distressed when she attended a sexual health appointment follow up, and clearly interpreted the lifting of bail restrictions as evidence of professionals not believing her.

9.25 A meeting was also scheduled between Beth and her social worker for May 16th but this meeting was cancelled by her social worker and re-arranged for a week later. However, Beth died as a result of a cocaine overdose on May 17th 2022.

9.26 The coroner presiding over the inquiry into Beth's death determined that Beth's overdose was linked to her mental health.

10. Analysis by Theme (Terms of Reference)

Information deduced from the provided individual agency reports, discussions which took place at both strategic panels and at the practitioner learning event, helped to identify key learning themes.

10.1 The entirety of this review considers the factors that led practitioners to act as they did. In addition, the agreed key themes have been analysed.

These key themes of this review can be summarised as:

- **The efficacy of transitional safeguarding arrangements**
- **Ability to recognise and respond to the continuum of exploitation into adulthood**
- **Recognising and responding to coercion and control in familial relationships**
- **The effectiveness of support for those presenting with "dual-diagnosis" (co-presenting mental health and substance dependency)**
- **Agencies recognition and response to trauma**
- **The quality and reliability of risk assessment processes**
- **Understanding Mental capacity and the interface with safeguarding**

Each theme will be considered in turn below, with any learning clearly identified and a focus on the factors that lead to practitioners acting in the way that they did.

The efficacy of transitional safeguarding arrangements

10.2 Transitional safeguarding can be defined as an approach to safeguarding adolescents and young adults **"***fluidly across developmental stages, which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives" (Holmes and Smale, 2018).*[20]

10.3 Transitional safeguarding is not a prescribed framework, but rather an over-arching approach that ensures the continual support needed to safeguard young people as they transition to adulthood. Effective transitional safeguarding approaches should be holistic, person-centred and seek to understand the young person in context; recognising their "*contextual, ecological, developmental and relational needs*". (Holmes, 2022).[21]

10.4 It is well recognised that transitional safeguarding is a complex area of practice due to systemic issues and barriers which means that the way that children and adult's services support those transitioning to adulthood do not align. This often results in well-documented "cliff edges" that report in young people not being effectively supported and safeguarded. This frequently manifests in needs and vulnerabilities not being met, cumulating in homelessness, substance misuse, acute mental heath crisis, and suicidality. (Cocker et al, 2021).

10.5 The need for robust transition planning for certain cohorts of young people, such as those that are care-experienced appears to be well researched and recognised. There has been national focus on how this cohort of young people face additional stressors and challenges due to the absence of support from family and uncertainty about living arrangements.

10.6 Whilst Beth was never a Child in Care, she was a hospital inpatient under section for three years from the age of 17 to 20. Therefore, she shared and faced many of the challenges experienced by care-experienced young people, namely fractured and challenging relationships with family members and an absence of consistent support systems. However, these challenges did not appear to have been recognised or featured in adult care planning.

10.7 Additionally, Beth also had limited opportunity between the ages of 17 and 20 to develop fundamental skills and be exposed to life experiences needed to help prepare her for adulthood and independence. The fact that Beth was an inpatient during a period of her life that is so important developmentally, coupled with an absence of safe, family support systems, does not appear to have been recognised consistently by practitioners as factors that are likely to impact on her ability to cope with the complexities presented by adulthood.

10.8 As such, risk management and crisis plans should have recognised that there was a multiplicity of factors that impacted adversely on Beth's developmental maturity. However, this did not appear to have been consistently understood by the agencies that supported Beth. One such example of this was the fact that Beth was provided with a considerable sum of DWP backpay (£8,000) in April 2020, with no intervention to support her with financial planning and management, skills she was unlikely to have acquired due to her lengthy

[20] Holmes, D. and Smale, E. (2018) Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood. Dartington: Research in Practice

[21] Holmes, D. (2022) 'Transitional Safeguarding: The Case for Change.'

hospitalisation. This indicates that agencies were instead viewing adulthood through the narrow lens of chronological age.

Ability to recognise and respond to the continuum of exploitation in adulthood.

10.9 When a young person has been a victim of coercion and other forms of control and exploitation in childhood contexts, these experiences and their impact rarely stop when a person reaches adulthood.

10.10 However, despite the risk of the continuation of exploitation and harm, young adults frequently are afforded fewer protections than child victims. This is due to young people often being viewed as being more cognisant and capable of identifying and navigating risk.

10.11 There was clear evidence that would indicate that Beth had indeed been exploited in childhood, and yet she had never been recognised as a victim of child exploitation. As such, this meant that practitioners did not fully recognise the risk of her being further exploited post-discharge as an adult.

10.12 Once again, the significant period of Beth's adolescence spent in hospital, which curtailed vital opportunities to develop independence and skills to identify and navigate risk, was overlooked.

10.13 Despite the multiplicity of agencies and practitioners that were in contact with Beth, and the presence of factors that were clear indicators of exploitation, the review found no evidence of any agency or professional undertaking an adult exploitation screening tool to better quantify and understand the risks that Beth was exposed to and navigating. The result of omitting to undertake any screening was a missed opportunity for agencies to work in partnership, to address immediate safety and protection concerns.

10.14 It would also appear that Beth's involvement in sex work was seen as a "choice" and a choice that she had freely made, rather than a potential indicator of exploitation. The presumption of Beth's mental capacity is also a likely factor that led to practitioners not viewing her sex work and substance use through the lens of exploitation. However, the presence of mental capacity does not protect an individual from being exploited, particularly when there are other vulnerabilities, and care and support needs present.

Recognising and responding to coercion and control in familial relationships

10.15 Coercive control is an act or a pattern of behaviour towards a person that has a serious effect on that person's wellbeing. Coercive control is a term that encompasses an expansive array of behaviours and may include acts of assault, threats, humiliation and intimidation or other forms of abuse that is used to harm, punish, or frighten victims.

10.16 Coercive control is a form of domestic abuse and was made a criminal offence in 2015. Whilst statistically, coercive control is reported and recorded as being more prevalent in intimate partner relationships, it can and does occur within familial contexts where the perpetrator is a family member such as a parent, child or sibling.

10.17 Although not always accompanied by physical violence, the impact of coercive control is equally as detrimental, with research highlighting how this form or abuse often has a significant psycho-social impact on victims; increasing the likelihood of emotional difficulties and the onset of mental health issues including depression, eating disorders, post-traumatic stress disorder (PTSD), self-harm, suicidal thoughts and disturbing thoughts, emotions and memories that cause distress or confusion. (Moylan et al., 2010; Sousa et al., 2011).

10.18 The review recognises that coercive control that features within families is perhaps more difficult for professionals to identify, as victims may have normalised toxic, problematic behaviour and therefore not recognise themselves as victims of abuse. However, it was evident that in this case, there were multiple and consistent red flags regarding the relational dynamics between Beth, her father and male family members.

10.19 There was consistent concern voiced by professionals supporting Beth about the control that Beth's father in particular, exercised over her and how fearful she appeared of him. One practitioner noted; "*Beth would at times present as frightened of her father and how he may react to situations*."

10.20 Beth herself also made several disclosures which indicated that she was consistently worried about her father's reactions, and also expressed how she felt pressure to not disappoint him, anxiety about his response to the allegations that she made about another family member, and pressure from her parents to mask how unwell she was so as to ensure she was granted S.17 leave[22] so that they could take her out.

10.21 Beth appeared to be equally fearful of other male family members, stating that one member of her family stating that "*had always controlled her*" and she feared that he would "*punch*" her due to her disclosure of him perpetrating sexual abuse against her."

10.22 In order to commit the offence of coercive control, "four tests" must be met or satisfied. Firstly, the **behaviour must take place, repeatedly or continuously**, and **that pattern of behaviour must have a serious effect on the victim.** The perpetrator must **know or ought to know that their behaviour is likely to have a serious impact on the victim**, and **the perpetrator and victim must be personally connected when the behaviour took place.**

10.23 It is evident from the records analysed during the review process, that there was indeed a chronology of concerns raised that were demonstrative of reoccurring behaviour, perpetrated by family members personally connected to Beth and that their behaviour was causing observable harm to her. Given that Beth was at the time sectioned for her own safety, it could be argued that any reasonable person would recognise the detrimental impact their behaviour was likely to have on her given her additional vulnerability.

10.24 Therefore, it could be concluded that the aforementioned threshold test of coercive control was met. And yet at no point did it appear that any professional working with Beth at any stage or phase of her life, considered that Beth was a victim of coercive control, which was perpetrated by the male members of her family.

10.25 At the practitioner learning event, it was discussed how Beth had appeared to make swift progress post her admission to hospital and that discharge from acute inpatient facilities were relatively swift. One practitioner observed "*It seems that nobody realised and that this was the biggest indicator. She recovered quickly because she had been removed from the main source of her trauma, her family.*"

[22] Section 17 of the Mental Health Act (1983) allows patients who are detained under sections 2,3,37 and 47 of the act leave of absence.

The intersect between coercive control and Mental Capacity

10.26 The review found that practitioners who knew Beth best shared the general consensus that despite extensive periods of acute illness, they *"assumed capacity through working so closely with Beth"* (in line with the first principal of the Mental Capacity Act (2005).

10.27 As such, Beth had the right to make decisions, unwise or otherwise even against professional advice and steer. However, this review questions whether Beth's ability to make decisions was compromised due to the coercion and control exercised by her family members of whom she was evidently fearful.

10.28 As there was no evidence of familial coercion and control being adequately explored, there was no consideration of how the levels of coercion she was exposed to adversely impacted her decision making and whether Beth *"[acted] on [her] own choices or that [she] "choose" to follow the preferences of the person inflicting harm rather than [her] own'* (Ingram 2016)

10.29 It is imperative that professionals are aware of the impact that coercive control has on the behaviour of victims, who may find it difficult to articulate the abuse and harm they have been subjected to, partly because they fear the consequences of doing so.

10.30 Where coercion is identified, and may be influencing the capacity for decision making, a best interest[23] decision should be considered. **(Recommendation 11)**

10.31 At no point was a best interests decision considered for Beth, perhaps because familial coercion was not identified and so not considered as potentially detrimental to her capacity. The review concludes that one example of where a best interest's decision should have at least been considered, was in response to Beth's reluctance to involve the police following her historical disclosure of sexual abuse, which she later disclosed was perpetrated by her brother. The lack of police involvement and therefore the absence of a police investigation meant that Beth was exposed to potential ongoing risk of sexual violence, and the potential risks posed to other children remained unquantified.

10.32 The fact that Beth was an inpatient appeared to have influenced professional decision making. It would appear that professional curiosity and multi-agency investigation was not as robust, as the assumption was made that because Beth was an inpatient, she was safe from further harm.

10.33 Even when vulnerable individuals are admitted to inpatient facilities, it vital that practitioners are professionally curious. In this case practitioners should have been professionally curious and continually triangulating information from different sources to gain a better understanding of family functioning which, in turn, helps to make predictions about what is likely to happen in the future.

[23] A best interest's decision is used by applying the best interests principle of the Mental Capacity Act 2005. This principle should be applied to make decisions for and on behalf of a person who lacks capacity to make their own decision

The effectiveness of support for those presenting with "dual-diagnosis" (co-presenting mental health and substance dependency)

10.34 The term "dual diagnosis" may be used to describe the presence of learning disabilities and mental illness. However, in the context of this review, dual diagnosis is used to refer to co-existing mental illness and substance misuse.

10.35 The interplay between substance misuse and mental illness is complex and can change over time. It can vary from person to person and may depend on the mental health diagnosis and on the type and amount of substance misused.[24]

10.36 Adults and young people who present with severe mental illness and substance misuse are among the most vulnerable in our society. They experience some of the worst health, wellbeing and social outcomes[25]. Therefore, it is essential that there are clear processes and arrangements in place locally to ensure that those with dual diagnosis benefit from carefully co-ordinated care that responds to the complex interplay of social, psychological and economic factors that feature in their lives.

10.37 Given the complexity presented by dual diagnosis, it is imperative that there are pathways and processes in place to support practitioners working in mental health and substance misuse services, to be clear on their roles and responsibilities in working in collaboration to support individuals who present with co-morbid mental health and substance use or dependency.

10.38 At the time of writing this review, the Black Country Healthcare NHS Foundation Trust (BCHFT) dual diagnosis pathway is currently being reviewed by an established working group as part of the Community Transformation Project.

10.39 It is worthy to note that BCHFT formed on April 1st 2020 after NHS England and Improvement approved the merger of Black County Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust. Prior to this merger, Dudley and Walsall Mental Health Partnership NHS Trust had a dual diagnosis policy in place. However, there is little evidence that this policy was referred to or followed. For example, there was no comprehensive risk assessment undertaken that explored the relationship between substance misuse and her diagnosed mental health conditions, patterns of substance misuse and Beth's presenting social and safeguarding needs.

10.40 Furthermore, the absence of an assessment meant that the impact of enduring substance misuse on Beth's mental capacity was also never considered and sufficiently explored. **(Recommendation 12)**

[24] NICE guideline: Severe mental illness and substance misuse (dual diagnosis): community health and social care services Scope

22 SCIE Research briefing 30: The relationship between dual diagnosis: substance misuse and dealing with mental health issues

Agencies recognition and response to trauma

10.41 As mentioned earlier in this review, trauma was a constant and enduring feature in Beth's short life.

10.42 Her mental health appeared to deteriorate as a result of the sexual violence and abuse she had been subjected to in childhood. Yet despite the identifiable presence of a complex trauma history which was a trigger for a decline in Beth's mental health, the response to Beth's needs were pathologised and medicalised, and not consistently trauma informed.

10.43 Beth had little psycho-social support post her discharge from hospital in 2020. The absence of psycho-social approaches to intervention and support alongside the medical management of Beth's mental and physical health, meant that Beth's behaviour was perhaps never truly understood in context. Instead, her behaviour was often viewed a symptom of her diagnosed mental health conditions rather than rational responses to the various historical and ongoing trauma and abuse she was being subjected to in a variety of contexts.

10.44 One such example of this was how her disordered eating was viewed solely through a medical lens, rather than being recognised as a trauma response and a means of her exercising control over her life that was often chaotic and disordered.

10.45 Beth clearly had insight into her presenting needs which she often shared with those practitioners supporting her. For example, she recognised that her sex work was underpinned by a need to exercise control over her life, her substance misuse was a coping mechanism to reduce unpleasant flashbacks, and her suicidal ideation was reduced when she felt she had more autonomy. Yet is not always clear how Beth's voice and explanation of her trauma responses were factored into care planning and risk management plans. **(Recommendation 13)**

The quality and reliability of risk assessment processes

10.46 The fact that not all risks were adequately identified (for example exploitation risks) undermined the quality and reliability of risk assessment processes.

10.47 There were also examples of risk assessments not being adequately reviewed at critical points in Beth's life. The most pertinent example of this being the review of the decision to end Beth's CTO three months post discharge. This did not take place despite there being an increase in safeguarding concerns being noted.

10.48 It was also observed during the scoping period that opportunities for all key agencies to be involved in regular opportunities for reflection and shared discussion were **missed,** and as such not all risks were realised, quantified, and responded to.

10.49 The fact that there were multiple agencies involved in supporting Beth was perhaps a contributory factor that impeded a co-ordinated safeguarding response. It appeared at times, that there was an absence of shared ownership and accountability, exercised equally by all agencies, perhaps due to the assumption that it was solely the responsibility of Adult Social Care and Community Mental Heath services to assess for capacity and risk.

10.50 Furthermore, it did not appear that there was an ownership of care plans and crisis plans to ensure that all key agencies were sighted on risks and could tailor support that was anticipatory and less reactive.

Understanding Mental capacity and the interface with safeguarding

10.51 Perhaps the most difficult issue in adult social care, the one that puts the greatest test on professional judgement and response to risk, is that of choice versus control, risk versus safety.[26]

10.52 Freedom and empowerment are cornerstones of the Mental Capacity Act (2005). However, ensuring that people retain power and control over their lives should not exclude them from safeguarding and protection from abuse and harm.

10.53 The Mental Capacity Act sets out five key principles that practitioners must consider when making an assessment of a person's capacity. Beth clearly had great insight into her behaviour and feelings and appeared to be consistently cognisant of the risk that some of her decision making posed. However, whilst the first principle of the MCA sets out that capacity should be assumed, even if a person has been diagnosed with mental health disorders, there are factors that can impact on capacity and decision making.

10.54 The review found that frequently, capacity was assumed, even on the multiplicity of occasions that Beth presented at ED intoxicated and under the influence of substances. When factors that may diminish capacity such as substance misuse are identified (and enduring), assumptions regarding capacity should not be made without a formal assessment.

10.55 One other key principle set out by the MCA is that a person should not be treated as lacking capacity simply because they are seen to be making unwise decisions. Beth's involvement in sex work, substance misuse and restricted dietary intake appear to have been consistently viewed through the lens of unwise decisions and as such, this view appeared to obscure some of the safeguarding risks that were clearly present.

10.56 When faced with such complexity, it is imperative that there is discussion between all agencies to explore perspectives, differences in opinion and the appropriateness of best interest decision making. However, such discussions appeared to be lacking in Beth's case.

10.57 When safeguarding adults who present with complex vulnerability but who have mental capacity, empowerment and choice must be balanced with a duty of care. Adults should not be left to navigate risk alone simply because offers of support and intervention are declined, particularly when factors such as coercion and exploitation are present as they were during Beth's life. **(Recommendation 14)**

10.58 The intersect between diminished capacity and Beth's disordered eating was also not considered. There is a growing evidence base that highlights how diminished capacity occurs in approximately a third of patients who present with low BMI. However, despite frequent attendance at ED with low blood sugar and significant weight loss the importance of assessing how these factors may have impacted on capacity were not considered. [27]

[26] Safeguarding adults who have mental capacity: Key principles. Community Care (2017).
[27] Mental Capacity to consent to treatment of anorexia: An explorative study. Danner et al (March 2016).

11. Conclusion

11.1 This review was complex to write. There were so many services involved in supporting Beth and so many safeguarding incidents recorded, that writing this report in a way that is succinct whilst encompassing all of the pertinent elements of Beth's short life was a significant challenge. Perhaps the complexity involved in producing this report is reflective of the significant challenges that agencies navigated; a challenge that is acknowledged and recognised by this review process.

11.2 At first glance, it would appear that due to the number of agencies involved in Beth's case, that she was well supported; her needs effectively recognised and met. Yet this review concludes that following further detailed analysis, that the care Beth received was often fragmented, provided in silos and consequently no one agency consistently understood Beth in true context.

11.3 As such, the true extent of the risks that Beth was exposed to, were not fully recognised, leaving Beth exposed to enduring harm in both intra-familial and extra-familial contexts.

11.4 Whilst Beth was sadly unable to contribute her voice to this review, it is felt that Beth was consistently seeking, and at times screaming out for help and support. However, it would appear that Beth's cries for help were often masked and silenced by her fear of repercussions and the impact that further agency action and intervention would have on the lives of those closest to her. It is imperative that practitioners are supported in recognising the role that fear has on consent, particularly when coercive control is an identifiable factor.

11.5 Although there is consistent evidence of Beth denying suicidal intent and being vocal about wanting to live, the review also concludes that given the complex trauma she endured throughout her life, the risk of early death either by suicide or accidental overdose was never fully explored nor recognised. Given the care provided to Beth was uncoordinated, there were opportunities missed to provide timely support and intervention that Beth so desperately needed.

11.6 There were red flags that indicated a further risk of overdose and potential suicidality. There was clear documented evidence of Beth having talked to both her CPN and practitioners about a clear plan and means to end her life stating that "*she would take an overdose of her medication that she had stockpiled in her flat and would take strong painkillers from her dad's house that she had easy access to*" Beth's planning went as far as to identify a location that she would go to which was "*a* peaceful secluded location where she would go and would not be found until it was too late".

11.7 Whilst there is no evidence of Beth intentionally ending her life, the pertinence of this plan and the likelihood of Beth coming to serious harm intentionally or unintentionally, was never recognised. This is likely due to fragmented information sharing and multi-agency review and discussion.

11.8 Beth's life was tragic and short. But it is hoped that this report means that her lived experience will drive learning and systemic development that will aid practitioners to better support young women like her, who have been subjected to complex adversity and trauma. As the report author I would like to acknowledge Beth for her bravery, candour and the impact that she has had during her short life. Impact that she will not ever know she has had.

Recommendations

Recommendation 1: Psychiatric inpatient services should review their organisational processes to ensure that safeguarding concerns are shared with relevant agencies via early notification for children and adults who are inpatients and due for discharge. This information should prompt relevant enquiries to ensure that risks that may be present upon discharge or risks that may impact others in the community are known and proactively responded to.

Recommendation 2: NHS England (NHSE) and Black Country Integrated Care Board (BCICB) are to request that Birmingham and Solihull Mental Health Foundation Trust - BSMHFT (the Provider Collaborative) and Black Country Health Foundation Trust (BCHFT) provide assurance to the Wolverhampton Safeguarding Partnership in relation to the joint approach taken to transition for all young people currently detained in CAMHs Tier 4 inpatient settings who are likely to transition to adult inpatient facilities. Assurance should include audit of transition plans to ensure that they meet the quality standards set out by NHS England and Improvement (Transitions from adolescent secure to adult secure inpatient services: Practice guidance for all secure services, Feb 2020.

Recommendation 3: BCHFT should develop an implementation plan to ensure that staff complete an Adult Exploitation Tool routinely as part of discharge planning process for patients in a Mental Health or Learning Disability (LD) inpatient settings, as hospitalisation may to lead increased exploitation risks in community contexts.

Recommendation 4: The lead mental health provider should seek to strengthen service specifications to set out greater clarity and monitoring of requirements in relation to CTO processes. It is also advised that an audit and review is undertaken to provide additional assurance that when CTOs cease, decision making is proportionate to patient risks identified. Monitoring and auditing of CTO processes should be managed via the BCHFT Patient Reference Group.

Recommendation 5: It is recommended that the learning from this review is disseminated across primary care by the ICB via the four-place based practice led safeguarding forums to drive GP practice improvement.

Recommendation 6: All agencies should seek assurance that they are not placing onus and responsibility on adults who present with complex care and support needs to seek support but rather are actively connecting them with relevant agencies and services. Further assurance should be sought to ensure that appropriate help and support has been established after connections have been made.

Recommendation 7: It is recommended as part of holistic care planning for all 117 patients, that all statutory funding agencies should include financial management support for patients prior to leaving inpatient settings and be able to provide documented evidence of having provided this intervention. This is to prevent the risk of financial abuse and exploitation post discharge.

Recommendation 8: Whilst a Frequent Attenders pathway has been developed and implemented across Wolverhampton to ensure that those who frequently attend ED benefit from bespoke ED care plans and multi-disciplinary case conferences to help identify unmet need, Royal Wolverhampton NHS Trust (RWT) should ensure that

arrangements for auditing and monitoring of the pathway are in place to ensure the pathway is being consistently utilised. Reporting should take place through their established reporting and governance arrangements.

Recommendation 9: Creative Support should undertake a review of their medicines management policy and processes and BCHFT should also review their policies and processes in relation to medicines management for patients who are known or suspected to stockpile medications.

Recommendation 10: BCHFT should provide assurance to the Joint Oversight Committee about the robustness of pathways into all age community eating disorders services and to ensure that there is a clear escalation pathway with NHSE when delays to Tier 4 inpatient beds occur.

Recommendation 11: It is recommended that all partners review their training in relation to Domestic Abuse and the Mental Capacity Act (MCA) to ensure that commissioned and provided training offers provide information about the signs of coercion and control in familial contexts and the impact that coercive control may have on decision making and mental capacity.

Recommendation 12: Public Health and BCHFT should collaborate to produce an agreed Dual Diagnosis pathway that provides co-ordinated care for those with co-morbid substance misuse and mental health problems in Wolverhampton. A clear dissemination plans should be developed to ensure the successful launch and system wide dissemination of this pathway.

Recommendation 13: Wolverhampton Safeguarding Together (WST) should consider the development and delivery of trauma informed training to ensure that support and interventions provided are more holistic, person centred and recognise how lived experience and trauma influence a person's behaviour and decision making.

Recommendation 14: WST should undertake a review existing practice guidance and consider developing a complex adult risk management pathway to support practitioners to work more equitably and effectively with adults who present with capacity but are exposed to risk of harm due to their complex needs. This pathway should aim to equip practitioners with clear and consistent advice of how to support adults who cannot be effectively managed via other processes or interventions, such as section 9 care and support assessment or section 42, safeguarding enquiry, under the Care Act 2014.

The review also further recommends that WST and key partners considers joining The Prevention Concordat for Better Mental Health to support with effective prevention planning arrangements locally.

Appendix A: Terms of Reference

Scope of the Review - The multi-agency review should consider the period from **Feb 2017** to the date of death which occurred on **18/05/2022.**

This scoping period is suggested to allow for BJ's early childhood context to be examined and explored.

Terms of Reference

- **Determine the effectiveness of arrangements that support young people's transition to adulthood and the efficacy of transitional safeguarding arrangements.**
  - Analysis of how policy, procedures, and systems support transition and how effective transition planning is in supporting the sharing of information and risk between child and adult services.

- **Determine how effectively agencies recognise and responded to the continuum of exploitation into adulthood.**
  - Analysis of how effectively partners recognised how given that BJ had a previous history of Child Sexual Exploitation and had been subjected to abuse in childhood, the risk of exploitation in adulthood was significant.
  - Exploration of how safety plans recognised and responded to the increased and ongoing risk of exploitation.
  - Analysis of how well professionals understood the cumulative impact of adversity on BJ.
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- **Establish how effectively individuals with "dual diagnosis" (co-occurring Mental Health and Substance Misuse) are supported.**
  - Whether appropriate agencies worked together in collaboration to provide carefully co-ordinated and choreographed support for BJ.
  - Analysis of the robustness of pathways, policies, and processes.
  - Review how effectively substance misuse is assessed and considered as a factor that may have exacerbated mental health and suicidal ideation.

- **Review of how well agencies recognise and respond to trauma.**

  - Analysis of how agencies understood the impact of BJ's lived experiences and how exposure to trauma and adversity impacted on her day-to-day life, quality of relationships, rationalisation of events and levels of resilience.
  - Evaluation of the quality and effectiveness of the therapeutic support provided to BJ.
  - Analysis of the impact that criminal investigations had on BJ and exploration of the appropriateness of multi-agency investigations into the allegations of sexually harmful behaviour.

- Analysis of how agencies recognised BJ's trauma responses and understood her presentation and behaviour in the context of trauma.

- **Determine the efficacy and reliability of risk assessment processes.**
  - Analysis of arrangements for prompt and effective inter and intra information sharing
  - Whether decision making by all agencies in the case was proportionate and reasonable, given the facts and information that were known at the time.

- **Understand the factors that influenced practitioners and agencies to respond the way that they did.**

  - Analysis of the effectiveness of systems methodology avoiding individual blame.

Key Learning Episodes

Key Learning Episode 1: Feb 2017 – July 2020

Section (S.3 MH Act) aged 17 years until discharge.
Examination of childhood context and response to allegations of sexual abuse.

Key Learning Episode 2; July 2020 – Jan 2021

Commencement and management of community treatment order
Response to allegations of further abuse
End of community treatment order

Key Learning Episode 3: Jan 2021 – Date of Death (May 2022)

Deterioration of MH
Allegations of rape