Olivia Safeguarding Adult Review 6 Step Briefing

The Background

Olivia was a young woman who lived in Southampton.

As a child, Olivia suffered from adverse childhood experiences, including witnessing domestic abuse between her parents. As a teenager, Olivia had incidents where she would self harm in order to deal with distressing emotions due to having difficult relationships. As an adult, Olivia became pregnant after being the victim of rape, and during her pregnancy, experienced periods of homelessness and living in temporary accommodation. Following the birth of Olivia's baby, concerns were raised around parenting and attachment, and following a serious safeguarding concern, Olivia's baby was removed from her care and was placed in the care of Olivia's mother, who was granted a Special Guardianship Order.

The Incident

Following a period of instability, Olivia was housed on the 10th floor of a tower block in late 2019. Olivia continued to have mental health issues, being diagnosed with Emotionally Unstable Personality Disorder, including episodes of self harm and suicidal ideation. On one occasion Olivia had been seen on her window ledge threatening to jump from her 10th floor flat.
In June 2021, Olivia was found outside of the block of flats. When found, Olivia was still breathing, however later died. It was believed that Olivia jumped from her 10th floor flat.

The Review

Southampton Safeguarding Adults Board concluded that the circumstances of Olivia's death met the criteria for carrying out a mandatory safeguarding adult review (SAR) under section 44 of the Care Act 2014.

An independent reviewer was commissioned to complete the SAR, which encompassed a period to June 2021, when Olivia died.

As part of the SAR, the independent reviewer considered information from each involved agency through reports and chronologies that were provided, as well as a learning event for practitioners who had worked closely with Olivia. The independent reviewer also spoke with Olivia's mother to gain her views.

Key Lines of Enquiry

- Evidence of collaboration between partner agencies including evidence of shared decision-making around risks identified and that robust risk assessments were in place for agencies involved in the care and support of Olivia.
- Agency referrals were timely and appropriate.
- Evidence of agencies involved in the care and support of Olivia seeking expert safeguarding advice/support in the light of any risks identified.
- Use and impact of the Multi Agency Risk Management Framework, Care Programme Approach and High Intensity User Group, including engagement by services.
- The impact of Olivia's child being placed with family members, and this being reflected in work with Olivia.
- Evidence of a family approach being taken given the suggestion contact time between Olivia and her child was not satisfactory and that Olivia had been living for a time with her child and the family members caring for the child.
- Agencies holistic understanding of Olivia given the considerable history of service involvement and how this was demonstrated in the provision of support and services.
- Effectiveness of service engagement at critical moments, including the closure to Children's Social Care following the birth of Olivia's child.
- Impact of the allegations of sexual harm on multi agency practice
- If Olivia had a formal diagnosis of Emotionally Unstable Personality Disorder (EUPD) was the care and support provided in line with the EUPD pathway?
- Multi agency communication and sharing of information regarding Olivia's housing situation and associated risk factors.

Findings

- Individual workers collaborated to discuss risks, and did demonstrate a high level of professional anxiety, however there did not appear to be a sense of shared decision-making, and no collaborative plan was formed. Children's Services did collaborate with some other agencies including mental health services, however it was felt that earlier inclusion of housing services would have been beneficial.
- Several examples of good practice were identified. Referrals to the High Intensity User Group were made appropriately, and Olivia's Care Coordinator and Psychologist showed great care and compassion. Referrals to adult safeguarding, however, were felt not to be consistent or timely, and it was also felt that advice from adult safeguarding was not consistently sought.
- The MARM process formed part of the approach to agree a plan for Olivia. Olivia did have a care plan in place which identified the need for greater awareness of EUPD. It was felt, however, that relevant agencies were not always involved, and a coordinated care approach through the multi-disciplinary team (MDT) would have been beneficial. Whilst agencies did try to understand Olivia's lived experiences, earlier use of the MARM process or the MDT would have helped following the removal of Olivia's baby. Better information sharing, particularly with housing, would also have been beneficial.
- Children's Services undertook care planning with regards to Olivia's baby. There was evidence of a family approach being taken, as well as attempts to maintain contact between Olivia and her baby, however this became more difficult throughout the Covid-19 pandemic. It was also felt that guidance for a multiagency response for parents where children are placed for permanence outside of their care was needed.
- It was felt that there was good service engagement at critical points for Olivia, especially with mental health teams. The reasons for the closure by Children's Services, however, were not clear, other than that it was felt that Olivia had support from her family.
- Agencies were aware of the allegations of sexual harm and the subsequent impact these had on Olivia's life, however it was felt that due to the diagnosis of EUPD and Olivia's presentations in crisis, staff may not have had the opportunity to reflect.
- Interpretation of the Transform pathway was variable. Planning was in place to manage transitions,, however when an admission was recommended or Olivia requested support herself, the rationale for decisions was less clear. It was felt by practitioners that the Transform pathway needs to be reviewed.

Recommendations

- The SSAB should review the findings of the 4LSAB MARM review.
- SHFT will review and further develop the complex personality disorder pathway.
- SSAB should consider additional training on understanding capacity with reference to people with EUPD.
- Southampton City Council should ensure that the reviewed policy is disseminated and part of supervision and training to ensure that someone who is at risk of harm and has support and housing needs, does not remain in choice-based lettings.
- UHS/the ICB/SHFT should consider working together to identify funding streams for an improved core HIUG service.
- There should be a coordinated multiagency system response for parents post proceedings. Such that when parents exit proceedings, a process should be triggered to include a review, summary of risks and pertinent sharing of information to adult services.
- There should now be a review of the way in which S75 arrangements are working within mental health teams in Southampton to ensure that statutory safeguarding enquiries are raised when required.
- The SSAB and SSCP should coordinate a system response and approach to the work with the WAVE Trust, reviewing best practice such as in Scotland and Blackpool.

Useful Links for Best Practice

1. SAR Olivia Full Report
2. Self-Neglect: Building an Evidence Base for Adult Social Care
3. Working with people who self-neglect: Practice Tool (2020)
4. 4LSAB Multi-Agency Risk Management Framework - MARM
5. Tackling Adverse Childhood Experiences (ACEs) State of the Art and Options for Action
6. Borderline Personality Disorder has the strongest link to childhood Trauma
7. Alcohol Change UK – Learning from Tragedies
8. Executive Functioning – The Science of Adult Capabilities