West of Berkshire Safeguarding Adults Board

Safeguarding Adults Review – 'Bree'

1.0 Introduction

1.1 Bree (a pseudonym) died in February 2022 after falling from a bridge in Reading town centre into the road below. Bree survived the fall but sustained severe injuries from which she later died in hospital. She was 24 years of age. Bree was a White British female who had learning difficulties and may have had undiagnosed autism spectrum condition (ASC). She had been living in supported accommodation in Reading since 2019. The placement was commissioned by Wokingham Borough Council and Bree received support from Provider A, an agency which specialises in providing support to people with learning disabilities and autism. Bree's presentation deteriorated markedly from January 2022. Her self-harming behaviours intensified as did her suicidal ideation. The Crisis Resolution and Home Treatment Team (CRHTT) supported her for a period and discharged Bree when her presentation appeared to have stabilised and at a time when her unhappiness in her supported accommodation was shortly to be addressed by a placement move. The incident in which Bree fell from the bridge took place on the day after she presented at her GP practice expressing suicidal thoughts and was seen by a specialist mental health practitioner within primary care who considered referring her back to the CRHTT, but after consulting with the latter service, provided Bree with reassurance that her placement move was imminent.

1.2 On 9th June 2023 the West of Berkshire Safeguarding Adults Board (SAB) decided to commission a discretionary Safeguarding Adults Review (SAR). A discretionary SAR can be carried out when the absolute duty to do so does not apply. Under Section 44 (4) the Care Act 2014 Safeguarding Adult Boards are free to arrange for a discretionary SAR to be carried out in a situation where the Board believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect and can include exploring examples of good practice that can be applied to future cases.

1.3 The West of Berkshire SAB commissioned David Mellor to conduct the SAR. He has several years experience of conducting SARs and other statutory reviews and has no connection to Reading or Wokingham. He was supported by an Extraordinary SAR Panel which consisted of managers from the agencies which had been involved in supporting Bree and other relevant professionals.

1.4 An inquest held in June 2023 recorded a conclusion of suicide.

1.5 The West of Berkshire Safeguarding Adults Board wishes to express heartfelt condolences to Bree's family and her friends.

2.0 Terms of reference

2.1 The period on which the SAR has focussed is from 1st July 2019 until Bree's death in February 2022. Significant events outside this timescale have also been considered.

2.2 The specific areas of concern on which the SAR was requested to focus are as follows:

- Are stakeholders across Berkshire clear about when suicidal ideation and/or self-harm require referral under Section 42 of the Care Act 2014, versus when other pathways should be used?
- Where there is suggestion of suicide risk or self-harm in particular those with Learning Disability and Autism Spectrum Condition (ASC), how do agencies work together to ensure a shared understanding of risk and a joined-up approach to risk management? – information sharing, multi-agency meetings etc.
- How do agencies work together to ensure all relevant history is known so that there can be trauma informed and attachment informed approach to risk management (To include consideration on how commissioned providers are equipped work in this way)
- How is all of this supported by the Berkshire suicide strategy, particularly in relation to those persons with Learning Disability/ Autism Spectrum Condition and how does the suicide strategy in Berkshire ensure multiagency learning from deaths by suicide through shared learning reviews?
- In Bree's situation what would best practice looked like?

2.3 Additionally, the West of Berkshire SAB requested a short-written report, which provides an executive summary of what happened in this case, answers to the specific questions set in the Terms of Reference and makes recommendations for the Board. As the SAR progressed the SAB requested the SAR to develop a small number of strategic recommendations to commissioners to address the gap in provision for supported accommodation for young women with complex trauma and to avoid multiple recommendations in relation to professional practice on the grounds that practice issues alone will not prevent or reduce risk to the vulnerable population of which Bree was a part.

3.0 Executive Summary of key events

3.1 Bree was born in 1997 and lived with her parents and younger sibling until 2017. At the age of 15 Bree was referred to child and adolescent mental health services (CAMHS) after expressing suicidal thoughts and tying a phone cable around her neck.

3.2 Bree was referred to the Learning Disability Service in 2017 after presenting with severe anxiety, depression and 'social phobia'. The Learning Disability Service provided Bree with support to help her manage her anxiety and later conducted a diagnostic assessment. It was thought by many agencies she subsequently came into contact with that Bree had been diagnosed with a mild learning disability at this point, but she met only 2 of the 3 criteria for a learning disability diagnosis. However, the Learning Disability Psychology Service continued to support Bree for a further year to assist her to transition to mainstream services.

3.3 Following her departure from her family home in October 2017, Bree lived with a friend and her mother (Friend 1) in the Wokingham Borough Council area for around 18 months until the latter Council arranged supported accommodation for her at Address 1. After discovering that the previous resident had apparently taken their own life, Bree was supported to move to accommodation at Address 2 in Reading in April 2019. Wokingham

also commissioned this placement, in a house which Bree shared with a middle aged female with higher needs. Both women were supported by Provider A, an agency which provides support to people with learning disabilities and autism.

3.4 Bree began a brief relationship with a male in 2019. The subsequent breakdown of this relationship was cited as one of the triggers for a self-harming incident, in which she cut her upper arm with a razor, for which Bree was seen at the Royal Berkshire Hospital (RBH) in October 2019. The RBH intended to submit a safeguarding concern, but this was not received by Reading Borough Council.

3.5 The following month Provider A raised a safeguarding concern after Bree said she wanted to take an overdose as she 'felt like a reject'. The safeguarding concern was closed by Wokingham Borough Council on the grounds that the issues raised did not amount to a safeguarding concern and could be adequately addressed through case management.

3.6 Bree was becoming increasingly unhappy in Address 2 and a friend who lived abroad (Friend 2) – with whom Bree spent the Christmas/New Year period in 2019/2020 - informed Wokingham that Bree had said she would kill herself if she had to return to address 2, where she had secreted a knife. When Bree subsequently met with her social worker she reiterated her desire to move placement. She was advised that 'shared lives' was not suitable because of her high needs and that finding an alternative placement could take time due to Bree's lack of priority housing need.

3.7 In early 2020 Friend 1 reported that Bree had been raped by a male and the Police initiated enquiries although Bree ultimately decided not to pursue the matter. Wokingham began a Section 42 Safeguarding Enquiry before realising that responsibility for this rested with Reading – in whose area the incident had taken place. Reading was notified but did not initiate a Section 42 Enquiry or contact Bree. No strategy meeting appears to have been arranged by either Council. However, the SAR has been advised that case notes indicate that the intervention initiated by Wokingham Borough Council and the Police continued over the following two months.

3.8 During April and May 2021 Bree took two overdoses of medication. Although the number of tablets taken was low it was felt that this needed to be seen in the context of her 'learning difficulty'. Bree was supported by the CRHTT which observed that the circumstances in which she was living, in particular sharing a fairly small town house – where significant renovations were taking place - with a 'much older' resident with higher needs, was intruding on Bree's independence and increasing her longing for more care which she said had been absent for much of her life. Poor self- image and an internal voice which was inclined to scold were also noted. Possible safeguarding concerns were identified in relation to sexual exploitation, alongside Bree's capacity to understand this. This was documented to be an issue which required 'Local Authority follow up' although there is no indication that the issue of sexual exploitation was raised with the Local Authority or was 'followed up' by any agency at that time. Bree was referred to Talking Therapies for support with her low mood and anxiety, although she was discharged by this service after not attending two initial telephone assessments. During this period Provider A raised a safeguarding concern which Reading concluded was inappropriate as the referral did not describe abuse or neglect.

3.9 After again spending the Christmas/New Year period staying with her friend abroad, Bree returned to the UK in early January 2022. She took an overdose of Nurofen tablets, ingested bleach in a separate incident and later took an overdose of 20 paracetamol 'with suicidal intent'.

3.10 Bree was supported by the CRHTT from 11th January until 2nd February 2022. Bree disclosed feeling low, alone, useless and wanting to end her life and constantly thinking

'what's the point?' She said that she wanted to move placement and receive more support and wished every day that her life was like other people with a family. She reported thoughts of walking into traffic, jumping in front of a train and jumping from a bridge. Bree was started on Vortioxetine[1] although there were concerns that her time away from her placement staying with her family, with whom she had reconnected, could affect the efficacy of her medication. Both the CRHTT and Wokingham attempted to refer Bree to the Learning Disability Service but their referrals were not accepted as Bree did not meet the criteria.

3.11 Provider A felt that Bree needed support which they were not qualified to provide. They raised a safeguarding concern which Reading concluded did not meet the threshold for a Section 42 Enquiry. Bree had agreed to a placement move but in the meantime Wokingham increased her support hours and considered a respite placement. South Central Ambulance Service (SCAS) also raised a safeguarding concern which was awaiting assessment at the time Bree fell from the bridge.

3.12 When discharged by the CRHTT, Bree was advised to self-refer to the Service User Network for support with her self-harming behaviour, to engage with her social worker, to utilise her safety plan and to use her support network.

3.13 Almost 2 weeks after her CRHTT discharge Bree visited her GP Practice where she was seen by a primary care specialist mental health practitioner who considered referring her back to the CRHTT, but after consulting with the latter service, provided Bree with reassurance that her placement move was imminent. The incident in which Bree fell from the bridge took place the following day. During her subsequent hospital admission, Bree's mother reported that her daughter had disclosed to her that she had been raped by 'two boys' a few days before she fell from the bridge. After all reasonable lines of enquiry had been completed with negative result the Police investigation was filed 'no further action'.

4.0 Analysis

4.1 In this section of the report each specific 'area of concern 'will be addressed in turn.

Are stakeholders across Berkshire clear about when suicidal ideation and/or self-harm require referral under Section 42 Care Act 2014, versus when other pathways should be used?

4.2 During the period on which the SAR focussed the following seven safeguarding concerns arose in respect of Bree, five of which were submitted and two of which were not:

- The safeguarding concern which RBH intended to submit in October 2019 after Bree cut her arm with a razor which was not received by Reading Borough Council (Paragraph 3.4).
- The safeguarding referral submitted in November 2019 by Provider A on the grounds that Bree was wishing to take an overdose as she 'felt like reject'. Following discussion with her Wokingham social worker the concern was 'closed' and was followed up under case management (Paragraph 3.5).
- The safeguarding referral made by Wokingham Borough Council in March 2020 after Bree disclosed a rape (Paragraph 3.7)
- The safeguarding referral made by Provider A in May 2021 after Bree took an overdose of paracetamol (Paragraph 3.8).

[1] Vortioxetine is recommended by the National Institute for Health and Care Excellence (NICE) for treating adults who are having a first or recurrent major depressive episode, if the current episode has not responded to 2 other antidepressants.

- Also during May 2021 the CRHTT identified a safeguarding concern in relation to possible sexual exploitation and her capacity to understand this although no safeguarding referral was made (Paragraph 3.8).
- A further safeguarding referral was submitted by Provider A on 10th January 2022 following Bree's overdose of 20 Nurofen tablets (Paragraph 3.11).
- The final safeguarding referral was made by SCAS on 20th January 2022 at which time they documented a 'mild' risk to self in respect of Bree and noted that her mental health appeared to have deteriorated over the past week (Paragraph 3.11).

4.3 The principal learning points arising from an analysis of the seven safeguarding concerns are as follows:

4.4 The fact that the placing authority was Wokingham Borough Council whilst the authority to which safeguarding referrals were submitted was Reading Borough Council was a complicating factor. One safeguarding referral was sent in error to Wokingham by Provider A (Paragraph 3.8) but this issue was quickly resolved. Wokingham initiated a Safeguarding Enquiry following Bree's rape disclosure before realising that responsibility for this rested with Reading – in whose area the incident had taken place. Reading was notified but did not initiate a Section 42 Enquiry or contact Bree. No strategy meeting appears to have been arranged by either Council (Paragraph 3.7). Arguably the most significant implication of the Wokingham/Reading dimension is that Reading Borough Council did not have immediate access to Bree's detailed records which Wokingham held and may therefore not have been fully sighted on historical and contextual issues which could have helped them to take a more holistic view of the safeguarding referrals they received in respect of Bree.

4.5 The decision by Wokingham Borough Council that the issues reflected in the November 2019 safeguarding referral from Provider A could be addressed through case management was appropriate (Paragraph 3.5). The Care Act statutory guidance makes it clear that safeguarding is not a substitute for provider's responsibilities to provide safe and high quality care and support or for commissioners regularly assuring themselves of the safety and effectiveness of commissioned services[2].

4.6 Turning to the 'Making Safeguarding Personal' principles, Bree was not contacted personally by Reading Borough Council. The strongest case for contact from Reading would have been when the safeguarding referral relating to Bree's March 2020 rape disclosure was passed to them by Wokingham – although Wokingham had substantial contact with Bree at that time. The Panel felt that the person best placed to speak to Bree personally when safeguarding referrals arose was her Wokingham social worker – and there is evidence that such contact took place.

4.7 During their May 2021 contact with Bree, the CRHTT identified safeguarding concerns in relation to possible sexual exploitation and Bree's capacity to understand this, but no safeguarding referral was made and there is no indication that this matter was further explored at that time (Paragraph 3.8). This sexual exploitation concern arose just over a year after Bree disclosed a rape. Given Bree's parent's reports that their daughter disclosed to them that she had been raped by 'two boys' a few days before the fall from the bridge which led to her death, there is an uncomfortable feeling that sexual exploitation was an issue which may have been insufficiently explored. In her contribution to the SAR, Friend 2 described that Bree had previously been in a destructive relationship where negative things had been said about her appearance that Bree 'couldn't let go of'. Friend 1 said that Bree wanted to feel loved, having previously been made to feel 'worthless'.

[2] Care Act Statutory Guidance. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

4.8 The possibility that Bree may have been financially exploited may have been overlooked. Whilst being interviewed about her March 2020 rape disclosure, Bree said that 'Some boy was using me – not in a sex way but for money. I need some help from social services'. There was a strong professional focus on Bree's disclosure of rape at that time and the SAR is not aware of any indication that her disclosure of financial abuse was enquired into. In her contribution to the SAR, Bree's Friend 1 stated that she 'made her save' whilst Bree was living with her, and that Bree managed to save £6000 but that she 'lost it all' when she left Friend 1 because 'people were taking advantage of her'.

4.9 Of the seven safeguarding concerns documented in respect of Bree, the first (RBH), second (Provider A), fourth (Provider A), sixth (Provider A) and seventh (SCAS) related to suicidal ideation/self-harm. Self-harm and the risk of suicide are not listed by the Care Act as a types of abuse or neglect and so they are frequently considered by Safeguarding Adult Boards to be 'out of scope'. The SAR has been advised that the number of 'out of scope' safeguarding concerns submitted in West Berkshire has been at a level which has adversely affected the capacity of the constituent Local Authorities of the Safeguarding Board to safeguard vulnerable residents. It is assumed that the high level of 'out of scope' safeguarding concerns was a factor in the delay in Reading Borough Council responding to some of the safeguarding referrals they received in respect of Bree.

4.10 However, abuse and neglect can take many forms and there may be circumstances in which it may be appropriate to treat suicidal ideation/self-harm as a safeguarding concern. This is highlighted in the Local Government Association (LGA) and the Association of Directors of Adult Social services (ADASS) *Understanding what constitutes a safeguarding concern and how to support effective outcomes* in September 2020[3] which states that self-harming including attempted suicide is often a way of dealing with difficult feelings and memories or overwhelming situations and experiences and that the individual may disclose that the root causes of suicidal thoughts are related to abuse or neglect. This point is also reinforced by the recently launched West of Berkshire Safeguarding Decision Tool entitled 'What do referrers need to consider before deciding to raise an adult safeguarding concern'.

4.11 However, the learning from this SAR strongly indicates that 'stakeholders across Berkshire' remain unclear about when suicidal ideation and/or self-harm require referral under Section 42 of the Care Act 2014 although it is recognised that the submission of a safeguarding referral can be a sign of desperation on the part of professionals if they feel that they have not been listened to or have not received an adequate response whilst sometimes they might submit safeguarding referrals to 'cover their back', or to prompt a multi-agency approach. The SAR acknowledges excellent local work in highlighting the distinction between Safeguarding with a capital 'S' and safeguarding with a lower case 's' and the development of the Safeguarding Decision Tool which should go a long way towards supporting professionals to determine whether suicidal ideation/self-harm requires a safeguarding referral or not. Where further guidance would be useful is in respect of the pathways to consider for suicidal ideation/self-harm if a safeguarding referral is not justified. The Safeguarding Decision Tool advises that where a safeguarding concern is not determined as the most appropriate route, then another pathway for support for the adult will be indicated. It is recommended that the Safeguarding Decision Tool is further developed to include advice on alternative pathways for support – which could be informed by the learning and recommendations arising from this SAR.

Recommendation 1
That the West of Berkshire Safeguarding Adults Board further develops the Safeguarding Decision Tool to include advice on pathways to consider when a safeguarding concern is not determined to be an appropriate response to the risk of self-harm and/or suicide.

4.12 There is also learning arising from how Bree's disclosure of rape was managed. Several processes were not followed. Reading Borough Council did not initiate a Section 42 Enquiry after it was established that the duty to consider a Section 42 Enquiry rested with them rather than Wokingham. No strategy meeting was arranged by either Borough Council. A key determinant of decision making appeared to be the TVP investigation – to which the criminal standard of proof applied – rather than a Section 42 Safeguarding Enquiry to which the criminal standard of proof did not apply - in that when Bree advised the social worker that she did not wish to pursue any possible prosecution, the Police were informed and the chronology shared with this SAR indicates no further action was taken by either Local Authority after that point. Bree was not supported by an advocate or offered the services of specialist ISVA support. Bree was asked a leading question during the interview – 'What did you say/do to (name of alleged perpetrator) to show you wanted to have sex?' – which may have been confusing to a person with learning difficulties and the framing of the question appears to imply that Bree's conduct had been a factor in what happened to her. The main focus of follow up work by professionals seemed to be dealing with practical issues such as pregnancy, sexually transmitted infections and safeguarding her from future contact with the males as opposed to considering how the event may have made her feel. Additionally it is unclear whether work on relationships, consent, sex and sexual boundaries was done with Bree at that time and whether it was emphasised that she had the right to a safe, loving relationship. It is noted that relationships work with Bree was planned and took place the following year but the Panel questioned whether such preventative work could have begun earlier.

Recommendation 2
That the West of Berkshire Safeguarding Adults Board seeks assurance that disclosures of sexual abuse by people with learning disability/ learning difficulty/ autism are responded to effectively in that the person making the disclosure

- *is provided with advocacy and/or specialist ISVA support,*
- *that safeguarding procedures are followed,*
- *that the person making the disclosure is interviewed in a manner which takes account of their learning disability/learning difficulty/autism,*
- *is safeguarded from further harm,*
- *and any necessary relationships work is completed.*

4.13 It is suggested that the Safeguarding Adults Board considers 'seeking assurance' by commissioning a multi-agency audit of an appropriate number of cases in which people with learning disability/difficulty/autism have made disclosures of sexual offences and/or consulting agencies which provide support to people with learning disability/difficulty/autism who make disclosures of sexual offences.

Where there is suggestion of suicide risk or self-harm in particular those with Learning Disability and Autism Spectrum Condition, how do agencies work together to ensure a shared understanding of risk and a joined-up approach to risk management? – information sharing, multi-agency meetings etc.

4.14 Many of the agencies with whom Bree came into contact believed her to have a diagnosis of mild learning disability. However, when a diagnostic assessment was completed by the Psychological Services for People with Learning Disabilities in July 2019, Bree met only two of the three British Psychological Society criteria for a learning disability diagnosis (Paragraph 3.3). Bree met the criterion of a 'significant impairment in intellectual functioning', particularly in relation to slow processing and poor cognitive abilities. She also met the criterion of 'age of onset before adulthood'. However, in terms of the third criterion – 'significant impairment of adaptive and social functioning', Bree scored below average but above the learning disability range. The assessment report concluded that given Bree's level of ability, any future psychological work could be met by mainstream services.

4.15 The learning disability psychology service remained involved in supporting Bree whilst she transitioned to mainstream services – and referred Bree to Psychiatry in September 2017 for an assessment. She was seen in an outpatient appointment in January 2018. Bree was formally closed to Learning Disability Psychology in July 2018. However, Bree continued to have six monthly outpatient appointments with the Learning Disability Consultant Psychiatrist for a time.

4.16 The main issue arising from professional's misunderstanding of Bree's diagnosis was that at several key points in their contact with Bree, professionals considered a referral to Learning Disability services to be a viable option until they were advised that she did not meet the criteria for Learning Disability services. For example when the CPE conducted a telephone risk triage with Bree on 11th January 2022 they noted that once stable, Bree may benefit from support from the Learning Disability team as she had been open to them in the past; on 17th January 2022 a Wokingham Borough Council senior manager advised Bree's social worker to contact Learning Disability Intensive Support to enquire as to what support they could offer and on 18th January 2022 Bree was discussed in a CRHTT team meeting, where the plan agreed included a referral to the Community Team for People with Learning Disabilities (CTPLD).

4.17 Therefore a referral to Learning Disability services was under active consideration by several professionals during the period when Bree was presenting in crisis and the prospect of support from Learning Disability services was initially regarded as a not unimportant part of planning for Bree until professionals were promptly advised that Bree was not eligible for that service. It is encouraging that the CRHTT was able to have a consultation with the CTPLD when they were considering referring Bree to that service. However, the CTPLD could have considered providing advice to assist professionals in supporting Bree when she was presenting in crisis notwithstanding that she was not eligible for a referral to CTPLD. It is noted that the period when Bree was under the care of Learning Disability services (early 2017 until July 2018) appeared to be a relatively stable period in respect of Bree's mental health and wellbeing.

4.18 In her contribution to the SAR, Friend 2 said that Bree had been 'really upset' that she was not considered to have a learning disability and was 'frightened' that she would get 'thrown out' as professionals no longer needed to support her. Provider A shared Bree's concerns that her support hours would be reduced following the 'reassessment of her learning difficulties' with her social worker. The SAR has been advised that Bree had been informed in-person and by letter that she did not have a learning disability diagnosis in 2017. However, if Bree became aware of professionals' intentions to refer her to learning disability services - and the subsequent declining of those referrals - this may have contributed to the anxieties she expressed to the primary care specialist mental health practitioner she saw on the day before she fell from the bridge (Paragraph 3.13). During this consultation Bree is documented to have said that she was unhappy with her social worker 'going around in circles', saying she was 'mainstream' and saying she 'can do more when she can't'.

4.19 It is noted that Bree said that she needed support to understand her safety plan prepared prior to her discharge from the CRHTT in February 2022. The BHFT Serious Incident Report states that it was not clear what steps were taken to adapt this process to increase her understanding given her learning difficulties. The SAR notes that no safety plan was completed with Bree when the CRHTT previously discharged her from their care in May 2021. The BHFT Serious Incident Report also noted no evidence of any adjustments being made to mental health services for Bree's learning difficulties. The Equality Act 2020 requires public sector organisations to make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else[4]. The fact that Bree did not have a formal learning disability diagnosis does not make any difference to this requirement as the Care Act includes the requirement that, 'Information and advice provided under this section must be accessible to, and proportionate to the needs of, those for whom it is being provided'[5]. BHFT has advised this SAR that safety planning should be seen as an ongoing multi-agency intervention.

Recommendation 3
That the West of Berkshire Safeguarding Adults Board obtains assurance from the Berkshire Healthcare NHS Foundation Trust that the Crisis Resolution and Home Treatment Team works in partnership with involved partner agencies
(i) to complete safety plans with patients prior to discharge
(ii) to ensure that reasonable adjustments are made to enable the patient to understand their safety plan and that
(iii) the safety plan is shared with involved professionals from partner agencies.

Autism

4.20 When Bree was first referred to the Learning Disabilities Service Psychology team in 2016, she is documented as believing that she had ASC but this was not formally assessed at that time. During 2019 there was a discussion between the CPE and Wokingham Borough Council about referring Bree for an ASC assessment and it was documented that arrangements had been made for Bree's GP to make the referral. Bree's GP practice has no record of being asked to refer Bree for an ASC assessment. It appears that Provider A were to be asked to follow this up with Bree's GP but they also have no record of this. Self-referrals are not accepted by the Adult Autism Assessment Team.

4.21 It is not known whether ASC was considered during Bree's childhood but it is not unusual for autism to be missed, or diagnosed late in girls as they may hide some signs of autism by copying how other children behave and play, withdraw in situations they find difficult, appear to cope better with social situations and show fewer signs of repetitive behaviours[6].

4.22 It is noted that at the time Bree's GP made a crisis referral to CPE in May 2021 she said that she been stressed due to work taking place in the kitchen and bathroom of her home and that when the CRHTT later visited her after she took an overdose of paracetamol, they documented that Bree found living in her home very difficult with little personal space in a fairly small town house - which was noted to be undergoing significant renovation work to the kitchen and bathroom with associated disruption. The National Autistic Society advises

[4] Equality Act guidance. https://www.gov.uk/guidance/equality-act-2010-guidance
[5] Care Act Statutory Guidance. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[6] National Autistic Society. https://www.autism.org.uk/advice-and-guidance/what-is-autism/autistic-women-and-girls

that where a person with autism is 'over-sensitive' to noise, the noise can be magnified and sounds can become distorted and muddled. Additionally a person with autism may have an inability to cut out sounds – notably background noise – leading to difficulties concentrating[7]. The SAR notes the current roll out of the Oliver McGowan training on learning disability and autism which will help professionals adopt an autism sensitive approach.

4.23 Turning to the question of how agencies work together to ensure a shared understanding of risk and achieve a joined-up approach to risk management, there was an important difference of view over the triggers for Bree's self-harming and suicidal ideation during the period she was in crisis in January and early February 2022. The CRHTT formed what appeared to be quite a firmly held view that Bree's dissatisfaction with her placement was the trigger for her self-harming and suicidal ideation. This CRHTT view was also informed by their involvement with Bree in May 2021 when they documented that Bree found living in her home very difficult and that this intruded on Bree's independence. The increased daily support in her existing placement, the impending move to her new placement in Address 3, together with the fact that Bree had begun staying with her father - with whom she said she felt safer - was a combination of factors which led the CRHTT to believe discharge from their service was appropriate. When the primary care mental health worker considered referring Bree back to the CRHTT on the day prior to the incident in which Bree fell from the bridge, the CRHTT did not feel that the referral was justified as they continued to feel that Bree's primary trigger was the lack of social care support.

4.24 However, Bree's dissatisfaction with her placement was of longstanding and preceded the crisis in her life which manifested itself following her return to the UK in early January 2022. Whilst her dissatisfaction with her placement certainly seemed to have increased, the growing certainty that she would be imminently moving to an alternative placement did not appear to diminish her distress and appeared to generate further anxieties for Bree. (An earlier change to a more suitable placement in which Bree may have been able to disclose issues of a sensitive nature may have been extremely beneficial).

4.25 Her Wokingham Borough Council student social worker felt that developing an understanding of why Bree was self-harming and talking of taking her own life required a deeper and more holistic approach. In particular, she felt that Bree's frequently articulated yearning to be part of a family environment needed to be fully explored. The Extraordinary SAR Panel established to oversee this SAR felt that Bree appeared to have been searching for a family environment in which she would be accepted ever since she left her family home in 2017.

4.26 Additionally, the dynamics of previous relationships may have been worthy of further exploration.

4.27 Bree gravitated back towards her birth family in the period immediately prior to the incident which led to her death which was generally viewed as a protective factor by professionals. Her social worker encouraged the development of the relationship between Bree and her family.

4.28 The Extraordinary SAR Panel felt that whilst Bree was not as complex as some people who are seen by mental health and social care services, she was more complex than she appeared to be in terms of social and relational matters, as opposed to psychiatric matters.

4.29 There was much effective information sharing between the CRHTT, Provider A, Bree's Wokingham social worker and Bree's GP Practice although there was not a sufficiently full

[7] National Autistic Society. https://www.autism.org.uk/advice-and-guidance/topics/sensory-differences/sensory-differences/all-audiences

understanding of her history, in particular the fact that she did not have a mild learning disability diagnosis, the fact that she had disclosed a rape in 2020 or that concerns in respect of possible sexual exploitation had surfaced in 2021. However the approach to risk assessment and management was not fully joined up. The CRHTT took the lead in assessing risk and there did not appear to be any system or process to encourage or facilitate a joint approach to understanding and assessing risk in Bree's case. As a result the CRHTT formulation of risk and the social worker's perspective were not brought together.

4.30 The National Confidential Inquiry into Suicide and Safety in Mental Health's study entitled *The assessment of clinical risk in mental health services* suggests ways in which clinical risk assessment processes might be improved. The study recommends that the emphasis should be on building relationships; and gathering good quality information on (i) the current situation, (ii) past history, and (iii) social factors to inform a collaborative approach to management[8]. It is unclear whether a more collaborative approach to risk management would have affected the outcome for Bree but it is in the interests of patients for the differing perspective of professionals in contact with them to be shared.

4.31 The study also recommended that families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. This was a complicated issue for professionals to manage in Bree's case as her parents became more involved in her life during the period in which she presented in crisis after a number of years in which other people, particularly Friends 1 and 2 had become involved in supporting Bree.

Recommendation 4
That the West of Berkshire Safeguarding Adults Board requests the Berkshire Healthcare NHS Foundation Trust to consider what steps need to be taken to enable their approach to clinical risk assessment in mental health services to become more collaborative and provide a report on the outcome to the Safeguarding Adults Board.

4.32 Looking back at professional involvement with Bree during the period in which she was presenting in crisis, although there is substantial evidence of collaboration between the CRHTT, Bree's social worker and Provider A, there are indications of professional disagreement. On 26th January 2022 Bree's social worker expressed concern about the CRHTT plans to discharge Bree, which the CRHTT agreed to discuss with their manager. On 1st February 2022 Bree's social worker contacted the CRHTT and explained that Bree had missed her medication for 4 days, was 'struggling to keep her mental health under control' and needed further input from the CRHTT. The CRHTT practitioner advised that this would be discussed at the CRHTT MDT the following day (2nd February 2022) when the decision to discharge Bree was confirmed. On 16th February 2022 – the day on which Bree fell from the bridge – Bree's social worker and her supervisor discussed how difficult it was proving to obtain services for Bree and the social worker was advised to make a referral through CPE for a full assessment of Bree as soon as possible – and if this was declined – to escalate to a manager. With hindsight, it may have been preferable for the social worker to have been supported to escalate her concerns sooner.

4.33 The West of Berkshire SAB has a safeguarding escalation protocol - 'Resolving Professional Disagreements In cases that meet the statutory criteria for Safeguarding Adults Escalation Policy' (March 2023) but this would not have applied in this case as the escalation policy relates only to professional disagreements which arise in cases which meet

[8] The Assessment of Clinical Risk in Mental Health Services. https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/

the statutory criteria for safeguarding adults. The independent reviewer suggests that the West of Berkshire SAB may wish to consider broadening their Resolving Professional Disagreements Policy to include cases which fall outside the statutory criteria for safeguarding adults. However, the SAR Extraordinary Panel do not agree with this suggestion as they feel that broadening the Policy could increase the pressure on an already stretched safeguarding system.

How do agencies work together to ensure all relevant history is known so that there can be trauma informed and attachment informed approach to risk management (To include consideration on how commissioned providers are equipped to work in this way).

4.34 Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development[9]. An attachment-based approach to therapy looks at the connection between early attachment experiences and the person's ability to develop healthy emotional and physical relationships as an adult. Attachment-based therapy aims to build or rebuild a trusting, supportive relationship that will help prevent or treat mental health conditions such as anxiety and depression[10]. (When considering therapy, it is necessary to recognise the limitations of therapy alone when there are relational and social complexities present).

4.35 Both approaches depend to an extent on all relevant history being available to practitioners. It proved challenging to ensure agencies had a shared and complete understanding of Bree's history. Wokingham Borough Council were aware of the work completed by the Learning Disability Service with Bree in 2017 and 2018 and made use of a report prepared by Learning Disability to inform their assessments of her needs. However, by the time Bree began presenting in crisis in January and February 2022, Wokingham appear to have lost sight of the fact that Bree was not eligible for learning disability services.. At the practitioner learning event arranged to inform this SAR, CRHTT colleagues said that they were unaware of Bree's 2020 disclosure of rape. The indications that Bree may have been subject to sexual and financial exploitation had not been fully explored and so they seem unlikely to have featured prominently in Bree's records. The possibility that Bree might have unassessed ASC had also been lost sight of. Bree had been allocated a new (student) social worker on 15th November 2021 but her efforts to arrange an early meeting with Bree were frustrated by her imminent departure to stay with Friend 2 abroad. When Bree returned to the UK in January 2022 she immediately began presenting in crisis and so there was very limited opportunity for the social worker to spend time with Bree in a non-crisis situation in order to gain a full understanding of her history.

4.36 During the period in which Bree was presenting in crisis in January and February 2022 she began reconnecting with her family. The extent to which her parents would have been aware of the key events in Bree's life after she left the family home in 2017 is unknown. There may have been benefit in professionals speaking to either Friend 1 or Friend 2 – with Bree's consent – who have both contributed to this SAR and appear to be very aware of Bree's history and have shared valuable insights into the impact of life experiences on Bree's presentation.

4.37 Although there was evidence of information sharing and joint working between professionals during the period in which Bree was presenting in crisis in January and

[9] Working Definition of Trauma-Informed Practice. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

[10] Psychology Today. https://www.psychologytoday.com/gb/therapy-types/attachment-based-therapy

February 2022, no multi-agency meeting was held – which would have been a valuable opportunity to take stock of Bree's circumstances and ensure that all partner agencies had a shared awareness of Bree's relevant history.

4.38 The SAR is asked to comment on how commissioned providers are equipped to work in a way in which relevant history is utilised to inform a trauma-informed and attachment informed approach to risk management. The SAR has been advised that this question refers to commissioned services as a whole. In particular, when care is commissioned for someone do the processes, documents and information sharing protocols support good sharing of relevant information to support this, do providers exist who have sufficient training and expertise to work in this way and are there enough of them to meet demand? *These are important questions which appear to be beyond the scope of this SAR to answer as the combined chronology of agency contact with Bree contains little information about how the services she received were commissioned.*

How is all of this supported by the Berkshire suicide strategy, particularly in relation to those persons with Learning Disability / Autism Spectrum Condition? and How does the suicide prevention strategy in Berkshire ensure multiagency learning from deaths by suicide through shared learning reviews?

4.39 Suicide prevention is a national responsibility and local authorities have a statutory duty to develop a local suicide prevention strategy and action plan which engages a wide network of stakeholders in reducing suicide. The Berkshire Suicide Prevention Partnership group meets regularly and works collaboratively to prevent suicide. In Berkshire West, each of the three unitary authorities is now developing a local action plan to sit beneath the Berkshire strategy.

4.40 At the Thames Valley level, the Suicide Prevention and Intervention Network (SPIN) - comprising of specialists, champions and people with lived experience of suicide and attempted suicide - aims to contribute to the reduction of suicide and improvement of resources for those at risk of, or affected by, suicide. SPIN seeks to influence commissioning and planning to encourage regional working.

4.41 The Berkshire Suicide Prevention Strategy 2021-26 is highly relevant to this SAR. Female Suicide Deaths was identified as a Priority Area after the Berkshire Suicide Prevention Group agreed that the number of female suspected suicides in Berkshire was sufficiently unusual to convene a response group to look at cases in more depth. A sub-group was therefore formed to carry out a deep-dive review. Although the numbers are too small to identify statistically significant themes, several themes were identified for more than one of the women who died, namely:
a. A mental ill-health diagnosis and /or history of contact with mental health services (found to be the case for all women where it proved possible to obtain further information from GP records); b. Adverse Childhood Experiences - most often related to sexual abuse, but also loss of or separation from parents; c. History of self-harm; d. History of alcohol or substance abuse; e. Parenting / carer stress; f. Financial stress; g. Domestic abuse; h. Workplace stresses and adjustment challenges, particularly for those in a health, care or other frontline role (including childcare and police); i. Neurodiversity; j. Bereavement and grief; k. History of disordered eating and l. Denial of suicidal intent at the time of last contact with services

4.42 Of the themes listed above, a, b, c, i (undiagnosed) and k were present in Bree's case. Domestic abuse from a former partner may also have been present although this may also have taken the form of sexual exploitation. Financial stress may have been apparent in the form of financial abuse which Bree reported on two occasions.

4.43 The Berkshire Suicide Prevention Strategy also needs to take note of the recently updated England Suicide Prevention Strategy (2023-2028) which includes 'autistic people' as a priority group for the first time on the grounds that autistic people may be at higher risk of dying by suicide compared with those who are not autistic[11]. Undiagnosed or late diagnosed autism is identified as a possible preventable risk factor for suicide and so earlier identification and timely access to autism assessment services is described as 'vital'. Undiagnosed autism may have been a factor in Bree's case. It would therefore be of value to share the SAR report with the Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and Intervention Network (SPIN).

Recommendation 5
That the West of Berkshire Safeguarding Adults Board share this SAR report with the Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and Intervention Network (SPIN), so that the learning from this SAR can inform work to prevent female suicide deaths.

4.44 The Extraordinary SAR Panel considered whether the existing annual multi-agency conference arranged by the Berkshire Suicide Prevention Partnership Group could be an appropriate forum through which to share learning from reviews of deaths by suicide. Mindful of resources, the independent reviewer was minded to recommend that the conference could be a useful forum for multi-agency learning from suicides arising from Mental Health NHS Trust Serious Incident Reviews, LeDeR reviews and any Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews involving an apparent suicide. However the Extraordinary Panel did not feel that this was sufficient as SARs would only be commissioned in cases of suicide when abuse or neglect was present and NHS Serious Incident Reviews are not multi-agency processes. Therefore it is recommended that a multi-agency learning process distinct from the existing multi-agency conference is developed and that the responsibility for leading this work rests with the Berkshire Suicide Prevention Partnership group.

Recommendation 6
That the West of Berkshire Safeguarding Adults Board shares the SAR report with the Berkshire Suicide Prevention Partnership group and requests the group to consider developing a multi-agency process for sharing and disseminating learning from deaths by suicide.

4.45 There would also be value in the three West of Berkshire Borough Councils sharing their draft suicide prevention plans with the West of Berkshire Safeguarding Board as part of the consultation process (It is suggested that this proposal could be included in the Safeguarding Adults Board multi-agency action plan to be developed in response to the learning from this SAR).

In Bree's situation what would best practice looked like?

Areas of effective practice:

4.46 There was much effective practice during the period in which Bree presented as in crisis in January and February 2022. Bree's GP made an urgent referral to the CPE after her overdose of Nurofen tablets on 10th January 2022. This led to Bree promptly receiving support from the CRHTT from 12th January until 2nd February 2022. The CRHTT arranged a

[11] Suicide Prevention Strategy for England 2023-2028. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy

medication review, maintained regular contact with Bree, monitored her risk to self and advised her on distraction techniques. Wokingham Borough Council increased Bree's support hours and accelerated Bree's move to supported accommodation at Address 3 and consulted Bree over the support she would receive there including support with meal preparation and community access. Bree's social worker encouraged Bree's father to spend regular family time with her each weekend. Provider A were assiduous in reporting concerns to Bree's Wokingham social worker and followed up with Reading Borough Council when they did not receive a prompt response to their safeguarding referral. When the CRHTT discharged Bree, she was reported to be eating and sleeping well with no clinical symptoms of depression although there was ongoing superficial self-harm.

4.47 The CRHTT advised Bree to self-refer, with the support of Provider A, to SUN which is a BHFT provided service which helps people living with an emotionally unstable personality disorder, or who are struggling with different parts of their personality such as your emotions, impulsivity, self-worth, or relationships. Help is provided through SUN's community peer support groups across Berkshire. People can access the service whether they have a formal diagnosis or not. The aim of the service is to support people in the community and reduce the need for further intervention from crisis services. There is no indication that Bree referred herself to SUN. It is unclear if she was prompted or encouraged to self-refer – which can be done by phone or email. It is not known whether there is any waiting time for support or whether Bree would have found the peer group approach suitable. Following her discharge by the CRHTT, there was then an interval of 12 days prior to Bree visiting her GP Practice to report feeling low. Bree was promptly offered an appointment with the primary care specialist mental health practitioner who initially discussed a referral back to the CRHTT before providing reassurance over the imminence of her move to Address 3.

Areas in which practice could have been improved.

4.48 There is no indication that partner agencies considered a professionals meeting during the period in which Bree was presenting in crisis.

4.49 The BHFT Serious Incident report notes that 'there does not appear to have been a request for clinical advice or consultation from the learning disability service, only referrals for direct input'. It is unclear whether professionals from all relevant disciplines are aware that there is a facility to request clinical advice or consultation from the learning disability service.

Recommendation 7
That the West of Berkshire Safeguarding Adults Board request the Berkshire Healthcare NHS Foundation Trust to promote awareness of the offer of clinical advice or consultation available from the Learning Disability Service to relevant partner agencies.

4.50 As previously stated it would have been beneficial to have assessed the risks to Bree jointly so that the subtly different assessments of risk arrived at by the CRHTT and Bree's Wokingham social worker could have been brought together. (Recommendation 4).

4.51 Bree could have been referred to the Community Mental Health Team. The BHFT Serious Incident report concluded that Bree should have been referred for a period of care under the CMHT, in light of her medication regime, escalating needs and the fact that she met the criteria for Care Cluster 7/8 pathway[12]. The CRHTT felt that Bree was not suitable

[12] The Department of Health requires that all people under the care of adult mental health services are allocated to a Care Cluster by their Mental Health Service provider. The purpose of this is to ensure that people are offered the right care and interventions using evidence based practice which is personalised to meet individual needs. The Care Cluster may change over the course of a person's treatment. Care Cluster 7 relates

for the CMHT and colleagues from the CRHTT who attended the practitioner learning event continued to take this view. The BHFT Serious Incident report authors felt that Bree may have benefitted from CMHT psychiatry and care coordinator input as well as an opportunity for safety plan adaptations. It is not known whether Bree would have been accepted by the CMHT had a referral been made. The CMHT's stated purpose is to help treat and support people for severe and complex mental health difficulties.

4.52 However, the BHFT Serious Incident Report authors acknowledged that the current system for allocating a care pathway is very subjective and there is high variation and different thresholds within and between teams resulting in patients receiving crisis support and reactive interventions. It would be of value to address this lack of consistency so that there is clarity within mental health services and those considering referring into mental health services. The BHFT SIR makes no recommendation in respect of this issue because the Trust has embarked on a significant programme of work around this.

Recommendation 8
That the West of Berkshire Safeguarding Adults Board requests Berkshire Healthcare NHS Foundation Trust to address the subjectivity, variation and different thresholds within the current system for allocating a care pathway and inform the Safeguarding Adults Board of the outcome of this work.

4.53 Bree did not benefit from the support of an advocate during a time when she was presenting in crisis and was also being supported to move to a placement in which her support hours were to be managed differently.

4.54 Reasonable adjustments were not always made for Bree's learning difficulty, for example in providing her with support to fully understand her safety plan (Recommendation 3).

4.55 A lack of clarity over when a safeguarding referral may be justified in response to suicidal ideation/self-harm and alternative pathways to follow should a safeguarding referral not be appropriate has been commented upon earlier in the report, as has Reading Borough Council's delay in responding to the safeguarding referrals submitted by Provider A and SCAS.

4.56 Bree twice left the RBH hospital during the period when she was in crisis, potentially missing two medical reviews. However, it would have been very challenging for Provider A to support unplanned hospital attendances and periods of waiting for treatment.

4.57 The CRHTT felt that Bree did not meet the criteria for admission under the Mental Health Act and reiterated this view at the practitioner learning event. A Mental Health Act assessment was not considered as an option in the BHFT Serious Incident Report. The two friends of Bree who have contributed to this SAR feel that this could have been considered.

Recent developments:

The Mental Health Integrated Community Service (MHICS) is a multi-disciplinary team established to support people with significant mental illness. The aim of the service is to provide early intervention to prevent escalation to services for serious mental illness. Mental health workers in primary care are amongst the professionals who can refer in.

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to 'Enduring high disability non-psychotic disorder' and Care Cluster 8 relates to 'non-psychotic chaotic and challenging disorders'.

The Managing Emotions Programme (MEP) is part of the personality disorder pathway. The Managing Emotions Programme is a range of courses designed to equip people with the tools and skills needed to manage overwhelming emotions more effectively.

Outreach workers – an Outreach Worker is currently based in each of the A&E psychological medicine services in the Royal Berkshire Hospital, Reading and the Wexham Park Hospital, Slough. This is a joint project involving BHFT and MIND, the aim of which is to offer follow-up support - in developing a safety plan and making a connection with relevant community support services - for those patients who would ordinarily have been discharged back to the care of their GP Practice. The outreach workers will provide face to face follow up where possible to help the patients implement their safety plans. The service will not provide psychological therapy or crisis support and is not an emergency service but will, in collaboration with other community resources, promote connection and reduce isolation, improve coping skills, signpost to other sources of support including escalation and provide educational strategies to help with difficulties which triggered the self-harm or distress.

(BHFT) Integrated Multi-Disciplinary Team at which complex cases can be discussed to enable a clear formulation of risk and needs. This forum will ensure the person gets the most suitable pathway and care plan to enable the patient to achieve their personal and treatment goals. It is also a place where important information can be shared across agencies pathways, for example, the primary care mental health worker could present a case here to ensure the correct pathway is in place, adult social care staff can attend to share any concerns.

The case for commissioning a new service.

4.58 The overall impression gained from completing this SAR is that the step down from CRHTT to primary care was too large a step for Bree - and those supporting her - to safely manage and that this was a situation exacerbated by Bree's ineligibility for the Learning Disability Service. The Extraordinary SAR Panel concluded that the learning from this SAR evidences a need for a robust supported living approach for young women who have complex trauma. A model which commissioners may wish to consider to inform this robust supported living approach is the Elmore complex needs floating support service which is provided by a charity which BHFT has previously commissioned elsewhere to provide support to people with a wide range of complex needs, who are at risk of falling between the gaps of existing services. Alongside the Trust's existing offer, Elmore provides innovative ways to build trust, increase patients' engagement with relevant agencies and deliver support tailored to the people who need it. The target group is those who have multiple support needs and complexity such as homelessness and rough sleeping, substance misuse, offending, physical disability, self-harm, learning difficulties, domestic abuse, sex working, or experience of abuse and neglect. The Elmore model would also need to be supported by an investment in dedicated supported housing placements.

Recommendation 9 (priority recommendation)
That the West of Berkshire Safeguarding Adults Board shares this SAR report with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) and invites the ICB to consider commissioning a robust supported living service for young women who have experienced complex trauma.

Safeguarding Case Review Multi Agency Action Plan
Bree SAR

BRAG STATUS KEY	Blue	Red	Amber	Green
	Action Embedded	Action not being implemented or serious delays/concerns identified or Action being implemented but with possible delays/concerns	Action being implemented and on track for completion within timescales	Action Completed
Dates discussed	Endorsed by SAR Panel Virtually 5/2/24.			

No	Recommendations	ACTION REQUIRED	BY WHEN	LEAD Agencies OFFICER(S)	OUTCOME TO BE ACHIEVED	BRAG STATUS	ACTIONS COMPLETED WITH EVIDENCE
1	That the West of Berkshire Safeguarding Adults Board further develops the Safeguarding Decision Tool to include advice on pathways to consider when a safeguarding concern is not determined to be an appropriate response to the risk of self-harm and/or suicide.	Review the What-do-referrers-need-to-consider-before-deciding-to-raise-an-adult-safeguarding-concern-V.1.0.pdf (sabberkshirewest.co.uk) document that was published in November 23, and consider if any further information is required on suicide idealisation in response to the learning from the SAR.	Feb 24	SAR Panel	The SAR Panel is assured that appropriate suicide pathway information is on the tool.		The SAR panel spent a lot of time considering how to refer to suicide idealisation when creating the document. It was the consensus of the SAR Panel that the toolkit needed to be clear that suicide idealisation is not a safeguarding concern unless the idealisation is thought to be triggered from abuse or neglect.
2	That the West of Berkshire Safeguarding Adults Board seeks assurance that disclosures of sexual abuse by people with learning disability/ learning difficulty/ autism are responded to effectively in that the person making the disclosure • is provided with advocacy and/or specialist ISVA support, • that safeguarding procedures are followed, • that the person making the disclosure is interviewed in a manner which takes account of	Assurance will be sought via the annual case file audit peer review that is undertaken, each LA will be required to submit safeguarding enquiries that fit these criteria and at least one per Local Authority Area will be audited.	Oct 24	Performance and Quality Subgroup	Assurance obtained via the SAB's QAF actions.		The case file audit peer review process is current under review, it is anticipated that this will go live in April 24. Delays to this will impact on this recommendations progress.

	their learning disability/learning difficulty/autism, • is safeguarded from further harm, • and any necessary relationships work is completed.						
3	That the West of Berkshire Safeguarding Adults Board obtains assurance from the Berkshire Healthcare NHS Foundation Trust that the Crisis Resolution and Home Treatment Team works in partnership with involved partner agencies (i) to complete safety plans with patients prior to discharge (ii) to ensure that reasonable adjustments are made to enable the patient to understand their safety plan and that (iii) the safety plan is shared with involved professionals from partner agencies.	Berkshire Healthcare Foundation Trust will be required to complete an audit, to provide the assurance required. Points (i) and (iii) have been amended slightly as consent needs to be obtained in order to share their safty plans. (i) To complete safety plans with patients prior to discharge and encourage patients to share their safety plan with other agencies who are involved (or could be involved in their care. (iii) Consider the role of other professionals as part of a safety plan and if they are named in a safety plan ensure that they are aware of this.	Aug 24	Berkshire Healthcare Foundation Trust	Assurance received through a SAB approved audit process.		The terms of reference will be presented to the P&Q subgroup in May 24 and the audit report in August 24.
4	That the West of Berkshire Safeguarding Adults Board requests the Berkshire Healthcare NHS Foundation Trust to consider what steps need to be taken to enable their approach to clinical risk assessment in mental health services to become more collaborative and provide a report on the outcome to the Safeguarding Adults Board	Berkshire Healthcare Foundation Trust to provide a formal response to this recommendation to the SAB.	Apr 24	Berkshire Healthcare Foundation Trust	Assurance that BHFT have carefully considered the learning from this SAR and will use this learning to ensure a more collaborate approach to risk assessments.		Response will be considered by the SAR Panel and the SAB Independent Chair.
5	That the West of Berkshire Safeguarding Adults Board share this SAR report with the Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and Intervention Network (SPIN), so that the	Report will be sent to Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and Intervention Network (SPIN), on publication of the SAR with a request for a response on what action they will be	Mar 24	Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and	Assurance that the Groups/Networks have carefully considered the learning from this SAR and will use this learning to		Response will be considered by the SAR Panel and the SAB Independent Chair.

	learning from this SAR can inform work to prevent female suicide deaths.	taking to prevent female suicide deaths in response to learning from this SAR.		Intervention Network (SPIN)	inform the work to prevent female suicide deaths.		
6	That the West of Berkshire Safeguarding Adults Board shares the SAR report with the Berkshire Suicide Prevention Partnership group and requests the group to consider developing a multi-agency process for sharing and disseminating learning from deaths by suicide.	Report will be sent to Berkshire Suicide Prevention Partnership Group and the Thames Valley Suicide Prevention and Intervention Network (SPIN), on publication of the SAR with a request for a response on what action they will be taking to support learning from deaths by suicide.	Mar 24	Berkshire Suicide Prevention Partnership Group	Assurance that the Groups have carefully considered the learning from this SAR and will use this learning to inform the work to prevent female suicide deaths.		Response will be considered by the SAR Panel and the SAB Independent Chair.
7	That the West of Berkshire Safeguarding Adults Board request the Berkshire Healthcare NHS Foundation Trust to promote awareness of the offer of clinical advice or consultation available from the Learning Disability Service to relevant partner agencies.	A request will be made to BHFT to provide evidence of their promotion to the SAB.	Apr 24	Berkshire Healthcare Foundation Trust	Assurance that the offer of Learning Disability Service is promoted across the partnership.		The response will be considered by the Communication and Publicity Subgroup.
8	That the West of Berkshire Safeguarding Adults Board requests Berkshire Healthcare NHS Foundation Trust to address the subjectivity, variation and different thresholds within the current system for allocating a care pathway and inform the Safeguarding Adults Board of the outcome of this work.	Berkshire Healthcare Foundation Trust to provide a formal response to this recommendation to the SAB.	Apr 24	Berkshire Healthcare Foundation Trust	Assurance that BHFT have carefully considered the learning from this SAR and have used it to inform work around care pathway thresholds.		Response will be considered by the SAR Panel and the SAB Independent Chair.
9	**Priority Recommendation** That the West of Berkshire Safeguarding Adults Board shares this SAR report with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) and invites the ICB to consider commissioning a robust supported living service for young women who have experienced complex trauma.	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, to provide a formal response to this recommendation to the SAB.	Mar 24	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Assurance that BOB ICB have carefully considered and responded to this recommendation.		Response will be considered by the SAR Panel and the SAB Independent Chair.