A TRI-BOROUGH SAR

7 MINUTE BRIEFING

SAFEGUARDING ADULTS REVIEW SYLVIA

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ABOUT THE ADULT

Croydon Safeguarding Adult Board (CSAB), in collaboration with Bromley Safeguarding Adults Board (BSAB) and Kingston Safeguarding Adult Board (KSAB), have commissioned this Safeguarding Adult Review (SAR) after Sylvia was tragically found dead in September 2021, of a suspected drug overdose.

Sylvia was a 19-year-old British Sri Lankan woman who was known for her smile, charm, love of dancing, and artistic expression. Her youth worker described her as a "beautiful soul" and provided support to her throughout her youth.

Sylvia and her siblings became known to Kingston's Children's Social Care in 2007 due to concerns about her lack of education since age 11, exploitation, drug use, and missing episodes. Despite a care order in 2016, suitable placements were difficult to find, leading to frequent moves and a stay in a specialist unit for young people at risk of child sexual exploitation.

BACKGROUND TO THE REVIEW

Sylvia experienced developmental struggles and was later assessed as having frontal lobe impairment, which may have resulted from head trauma injuries she sustained as a child.

Sylvia's experimentation with drugs and alcohol as a teenager, including the use of a synthetic drug called Spice at 16, had devastating consequences. She suffered acute psychosis and never fully recovered, leading to long-term impacts on her mental health and cognitive function, making her more vulnerable to exploitation and leading to entrenched substance use.

Despite receiving care from Kingston as an adult, Sylvia faced multiple placements, including under a Community Treatment Order, and experienced physical and verbal outbursts that led to the breakdown of several placements. There were concerns that she was being exploited as an adult.

WHAT HAPPENED

In 2018, Sylvia was detained under the Mental Health Act 1983, due to her drug-induced psychosis, and was placed in a Child and Adolescent Mental Health Services (CAMHS) bed with the South London and Maudsley (SLaM) Mental Health Trust. She was later diagnosed with schizophrenia, emotionally unstable personality disorder, substance misuse, and a possible mild learning disability.

Sylvia, who was detained in a hospital under the Mental Health Act, went missing in 2021 and was found attempting to jump into a canal. Despite being granted s17 leave on the hospital grounds, accompanied by two staff members, she managed to evade her escorts and disappeared. Tragically, she was found deceased two days later in a flat in Croydon.

REVIEW FINDINGS

EDUCATION AND EARLY INTERVENTION

Knowledge across partner agencies of the multiple traumas Sylvia had experienced in childhood including a head injury, physical and emotional abuse, and insecure accommodation, should have resulted in early intervention and practical support to help her engage in education. A better understanding of trauma-informed care and the development of a specialist emotional health service, embedding relational practice across partner agencies would create greater resilience across support networks.

RESPONSE TO EXPLOITATION

The multi-agency response to child sexual exploitation was proactive and appropriate steps were taken to disrupt the perpetrators of abuse. However, knowledge of criminal exploitation was less well embedded, and partners acknowledge that safeguarding training for some agencies does not fully equip staff for the challenges of this complex issue.

DISCHARGE PLANNING AND S117 AFTERCARE

Due to poor understanding of Section 117 aftercare duties, Sylvia's complex mental health needs were not addressed properly, resulting in a higher risk of relapse. Mental health bed pressures led to discharge without a detailed plan, and legal options were not considered in a timely manner to ensure Sylvia's safety.

TRANSITION TO ADULTHOOD

Sylvia received good quality, person-centred support from Achieving for Children (AfC) as a child and young adult. However, the transition planning for Sylvia's post-18 complex needs, particularly mental health needs, was inadequate and lacked detail. This highlights a failure in mental health services to provide proactive care due to service pressures, and agencies did not challenge poor planning or decisions. Transitional safeguarding issues were not fully understood, resulting in significant gaps in the service Sylvia received.

UNDERSTANDING THE LEGAL AND POLICY FRAMEWORKS AND MANAGING MULTIPLE RISKS

There were gaps in legal literacy across the safeguarding partnership, which need addressing, in respect of options available to other agencies, impacting on the range and timeliness of the options that were considered in respect of safeguarding Sylvia.

S17 LEAVE AND RISK MANAGEMENT

There was a heavy reliance on the police to manage the identified risks in respect of Sylvia absconding from hospital, without adequate understanding of how information was held, and decisions would be weighed in order to identify the response. Where S17 leave is being considered, NHS Trusts must ensure that realistic risk management plans are used to mitigate risk.

RECOMMENDATIONS

- The Children's and Adult Social Care departments for each partner SAB should introduce contextual risk assessments when arranging placements for children or adults with care and support needs who are known to be at risk of sexual or criminal exploitation or substance misuse.

- To support practitioners in improving their legal literacy, particularly in relation to working with young people who have complex health, mental health and social care needs so they are fully cognisant of their duties and powers, including safeguarding responsibilities, mental capacity assessments, and S117 aftercare support.

- Family members should be seen as valued partners in the safeguarding process for young people and young people's participation should be sought, recorded, and monitored (reviewed via case file audit), when it is safe to do so.

- To raise the profile of repeated missing episodes as a safeguarding issue, to ensure front line staff understand the police response to missing episodes and promote sustainable joint responsibility for managing risk where people go missing frequently.

- To review how services are commissioned to ensure young people are supported through the transition period either by designing bespoke services for young people 16+, extending children's services post 18, or joining waiting lists for adult services pre-18.

- Partners should agree a joined-up approach across the wider partnership to improve transition planning, including for care experienced young people. This may involve setting up a transitions panel or identifying a lead practitioner to coordinate the professional network, to enable the young person's needs and choices to be met during and post-transition.